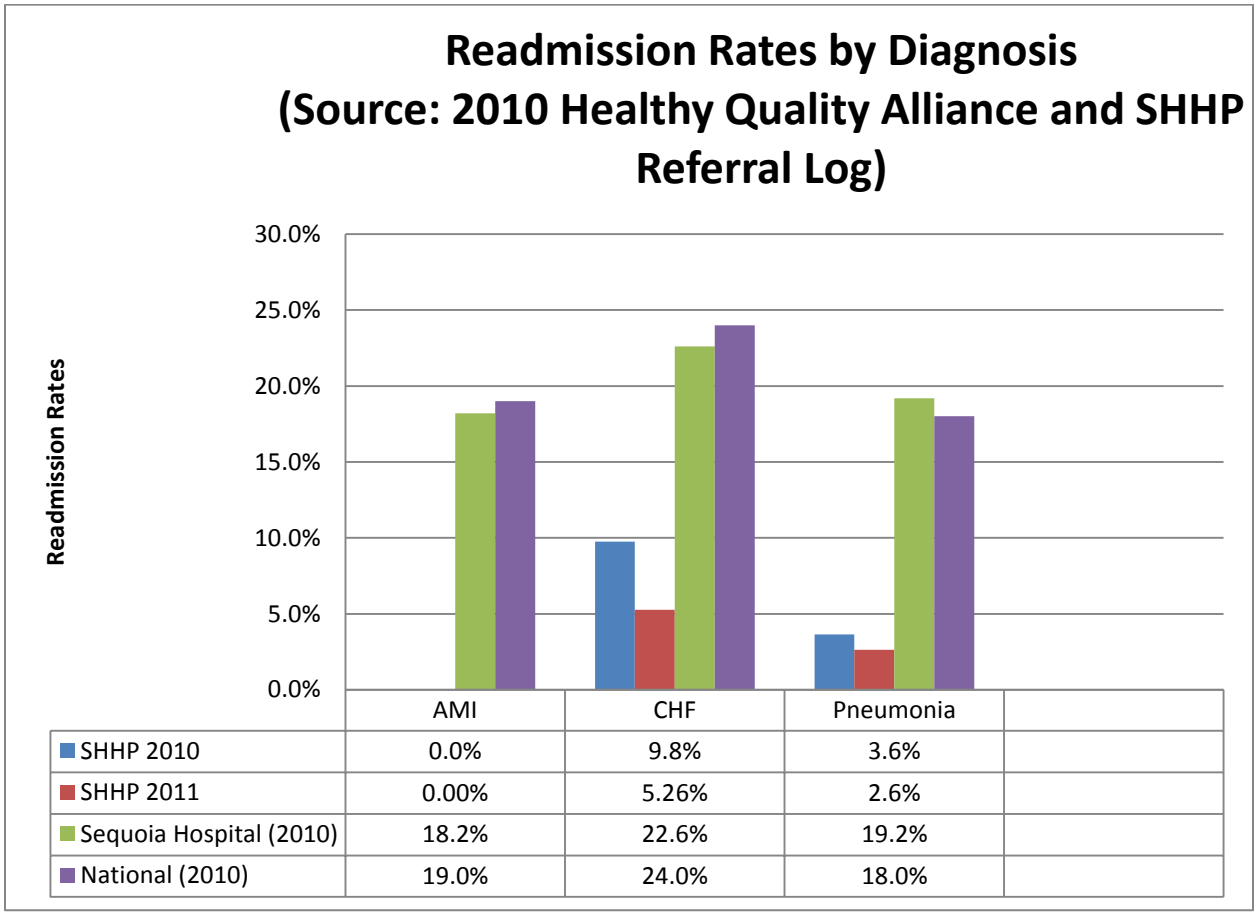
Sequoia Hospital Homecoming Project

Peninsula Family Service, Sequoia Hospital and other community partners have partnered together to develop the Sequoia Hospital Homecoming Project, a hospital-to-home transitional model. Upon leaving the hospital, many patients face multiple issues that place them at risk for readmission including isolation, language and cultural barriers that impact their ability to follow physician's orders, disability and limited mobility. As part of the Sequoia Hospital Homecoming Project, when patients aged 50 and over are discharged from the hospital, our social worker meets them in their home. He then assesses their needs and coordinates services with other community partners for nutrition, medical care management, home renovation (for example, adding ramps or grab bars in the shower) and grocery delivery during the recovery process. The goal is to support vulnerable patients, regardless of income, by helping them receive the home and health services they need to continue steady improvement and avoid readmission to the hospital.

Since it began in 2010, the program has made a significant difference in the lives of many patients and reduced hospital readmission rates. Participating patients have experienced lower rates of readmission for acute myocardial infarcation (AMI), congestive heart failure (CHF) and pneumonia. Please consider the chart below (we're the small bars!):



	AMI	CHF	Pneumonia
SHHP 2010	0.0%	9.8%	3.6%
SHHP 2011	0.00%	5.26%	2.6%
Sequoia Hospital (2010)	18.2%	22.6%	19.2%
National (2010)	19.0%	24.0%	18.0%