California Department of
State Hospitals

Department of Healthcare Access and Information (HCAI) Health Equity Plan

Department of State Hospitals- Coalinga

2025

HCAI HEALTH EQUITY PLAN TEMPLATE

Department of State Hospitals – Coalinga

SECTION 1 — ORGANIZATION INFORMATION

Organization Name: Department of State Hospitals – Coalinga

Reporting Period: January 1 – December 31, 2024

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SECTION 2 — DATA LIMITATIONS & CONTEXT

Multidisciplinary team members at Department of State Hospitals – Coalinga (DSH-C) work to gather relevant data and input from the patients within our care upon admission, throughout the course of their hospitalization and their treatment planning conferences. Much of the information gathered is inputted and maintained in hardcopy format within the patients' record with limited information electronically tracked. Currently, DSH-C is in the process of improving patient care by implementing an Electronic Health Record (EHR) system for data accuracy and enabling better care coordination through instant, secure access to a patient's complete medical history and record.

Currently data can only be collected through manual abstraction by review of charts which is a collection limitation of the hospital due to staffing, however with the implementation of the Electronic Health Record (EHR) automation and accuracy of data extraction can be made with direct database inquiries of patient information.

Staff will continue to assess patients and capture manual information in the record until the EHR is implemented. Trainings and staff education will also continue on current trends of healthcare disparities and equity principles to provide excellent care to our patients and effective discharge planning.

Patients at this hospital are legally committed, which affects admission and discharge timelines.

Small patient populations limit statistical power for some measures. 30-day readmission tracking is constrained by facility resources.

Due to the high rate of patients returning to the judicial system post-treatment (rather than the general community), we have a data deficiency concerning the efficacy of community-based care coordination and discharge planning protocols.

SECTION 3 — IDENTIFICATION OF DISPARITIES

Methods Used to Identify Disparities:

DSH-C performed a comprehensive analysis of all core quality measures, stratified by the eight required demographics and social factors, using HCAI recommended rate ratio (RR) methodology. No statistically supported disparities met the HCAI disparity guidelines across any of the required measures during the reporting period. Therefore, DSH-C does not have a list of "Top 10 Disparities" to report for this cycle. Our outcomes were consistent across all analyzed patient populations, suggesting equitable care delivery for the measured metrics.

Ranked List of Identified Disparities:

Rank	Measure	Stratification	Disparity Group	Rate	Reference Group	Relative Ratio
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						

SECTION 4— PERFORMANCE ACROSS 6 PRIORITY CARE AREAS

This section provides an overview of performance in HCAI's six priority care areas and highlights equity implications.

1. Person-Centered Care

DSH-Coalinga advances health equity by ensuring that all patients receive respectful, culturally responsive, and trauma-informed care. Staff training occurs through New Employee Orientation (NEO), ongoing education, and targeted Trauma-Informed Care (TIC) programs.

Key Practices and Metrics:

- Interdisciplinary teams develop individualized treatment plans. **Goal:** 100% of patients to have a documented person-centered treatment plan within 90 days of admission.
- Trauma-Informed Care Committee (TICC) monitors disparities and implements interventions. **Metric:** Annual TIC Survey results disaggregated by unit, discipline, and demographic group; aim for ≥90% of staff reporting understanding of TIC principles.
- TGNC care: Transgender Treatment Advisory Committee (TTAC) evaluates needs and monitors outcomes. **Metric:** 95% of TGNC patients report affirming care experiences in annual satisfaction surveys.

2. Patient Safety

Patient safety encompasses risk reduction, high-quality care, and active patient participation. Patients communicate preferences, participate in committees, and utilize anonymous reporting mechanisms.

Key Practices and Metrics:

- Safety-related trainings (TIC, Racial Justice & Equity, Patients' Rights) completed by ≥90% of staff annually.
- Anonymous reporting tracked; **target:** respond to 100% of reported incidents within 5 business days.
- Patient Safety Culture and Workplace Surveys conducted biennially. **Goal:** ≥85% staff agreement on safety culture measures; trends analyzed to guide interventions

3. Addressing Social Drivers of Health (SDOH)

DSH-Coalinga addresses social, structural, and environmental determinants that affect health, integrating health equity throughout the care continuum.

Key Practices and Metrics:

- Biopsychosocial Assessments completed for 100% of patients within 30 days of admission.

- Community Resource Needs Questionnaire completed and updated annually for all patients.
- Community Integration Team (CIT) ensures access to services; **metric:** 95% of patients discharged with verified housing, benefits, and behavioral health support.
- Conditional Release Program (CONREP): **Goal:** 90% of eligible patients maintain community engagement and remain incident-free for 6 months post-transition.

4. Effective Treatment

DSH-Coalinga provides safe, timely, and individualized treatment. Treatment Plans are developed by interdisciplinary teams and reviewed regularly.

Key Practices and Metrics:

- Administrative Directives (A.D.s) reviewed annually; **metric:** 100% of A.D.s updated on schedule.
- Language access: Preferred language captured for ≥90% of patients by end of 2026.
- Racial, Justice, and Equity Committee monitors disparities; **metric:** conduct quarterly analysis of treatment outcomes by demographic group to identify and reduce inequities.
- Patient engagement: 95% of patients participate in treatment planning conferences, documented in health records.

5. Care Coordination

Care coordination ensures continuity and safe transitions, both during hospitalization and upon discharge.

Key Practices and Metrics:

- Daily interdisciplinary collaboration and high-risk patient monitoring. **Metric:** 100% of high-risk patients have documented risk interventions within 24 hours of identification.
- Discharge planning: ≥95% of patients receive documented discharge plans including community resources, benefits, and instructions in preferred language.
- Partnerships with external agencies monitored; **metric:** 90% of post-discharge appointments successfully scheduled within 30 days of discharge.

6. Access to Care

DSH-Coalinga provides 24/7 healthcare, including nursing, medical, psychiatric, and specialty services.

Key Practices and Metrics:

- All patients receive physician assessments annually or as needed. **Metric:** 100% compliance with required assessments.
- Specialty care referrals: Goal: ≥95% of patients referred to specialty services are seen within 14 days of referral.
- Medical clinic expansion: new services (dialysis, CT, MRI, colonoscopy) aim to reduce wait times and increase access by 20% within the first year of implementation.

SECTION 5 — CONTRIBUTING FACTORS

1. Legal Commitment of Patients
    - Admissions, treatment, and discharges are governed by the legal system, which limits clinical autonomy in determining timelines and discharge readiness.
    - Extended hospital stays are standard compared to acute care settings, affecting care planning and post-discharge transitions.
2. Limited Electronic Health Record (EHR) Infrastructure
    - Most patient information is maintained in hardcopy format, limiting real-time data access and analysis.
    - Manual chart reviews constrain timely data collection, reporting, and evaluation of treatment outcomes.
    - Implementation of an EHR is expected to improve accuracy, accessibility, and continuity of patient information.
3. Small Patient Populations
    - Certain demographic groups within the patient population are small, limiting statistical power for analyzing outcomes or trends.
    - This may make it difficult to detect disparities even when they exist.
4. Complex Care Needs
    - Patients often have co-occurring psychiatric, medical, and behavioral conditions requiring multidisciplinary care.
    - These complex needs increase variability in treatment approaches and outcomes.
5. Structured Hospital Operations
    - Care processes are influenced by standardized hospital protocols, administrative directives, and risk management procedures, which are necessary for safety but may constrain individualized flexibility.
6. High Rate of Reentry to Judicial System
    - Many patients return to the judicial system rather than the general community post-treatment, limiting long-term outcome tracking and assessment of community reintegration programs.
7. Staffing Constraints and Resource Limitations
    - Manual data collection, high patient acuity, and multidisciplinary coordination place significant demands on staff.

    - Resource limitations can affect timely assessments, interventions, and discharge planning.
8. Language and Communication Barriers
    - While preferred language data is being collected, current limitations in multilingual support and documentation may impact patient engagement and education.
9. Transition of Care Complexity
    - Coordination with external agencies, community resources, and conditional release programs is complex and may introduce variability in discharge planning and post-hospital support.

SECTION 6 — Specific, Measurable, Achievable, Relevant and Time bound (S.M.A.R.T) EQUITY GOALS

Due to no disparities identified, goals focus on maintenance and proactive screening.

SECTION 7 — INTERVENTIONS & ACTION PLAN

- EHR implementation and data automation
- Expansion of interpreter access
- Racial Justice & Equity (RJE) training
- Trauma-Informed Care enhancements
- Improved documentation workflows
- Discharge planning partnerships
- Transgender and gender nonconforming (TGNC)-affirming care expansion

SECTION 8 — MONITORING & EVALUATION PLAN

DSH-C will monitor:

- Documentation improvements
- Interpreter utilization
- Staff training completion
- EHR adoption rates
- Culture survey results

Evaluations occur quarterly, annually, and at key implementation milestones.

SECTION 9 — IMPLEMENTATION TIMELINE

Year	Action Items	Lead Department	Timeline
2026	EHR build finalized; staff training begins	Technology Services Division (TSD), Training	Q1
2026	Language documentation initiative	Rehabilitation Therapy, Nursing, Social Work	Q2
2026	TIC & RJE annual training rollout	Training	Q3
2026	EHR go-live	All Departments	Q4
2026	First automated equity data review	Quality Council	Q4
2026	County data-sharing agreements	Social Work, CIT	Q1
2026	Disability/accommodation workflows in EHR	Nursing, Psychology	Q2
2026	Equity dashboard development	Data Analytics	Q3
2026	First full equity review cycle	Executive Leadership	Q4

SECTION 10 — CORE AND STRUCTURAL MEASURES

Core Measures:

Measure	Description	Target	Stratification	Example Value
Readmission_ Inpatient Psychiatric Facility (IPF)	30-day IPF readmission			0
MHD_Readmission	Mental health readmission			0
SUD_Readmission	Substance use readmission			0
SUB3a_Treatment_Accepted	Treatment acceptance			0

Structural Measures:

Measure	Description	Status	Notes
Interpreter Availability	Access to interpreters for all patients	100% coverage	Track usage quarterly
Patient Engagement	Patient Civil Detainees Advisory Board (CDAC), Quality Council Meetings	Monthly	Include diverse representation
Policy Review	Equity and TIC focused policy updates by Patient Care Policy Committee (PCPC)	Annual	Document updates
Preferred Language Data	Data captured through Patient Linguistic Questionnaire by Rehabilitation Therapists	Quarterly	Track progress through electronic database

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SECTION 11 — PATIENT AND COMMUNITY ENGAGEMENT

- Quarterly treatment plan conferences with patients and community support (family, attorney)
- Linguistics Questionnaire Survey
- Unit Advisory Council participation in program planning

SECTION 12 — NO DISPARITIES IDENTIFIED

Narrative Example:

Analysis of core and structural measures revealed no statistically significant disparities in this reporting period.

Actions to Maintain Equity:

1. Continue monitoring equity measures quarterly.
2. Maintain patient/community engagement initiatives.
3. Update policies proactively to prevent disparities.
4. Implement equity-focused quality improvement projects.

SECTION 13 — LEADERSHIP REVIEW & APPROVAL

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Signature: Katie Vest Date: 2/5/2026

Approved By: Janine Wallace, Executive Director
Signature: _____ Date: 2/27/26