

California Department of
State Hospitals

Department of Healthcare Access and Information (HCAI) Health Equity Plan **Department of State Hospitals- Coalinga 2026**

HCAI HEALTH EQUITY PLAN

Department of State Hospitals – Coalinga

SECTION 1 — ORGANIZATION INFORMATION

Organization Name: Department of State Hospitals – Coalinga

Reporting Period: January 1 – December 31, 2025

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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 is primarily 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 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. Training and staff education will also continue current trends of healthcare disparities and equity principles to provide excellent care for 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-Coalinga's analysis identified 11 calculated, masked findings for SUB-3a treatment acceptance across certain language, race, and age categories. The available table does not include the underlying numerators, denominators, group and reference rates, masking reasons, or statistical-test information. Therefore, the masked findings do not independently establish statistically significant or confirmed disparities, nor do they establish that outcomes were equivalent across groups. No reportable disparities were identified based on the applicable HCAI reporting criteria for this reporting period. DSH-Coalinga will continue to review and monitor the masked SUB-3a findings.

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, Racial Justice and Equity Speaker Series, and targeted Trauma-Informed Care (TIC) programs. Social Work Team has surveyed current patients to gather sexual orientation, gender identity, and sex characteristics/intersex status (SOGISC) data.

Key Practices and Metrics:

- Interdisciplinary teams develop individualized treatment plans. **Goal:** 100% of patients 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 training (TIC, Racial Justice & Equity, Patients' Rights) completed by ≥ 90% of staff annually.
- Anonymous reporting tracked; **target:** respond to 100% 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.
- 30-day assessment, gender assessment, and reassessment forms have been updated and are completed for 100% of newly admitted patients.
- 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 100% of patients by 1st quarter of 2027.
- 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.
- The Risk Management Program establishes a multifaceted risk management process to support proper and timely identification of high-risk situations of an immediate nature as well as long-term systemic problems that need corrective actions to remedy risks, and timely interventions to prevent or minimize harm to patients. **Metric:** 100% of Key Indicators/Triggers are reviewed by the Treatment Team.
- 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, hospice 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.

- Inpatient care with a licensed Medicare certified hospice agency to provide palliative and supporting services to patients who are seriously ill and with life-limiting illness that can no longer benefit from curative treatments. 100% of referrals to hospice have been admitted.

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 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. Currently 76% of language spoken at home and 71% of preferred language for patients have been captured.

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

By September 2027, the Quality Council will review and document the disposition of 100% of the 11 masked SUB-3a treatment-acceptance findings, including whether additional internal data are available to evaluate the findings.

Beginning with the first quarterly audit following plan approval, DSH–Coalinga will audit SUB-3a records for eligibility, clinical appropriateness, treatment offer or provision, acceptance or refusal, preferred language, language assistance, and documentation completeness.

The Racial Justice & Equity (RJE) Committee will establish a validated documentation baseline through the first quarterly audit and approve a measurable improvement or maintenance target after reviewing the results.

DSH–Coalinga will complete and document four quarterly SUB-3a reviews stratified by available language, race, and age categories by September 2027

SECTION 7 — INTERVENTIONS & ACTION PLAN

- EHR implementation and data automation
- Expansion of interpreter access
- 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
2027	EHR build finalized; staff training begins	Technology Services Division (TSD), Training	Q2
2027	Language documentation initiative	Rehabilitation Therapy, Nursing, Social Work	Q1
2027	TIC & RJE annual training rollout	Training	Q1
2027	EHR go-live	All Departments	Q3
2027	First automated equity data review	Quality Council	Q2
2027	County data-sharing agreements	Social Work, CIT	Q1
2027	Disability/accommodation workflows in EHR	Nursing, Psychology	Q3
2026	Equity dashboard development	Data Analytics	Q4
2027	First full equity review cycle	Executive Leadership	Q2

SECTION 10 — CORE AND STRUCTURAL MEASURES

Core Measures:

Measure	Description	Target	Stratification	Example Value
SUB3a_Treatment_Accepted	Treatment provided or offered at discharge and patient acceptance	By September 2027, review and document the disposition of 100% of the masked SUB-3a findings. Establish a validated documentation baseline through the first quarterly medical-record audit and approve a measurable maintenance or improvement	Language, race, and age	SUB-3a was the only measure represented among the ten top-ranked entries. The entries consisted of language, race, and age comparisons. The reference rates and relative ratios were masked in the Equity Plan data extract. A separate table identified 11 calculated SUB-

Measure	Description	Target	Stratification	Example Value
		target following baseline review.		3a findings, all marked as masked.

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)	Monthly	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

No reportable disparities were identified based on the applicable HCAI reporting criteria for this reporting period. However, DSH–Coalinga identified 11 calculated, masked SUB-3a treatment-acceptance findings across certain language, race, and age categories. Because the available data did not include the underlying group and reference rates, numerators, denominators, masking reasons, or statistical-test information, the findings do not independently establish confirmed disparities or equivalent outcomes across groups. The hospital will continue reviewing documentation completeness, treatment eligibility and clinical appropriateness, whether treatment was provided or offered, patient acceptance or refusal, preferred-language documentation, and language-assistance needs.

Actions to Maintain Equity:

1. Review the masked SUB-3a findings quarterly through September 2027.

2. By September 2027, review and document the disposition of 100% of the 11 masked SUB-3a findings.
3. Establish a validated SUB-3a documentation baseline through the first quarterly medical-record audit and approve a measurable maintenance or improvement target after baseline review.
4. Continue reviewing SUB-3a results by available language, race, and age categories and document any necessary monitoring, corrective action, and follow-up.

SECTION 13 — LEADERSHIP REVIEW & APPROVAL

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Signature: _____ Date: 9/24/24

Approved By: Janine Wallace, Executive Director

Signature: _____ Date: 9/24/24