

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: 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/>

Measure: 04 Patient Safety Indicator

Description of Interventions:

Your safety is our top priority. We know that serious complications can happen during a hospital stay. That's why we use proven strategies to help prevent these risks.

Our care teams use safety checklists and team huddles, often called a "timeout", before surgeries and procedures. These steps help us spot potential problems early and make sure everyone knows the plan for your care. We know that when patients and families are unclear about what to expect before and after surgery it can increase the risk of a complication. That's why we talk with you and your family and keep you informed of changes in your health.

We train our staff to recognize warning signs of complications quickly. For example, we monitor for symptoms of infection, blood clots, and breathing problems, and act fast if issues arise. Our electronic health record also has embedded tools to help identify risks such as potential sepsis or declines in status. Our teams use evidence-based protocols for treating sepsis, shock, and other emergencies. Our rapid response team (RRT) of trained clinicians will respond quickly to the bedside to urgent concerns about your health. We encourage you and your family to request a care intervention if you have any concerns.

After your procedure, we keep a close eye on your recovery. Nurses and doctors check your vital signs, review your medications, and make sure you're getting the right support. If you need extra help—like physical therapy, nutrition, or respiratory care—we bring in specialists to support your healing. Before you leave the hospital, we can help you understand what to expect during recovery and how to arrange the right help at home. We can make connections to care outside the hospital as needed.

We continuously track outcomes through CMS data and look for ways to improve safety. By reviewing cases and listening to patient feedback, we make our care even better.
