

Health Equity Plan

Summary of Disparities

Ranking	Measure	Stratification	Disparity group identified	High vs Low (%)	Rate Ratio
1	Readmission	Sex	Men	Men 2.8 / Women 2.1	1.333
2	Non-BH Readmission	Sex	Men	Men 2.8 / Women 2.1	1.333
3	HCAHPS Symptoms Info	Language	Spanish language	Eng 94.3 / Span 80	1.179
4	HCAHPS Recommend	Race	Asian	93.8 white / Asian 83.3	1.126
5	HCAHPS Symptoms Info	Race	Multi racial	100 Black / Multi racial 89	1.124
6	HCAHPS Recommend	Age	≥ 65	100 35-49yrs / 89.8 ≥ 65	1.114
7	HCAHPS Recommend	Payer	Medicare	96.2 Private pay / Medicare 89.9	1.070
8	HCAHPS Symptoms Info	Sex	Male	95.2 female / Male 90.9	1.047
9	HCAHPS Symptoms Info	Gender Identity	Male	95.2 female / Male 90.9	1.047
10	HCAHPS Recommend	Sex	Male	92.3 female / Male 88.9	1.038

These disparities were developed in accordance with the specifications and methodologies established by the California Department of Healthcare Access and Information (HCAI), pursuant to the requirements outlined in the California Health and Safety Code, Sections 127370–127376. Additional information regarding the Hospital Equity Measures Reporting Program and related regulations can be found at <https://hcai.ca.gov/data/healthcare-quality/hospital-equity-measures-reporting-program/#laws-and-regulations>.

Disparity #1 – Readmission by Sex

Measure	Hospital-wide Readmission Rate
Stratification Group	Sex
Best Performing Reference Group	Women (2.1% readmission rate)
Lowest Performing Group & Relative Risk (RR)	Men (2.8% readmission rate) ; RR = 1.333 vs men

Measure , Hospital-wide Readmission Rate

Stratification Group , Sex

Best Performing Reference Group , Women (2.1% readmission rate)

Lowest Performing Group & Relative Risk (RR) , Men (2.8% readmission rate) ; RR = 1.333 vs men

Actions to Address the Disparity

Population Impact: Focus on reducing readmissions among men through identification of Social Determinants of health risk factors SDOH risk factors and tailoring discharge education for men.

Measurable Objectives:

- Reduce male readmission rate from 2.8% to $\leq 2.45\%$ within 12 months.
- Narrow the readmission disparity between men and women by 50% within 12 months.

Specific Actions and Timeframes:

1. Ensure $\geq 90\%$ of male discharges are to be screened for SDOH and implement interventions to help reduce identified risk factors.

2. Strengthen discharge education for men. Implement use of the teach back method to confirm comprehension and incorporate caregivers and family in the training

Disparity #2 – Non-Behavioral Health Readmission by Sex

Measure	Non-Behavioral Health Readmission Rate
Stratification Group	Sex
Best Performing Reference Group	Women (2.1% readmission rate)
Lowest Performing Group & Relative Risk (RR)	Men (2.8% readmission rate) ; RR = 1.333 vs men

Actions to Address the Disparity

Population Impact: Focus on reducing excess readmissions among men through identification of SDOH risk factors and tailoring discharge education for men.

Measurable Objectives:

- Reduce male readmission rate from 2.8% to $\leq 2.45\%$ within 12 months.
- Narrow the readmission disparity between men and women by 50% within 12 months.

Specific Actions and Timeframes:

1. Ensure $\geq 90\%$ of male discharges are to be screened for SDOH and implement interventions to help reduce identified risk factors.

2. Strengthen discharge education for men. Implement use of the teach back method to confirm comprehension and incorporate caregivers and family in the training

Disparity #3 – HCAHPS: Information About Symptoms After Hospital Stay (Language)

Measure	HCAHPS – “Did you get information in writing about what symptoms or health problems to look out for after discharge?”
Stratification Group	Language
Best Performing Reference Group	English-speaking patients (94.3%)
Lowest Performing Group & Relative Risk (RR)	Spanish-speaking patients (80%); RR = 1.179 vs English-speaking patients

Actions to Address the Disparity

Population Impact: Ensure Spanish-speaking patients receive timely, clear, and culturally appropriate written information to reduce post-discharge complications and readmissions, while also improving their comfort and confidence in communicating with healthcare providers.

Measurable Objectives:

- Increase Spanish-speaking patient understanding of post-discharge symptoms from 80% to $\geq 90\%$ within 12 months.
- Reduce language-related disparities in discharge information by 50% within 12 months.

Specific Actions and Timeframes:

1. When possible, make provision to provide concordant care assigning Spanish speaking care providers to the care of Spanish speaking patients.
2. Train nurses and case managers in culturally and linguistically appropriate communication and education.

Disparity #4 – HCAHPS: Would You Recommend This Hospital (Race)

Measure	HCAHPS – “Would you recommend this hospital to your friends and family?”
Stratification Group	Race
Best Performing Reference Group	Highest group White: 93.8%
Lowest Performing Group & Relative Risk (RR)	Asian patients (83.3%); RR = 1.126 vs highest group

Actions to Address the Disparity

Population Impact: Implement interventions focused on the Asian patient population, with the goal of improving patient satisfaction, strengthening trust, and reducing disparities in care delivery.

Measurable Objectives:

- - Increase Asian patient recommendation rates from 83.3% to $\geq 88.55\%$ within 12 months.
- - Reduce the recommendation gap between Asian and highest performing group by 50% within 12 months.

Specific Actions and Timeframes:

1. Conduct a survey with Asian patients to identify key drivers of dissatisfaction and gather insights to guide targeted improvements in care delivery and patient experience.
2. Provide cultural competence and sensitivity training to staff to enhance understanding of the Asian patient population and improve the delivery of respectful, patient-centered care.
3. Review HCAHPS recommendation scores stratified by race quarterly and adapt interventions (ongoing).

Disparity #5 – HCAHPS: Information About Symptoms After Hospital Stay (Race)

Measure	HCAHPS – “Did you get information in writing about what symptoms or health problems to look out for after discharge?”
Stratification Group	Race
Best Performing Reference Group	100% (Black)
Lowest Performing Group & Relative Risk (RR)	Multi-Race patients (89%); RR = 1.124 vs highest group

Actions to Address the Disparity

Population Impact: Improve written discharge information and comprehension among multi-race patients to reduce post-discharge complications and readmissions.

Measurable Objectives:

- - Increase multi-race patient rate from 89% to $\geq 95\%$ within 12 months.
- - Reduce the disparity gap between multi-race and the highest group by 50% within 12 months.

Specific Actions and Timeframes:

1. Strengthen discharge education through providing education materials in the patients' preferred language for the use of interpreters and ensuring comprehension through use of the teach-back method.
2. Employee Training: focusing on providing culturally competent, patient-centered care, emphasizing cultural humility, effective communication, bias awareness, family and social dynamics, and the healthcare beliefs of the patients we serve.
3. Review HCAHPS recommendation Health education scores stratified by race quarterly and adapt interventions (ongoing).

Disparity #6 – HCAHPS: Would You Recommend This Hospital (Age)

Measure	HCAHPS – “Would you recommend this hospital to your friends and family?”
Stratification Group	Age
Best Performing Reference Group	100% (35-49yrs)
Lowest Performing Group & Relative Risk (RR)	Age >65 (89.8%); RR = 1.114 vs highest group

Actions to Address the Disparity

Population Impact: Improve hospital recommendation ratings among patients >65 by enhancing communication, comfort, and post-discharge support efforts.

Measurable Objectives:

- - Increase patient recommendation rates for >65 from 89.8% to ≥95% within 12 months.
- - Reduce the recommendation gap between >65 and the highest performing group by 50% within 12 months.

Specific Actions and Timeframes:

1. Conduct patient experience surveys for >65 group to identify areas of concern.
2. Train staff in enhanced communication and education strategies for patients over 65, incorporating plain language, teach-back, visual aids, and techniques for addressing hearing, vision, or cognitive challenges. The training will also include the *Commit to Sit* approach, with an emphasis on clarity and empathetic patient interactions.
3. Review HCAHPS recommendation scores by age quarterly and adapt interventions.

Disparity #7 – HCAHPS: Would You Recommend This Hospital (Payer)

Measure	HCAHPS – “Would you recommend this hospital to your friends and family?”
Stratification Group	Payer
Best Performing Reference Group	96.2% (private pay)
Lowest Performing Group & Relative Risk (RR)	Medicare patients (89.9%); RR = 1.070 vs highest group

Actions to Address the Disparity

Population Impact: Improve hospital recommendation ratings among Medicare recipient patients >65 by enhancing communication, comfort, and post-discharge support efforts.

Measurable Objectives:

- - Increase patient recommendation rates for Medicare patients 89.8% to ≥93.05% within 12 months.
- - Reduce the recommendation gap between Medicare recipients and highest performing group by 50% within 12 months.

Specific Actions and Timeframes:

1. Conduct patient experience surveys for Medicare patients to identify areas of concern.
2. Train staff in enhanced communication and education strategies for patients over 65, incorporating plain language, teach-back, visual aids, and techniques for addressing hearing, vision, or cognitive challenges. The training will also include the *Commit to Sit* approach, with an emphasis on clarity and empathetic patient interactions.
3. Review HCAHPS recommendation scores by age quarterly and adapt interventions.

Disparity #8 – HCAHPS: Information About Symptoms After Hospital Stay (Sex)

Measure	HCAHPS – “Did you get information in writing about what symptoms or health problems to look out for after discharge?”
Stratification Group	Sex
Best Performing Reference Group	95.2% (Female)
Lowest Performing Group & Relative Risk (RR)	Male patients (90.9%); RR = 1.047 vs highest group

Actions to Address the Disparity

Population Impact: Improve the clarity and comprehension of written discharge information for male patients to reduce post-discharge complications and readmissions, while improving patient understanding of their health conditions.

Measurable Objectives:

- - Increase male patient rate from 90.9% to $\geq 93.05\%$ within 12 months.
- - Reduce the disparity gap between male and highest group by 50% within 12 months.

Specific Actions and Timeframes:

1. Ensure $\geq 90\%$ of male discharges are to be screened for SDOH and implement interventions to help reduce identified risk factors.

2. Strengthen discharge education for men. Implement use of the teach back method to confirm comprehension and incorporate caregivers and family in the training

Disparity #9 – HCAHPS: Information About Symptoms After Hospital Stay

(Gender Identity)

Measure	HCAHPS – “Did you get information in writing about what symptoms or health problems to look out for after discharge?”
Stratification Group	Gender Identity
Best Performing Reference Group	95.2% (female)
Lowest Performing Group & Relative Risk (RR)	Male (90.9%); RR = 1.047 vs highest group

Actions to Address the Disparity

Population Impact: Improve the clarity and comprehension of written discharge information for male patients to reduce post-discharge complications and readmissions, while improving patient understanding of their health conditions.

Measurable Objectives:

- - Increase male patient rate from 90.9% to $\geq 93.05\%$ within 12 months.
- - Reduce the disparity gap between male and highest group by 50% within 12 months.

Specific Actions and Timeframes:

1. Ensure $\geq 90\%$ of male discharges are to be screened for SDOH and implement interventions to help reduce identified risk factors.

2. Strengthen discharge education for men. Implement use of the teach back method to confirm comprehension and incorporate caregivers and family in the training

Disparity #10 – HCAHPS: Would You Recommend This Hospital (Sex)

Measure	HCAHPS – “Would you recommend this hospital to your friends and family?”
Stratification Group	Sex
Best Performing Reference Group	92.3% (female)
Lowest Performing Group & Relative Risk	Male patients (88.9%); RR = 1.038 vs highest group

Actions to Address the Disparity

Population Impact: Improve hospital recommendation ratings among male patients by enhancing communication, comfort, and overall patient experience efforts.

Measurable Objectives:

- - Increase male patient recommendation rates from 88.9% to $\geq 92\%$ within 12 months.
- - Reduce the recommendation gap between male and highest performing group by 50% within 12 months.

Specific Actions and Timeframes:

1. Conduct patient experience surveys for male patients to identify areas of opportunity to focus interventions.
2. Provide staff training on patient-centered communication and engagement including the sit to commit process and evidence-based strategies for improving communication with men.

Section B

The top two ranked disparities were in the measure related to readmission rate. Analysis of readmission rates by sex demonstrated that women were the best-performing group, with a readmission rate of 2.1%, while men represented the lowest-performing group, with a 2.8% readmission rate. The goal is to reduce the readmission rate among men to $\leq 2.45\%$ within the next year by ensuring that at least 90% of male discharges are screened for social determinants of health (SDOH) and that appropriate support services are provided to address identified risk factors. Additional efforts will focus on strengthening discharge education for men through the teach-back method to verify comprehension and reinforce adherence to follow-up care. Implementation of these strategies aims to improve continuity of care and reduce preventable readmissions in this population.

Four of the top ten identified disparities were associated with the measure evaluating the provision of written discharge education related to the medical diagnosis and symptoms to monitor after discharge. The analysis showed that Spanish-speaking patients had an 80% compliance rate with a rate ratio (RR) of 1.179 compared to the highest-performing group, English-speaking patients, at 94.3%. Multi-Race patients had an 89% rate (RR = 1.124) compared to the highest-performing group, Black patients, at 100%. Male patients had a 90.9% rate ratio (RR = 1.047) compared to the highest-performing group, female patients, at 95.2%, with similar values identified for the gender identity and sex categories. The goal for each

disparity is to reduce the gap between the identified group and the highest-performing group by 50% within the next year. Planned interventions include strengthening discharge education by ensuring materials are provided in the patient's preferred language, integrating interpreter services, and confirming understanding through use of the teach-back method. In addition, staff training will be implemented to enhance culturally competent, patient-centered care. Training content will emphasize cultural humility, effective communication, implicit bias awareness, family and social dynamics, and an understanding of the healthcare beliefs of the diverse populations served.

The remaining three disparities were associated with the patient experience measure evaluating the willingness to recommend the facility to family or friends. Analysis identified the following disparities: Asian patients had an 83.3% positive response rate with a relative risk of 1.126 compared to the highest-performing group, White patients, at 93.8%; patients aged over 65 years had an 89.8% rate (RR = 1.114) compared to the highest-performing group, those aged 35–49 years, at 100%; and Medicare patients had an 89.9% rate (RR = 1.070) compared to the highest-performing group, private pay patients, at 96.2%. The goal for each disparity is to decrease the gap between the identified disparity group and the highest-performing group by 50% within the next year. Interventions to address these gaps will include staff education focused on enhanced communication and teaching strategies for patients aged 65 years and older, emphasizing the use of plain language, visual aids, and teach-back techniques while accounting for hearing, vision, or cognitive limitations. The Commit to Sit initiative will also be used to promote empathy, active listening, and effective communication during patient interactions. Additionally, a targeted survey will be conducted among Asian patients to identify key drivers of dissatisfaction and gather actionable insights to guide quality improvement efforts and improve the overall patient experience.

Section C

Person Centered Care

The organization is committed to providing person-centered care that is respectful of and responsive to the individual needs, preferences, and values of each patient. The Patient and Family Advisory Council (PFAC) plays a key role in advancing patient-centered practices, representing a diverse cross-section of the community in terms of race, ethnicity, gender, sexual orientation and age, and providing direct input into organizational policies, programs, and improvement initiatives. The integration of the PATH assessment tool within rehabilitation services enables the organization to identify and address discharge barriers and concerns identified by patients and their caregivers. As an employer committed to fair hiring practices and is committed to promoting diversity we have a workforce that reflects the racial and ethnic diversity of the community it serves, thereby enhancing culturally concordant care. Organization leaders are committed to the strategic initiative to increase board diversity with the goal of strengthening philanthropic engagement and expanding free and charitable care. Additionally, the organization has invested in “face-time” language services and three-way calling capabilities to improve communication among patients, caregivers, and providers, fostering inclusive care coordination and patient engagement.

Patient Safety

The organization maintains a strong commitment to patient safety and the reduction of risk across all stages of care delivery. A culture of safety is actively fostered through leadership engagement, ongoing staff education, and structured feedback mechanisms that promote transparency and accountability. Results from the most recent Press Ganey Employee Safety Culture Survey demonstrated performance exceeding national benchmarks across all measured safety and culture domains, with an overall safety culture score of 4.13 compared to the national average of 3.95. The organization participates in two patient safety organizations to enhance, data-driven benchmarking, and system-wide safety improvements. The Organization has made a commitment to zero patient harm as one of the organizations aspirational goals. A focused effort on the prevention of hospital-acquired pressure injuries (HAPT) resulted in an 80% reduction in 2024.

Social determinants of health.

Addressing social determinants of health (SDOH) continues to be a strategic priority. In 2024, the organization implemented the Accountable health Communities Health-related Social Needs Screening Tool (AHC HRSN) core questions. The tool is a standardized screening process to assess key risk factors such as housing, income, food security, and transportation. Patients identified with unmet needs are provided with community-based resources. Furthermore, access to the findhelp.org website is provided to patients through our patient access portal.

The governing board identified SDOH as a key action item in the 2025 Strategic Plan, reinforcing organizational commitment to reducing health disparity and reducing advancing health equity for vulnerable populations.

Effective Treatment

The organization remains dedicated to providing evidence-based, timely, and appropriate clinical care to all patients. Clinical teams consistently apply established best practices to guide treatment decisions, ensuring quality, consistency, and equity in clinical outcomes. This commitment to disease-specific excellence has earned the organization Joint Commission Disease-Specific Certification for Advanced Hip and Knee Replacement, as well as Specialty Certification through the Commission on Accreditation of Rehabilitation Facilities (CARF) for Brain Injury, Spinal Cord Injury, and Stroke programs. In recognition of its leadership in infection prevention and responsible antimicrobial use, the organization was also awarded the Bronze Antimicrobial Stewardship Honor Roll by the California Department of Public Health for promoting optimal antimicrobial use, preventing antibiotic resistance, and improving patient outcomes.

Care Coordination

Care coordination remains a core element of high-quality care delivery. The implementation of the PATH assessment tool is enhancing the organization's ability to identify patient and

caregiver needs during transitions of care, supporting safe discharge planning and improved continuity across care settings. The Patient and Family Advisory Council (PFAC) also plays an active role in evaluating and advising on care transition processes, contributing to the development of patient and family resources that improve transition from inpatient rehabilitation to the home environment. Additionally, the organization continues to collaborate with community agencies and benefit programs to connect patients with local support services that address post-discharge needs and social determinants of health, ensuring a holistic and sustainable recovery process. The organization has a dedicated Patient Navigator to guide and assist individuals throughout the total joint replacement process, improving patient engagement, education, and overall care coordination.

Access to Care

Ensuring equitable and timely access to care remains a key organizational priority. The organization has strengthened partnerships with local hospitals and community providers to enhance limb preservation programs for patients with diabetes, with a focus on reducing disparities among Spanish-speaking populations. These efforts include providing health screenings, education, and financial assistance to improve clinical outcomes and promote health equity. To further support culturally responsive care, a Spanish-speaking diabetes educator was hired to expand outreach and education within the community, in alignment with priorities established by the Diversity Task Force. The organization also collaborates with a regional trauma center to ensure timely access to post-acute rehabilitation services and to initiate rehabilitation planning early, supporting the best possible recovery for patients following a traumatic injury. In addition, the organization continues to expand services to reduce wait times and improve access across the continuum of care and multiple service lines. The organization is committed to eliminating barriers by providing patients with timely and secure access to their health-related data through an ADA compliant patient portal and investment operationalization of interoperability standards.