# 2027 Health Equity Plan
# Sutter Health

**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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**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, we work with you to make sure you understand your care and follow-up plan. Education can be provided in your preferred language with interpreter services when needed, and our teams use teach-back to help confirm your understanding.

Before you leave the hospital, if you consent, we can screen for social factors that may affect your health, such as housing, food, transportation, personal safety or financial resource strain, and help connect you

with community resources. When an unmet need is identified, Social Work and Care Management can help assess your needs and connect you with available 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. Our care teams can also identify patients at increased risk for readmission and provide additional planning based on individual needs, including potential barriers related to medications, follow-up care, transportation and other social needs.

Following discharge, it is important to identify problems such as worsening symptoms, medication concerns or difficulty accessing follow-up care and connect with appropriate services.

We also monitor these readmission rates through the Centers for Medicare & Medicaid Services (CMS) and patient feedback surveys to make sure our approach is working.

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**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.

Patients and families receive education in their preferred language, with interpreter services utilized when needed. For patients with complex recovery needs, care teams assess social factors that may affect recovery, including transportation, food access, housing stability, and other barriers, and connect patients with appropriate community resources and support services.

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. Care teams also identify community-based support programs and rehabilitation services, with attention to barriers such as transportation, understanding of the program, and access to follow-up care.

We monitor mortality rates annually through CMS. Found here: https://www.medicare.gov/care-compare/