Hospital Equity Measures Report

General Information

Report Type:	Hospital Equity Measures Report
Year:	2024
Hospital Name:	MERCY MEDICAL CENTER - MERCED
Facility Type:	General Acute Care Hospital
Hospital HCAI ID:	106240942
Report Period:	1/1/2024 - 12/31/2024
Status:	Submitted
Due Date:	09/30/2025
Last Updated:	02/03/2026
Hospital Location with Clean Water and Air:	N
Hospital Web Address for Equity Report:	https://tinyurl.com/3ukvjpxf

Overview

Assembly Bill No. 1204 requires the Department of Health Care Access and Information (HCAI) to develop and administer a Hospital Equity Measures Reporting Program to collect and post summaries of key hospital performance and patient outcome data regarding sociodemographic information, including but not limited to age, sex, race/ethnicity, payor type, language, disability status, and sexual orientation and gender identity.

Hospitals (general acute, children's, and acute psychiatric) and hospital systems are required to annually submit their reports to HCAI. These reports contain summaries of each measure, the top 10 disparities, and the equity plans to address the identified disparities. HCAI is required to maintain a link on the HCAI website that provides access to the content of hospital equity measures reports and equity plans to the public. All submitted hospitals are required to post their reports on their websites, as well.

Laws and Regulations

For more information on Assembly Bill No. 1204, please visit the following link by copying and pasting the URL into your web browser:
https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202120220AB1204

Hospital Equity Measures

Joint Commission Accreditation

General acute care hospitals are required to report three structural measures based on the Commission Accreditation's Health Care Disparities Reduction and Patient-Centered Communication Accreditation Standards. For more information on these measures, please visit the following link by copying and pasting the URL into your web browser:
https://www.jointcommission.org/standards/r3-report/r3-report-issue-36-new-requirements-to-reduce-health-care-disparities/

The first two structural measures are scored as "yes" or "no"; the third structural measure comprises the percentages of patients by five categories of preferred languages spoken, in addition to one other/unknown language category.

Designate an individual to lead hospital health equity activities (Y = Yes, N = No).

Y

Provide documentation of policy prohibiting discrimination (Y = Yes, N = No).

Y

Number of patients that were asked their preferred language, five defined categories and one other/unknown languages category.

80292

Table 1. Summary of preferred languages reported by patients.

Languages	Number of patients who report preferring language	Total number of patients	Percentage of total patients who report preferring language (%)
English Language	67171	80292	83.7
Spanish Language	11743	80292	14.6
Asian Pacific Islander Languages	886	80292	1.1
Middle Eastern Languages	86	80292	0.1
American Sign Language	53	80292	0.1
Other Languages	182	80292	0.2

Centers for Medicare & Medicaid Services (CMS) Hospital Commitment to Health Equity Structural (HCHE) Measure

There are five domains that make up the CMS Hospital Commitment to HCHE measures. Each domain is scored as "yes" or "no." In order to score "yes," a general acute care hospital is required to confirm all the domain's attestations. Lack of one or more of the attestations results in a score of "no." For more information on the CMS Hospital Commitment to HCHE measures, please visit the following link by copying and pasting the URL into your web browser: https://data.cms.gov/provider-data/topics/hospitals/health-equity

Centers for Medicare & Medicaid Services (CMS) Hospital Commitment to Health Equity Structural (HCHE) Measure Domain 1: Strategic Planning (Yes/No)

- Our hospital strategic plan identifies priority populations who currently experience health disparities.
- Our hospital strategic plan identifies healthcare equity goals and discrete action steps to achieve these goals.
- Our hospital strategic plan outlines specific resources that have been dedicated to achieving our equity goals.
- Our hospital strategic plan describes our approach for engaging key stakeholders, such as community-based organizations.

Y

CMS HCHE Measure Domain 2: Data Collection (Yes/No)

- Our hospital strategic plan identifies healthcare equity goals and discrete action steps to achieve these goals.
- Our hospital has training for staff in culturally sensitive collection of demographics and/or social determinant of health information.

• Our hospital inputs demographic and/or social determinant of health information collected from patients into structured, interoperable data elements using a certified electronic health record (EHR) technology.

Y

CMS HCHE Measure Domain 3: Data Analysis (Yes/No)

• Our hospital stratifies key performance indicators by demographic and/or social determinants of health variables to identify equity gaps and includes this information in hospital performance dashboards.

Y

CMS HCHE Measure Domain 4: Quality Improvement (Yes/No)

• Our hospital participates in local, regional or national quality improvement activities focused on reducing health disparities.

Y

CMS HCHE Measure Domain 5: Leadership Engagement (Yes/No)

• Our hospital senior leadership, including chief executives and the entire hospital board of trustees, annually reviews our strategic plan for achieving health equity.

• Our hospital senior leadership, including chief executives and the entire hospital board of trustees, annually review key performance indicators stratified by demographic and/or social factors.

Y

Centers for Medicare & Medicaid Services (CMS) Social Drivers of Health (SDOH)

General acute care hospitals are required to report on rates of screenings and intervention rates among patients above 18 years old for five health related social needs (HRSN), which are food insecurity, housing instability, transportation problems, utility difficulties, and interpersonal safety. These rates are reported separately as being screened as positive for any of the five HRSNs, positive for each individual HRSN, and the intervention rate for each positively screened HRSN. For more information on the CMS SDOH, please visit the following link by copying and pasting the URL into your web browser:
https://www.cms.gov/priorities/innovation/key-concepts/social-drivers-health-and-health-related-social-needs

Number of patients admitted to an inpatient hospital stay who are 18 years or older on the date of admission and are screened for all of the five HRSN

5992

Total number of patients who are admitted to a hospital inpatient stay and who are 18 years or older on the date of admission

7332

Rate of patients admitted for an inpatient hospital stay who are 18 years or older on the date of admission, were screened for an HRSN, and who screened positive for one or more of the HRSNs

81.7

Table 2. Positive screening rates and intervention rates for the five Health Related Social Needs of the Centers of Medicare & Medicaid Services (CMS) Social Drivers of Health (SDOH).

Social Driver of Health	Number of positive screenings	Rate of positive screenings (%)	Number of positive screenings who received intervention	Rate of positive screenings who received intervention (%)
Food Insecurity	578	9.6	0	0
Housing Instability	241	4.0	0	0
Transportation Problems	862	14.4	0	0
Utility Difficulties	303	5.1	0	0
Interpersonal Safety	179	2.4	0	0

Core Quality Measures for General Acute Care Hospitals

There are two quality measures from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey. For more information on the HCAHPS survey, please visit the following link by copying and pasting the URL into your web browser: https://hcahpsonline.org/en/survey-instruments/

Patient Recommends Hospital

The first HCAHPS quality measure is the percentage of patients who would recommend the hospital to friends and family. For this measure, general acute care hospitals provide the percentage of patient respondents who responded "probably yes" or "definitely yes" to whether they would recommend the hospital, the percentage of the people who responded to the survey (i.e., the response rate), and the inputs for the percentages. The percentages and inputs are stratified by race and/or ethnicity, non-maternal age categories, sex, payer type, preferred language, disability status, sexual orientation, and gender identity. The corresponding HCAHPS question number is 19.

Number of respondents who replied "probably yes" or "definitely yes" to HCAHPS Question 19, "Would you recommend this hospital to your friends and family?"

457

Total number of respondents to HCAHPS Question 19

508

Percentage of total respondents who responded "probably yes" or "definitely yes" to HCAHPS Question 19

90

Total number of people surveyed on HCAHPS Question 19

4233

Response rate, or the percentage of people who responded to HCAHPS Question 19

12

Table 3. Patient recommends hospital by race and/or ethnicity, non-maternal age categories, sex, payer type, preferred language, disability status, sexual orientation, and gender identity.

Race and/or Ethnicity	Number of "probably yes" or "definitely yes" responses	Total number of responses	Percent of "probably yes" or "definitely yes" responses (%)	Total number of patients surveyed	Response rate of patients surveyed (%)
American Indian or Alaska Native					
Asian					
Black or African American					
Hispanic or Latino					
Middle Eastern or North African					
Multiracial and/or Multiethnic (two or more races)					
Native Hawaiian or Pacific Islander					
White					

Age	Number of "probably yes" or "definitely yes" responses	Total number of responses	Percent of "probably yes" or "definitely yes" responses (%)	Total number of patients surveyed	Response rate of patients surveyed (%)
Age < 18					
Age 18 to 34					
Age 35 to 49					
Age 50 to 64					
Age 65 Years and Older					

Sex assigned at birth	Number of "probably yes" or "definitely yes" responses	Total number of responses	Percent of "probably yes" or "definitely yes" responses (%)	Total number of patients surveyed	Response rate of patients surveyed (%)
Female					
Male					
Unknown					

Payer Type	Number of "probably yes" or "definitely yes" responses	Total number of responses	Percent of "probably yes" or "definitely yes" responses (%)	Total number of patients surveyed	Response rate of patients surveyed (%)
Medicare					
Medicaid					
Private					
Self-Pay					
Other					

Preferred Language	Number of "probably yes" or "definitely yes" responses	Total number of responses	Percent of "probably yes" or "definitely yes" responses (%)	Total number of patients surveyed	Response rate of patients surveyed (%)
English Language					
Spanish Language					
Asian Pacific Islander Languages					
Middle Eastern Languages					
American Sign Language					
Other/Unknown Languages					

Disability Status	Number of "probably yes" or "definitely yes" responses	Total number of responses	Percent of "probably yes" or "definitely yes" responses (%)	Total number of patients surveyed	Response rate of patients surveyed (%)
Does not have a disability					
Has a mobility disability					
Has a cognition disability					
Has a hearing disability					
Has a vision disability					
Has a self-care disability					
Has an independent living disability					

Sexual Orientation	Number of "probably yes" or "definitely yes" responses	Total number of responses	Percent of "probably yes" or "definitely yes" responses (%)	Total number of patients surveyed	Response rate of patients surveyed (%)
Lesbian, gay or homosexual					
Straight or heterosexual					
Bisexual					
Something else					
Don't know					
Not disclosed					

Gender Identity	Number of "probably yes" or "definitely yes" responses	Total number of responses	Percent of "probably yes" or "definitely yes" responses (%)	Total number of patients surveyed	Response rate of patients surveyed (%)
Female					
Female-to-male (FTM)/ transgender male/trans man					
Male					
Male-to-female (MTF)/ transgender female/trans					
Non-conforming gender					
Additional gender category or other					
Not disclosed					

Patient Received Information in Writing

The second HCAHPS quality measure is the percentage of patients who reported receiving information in writing on symptoms and health problems to look out for after leaving the hospital. General acute care hospitals are required to provide the percentage of patient respondents who responded "yes" to being provided written information, the percentage of the people who responded to the survey (i.e., the response rate), and the inputs for these percentages. These percentages and inputs are stratified by race and/or ethnicity, non-maternal age categories, sex, payer type, preferred language, disability status, sexual orientation, and gender identity. The corresponding HCAHPS question number is 17.

Number of respondents who replied "yes" to HCAHPS Question 17, "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?"

417

Total number of respondents to HCAHPS Question 17

508

Percentage of respondents who responded "yes" to HCAHPS Question 17

82.1

Total number of people surveyed on HCAHPS Question 17

4233

Response rate, or the percentage of people who responded to HCAHPS Question 17

12

Table 4. Patient reports receiving information in writing about symptoms or health problems by race and/or ethnicity, non-maternal age categories, sex, payer type, preferred language, disability status, sexual orientation, and gender identity.

Race and/or Ethnicity	Number of "yes" responses	Total number of responses	Percentage of "yes" responses (%)	Total number of patients surveyed	Response rate of patients surveyed (%)
American Indian or Alaska Native					
Asian					
Black or African American					
Hispanic or Latino					
Middle Eastern or North African					
Multiracial and/or Multiethnic (two or more races)					
Native Hawaiian or Pacific Islander					
White					

Age	Number of "yes" responses	Total number of responses	Percentage of "yes" responses (%)	Total number of patients surveyed	Response rate of patients surveyed (%)
Age < 18					
Age 18 to 34					
Age 35 to 49					
Age 50 to 64					
Age 65 Years and Older					

Sex assigned at birth	Number of "yes" responses	Total number of responses	Percentage of "yes" responses (%)	Total number of patients surveyed	Response rate of patients surveyed (%)
Female					
Male					
Unknown					

Payer Type	Number of "yes" responses	Total number of responses	Percentage of "yes" responses (%)	Total number of patients surveyed	Response rate of patients surveyed (%)
Medicare					
Medicaid					
Private					
Self-Pay					
Other					

Preferred Language	Number of "yes" responses	Total number of responses	Percentage of "yes" responses (%)	Total number of patients surveyed	Response rate of patients surveyed (%)
English Language					
Spanish Language					
Asian Pacific Islander Languages					
Middle Eastern Languages					
American Sign					
Other/Unknown Languages					

Disability Status	Number of "yes" responses	Total number of responses	Percentage of "yes" responses (%)	Total number of patients surveyed	Response rate of patients surveyed (%)
Does not have a disability					
Has a mobility disability					
Has a cognition					
Has a hearing disability					
Has a vision disability					
Has a self-care					
Has an independent living disability					

Sexual Orientation	Number of "yes" responses	Total number of responses	Percentage of "yes" responses (%)	Total number of patients surveyed	Response rate of patients surveyed (%)
Lesbian, gay or homosexual					
Straight or heterosexual					
Bisexual					
Something else					
Don't know					
Not disclosed					

Gender Identity	Number of "yes" responses	Total number of responses	Percentage of "yes" responses (%)	Total number of patients surveyed	Response rate of patients surveyed (%)
Female					
Female-to-male (FTM)/ transgender male/trans man					
Male					
Male-to-female (MTF)/ transgender female/ trans woman					
Non-conforming gender					
Additional gender category or other					
Not disclosed					

Agency for Healthcare Research and Quality (AHRQ) Indicators

General acute care hospitals are required to report on two indicators from the Agency for Healthcare Research and Quality (AHRQ). For general information about AHRQ indicators, please visit the following link by copying and pasting the URL into your web browser: https://qualityindicators.ahrq.gov/

Pneumonia Mortality Rate

The Pneumonia Mortality Rate is defined as the rate of in-hospital deaths per 1,000 hospital discharges with a principal diagnosis of pneumonia or a principal diagnosis of sepsis with a secondary diagnosis of pneumonia present on admission for patients ages 18 years and older. General acute care hospitals report the Pneumonia Mortality Rate by race and/or ethnicity, non-maternal age categories, sex, payer type, preferred language, disability status, sexual orientation, and gender identity. The corresponding AHRQ Inpatient Quality Indicator is 20. For more information about this indicator, please visit the following link by copying and pasting the URL into your web browser: https://qualityindicators.ahrq.gov/Downloads/Modules/IQI/V2023/TechSpecs/IQI_20_Pneumonia_Mortality_Rate.pdf

Number of in-hospital deaths with a principal diagnosis of pneumonia or a principal diagnosis of sepsis with a secondary diagnosis of pneumonia present on admission

19

Total number of hospital discharges with a principal diagnosis of pneumonia or a principal diagnosis of sepsis with a secondary diagnosis of pneumonia present on admission

431

Rate of in-hospital deaths per 1,000 hospital discharges with a principal diagnosis of pneumonia or a principal diagnosis of sepsis with a secondary diagnosis of pneumonia present on admission

44.1

Table 5. Pneumonia Mortality Rate by race and/or ethnicity, non-maternal age categories, sex, payer type, preferred language, disability status, sexual orientation, and gender identity.

Race and/or Ethnicity	Number of in-hospital deaths that meet the inclusion/exclusion criteria	Number of hospital discharges that meet the inclusion/exclusion criteria	Rate of in-hospital deaths per 1,000 hospital discharges that meet the inclusion/exclusion criteria (%)
American Indian or Alaska Native			
Asian	suppressed	suppressed	suppressed
Black or African American	suppressed	suppressed	suppressed
Hispanic or Latino	suppressed	suppressed	suppressed
Middle Eastern or North African			
Multiracial and/or Multiethnic (two or more	suppressed	suppressed	suppressed
Native Hawaiian or Pacific Islander			
White	suppressed	suppressed	suppressed

Age	Number of in-hospital deaths that meet the inclusion/exclusion criteria	Number of hospital discharges that meet the inclusion/exclusion criteria	Rate of in-hospital deaths per 1,000 hospital discharges that meet the inclusion/exclusion criteria (%)
Age < 18			
Age 18 to 34	suppressed	suppressed	suppressed
Age 35 to 49	suppressed	suppressed	suppressed
Age 50 to 64	suppressed	suppressed	suppressed
Age 65 Years and Older	13	275	47.3

Sex assigned at birth	Number of in-hospital deaths that meet the inclusion/exclusion criteria	Number of hospital discharges that meet the inclusion/exclusion criteria	Rate of in-hospital deaths per 1,000 hospital discharges that meet the inclusion/exclusion criteria (%)
Female	suppressed	suppressed	suppressed
Male	suppressed	suppressed	suppressed
Unknown			

Payer Type	Number of in-hospital deaths that meet the inclusion/exclusion criteria	Number of hospital discharges that meet the inclusion/exclusion criteria	Rate of in-hospital deaths per 1,000 hospital discharges that meet the inclusion/exclusion criteria (%)
Medicare	15	288	52.1
Medicaid	suppressed	suppressed	suppressed
Private	suppressed	suppressed	suppressed
Self-Pay	suppressed	suppressed	suppressed
Other	suppressed	suppressed	suppressed

Preferred Language	Number of in-hospital deaths that meet the inclusion/exclusion criteria	Number of hospital discharges that meet the inclusion/exclusion criteria	Rate of in-hospital deaths per 1,000 hospital discharges that meet the inclusion/exclusion criteria (%)
English Language	suppressed	suppressed	suppressed
Spanish Language	suppressed	suppressed	suppressed
Asian Pacific Islander Languages	0	20	0
Middle Eastern Languages	suppressed	suppressed	suppressed
American Sign Language			
Other/Unknown Languages	suppressed	suppressed	suppressed

Disability Status	Number of in-hospital deaths that meet the inclusion/exclusion criteria	Number of hospital discharges that meet the inclusion/exclusion criteria	Rate of in-hospital deaths per 1,000 hospital discharges that meet the inclusion/exclusion criteria (%)
Does not have a disability			
Has a mobility disability			
Has a cognition disability			
Has a hearing disability			
Has a vision disability			
Has a self-care disability			
Has an independent living disability			

Sexual Orientation	Number of in-hospital deaths that meet the inclusion/exclusion criteria	Number of hospital discharges that meet the inclusion/exclusion criteria	Rate of in-hospital deaths per 1,000 hospital discharges that meet the inclusion/exclusion criteria (%)
Lesbian, gay or homosexual			
Straight or heterosexual			
Bisexual			
Something else			
Don't know			
Not disclosed			

Gender Identity	Number of in-hospital deaths that meet the inclusion/exclusion criteria	Number of hospital discharges that meet the inclusion/exclusion criteria	Rate of in-hospital deaths per 1,000 hospital discharges that meet the inclusion/exclusion criteria (%)
Female			
Female-to-male (FTM)/ transgender male/trans man			
Male			
Male-to-female (MTF)/ transgender female/trans woman			
Non-conforming gender			
Additional gender category or other			
Not disclosed			

Death Rate among Surgical Inpatients with Serious Treatable Complications

The Death Rate among Surgical Inpatients with Serious Treatable Complications is defined as the rate of in-hospital deaths per 1,000 surgical discharges among patients ages 18-89 years old or obstetric patients with serious treatable complications. General acute care hospitals report this measure by race and/or ethnicity, non-maternal age categories, sex, payer type, preferred language, disability status, sexual orientation, and gender identity. The corresponding AHRQ Patient Safety Indicator is 04. For more information about this indicator, please visit the following link by copying and pasting the URL into your web browser:
https://qualityindicators.ahrq.gov/Downloads/Modules/PSI/V2023/TechSpecs/PSI_04_Death_Rate_among_Surgical_Inpatients_with_Serious_Treatable_Complications.pdf

Number of in-hospital deaths among patients aged 18-89 years old or obstetric patients with serious treatable complications

suppressed

Total number of surgical discharges among patients aged 18-89 years old or obstetric patients

suppressed

Rate of in-hospital deaths per 1,000 surgical discharges, among patients aged 18-89 years old or obstetric patients with serious treatable complications

suppressed

Table 6. Death Rate among Surgical Inpatients with Serious Treatable Complications by race and/or ethnicity, non-maternal age categories, sex, payer type, preferred language, disability status, sexual orientation, and gender identity.

Race and/or Ethnicity	Number of in-hospital deaths that meet the inclusion/exclusion criteria	Number of surgical discharges that meet the inclusion/exclusion criteria	Rate of in-hospital deaths per 1,000 hospital discharges that meet the inclusion/exclusion criteria (%)
American Indian or Alaska Native			
Asian			
Black or African American	suppressed	suppressed	suppressed
Hispanic or Latino	suppressed	suppressed	suppressed
Middle Eastern or North African			
Multiracial and/or Multiethnic (two or more	suppressed	suppressed	suppressed
Native Hawaiian or Pacific Islander			
White	suppressed	suppressed	suppressed

Age	Number of in-hospital deaths that meet the inclusion/exclusion criteria	Number of surgical discharges that meet the inclusion/exclusion criteria	Rate of in-hospital deaths per 1,000 hospital discharges that meet the inclusion/exclusion criteria (%)
Age < 18			
Age 18 to 34	suppressed	suppressed	suppressed
Age 35 to 49	suppressed	suppressed	suppressed
Age 50 to 64	suppressed	suppressed	suppressed
Age 65 Years and Older	suppressed	suppressed	suppressed

Sex assigned at birth	Number of in-hospital deaths that meet the inclusion/exclusion criteria	Number of surgical discharges that meet the inclusion/exclusion criteria	Rate of in-hospital deaths per 1,000 hospital discharges that meet the inclusion/exclusion criteria (%)
Female	suppressed	suppressed	suppressed
Male	suppressed	suppressed	suppressed
Unknown			

Payer Type	Number of in-hospital deaths that meet the inclusion/exclusion criteria	Number of surgical discharges that meet the inclusion/exclusion criteria	Rate of in-hospital deaths per 1,000 hospital discharges that meet the inclusion/exclusion criteria (%)
Medicare	suppressed	suppressed	suppressed
Medicaid	suppressed	suppressed	suppressed
Private	suppressed	suppressed	suppressed
Self-Pay			
Other	suppressed	suppressed	suppressed

Preferred Language	Number of in-hospital deaths that meet the inclusion/exclusion criteria	Number of surgical discharges that meet the inclusion/exclusion criteria	Rate of in-hospital deaths per 1,000 hospital discharges that meet the inclusion/exclusion criteria (%)
English Language	suppressed	suppressed	suppressed
Spanish Language	suppressed	suppressed	suppressed
Asian Pacific Islander Languages			
Middle Eastern Languages			
American Sign Language			
Other/Unknown Languages			

Disability Status	Number of in-hospital deaths that meet the inclusion/exclusion criteria	Number of surgical discharges that meet the inclusion/exclusion criteria	Rate of in-hospital deaths per 1,000 hospital discharges that meet the inclusion/exclusion criteria (%)
Does not have a disability			
Has a mobility disability			
Has a cognition disability			
Has a hearing disability			
Has a vision disability			
Has a self-care disability			
Has an independent living disability			

Sexual Orientation	Number of in-hospital deaths that meet the inclusion/exclusion criteria	Number of surgical discharges that meet the inclusion/exclusion criteria	Rate of in-hospital deaths per 1,000 hospital discharges that meet the inclusion/exclusion criteria (%)
Lesbian, gay or homosexual			
Straight or heterosexual			
Bisexual			
Something else			
Don't know			
Not disclosed			

Gender Identity	Number of in-hospital deaths that meet the inclusion/exclusion criteria	Number of surgical discharges that meet the inclusion/exclusion criteria	Rate of in-hospital deaths per 1,000 hospital discharges that meet the inclusion/exclusion criteria (%)
Female			
Female-to-male (FTM)/ transgender male/trans man			
Male			
Male-to-female (MTF)/ transgender female/trans woman			
Non-conforming gender			
Additional gender category or other			
Not disclosed			

California Maternal Quality Care Collaborative (CMQCC) Core Quality Measures

There are three core quality maternal measures adopted from the California Maternal Quality Care Collaborative (CMQCC).

CMQCC Nulliparous, Term, Singleton, Vertex (NTSV) Cesarean Birth Rate

The CMQCC Nulliparous, Term, Singleton, Vertex (NTSV) Cesarean Birth Rate is defined as nulliparous women with a term (at least 37 weeks gestation), singleton baby in a vertex position delivered by cesarian birth. General acute care hospitals report the NTSV Cesarean Birth Rate by race and/or ethnicity, maternal age categories, sex, payer type, preferred language, disability status, sexual orientation, and gender identity. For more information, please visit the following link by copying and pasting the URL into your web browser: https://www.cmqcc.org/quality-improvement-toolkits/supporting-vaginal-birth/ntsv-cesarean-birth-measure-specifications

Number of NTSV patients with Cesarean deliveries

166

Total number of nulliparous NTSV patients

681

Rate of NTSV patients with Cesarean deliveries

0.244

Table 7. Nulliparous, Term, Singleton, Vertex (NTSV) Cesarean Birth Rate by race and/or ethnicity, maternal age categories, sex, payer type, preferred language, disability status, sexual orientation, and gender identity.

Race and/or Ethnicity	Number of NTSV patients with cesarean deliveries	Total number of NTSV patients	Rate of NTSV patients with Cesarean deliveries (%)
American Indian or Alaska Native	suppressed	suppressed	suppressed
Asian	suppressed	suppressed	suppressed
Black or African American	suppressed	suppressed	suppressed
Hispanic or Latino	107	469	0.228
Middle Eastern or North African			
Multiracial and/or Multiethnic (two or more races)	suppressed	suppressed	suppressed
Native Hawaiian or Pacific Islander	suppressed	suppressed	suppressed
White	suppressed	suppressed	suppressed

Age	Number of NTSV patients with cesarean deliveries	Total number of NTSV patients	Rate of NTSV patients with Cesarean deliveries (%)
Age < 18	suppressed	suppressed	suppressed
Age 18 to 29	116	525	0.221
Age 30 to 39	suppressed	suppressed	suppressed
Age 40 Years and Older	suppressed	suppressed	suppressed

Sex assigned at birth	Number of NTSV patients with cesarean deliveries	Total number of NTSV patients	Rate of NTSV patients with Cesarean deliveries (%)
Female			
Male			
Unknown			

Payer Type	Number of NTSV patients with cesarean deliveries	Total number of NTSV patients	Rate of NTSV patients with Cesarean deliveries (%)
Medicare	0		
Medicaid	0		
Private	0		
Self-Pay	0		
Other	166	681	0.244

Preferred Language	Number of NTSV patients with cesarean deliveries	Total number of NTSV patients	Rate of NTSV patients with Cesarean deliveries (%)
English Language	suppressed	suppressed	suppressed
Spanish Language	suppressed	suppressed	suppressed
Asian Pacific Islander Languages	suppressed	suppressed	suppressed
Middle Eastern Languages	suppressed	suppressed	suppressed
American Sign Language	0		
Other/Unknown Languages	suppressed	suppressed	suppressed

Disability Status	Number of NTSV patients with cesarean deliveries	Total number of NTSV patients	Rate of NTSV patients with Cesarean deliveries (%)
Does not have a disability			
Has a mobility disability			
Has a cognition disability			
Has a hearing disability			
Has a vision disability			
Has a self-care disability			
Has an independent living disability			

Sexual Orientation	Number of NTSV patients with cesarean deliveries	Total number of NTSV patients	Rate of NTSV patients with Cesarean deliveries (%)
Lesbian, gay or homosexual			
Straight or heterosexual			
Bisexual			
Something else			
Don't know			
Not disclosed			

Gender Identity	Number of NTSV patients with cesarean deliveries	Total number of NTSV patients	Rate of NTSV patients with Cesarean deliveries (%)
Female			
Female-to-male (FTM)/transgender male/ trans man			
Male			
Male-to-female (MTF)/transgender female/ trans woman			
Non-conforming gender			
Additional gender category or other			
Not disclosed			

CMQCC Vaginal Birth After Cesarean (VBAC) Rate

The CMQCC Vaginal Birth After Cesarean (VBAC) Rate is defined as vaginal births per 1,000 deliveries by patients with previous Cesarean deliveries. General acute care hospitals report the VBAC Rate by race and/or ethnicity, maternal age categories, sex, payer type, preferred language, disability status, sexual orientation, and gender identity. The VBAC Rate uses the specifications of AHRQ Inpatient Quality Indicator 22. For more information, please visit the following link by copying and pasting the URL into your web browser: https://qualityindicators.ahrq.gov/Downloads/Modules/IQI/V2023/TechSpecs/IQI_22_Vaginal_Birth_After_Cesarean_(VBAC)_Delivery_Rate_Uncomplicated.pdf

Number of vaginal delivery among cases with previous Cesarean delivery that meet the inclusion and exclusion criteria

suppressed

Total number of birth discharges with previous Cesarean delivery that meet the inclusion and exclusion criteria

suppressed

Rate of vaginal delivery per 1,000 deliveries by patients with previous Cesarean deliveries

suppressed

Table 8. Vaginal Birth After Cesarean (VBAC) Rate by race and/or ethnicity, maternal age categories, sex, payer type, preferred language, disability status, sexual orientation, and gender identity.

Race and/or Ethnicity	Number of vaginal deliveries with previous Cesarean delivery	Total number of birth discharges with previous Cesarean delivery	Rate of vaginal delivery per 1,000 deliveries by patients with previous Cesarean deliveries (%)
American Indian or Alaska Native	0		
Asian	0	22	0
Black or African American	0	12	0
Hispanic or Latino	suppressed	suppressed	suppressed
Middle Eastern or North African			
Multiracial and/or Multiethnic (two or more races)	suppressed	suppressed	suppressed
Native Hawaiian or Pacific	suppressed	suppressed	suppressed
White	suppressed	suppressed	suppressed

Age	Number of vaginal deliveries with previous Cesarean delivery	Total number of birth discharges with previous Cesarean delivery	Rate of vaginal delivery per 1,000 deliveries by patients with previous Cesarean deliveries (%)
Age < 18	suppressed	suppressed	suppressed
Age 18 to 29	suppressed	suppressed	suppressed
Age 30 to 39	suppressed	suppressed	suppressed
Age 40 Years and Older	0	18	0

Sex assigned at birth	Number of vaginal deliveries with previous Cesarean delivery	Total number of birth discharges with previous Cesarean delivery	Rate of vaginal delivery per 1,000 deliveries by patients with previous Cesarean deliveries (%)
Female			
Male			
Unknown			

Payer Type	Number of vaginal deliveries with previous Cesarean delivery	Total number of birth discharges with previous Cesarean delivery	Rate of vaginal delivery per 1,000 deliveries by patients with previous Cesarean deliveries (%)
Medicare	0		
Medicaid	0		
Private	0		
Self-Pay	0		
Other	suppressed	suppressed	suppressed

Preferred Language	Number of vaginal deliveries with previous Cesarean delivery	Total number of birth discharges with previous Cesarean delivery	Rate of vaginal delivery per 1,000 deliveries by patients with previous Cesarean deliveries (%)
English Language	suppressed	suppressed	suppressed
Spanish Language	suppressed	suppressed	suppressed
Asian Pacific Islander Languages	suppressed	suppressed	suppressed
Middle Eastern Languages	suppressed	suppressed	suppressed
American Sign Language	0		
Other/Unknown Languages	suppressed	suppressed	suppressed

Disability Status	Number of vaginal deliveries with previous Cesarean delivery	Total number of birth discharges with previous Cesarean delivery	Rate of vaginal delivery per 1,000 deliveries by patients with previous Cesarean deliveries (%)
Does not have a disability			
Has a mobility disability			
Has a cognition disability			
Has a hearing disability			
Has a vision disability			
Has a self-care disability			
Has an independent living			

Sexual Orientation	Number of vaginal deliveries with previous Cesarean delivery	Total number of birth discharges with previous Cesarean delivery	Rate of vaginal delivery per 1,000 deliveries by patients with previous Cesarean deliveries (%)
Lesbian, gay or homosexual			
Straight or heterosexual			
Bisexual			
Something else			
Don't know			
Not disclosed			

Gender Identity	Number of vaginal deliveries with previous Cesarean delivery	Total number of birth discharges with previous Cesarean delivery	Rate of vaginal delivery per 1,000 deliveries by patients with previous Cesarean deliveries (%)
Female			
Female-to-male (FTM)/ transgender male/trans man			
Male			
Male-to-female (MTF)/transgender female/trans woman			
Non-conforming gender			
Additional gender category or			
Not disclosed			

CMQCC Exclusive Breast Milk Feeding Rate

The CMQCC Exclusive Breast Milk Feeding Rate is defined as the newborns per 100 who reached at least 37 weeks of gestation (or 3000g if gestational age is missing) who received breast milk

exclusively during their stay at the hospital. Other criteria are that the newborns did not go to the neonatal intensive care unit (NICU), transfer, or die, did not reflect multiple gestation, and did not have codes for parenteral nutrition or galactosemia. General acute care hospitals report the Exclusive Breast Milk Feeding Rate by race and/or ethnicity, maternal age categories, sex, payer type, preferred language, disability status, sexual orientation, and gender identity. The CMQCC Exclusive Breast Milk Feeding Rate uses the Joint Commission National Quality Measure PC-05. For more information, please visit the following link by copying and pasting the URL into your web browser: https://manual.jointcommission.org/releases/TJC2024B/MIF0170.html

Number of newborn cases that were exclusively fed breast milk during their hospital stay and meet the inclusion and exclusion criteria

NA

Total number of newborn cases born in the hospital that meet the inclusion and exclusion criteria

NA

Rate of newborn cases per 100 that were exclusively fed breast milk during their hospital stay and meet the inclusion and exclusion criteria

NA

Table 9. Exclusive Breast Milk Feeding Rate by race and/or ethnicity, maternal age categories, sex, payer type, preferred language, disability status, sexual orientation, and gender identity.

Race and/or Ethnicity	Number of newborn cases that were exclusively breastfed and meet inclusion/exclusion criteria	Total number of newborn cases born in the hospital that meet inclusion/ exclusion criteria	Rate of newborn cases per 100 that were exclusively breastfed and met inclusion/ exclusion criteria (%)
American Indian or Alaska Native			
Asian			
Black or African American			
Hispanic or Latino			
Middle Eastern or North African			
Multiracial and/or Multiethnic (two or more races)			
Native Hawaiian or Pacific			
White			

Age	Number of newborn cases that were exclusively breastfed and meet inclusion/exclusion criteria	Total number of newborn cases born in the hospital that meet inclusion/ exclusion criteria	Rate of newborn cases per 100 that were exclusively breastfed and met inclusion/ exclusion criteria (%)
Age < 18			
Age 18 to 29			
Age 30 to 39			
Age 40 Years and Older			

Sex assigned at birth	Number of newborn cases that were exclusively breastfed and meet inclusion/exclusion criteria	Total number of newborn cases born in the hospital that meet inclusion/ exclusion criteria	Rate of newborn cases per 100 that were exclusively breastfed and met inclusion/ exclusion criteria (%)
Female			
Male			
Unknown			

Payer Type	Number of newborn cases that were exclusively breastfed and meet inclusion/exclusion criteria	Total number of newborn cases born in the hospital that meet inclusion/ exclusion criteria	Rate of newborn cases per 100 that were exclusively breastfed and met inclusion/ exclusion criteria (%)
Medicare			
Medicaid			
Private			
Self-Pay			
Other			

Preferred Language	Number of newborn cases that were exclusively breastfed and meet inclusion/exclusion criteria	Total number of newborn cases born in the hospital that meet inclusion/ exclusion criteria	Rate of newborn cases per 100 that were exclusively breastfed and met inclusion/ exclusion criteria (%)
English Language			
Spanish Language			
Asian Pacific Islander Languages			
Middle Eastern Languages			
American Sign Language			
Other/Unknown Languages			

Disability Status	Number of newborn cases that were exclusively breastfed and meet inclusion/exclusion criteria	Total number of newborn cases born in the hospital that meet inclusion/ exclusion criteria	Rate of newborn cases per 100 that were exclusively breastfed and met inclusion/ exclusion criteria (%)
Does not have a disability			
Has a mobility disability			
Has a cognition disability			
Has a hearing disability			
Has a vision disability			
Has a self-care disability			
Has an independent living			

Sexual Orientation	Number of newborn cases that were exclusively breastfed and meet inclusion/exclusion criteria	Total number of newborn cases born in the hospital that meet inclusion/ exclusion criteria	Rate of newborn cases per 100 that were exclusively breastfed and met inclusion/ exclusion criteria (%)
Lesbian, gay or homosexual			
Straight or heterosexual			
Bisexual			
Something else			
Don't know			
Not disclosed			

Gender Identity	Number of newborn cases that were exclusively breastfed and meet inclusion/exclusion criteria	Total number of newborn cases born in the hospital that meet inclusion/ exclusion criteria	Rate of newborn cases per 100 that were exclusively breastfed and met inclusion/ exclusion criteria (%)
Female			
Female-to-male (FTM)/ transgender male/trans man			
Male			
Male-to-female (MTF)/transgender female/trans woman			
Non-conforming gender			
Additional gender category or			
Not disclosed			

HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate

General acute care hospitals are required to report several HCAI All-Cause Unplanned 30-Day Hospital Readmission Rates, which are broadly defined as the percentage of hospital-level, unplanned, all-cause readmissions after admission for eligible conditions within 30 days of hospital discharge for patients aged 18 years and older. These rates are first stratified based on any eligible condition, mental health disorders, substance use disorders, co-occurring disorders, and no behavioral health diagnosis. Then, each condition-stratified hospital readmission rate is further stratified by race and/or ethnicity, non-maternal age categories, sex, payer type, preferred language, disability status, sexual orientation, and gender identity. For more information on the HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate, please visit the following link by copying and pasting the URL into your web browser:
https://hcai.ca.gov/wp-content/uploads/2024/10/HCAI-All-Cause-Readmission-Rate-Exclusions_ADA.pdf

HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate – Any Eligible Condition

Number of inpatient hospital admissions which occurs within 30 days of the discharge date of an eligible index admission and were 18 years or older at time of admission

868

Total number of patients who were admitted to the general acute care hospital and were 18 years or older at time of admission

8310

Rate of hospital-level, unplanned, all-cause readmissions after admission for any eligible condition within 30 days of hospital discharge for patients aged 18 and older

10.4

Table 10. HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate for any eligible condition by race and/or ethnicity, non-maternal age categories, sex, payer type, preferred language, disability status, sexual orientation, and gender identity.

Race and/or Ethnicity	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
American Indian or Alaska Native	suppressed	suppressed	suppressed
Asian	69	589	11.7
Black or African American	98	644	15.2
Hispanic or Latino	271	3357	8.1
Middle Eastern or North African			
Multiracial and/or Multiethnic (two or more races)	suppressed	suppressed	suppressed
Native Hawaiian or Pacific Islander	suppressed	suppressed	suppressed
White	413	3520	11.7

Age	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Age 18 to 34	88	2213	4
Age 35 to 49	148	1296	11.4
Age 50 to 64	229	1687	13.6
Age 65 Years and Older	403	3114	12.9

Sex assigned at birth	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Female	457	5289	8.6
Male	411	3021	13.6
Unknown			

Payer Type	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Medicare	458	3437	13.3
Medicaid	326	3309	9.9
Private	60	1272	4.7
Self-Pay	suppressed	suppressed	suppressed
Other	suppressed	suppressed	suppressed

Preferred Language	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
English Language	772	7283	10.6
Spanish Language	suppressed	suppressed	suppressed
Asian Pacific Islander Languages	suppressed	suppressed	suppressed
Middle Eastern Languages	suppressed	suppressed	suppressed
American Sign Language	suppressed	suppressed	suppressed
Other/Unknown Languages	suppressed	suppressed	suppressed

Disability Status	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Does not have a disability			
Has a mobility disability			
Has a cognition disability			
Has a hearing disability			
Has a vision disability			
Has a self-care disability			
Has an independent living disability			

Sexual Orientation	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Lesbian, gay or homosexual			
Straight or heterosexual			
Bisexual			
Something else			
Don't know			
Not disclosed			

Gender Identity	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Female			
Female-to-male (FTM)/transgender male/ trans man			
Male			
Male-to-female (MTF)/transgender female/ trans woman			
Non-conforming gender			
Additional gender category or other			
Not disclosed			

HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate - Mental Health Disorders

Number of inpatient hospital admissions which occurs within 30 days of the discharge date for mental health disorders and were 18 years or older at time of admission

173

Total number of patients who were admitted to the general acute care hospital and were 18 years or older at time of admission

1270

Rate of hospital-level, unplanned, all-cause readmissions after admission for mental health disorders within 30 days of hospital discharge for patients aged 18 and older

13.6

Table 11. HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate for mental health disorders by race and/or ethnicity, non-maternal age categories, sex, payer type, preferred language, disability status, sexual orientation, and gender identity.

Race and/or Ethnicity	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
American Indian or Alaska Native			
Asian	suppressed	suppressed	suppressed
Black or African American	suppressed	suppressed	suppressed
Hispanic or Latino	suppressed	suppressed	suppressed
Middle Eastern or North African			
Multiracial and/or Multiethnic (two or more races)	suppressed	suppressed	suppressed
Native Hawaiian or Pacific Islander	suppressed	suppressed	suppressed
White	suppressed	suppressed	suppressed

Age	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Age 18 to 34	suppressed	suppressed	suppressed
Age 35 to 49	suppressed	suppressed	suppressed
Age 50 to 64	suppressed	suppressed	suppressed
Age 65 Years and Older	suppressed	suppressed	suppressed

Sex assigned at birth	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Female	suppressed	suppressed	suppressed
Male	suppressed	suppressed	suppressed
Unknown			

Payer Type	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Medicare	suppressed	suppressed	suppressed
Medicaid	suppressed	suppressed	suppressed
Private	suppressed	suppressed	suppressed
Self-Pay	suppressed	suppressed	suppressed
Other	suppressed	suppressed	suppressed

Preferred Language	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
English Language	suppressed	suppressed	suppressed
Spanish Language	suppressed	suppressed	suppressed
Asian Pacific Islander Languages	suppressed	suppressed	suppressed
Middle Eastern Languages	suppressed	suppressed	suppressed
American Sign Language			
Other/Unknown Languages	suppressed	suppressed	suppressed

Disability Status	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Does not have a disability			
Has a mobility disability			
Has a cognition disability			
Has a hearing disability			
Has a vision disability			
Has a self-care disability			
Has an independent living disability			

Sexual Orientation	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Lesbian, gay or homosexual			
Straight or heterosexual			
Bisexual			
Something else			
Don't know			
Not disclosed			

Gender Identity	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Female			
Female-to-male (FTM)/transgender male/ trans man			
Male			
Male-to-female (MTF)/transgender female/ trans woman			
Non-conforming gender			
Additional gender category or other			
Not disclosed			

HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate - Substance Use Disorders

Number of inpatient hospital admissions which occurs within 30 days of the discharge date for substance use disorders and were 18 years or older at time of admission

98

Total number of patients who were admitted to the general acute care hospital and were 18 years or older at time of admission

681

Rate of hospital-level, unplanned, all-cause readmissions after admission for substance use disorders within 30 days of hospital discharge for patients aged 18 and older

14.4

Table 12. HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate for substance use disorders by race and/or ethnicity, non-maternal age categories, sex, payer type, preferred language, disability status, sexual orientation, and gender identity.

Race and/or Ethnicity	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
American Indian or Alaska Native	suppressed	suppressed	suppressed
Asian	suppressed	suppressed	suppressed
Black or African American	suppressed	suppressed	suppressed
Hispanic or Latino	suppressed	suppressed	suppressed
Middle Eastern or North African			
Multiracial and/or Multiethnic (two or more races)	suppressed	suppressed	suppressed
Native Hawaiian or Pacific Islander			
White	suppressed	suppressed	suppressed

Age	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Age 18 to 34	suppressed	suppressed	suppressed
Age 35 to 49	suppressed	suppressed	suppressed
Age 50 to 64	suppressed	suppressed	suppressed
Age 65 Years and Older	suppressed	suppressed	suppressed

Sex assigned at birth	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Female	suppressed	suppressed	suppressed
Male	suppressed	suppressed	suppressed
Unknown			

Payer Type	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Medicare	suppressed	suppressed	suppressed
Medicaid	suppressed	suppressed	suppressed
Private	suppressed	suppressed	suppressed
Self-Pay	suppressed	suppressed	suppressed
Other	suppressed	suppressed	suppressed

Preferred Language	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
English Language	suppressed	suppressed	suppressed
Spanish Language	suppressed	suppressed	suppressed
Asian Pacific Islander Languages	suppressed	suppressed	suppressed
Middle Eastern Languages			
American Sign Language			
Other/Unknown Languages	suppressed	suppressed	suppressed

Disability Status	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Does not have a disability			
Has a mobility disability			
Has a cognition disability			
Has a hearing disability			
Has a vision disability			
Has a self-care disability			
Has an independent living disability			

Sexual Orientation	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Lesbian, gay or homosexual			
Straight or heterosexual			
Bisexual			
Something else			
Don't know			
Not disclosed			

Gender Identity	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Female			
Female-to-male (FTM)/transgender male/ trans man			
Male			
Male-to-female (MTF)/transgender female/ trans woman			
Non-conforming gender			
Additional gender category or other			
Not disclosed			

HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate - Co-occurring disorders

Number of inpatient hospital admissions which occurs within 30 days of the discharge date for co-occurring disorders and were 18 years or older at time of admission

57

Total number of patients who were admitted to the general acute care hospital and were 18 years or older at time of admission

375

Rate of hospital-level, unplanned, all-cause readmissions after admission for co-occurring disorders within 30 days of hospital discharge for patients aged 18 and older

15.2

Table 13. HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate for co-occurring disorders by race and/or ethnicity, non-maternal age categories, sex, payer type, preferred language, disability status, sexual orientation, and gender identity.

Race and/or Ethnicity	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
American Indian or Alaska Native	suppressed	suppressed	suppressed
Asian	suppressed	suppressed	suppressed
Black or African American	suppressed	suppressed	suppressed
Hispanic or Latino	suppressed	suppressed	suppressed
Middle Eastern or North African			
Multiracial and/or Multiethnic (two or more races)	suppressed	suppressed	suppressed
Native Hawaiian or Pacific Islander	suppressed	suppressed	suppressed
White	suppressed	suppressed	suppressed

Age	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Age 18 to 34	suppressed	suppressed	suppressed
Age 35 to 49	suppressed	suppressed	suppressed
Age 50 to 64	suppressed	suppressed	suppressed
Age 65 Years and Older	suppressed	suppressed	suppressed

Sex assigned at birth	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Female	suppressed	suppressed	suppressed
Male	suppressed	suppressed	suppressed
Unknown			

Payer Type	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Medicare	suppressed	suppressed	suppressed
Medicaid	suppressed	suppressed	suppressed
Private	suppressed	suppressed	suppressed
Self-Pay	suppressed	suppressed	suppressed
Other	suppressed	suppressed	suppressed

Preferred Language	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
English Language	suppressed	suppressed	suppressed
Spanish Language	suppressed	suppressed	suppressed
Asian Pacific Islander Languages	suppressed	suppressed	suppressed
Middle Eastern Languages			
American Sign Language			
Other/Unknown Languages	suppressed	suppressed	suppressed

Disability Status	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Does not have a disability			
Has a mobility disability			
Has a cognition disability			
Has a hearing disability			
Has a vision disability			
Has a self-care disability			
Has an independent living disability			

Sexual Orientation	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Lesbian, gay or homosexual			
Straight or heterosexual			
Bisexual			
Something else			
Don't know			
Not disclosed			

Gender Identity	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Female			
Female-to-male (FTM)/transgender male/ trans man			
Male			
Male-to-female (MTF)/transgender female/ trans woman			
Non-conforming gender			
Additional gender category or other			
Not disclosed			

HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate - No Behavioral Health Diagnosis

Number of inpatient hospital admissions which occurs within 30 days of the discharge date with no behavioral diagnosis and were 18 years or older at time of admission

540

Total number of patients who were admitted to the general acute care hospital and were 18 years or older at time of admission

5984

Rate of hospital-level, unplanned, all-cause readmissions after admission with no behavioral diagnosis within 30 days of hospital discharge for patients aged 18 and older

9

Table 14. HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate with No Behavioral Diagnosis by race and/or ethnicity, non-maternal age categories, sex, payer type, preferred language, disability status, sexual orientation, and gender identity.

Race and/or Ethnicity	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
American Indian or Alaska Native	suppressed	suppressed	suppressed
Asian	suppressed	suppressed	suppressed
Black or African American	suppressed	suppressed	suppressed
Hispanic or Latino	suppressed	suppressed	suppressed
Middle Eastern or North African			
Multiracial and/or Multiethnic (two or more races)	suppressed	suppressed	suppressed
Native Hawaiian or Pacific Islander	suppressed	suppressed	suppressed
White	suppressed	suppressed	suppressed

Age	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Age 18 to 34	suppressed	suppressed	suppressed
Age 35 to 49	suppressed	suppressed	suppressed
Age 50 to 64	suppressed	suppressed	suppressed
Age 65 Years and Older	suppressed	suppressed	suppressed

Sex assigned at birth	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Female	290	3940	7.4
Male	250	2044	12.2
Unknown			

Payer Type	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Medicare	suppressed	suppressed	suppressed
Medicaid	suppressed	suppressed	suppressed
Private	suppressed	suppressed	suppressed
Self-Pay	0	26	0
Other	suppressed	suppressed	suppressed

Preferred Language	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
English Language	suppressed	suppressed	suppressed
Spanish Language	suppressed	suppressed	suppressed
Asian Pacific Islander Languages	suppressed	suppressed	suppressed
Middle Eastern Languages	0	12	0
American Sign Language	suppressed	suppressed	suppressed
Other/Unknown Languages	suppressed	suppressed	suppressed

Disability Status	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Does not have a disability			
Has a mobility disability			
Has a cognition disability			
Has a hearing disability			
Has a vision disability			
Has a self-care disability			
Has an independent living disability			

Sexual Orientation	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Lesbian, gay or homosexual			
Straight or heterosexual			
Bisexual			
Something else			
Don't know			
Not disclosed			

Gender Identity	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Female			
Female-to-male (FTM)/transgender male/ trans man			
Male			
Male-to-female (MTF)/transgender female/ trans woman			
Non-conforming gender			
Additional gender category or other			
Not disclosed			

Health Equity Plan

All general acute care hospitals report a health equity plan that identifies the top 10 disparities and a written plan to address them.

Top 10 Disparities

Disparities for each hospital equity measure are identified by comparing the rate ratios by stratification groups. Rate ratios are calculated differently for measures with preferred low rates and those with preferred high rates. Rate ratios are calculated after applying the California Health and Human Services Agency's "Data De-Identification Guidelines (DDG)," dated September 23, 2016.

Table 15. Top 10 disparities and their rate ratio values.

Measures	Stratifications	Stratification Group	Stratification Rate	Reference Group	Reference Rate	Rate Ratio
HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate	Age (excluding maternal measures)	50 to 64	13.6	18 to 34	4	3.4
HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate	Age (excluding maternal measures)			18 to 34	4	3.3
HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate	Age (excluding maternal measures)	35 to 49	11.4	18 to 34	4	2.9
HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate	Expected Payor	Medicare	13.3	Private	4.7	2.8
HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate	Expected Payor	Medicaid	9.9	Private	4.7	2.1
HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate	Race and/or Ethnicity	Black or African American	15.2	Hispanic or Latino	8.1	1.9
HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate, stratified by behavioral health diagnosis (No Behavioral Health Diagnosis)	Sex Assigned at Birth	Male	12.2	Female	7.4	1.7
HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate	Sex Assigned at Birth	Male	13.6	Female	8.6	1.6
HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate	Race and/or Ethnicity			Hispanic or Latino	8.1	1.5
HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate	Race and/or Ethnicity			Hispanic or Latino	8.1	1.5

Plan to address disparities identified in the data

HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate Ð
Measurable Objectives: Reduce 30-day all-cause readmissions by 15% over the next 2 years.Ð
Ð
?”F—7 ity: 1, 2, & 3 Stratification: Age-Related Readmit Disparities (65+, 50-64, and 35-49 Vs. 18-34) Population Impact: Adults 35-65+ experiencing higher unplanned readmissions compared to younger patients (18-34).Ð
?” 7F–öâ Æ ã Enhanced chronic disease management education during hospitalization for older patients, including tailored content on medication adherence and symptom recognition specific to their conditions. All patients to be discharged home with disease specific Zone tools, with clear instructions and educational reinforcement provided by nursing staff prior to discharge. Increase utilization of Rural Health Clinics as transitional clinics to bridge the gap for high risk/older patients, ensuring seamless communication and information transfer between hospital and clinic teams. Follow up phone calls within 48-72 hours after discharge, providing an opportunity to address immediate post-discharge concerns and reinforce discharge instructions. Ensure discharge follow-up appointment is scheduled prior to discharge, with transportation and scheduling barriers proactively addressed for vulnerable populations. Ð
?”F—7 ity: 4 & 5 Stratification: Expected Payor Related readmit Disparities (Medicare and Medicaid VS Private Insurance) Population Impact: Adults over 65, persons with disabilities, and persons of all ages with state/federal funded healthcareÐ
?” 7F–öâ Æ ã Enhanced chronic disease management education during hospitalizations for patients with high risk factors and/or complex comorbidities, tailoring educational materials to address common barriers faced by Medicare and Medicaid recipients, such as health literacy and access to

resources. Increase utilization of Rural Health Clinics as transitional care clinics, telemedicine, and home health to bridge the gap and ensure a smoother transition to recovery, proactively addressing financial and logistical barriers that might prevent Medicare and Medicaid patients from accessing these vital services. Follow up phone calls within 48-72 hours after hospital discharge, specifically inquiring about medication access, understanding of discharge instructions, and identifying any new social determinants of health barriers. Ensure discharge follow-up appointment is scheduled with providers who accept their specific insurance plans and are geographically accessible. Use of Mobile care clinics for population needs, bringing essential healthcare services directly to underserved communities with high rates of Medicare and Medicaid enrollment. Ð
?”F—7 ity: 7 & 8 Stratification: Sex Assigned at Birth Related Readmit Disparities Population Impact: MalesÐ
?” 7F–öâ Æ ã Provide male-centered health education focusing on medication adherence, lifestyle management, and follow-up care, utilizing communication styles and materials that resonate more effectively with male patients. This education will also address potential male-specific barriers to seeking care or disclosing symptoms. Strengthen discharge planning with clear, simplified instructions and early outpatient follow-up for high-risk male patients, ensuring follow-up appointments are scheduled conveniently and transportation assistance is offered if needed. Furthermore, we will explore incorporating "peer support" or male-centric health coaching programs to foster accountability and engagement in their post-discharge recovery. Ð
?”F—7 ity: 6, 9 & 10 Stratification: Race and/or Ethnicity Readmit Disparities (Black or African American, White and Asian VS Hispanic or Latino) Population Impact: Black or African American, White and Asian populationsÐ
?” 7F–öâ Æ ã Provide discharge instructions and health education in culturally relevant formats and languages, ensuring that these materials are not merely translated but also culturally adapted to resonate with the specific health beliefs and practices of Black or African American, White and Asian communities. This includes utilizing diverse patient educators and community health workers who can build trust and effectively communicate critical information. Address barriers such as housing, food security, and access to medications that disproportionately affect Black or African American, White and Asian populations, by establishing robust partnerships with community-based social services and providing direct referrals to support organizations during hospitalization and follow-up. We will also integrate social determinants of health screenings into the admission and discharge processes to identify and proactively address these needs. Collaborate with outreach events for these populations, to offer health screenings, educational workshops, and direct access to healthcare navigators who can assist with post-discharge planning and resource connection.

Performance in the priority area

General acute care hospitals are required to provide hospital equity plans that address the top 10 disparities by identifying population impact and providing measurable objectives and specific timeframes. For each disparity, hospital equity plans will address performance across priority areas: person-centered care, patient safety, addressing patient social drivers of health, effective treatment, care coordination, and access to care.

Person-centered care

At Mercy Medical Center Merced (MMCM), our performance in the priority area of Person-Centered Care, as guided by our ministry's core values of compassion, inclusion, integrity, excellence, and collaboration, has been demonstrably strong and has contributed directly to the significant steps taken to address health disparities and build trust within diverse communities. We have actively embodied the holistic approach to health delivery that places individuals, their values, preferences, and lived experiences at the center of decision-making, moving beyond solely disease management

to emphasize dignity, respect, and collaboration.Ð
We have been instrumental in ensuring that patient voices are not merely heard, but actively incorporated into care planning at multiple touchpoints:Ð
?”V× F†WF–2 Væv vVÖVçC We consistently engage patients in open and honest conversations, actively listening to their concerns, understanding their unique life circumstances, and seeking to comprehend their goals and preferences beyond their immediate medical condition. This involves asking open-ended questions and validating their perspectives in their care. Ð
?•6† &VB FV6—6–öâÔÖ ¶–æs We facilitate shared decision-making by presenting various treatment options in an understandable manner, discussing the potential benefits and risks, and explicitly inquiring about the patient's values and priorities. For example, when a patient expresses a strong preference for maintaining a particular lifestyle, we work to integrate that preference into their treatment plan, offering alternatives that align with their goals.Ð
?”7VÇGW al Humility: We actively practice cultural humility, recognizing that each patient's cultural background, beliefs, and lived experiences will shape their health perceptions and preferences. This informs how we introduce and discuss care options, ensuring they are presented in a culturally sensitive and respectful manner. For instance, understanding the importance of family in some cultures, we proactively involve designated family members in discussions, if the patient wishes.Ð
?” G`ocacy for Patient Preferences: When faced with system-level constraints, we advocate for patient preferences within the care team, explaining the patient's rationale and working collaboratively to find solutions that best accommodate their wishes while upholding optimal clinical care. Ð
?”6öçG ibuting to Quality Improvement Initiatives: We actively participate in quality improvement initiatives that emerge from patient experience data. This includes participating in discussions to analyze data trends, brainstorm solutions, and implement changes to care delivery. Our hands-on experience on the front lines provides valuable insights for these discussions.Ð
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In summary, our performance in Person-Centered Care is rooted in the conviction that every individual deserves dignity, respect, and an equal opportunity to achieve optimal health outcomes. We consistently demonstrate this through my active listening, shared decision-making, cultural humility, proactive utilization of language access services, and my commitment to advocating for patient needs and providing feedback that supports continuous improvement in equitable care delivery. We understand that person-centered care is an ongoing journey, and we are dedicated to continuously learning and refining my practice to better serve our diverse communities.

Patient safety

At Mercy Medical Center Merced (MMCM), our performance in the critical area of Patient Safety is intrinsically linked to our unwavering commitment to health equity. We firmly believe that exceptional, safe care is a fundamental right for every individual, and this belief guides our comprehensive approach to identifying, understanding, and actively dismantling systemic inequities that often disproportionately affect our most vulnerable populations. Our commitment ensures that health equity principles are deeply woven into the fabric of all our patient safety endeavors, leading to tangible improvements in safety for every patient, irrespective of their background.Ð
When safety events unfortunately occur, our investigation process is robust and thorough, utilizing both Event Investigation & Analysis (often referred to as Root Cause Analysis) and Apparent Cause Analysis, always viewed through an equity lens. Our investigations delve beyond immediate contributing factors, systematically exploring the underlying systemic inequities and broader social determinants of health that may have played a role in the event. This depth of inquiry ensures we address root causes rather than merely symptoms.Ð
We embrace a philosophy of continuous learning and improvement in our pursuit of patient safety equity. This means our strategies are adapting based on emerging data, evidence based research,

and invaluable community feedback. Our transparent sharing of both successes and challenges underscores our accountability, fostering a highly reliable environment that is singularly focused on equitable outcomes and ensuring every patient benefits from the absolute highest standards of safety and care.Ð

Areas of Work Within Patient Safety and Equity at MMCM:Ð

?•pelcome Packet for Each Patient: One important way we keep our patients informed and included in their safe care is upon admission, each patient receives a welcome packet. The welcome packet serves as a foundational tool for proactive patient and family engagement by immediately empowering them with crucial information and fostering a culture of safety from the beginning.. By comprehensively covering topics such as fall prevention, infection control, medication safety, and Condition H, the packet not only educates but also instills confidence in patients and families to actively participate in their care, becoming invaluable partners in preventing adverse events. To advance health equity and ensure comprehensive understanding for all, the welcome packet is currently transitioning to a scannable QR code format. This innovative approach allows for immediate access to the same vital information in multiple different languages, directly assisting every patient and family member, regardless of their primary language, in fully comprehending the content. This dedicated effort to overcome language barriers significantly amplifies the value of the information provided, establishing a robust commitment to patient safety and patient/family partnership from the very beginning. Ð

?”Væ† æ6–ær 6öÖÐunication Through Culturally Sensitive Interpreters: We have made a significant investment in implementing and consistently utilizing in-person, culturally sensitive Spanish translators as integral members of our healthcare team. This critical resource effectively demolishes language barriers and profoundly respects diverse cultural contexts. It ensures that all patients can fully engage in their care, that essential safety information is completely understood, misunderstandings are prevented, and optimal health outcomes are vigorously promoted. Beyond Spanish, we provide comprehensive translation services across numerous languages, facilitated by our contracted language line, to ensure all patients achieve optimal understanding of their disease processes.Ð

?”f–v‡B F†R `all Campaign Education: Recognizing diverse needs, we developed fall risk and prevention education specifically adapted for Spanish-speaking patients. These materials guarantee language is no impediment, enabling Spanish-speaking patients and caregivers to participate in strategies for balance, mobility, and a safer environment.Ð

?•6 `ety First Culture (HRO Model): At MMCM, patient safety is central to quality care. We've adopted the High Reliability Organization (HRO) model, learning from safety-focused industries like aviation. MMCM has named our HRO Model, ?Safety First?. This framework allows exceptional safety and effectiveness in a complex healthcare setting. Our objective is a pervasive culture where harm is rare, errors are anticipated, and robust systems respond swiftly to risks. Applying HRO transforms safety from isolated initiatives into a deeply ingrained culture of reliability and trust. Our demonstrable decrease in Hospital Acquired Infections (HAIs) over the past two years evidences our steadfast commitment to outstanding patient safety.

Addressing patient social drivers of health

At Mercy Medical Center Merced (MMCM), we recognize that addressing patient Social Determinants of Health (SDOH) is critical, especially since 100% of our top 10 patient outcome disparities are linked to 30-day all-cause readmissions. Our health system is deeply committed to closing these equity gaps by actively reducing avoidable readmissions through a multipronged, patient-centered approach.Ð

We understand that social and structural barriers disproportionately affect vulnerable populations. To ensure every patient, regardless of their background, receives equitable support during their transition from hospital to home, we've implemented three core strategies:Ð

1.• &ö 7F—`e Follow-up Appointment Scheduling: We facilitate continuity of care by scheduling follow-up appointments before patients are discharged. This practice significantly reduces missed visits and ensures timely recovery monitoring, proving especially beneficial for patients facing health literacy or transportation challenges. In 2024, our screening efforts identified that 14.4% of patients reported transportation difficulties and 6.9% experienced food insecurity. To immediately address these, social workers receive automatic EHR consults for high-need patients. Additionally, our Community Health Workers (CHWs) provide targeted follow-up for patients in our top four diagnosis groups (Diabetes, COPD, CHF, and Sepsis) to ensure SDOH gaps are addressed and all resource needs are met.Ð
2.•'W al Health Clinics: Our Rural Health Clinics provide a vital bridge for high-risk patients moving from hospital to primary care. These clinics prioritize medication reconciliation, patient education, and reinforcing discharge instructions ? all crucial for those with multiple chronic conditions. By integrating culturally appropriate communication and interpreter services, we break down barriers that often hinder underserved populations from understanding and adhering to their care plans.Ð
3.•@argeted Post-Discharge Follow-up Calls: Within 48-72 hours of discharge, high-risk patients receive personalized phone calls in our top four diagnosis groups (Diabetes, COPD, CHF, and Sepsis) from our CHWs. These calls proactively address medication concerns, clarify instructions, and crucially, identify emerging social needs like access to food, housing, or transportation. When social barriers are identified, we swiftly connect patients with community-based resources, directly tackling upstream determinants of health that contribute to readmission risk.Ð
To validate the effectiveness of these strategies in reducing disparities, we meticulously monitor readmission rates, stratified by race, ethnicity, language, and insurance status. Our comprehensive approach includes advanced risk assessments, patient-centered interventions, and proactive SDOH screening both at admission and throughout hospitalization.Ð
By embedding equity into our care transitions, we are not only dedicated to reducing readmissions but also to narrowing the existing gaps in access and outcomes. Through proactive follow-up, robust transition support, and patient-centered communication, MMCM is building a system where every patient, especially those most at risk, has the necessary resources and support for a safe and successful recovery. Our overarching goal is to decrease identified readmission disparity gaps by 15% over the next two years.

Performance in the priority area continued

Performance across all of the following priority areas.

Effective treatment

At MMCM, our performance in the priority area of Effective Treatment is fundamentally driven by our mission to provide high-quality, compassionate care for all who seek it, with an unwavering commitment to health equity. We believe effective treatment is not just about medical protocols, but about delivering care that is tailored, accessible, and ultimately, achieves the best possible outcomes for every individual in our community.Ð
Foundation in Evidence-Based, Equitable Care: Our approach to effective treatment is built upon rigorous adherence to evidence-based guidelines for both chronic and acute diseases. However, our commitment extends beyond mere adherence. Ð
Leveraging Technology and Integrated Support for Holistic Treatment: Ð
Our Electronic Health Record (EHR) is a cornerstone of our strategy, designed to capture not only essential demographic data but also patient-reported health-related social needs. This crucial information is seamlessly integrated into clinical workflows, flagging potential barriers to care before they impact treatment effectiveness. This proactive identification enables our multidisciplinary team ? including skilled interpreters (with on-site Spanish interpreters and a comprehensive

interpretation service), compassionate social workers, dedicated care coordinators, and culturally sensitive nurses, physicians, and ancillary care team members ? to collaborate in connecting patients with vital community resources and primary care services. This team also includes our dedicated Community Health Workers (CHWs), who play an invaluable role in directly addressing the social determinants of health identified through our EHR and patient interactions. Their deep understanding of the community and ability to build trust enables us to bridge gaps in care, navigate complex social support systems, and ensure patients can access essential resources like food, housing, or transportation that directly impact their ability to adhere to treatment plans and achieve optimal health outcomes.This holistic approach ensures that effective treatment addresses not just the medical condition, but also the broader determinants of health that impact recovery and long-term well-being.Ð

Strengthening Community-Based Care and Access: Recognizing that effective treatment often begins outside our hospital walls, we are actively strengthening our primary care network. We actively recruit primary care providers to our service area and operate a robust family practice residency program with the express aim of retaining our residents to serve our community, thereby enhancing access to foundational care. Our targeted community programs, including specialized chronic disease management, innovative street medicine initiatives, and community grants, further extend our reach, ensuring effective treatment and preventative care are accessible to the most vulnerable populations.

Care coordination

At Mercy Medical Center Merced (MMCM), our performance in the priority area of Care Coordination is a direct reflection of our mission: to provide high quality, compassionate care for all who seek it. We are profoundly committed to delivering equitable care to every patient, proactively recognizing and mitigating the impact of social determinants of health and systemic biases that often complicate care transitions.Ð

Advancing Health Equity Through Focused Care Coordination: Our hospital is deeply committed to advancing health equity by systematically improving care coordination and directly addressing disparities in access, communication, and outcomes. We explicitly acknowledge that patients from underserved populations ? including those with limited English proficiency, low income, or complex chronic conditions ? face disproportionate barriers during care transitions. To reduce avoidable readmissions and significantly improve health outcomes, we are embedding comprehensive, equity-focused strategies into every step of the care continuum.Ð

Seamless Transitions and Proactive Planning: We prioritize seamless and well-supported transitions between hospital, primary care, and specialty services. A cornerstone of our approach is the proactive scheduling of follow-up appointments for high-risk patients with their primary and specialty providers prior to discharge. We have implemented a program with our Rural Health Clinics for patients to be seen just after discharge if they cannot be seen by their primary provider, enhancing their transitional care. This crucial step significantly reduces the burden on patients to navigate the often-complex healthcare system independently.Ð

Our standardized discharge planning protocols are meticulously designed to ensure every patient leaves the hospital with clear, actionable next steps. This includes:Ð

?”6ö× &V†Vç6—`e medication reconciliation and education: With materials readily available in multiple languages to ensure understanding and adherence.Ð

?” 7F—`e inclusion of family members or caregivers: They are empowered to participate in discharge discussions to reinforce understanding and provide ongoing support.Ð

?• &ö 7F—`e assessment of social determinants of health: We systematically assess factors such as housing, transportation, and food access, providing direct referrals to our extensive network of community partners as needed.Ð

?•@argeted follow-up calls: For high-risk patients, we conduct follow-up phone calls within 48-72

hours post-discharge to address immediate concerns, clarify instructions, prevent complications and schedule appointments as needed. Ð

Empowering Patients and Addressing Disparities: To ensure true equity in care coordination, we actively engage a dedicated team of interpreters, patient navigators, and our network of community partners. This collaborative effort is vital in supporting vulnerable populations and ensuring that no patient is left behind due to language or social barriers. We view patients and their families as invaluable, active partners in their care, empowering them to participate in shared decision-making and to voice any concerns they may have.Ð

Strategic Integration and Community Focus: Our commitment to care coordination extends to strengthening our community health infrastructure. We utilize evidence-based guidelines for chronic and acute diseases, and critically, differentiate outcomes of guideline adherence by race, ethnicity, language, socioeconomic status, and geographic location to identify and close equity gaps in chronic disease management that are often exacerbated by poor coordination. We actively recruit primary care providers to our service area and operate a vibrant family practice residency program, aiming to retain our residents to service our community and bolster our ability to provide continuous, coordinated care. Ð

By aligning our care coordination strategies with our core equity principles, MMCM is creating a system where patients experience smoother transitions, greater confidence in their care plan, and significantly fewer avoidable hospitalizations. Our unwavering commitment is not only to reduce readmissions but also to close gaps in care, improve patient trust, and ultimately ensure that every patient receives safe, reliable, and profoundly person-centered care across the entire continuum.

Access to care

At Mercy Medical Center Merced (MMCM), our performance in Access to Care is fundamental to our mission: providing high-quality, compassionate care and achieving genuine health equity for every patient. We understand that access encompasses affordability, timeliness, cultural responsiveness, and ease of navigation, and our strategies actively mitigate social determinants of health and systemic biases.Ð

Our approach is directly shaped by the Community Health Needs Assessment (CHNA), which identified key priority areas guiding our initiatives:Ð

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?”÷`erweight/Obesity/Healthy Eating/Physical ActivityÐ

?• &Pventive CareÐ

Diverse Programs and Services Enhancing Access in 2024: MMCM has implemented a robust array of programs addressing these needs:Ð

?” 66W72 Fò †V ÇF, 6 &S Financial assistance, accessible primary care clinics, and our Connected Community Network. Notably, our Mobile Health Clinic extends services to vulnerable patients.Ð

?”&— th Indicators: Comprehensive education, Baby Café support, and prenatal yoga.Ð

?”6‡&öæ–2 F—6V 6W3 Education and outreach for asthma, cancer, diabetes, stroke, plus tobacco cessation clinics.Ð

?”÷`erweight/Obesity/Healthy Eating/Physical Activity: Community classes like yoga, "Walk with Ease," and Zumba.Ð

?• &Pventive Care: Broad health education, community outreach, and vital screening programs, including cancer and cardiovascular screenings, Chronic Disease Self-Management workshops, and the Diabetes Education Empowerment Program (DEEP).Ð

Reaching Underserved Populations with Mobile and Community Initiatives: A cornerstone of our strategy is the Mobile Health Clinic, launched September 16, 2024. This initiative has already reached over 1,300 patients, bringing health screenings, preventive care, and education directly to

those facing barriers like distance and limited provider availability, including unhoused individuals and school communities. The clinic provides primary medical care, immunizations, and wellness outreach, focusing on meeting people where they are. It also partners with hospital discharge planning and shelters for recuperative care support. The mobile team includes a social worker and community health workers (CHWs) to address not only medical needs but also social determinants like food, housing, and transportation, promoting dignity and stability.Ð
Holistic Support Addressing Non-Medical Barriers: We understand that clinical services are only one piece of the puzzle. Our CHWs are pivotal in providing essential post-discharge services for vulnerable populations, including direct follow-up and crucial connections to community resources for transportation, food security, and other social needs that profoundly impact a patient's ability to access and benefit from care.Ð
Ensuring Equitable Access: Through Communication and Empowerment: Our commitment to equitable access is embedded in every interaction. We offer comprehensive interpreter services and translated materials, ensuring culturally responsive communication. We collaborate with local organizations to provide essential support like housing, transportation assistance, and social support. We also assist patients with insurance options and financial support programs, reducing cost-related delays. Patient and family engagement is paramount; we empower patients through health education, shared decision-making, and clear discharge instructions, strengthening support systems beyond the clinical setting.Ð
In summary, MMCM's dedication to increasing access to care is driven by a holistic, equity-driven approach that integrates clinical excellence with vital social support, innovative technology, comprehensive language access, and robust community partnerships. This ensures all patients, regardless of background, have the opportunity to achieve their best health, reducing disparities and building enduring community trust.

Methodology Guidelines

Did the hospital follow the methodology in the Measures Submission Guide? (Y/N)

Y