# 2027 Health Equity Plan
# Sutter Tracy Community Hospital

**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.

**Quality Measures**

HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate
HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate, stratified by Behavioral Health Diagnosis
AHRQ Quality Indicator Pneumonia Mortality Rate
AHRQ Patient Safety Indicator Death Rate among Surgical Inpatients with Serious Treatable Complications

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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. Whenever available, discharge materials are provided in your preferred language and in clear, easy-to-understand formats. We may also use literacy-friendly tools, including stoplight guides, to help you recognize changes in symptoms, understand when to seek help, and manage your care safely at home. 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. We assess your readmission risk, including clinical and social needs, so patients who may need additional support can receive enhanced discharge planning. 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. After discharge, it is important to obtain the equipment and home services you need. When appropriate, we connect patients experiencing financial hardship with transitional care support and patients without a primary care provider with a community health center.

For patients who have frequent emergency department visits or hospital stays, an interdisciplinary team may develop an individualized care plan that reflects their medical, behavioral health, and social needs. This may include coordination among your care team and support services as appropriate.

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. We use standardized screening information to identify gaps in care and tailor support to your needs, including referrals through community-based partners and resource navigation services.

We are also implementing age-friendly practices for patients over 65 to improve care, transitions, and outcomes for older adults. This includes assessing social isolation, caregiver strain, and additional barriers that may affect recovery; connecting patients and caregivers with social work and community resources; and using interdisciplinary care planning to support a safe transition. We also review outcomes such as falls, pressure injuries, readmissions, mortality, and hospital-acquired delirium to identify age-related disparities and guide improvements.

After discharge, our Transition of Care (TOC) team follows 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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**Patient Experience Measures**

HCAHPS survey: Received information and education
HCAHPS survey: Would recommend hospital

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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:**

Helping patients and families understand how to care for themselves after leaving the hospital is an important part of Sutter commitment to connected, compassionate care. Care teams use a combination of verbal explanations, written materials, teach-back techniques, and digital tools to help patients feel prepared, informed, and confident when transitioning home.

As part of the ONE Sutter Experience, caregivers are trained to use **relationship-centered communication practices** and the **Three-Step Communication standard**, helping ensure patients

receive clear explanations about their condition, medications, follow-up care, warning signs, and recovery expectations. Care teams reinforce this information throughout the hospitalization, including during purposeful rounding, bedside shift handoff discussions, discharge planning conversations, and leader rounding encounters.

In 2026, Sutter Health continued to strengthen its focus on patient education through a multidisciplinary **Patient Education Governance Committee**, which helps ensure patients receive the right information, to the right patient, at the right time. The committee supports the development, review, and distribution of evidence-based, patient-friendly educational materials that are clear, accessible, and available in patients' preferred languages whenever possible. These materials are used by care teams across the continuum of care and are available in both print and digital formats.

Patients and families also benefit from tools that keep them informed throughout their stay. **MyChart Bedside and MyHealthOnline** provide convenient access to information about the hospitalization, care plans, medications, tests, and discharge instructions, helping patients and designated family members stay engaged in care decisions and prepared for recovery after discharge. Written discharge instructions and after-visit summaries include important information about symptoms or health problems to watch for, medication guidance, follow-up appointments, and when to seek additional medical attention.

Sutter Health further supports these efforts through Experience of Care Summits, Communities of Practice, RN Peer Coaching, and Get-to-Green Improvement Sprints that focus on improving communication, patient understanding, and discharge readiness across care settings. By combining clear communication, reliable education practices, and accessible written resources, Sutter Health aims to ensure every patient leaves the hospital with the information needed to safely recover and manage their health after discharge.

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**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 connected, compassionate, and reliable care that patients and families would confidently recommend to their loved ones. In 2026, Sutter strengthened this commitment through the expansion of the **ONE Sutter Experience strategy**, bringing together systemwide standards, leadership practices, training, and improvement efforts designed to create exceptional experiences in every care setting.

A cornerstone of this work is the launch of the P**atients First, People Always (ONE TEAM) Behaviors**, which establish shared expectations for how employees, clinicians, and leaders interact with patients, families, and one another. These behaviors emphasize ownership, engagement, teamwork, safety, and creating welcoming environments that support trust and confidence in care.

Sutter Health also expanded hospitality-focused training and Experience of Care education programs that reinforce relationship-centered communication, service excellence, and compassionate interactions. Through annual learning programs, Experience of Care Summits, Communities of Practice,

and leader development activities, care teams continue to build the skills that matter most to patients and families.

Several evidence-based practices help ensure patients feel informed, cared for, and connected throughout their stay, including:
**Purposeful Rounding**, where nurses and care team members proactively check on patients' comfort, safety, concerns, and care needs.
**Bedside Shift Handoff**, which includes patients and families in discussions about the care plan during nursing shift changes.
**Leader Rounding**, where leaders routinely visit patients and families to listen, address concerns in real time, and recognize excellent care.
**Patient Communication Boards** and other tools that keep patients informed about their care team, goals, and plans for discharge.
**Working Together as a Team**, which emphasizes coordinated communication and seamless care transitions.

To accelerate improvement, Sutter Health continues to conduct **Experience of Care Improvement Sprints**, focused efforts that use patient feedback, data review, coaching, and local action planning to strengthen care experiences. The organization has also expanded RN Peer Coaching, providing real-time observation, feedback, and support to help hardwire effective communication and service behaviors.

Digital tools further support a connected experience. Through **MyChart Bedside** and other patient portals, patients and families have access to important information about their hospitalization, care plan, and care team, helping them stay informed and engaged throughout their stay. Sutter Health also partners with volunteer **Patient and Family Advisors** to ensure the voices of patients and families help shape programs and improvement efforts. Finally, **patient feedback** is actively gathered during and after care visits and used to guide ongoing improvements in the patient experience.