

# **2026 Health Equity Plan**

## **Alta Bates Summit Medical Center**

### **Overview**

At Sutter Health, we believe that every person deserves compassionate, high-quality care—no matter who they are. We are committed to addressing gaps by ensuring that patients receive the care, support, and resources they need to live a healthier life.

We recognize that factors like race, ethnicity, age, income, language, disability status, sexual orientation, gender identity, and access to services can influence health outcomes. That's why we work every day to remove barriers to care, listen to our patients' unique needs, and provide support to achieve better health.

As a national leader in healthcare quality, Sutter Health participates in the Hospital Equity Reporting Program developed and administered by California's Department of Health Care Access and Information (HCAI). This annual reporting initiative—guided by the Hospital Equity Measures Advisory Committee — requires hospitals to publicly share data on patient access, quality and outcomes across key demographic dimensions. It also includes a plan to prioritize and address identified gaps.

This strategic plan identifies the top 10 differences in health outcomes between patient groups and explains how the hospital will address those gaps. For each difference, the hospital must show which group is affected, which group is doing best, how big the gap is, and what actions will be taken to help improve outcomes.

Whether it's through linguistically and contextually appropriate care, community partnerships, or personalized health resources, we strive to create an environment where patients receive optimal care for their condition.

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**Measure:** Readmissions - All

**Description of Interventions:**

Your health and recovery continue after you leave the hospital. We're here to support you along the way. Our goal is to help you stay well and avoid an unnecessary hospital readmission by providing care that meets your needs.

During your hospital stay, your care team will talk with you about your care and discharge plans and encourage you to ask questions. We know that when patients are unclear about their diagnoses and treatment plans, it can increase the risk of hospital readmission. That's why, before you go home, we visit with you to make sure you understand your condition and care plan.

We provide health education that respects all backgrounds, to help you feel informed and confident about your care. We value effective communication when providing your care and provide medically certified interpreters – available in person, over the phone or via video – if you need assistance.

Our care management team will also conduct a review of your ongoing care needs, including medications and equipment, for your recovery at home. Before you leave the hospital, we can help you understand what to expect during recovery and can make connections to care outside the hospital as needed.

Finally, if you consent, we can screen for social factors that may affect your health—such as housing, food, or transportation—and help connect you with services like home health care, transportation, and community resources.

After discharge, our Transition of Care (TOC) team may follow up with you by phone call to answer questions and remind you about medications. This call is designed to ensure smooth and safe transitions after you've been discharged from the hospital. To keep improving, we track how many patients return to the hospital annually through the Centers of Medicare and Medicaid Services (CMS). Our results are available here:

<https://www.medicare.gov/care-compare/>

We also encourage your participation! The surveys that you complete help improve our care. Our goal is simple: to help you recover safely at home and stay healthy long after your hospital stay.

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## **Measure: Readmissions – Behavioral Health Diagnosis**

### **Description of Interventions:**

We know that recovery from behavioral health hospitalization continues when you leave the hospital. We support you in a variety of ways to help decrease your chance of returning to the hospital.

During your stay, we ensure you have a safe space to heal, with a care team that listens to you and your personal goals. We start by checking for signs of anxiety, depression, and other behavioral health needs. Screening tools are available – both in your patient portal and in paper copy – in the languages most commonly spoken in your community. Screening for mental health needs during your hospital stay helps us connect you with counselors and support services for ongoing care once you are ready to continue your recovery at home.

Before you leave the hospital, if you consent, we can screen for social factors that may affect your health—such as housing, food, or transportation—and help connect you with community resources.

Ongoing support and strong community connections are often vital to your recovery at home. We may offer telehealth options like virtual therapy and digital tools, so you can receive mental health support wherever you are.

We also monitor these readmission rates through the Center of Medicare and Medicaid Services (CMS) and patient feedback surveys to make sure our approach is working.

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## **Measure: Pneumonia Mortality**

### **Description of Interventions:**

Pneumonia, especially aspiration pneumonia, can be serious, but with early risk assessment, early detection, and proactive care, we work hard to prevent it and keep you well.

We follow evidence-based care bundles and checklists to help prevent aspiration pneumonia in the hospital. We start by identifying who may be at higher risk. Using proven screening tools, we check swallowing ability and perform regular swallow assessments. If needed, we adjust your diet and make sure you're positioned safely.

Good oral hygiene is another key step. Our team promotes and, when necessary, provides oral care at least twice daily, including tooth brushing or using suction and oral swabs if you cannot brush your teeth yourself. We also encourage early movement—even if you are on a ventilator—because mobility helps prevent complications.

Finally, Sutter's Targeted Condition Outreach program blends predictive analytics and proactive care management to help patients avoid preventable complications, including pneumonia. Nurses, pharmacists and care coordinators connect with high-risk patients, record outreach activities in the patient's electronic health record, and support timely follow-up with each patient's primary care provider.

We monitor mortality rates annually through CMS. Found here: <https://www.medicare.gov/care-compare/>

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**Measure: HCAHPS-Received Info and Education**

**Survey Question:** During this hospital stay, did you get information in writing about what symptoms or health problems to look out for after you left the hospital? *Yes, No*

**Description of Interventions:**

Communicating with our patients and their family in a way everyone understands is central to Sutter Health's commitment to connected, compassionate care. Each care team will consider preferred language, how and when information is provided, and use verbal, written, and teach-back methods to help patients feel comfortable and confident about their plan of care —during the stay and after patients leave.

As part of the care, patients and their family benefit from Sutter Health's ONE Sutter Experience framework, which guides care teams in using the Three Step Communication standard (Warm Welcome, Narrate the Care, and Fond Farewell) to build trust and teamwork. Our doctors, nurse practitioners, and physician assistants also receive Relationship Centered Care training to enhance patient engagement.

Sutter Health also manages a Patient Education Governance Committee that supports the development and publication of evidence-based, patient-friendly materials for the care team to share with patients during their care, during their visit, through My Health Online, and on our public website for easy access. The committee is multidisciplinary and patient-focused, ensuring that information about care is clear, accessible, and can be made available in the patient's preferred spoken language.

In addition to the care team sharing important information about the patient's medications, symptoms, side effects, and care plan during the stay, detailed instructions are also saved in the patient's My Health Online portal. Through the Notes and After Visit Summary, the patient has access to key information after they leave the hospital or care setting. My Health Online also connects patients to their care team for follow-up questions or visits.