

2026 Health Equity Plan

California Pacific Medical Center- Mission Bernal Campus and Orthopedic Institute

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.

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.

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.

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.

Measure: HCAHPS-Would Recommend

Survey Question: Would you recommend this hospital to friends and family? *Definitely no, Probably no, Probably yes, Definitely yes*

Description of Interventions:

Sutter is committed to delivering the most connected and compassionate care. All members of the care team are trained in relationship-centered communication practices, called the “ONE Sutter Experience.” The ONE Sutter Experience includes key actions that patients have identified as most important in their care. Each care site maintains Experience of Care action plans, monthly committees, and accountability programs. Key components of the “ONE Sutter Experience” are listed below.

- **Three Step Communication Standard** – “Warm Welcome, Narrate the Care, and Fond Farewell” provides consistent and compassionate communication in every interaction.
- **Nurse Bundle** – An effective safety and communication practice that includes:
 - Regular and purposeful rounding to check on the patient’s pain, positioning, personal needs, and room cleanliness.
 - The Patient Communication Board in the patient’s room is used to visibly document what’s most important to the patient, note names of the care team members, medication and dietary instructions, and estimated date of discharge.
 - Bedside Shift Report, where at the change of shift, the nurse leaving will join the nurse arriving at the patient’s bedside to discuss the key details about the care plan with the patient and family directly involved.
- **Additional Key Actions**
 - Care providers often connect with patients at eye level, pulling up a chair to demonstrate presence, active listening, and genuine concern for the patient. This is a standard called “Commit to Sit” and includes the placement of stools in all care settings.
 - “Working Together as a Team” is demonstrated through seamless hand-offs of information and care between the team members actively caring for the patient.
 - “First Impressions Rounding” encourages care team members to evaluate facilities for cleanliness, safety, and comfort.
 - “Connected Care” provides critical digital engagement in the My Health Online patient portal, providing patients with information about their visit history, medications, test results, and care plans.

Sutter Health engages volunteer Patient and Family Advisors to participate in leadership forums and program development.

Finally, Sutter Health invites patient feedback during and after each care visit, asking patients about their experience from start to finish, and whether they would recommend Sutter Health to their loved ones.