

Equity Report Summary

Summary Statement:

Although our data did not identify more than 10 disparities, our team remains committed to advancing health equity. We have prioritized actionable strategies to address key barriers, such as language access, and are implementing targeted interventions to improve care for underserved populations.

Equity Plan:

Although our data did not identify health disparities, our team remains committed to advancing health equity. We have prioritized actionable strategies to address key barriers, such as language access, and are implementing targeted interventions to improve care for underserved populations. Disparity: Improve access to interpreter services for non-English speakers. Expanded professional teaching materials in top languages spoken through our AMN interpreter services, including Braille. Spanish-speaking patients Population Impact: 22% of patient population Objective: Increase interpreter availability by 50% within 12 months Timeframe: Jan 2026 – Dec 2026 Actions: Professional materials developed in 2025. AMN services provided 24-7 in all languages Video/audio. Implemented on-demand video interpretation Staff training on cultural competency

Person-Centered Care:

We launched a Patient Access /patient experience committee. Feedback from PAC led to changes in meal options, visiting hours, and discharge planning. Patient satisfaction scores rose by 8% in Press Ganey surveys. We plan to expand PAC representation to include more diverse voices in 2026.

Patient Safety:

Implemented a fall prevention program using hourly rounding and bed alarms. Fall rates decreased by 5% over 12 months. Staff now receive quarterly safety training. Next steps include piloting additional risk stratification and risk prediction tools.

Social Determinants of Health (SDOH):

Began screening for food insecurity and housing instability in 2023. Partnered with local community organizations for referrals for food vouchers and temporary housing. Plan to expand screening resources by Q2 2026.

Treatment:

Standardized care pathways for stroke rehab led to a 10% reduction in length of stay and improved functional outcomes. Introduced weekly interdisciplinary rounds to ensure alignment on treatment goals.

Care Coordination:

Intend to Introduce a digital discharge planning tool that connects patients with outpatient providers and community resources. Plan to integrate with regional HIE by end of 2026.

Care Access:

Expanded referral-based services to rural areas, increasing access to necessary outpatient and home health resources. Partnered with transportation services for patients with mobility challenges. Intent to reduce 30-day readmission rates through secured post discharge services.