

California Department of
State Hospitals

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

Department of State Hospitals- Napa

2026

HCAI HEALTH EQUITY PLAN

Department of State Hospitals – Napa

SECTION 1 — ORGANIZATION INFORMATION

DSH-Napa is one of five state hospitals within the Department of State Hospitals. The hospital provides inpatient, comprehensive mental health services to approximately 1,100 patients across a continuum of care in five residential Programs. Patients benefit from a range of therapeutic treatment options including medication management, individual and group therapy, vocational services, and medical treatment focused on aiding recovery. The hospital environment is designed to be therapeutic, offering a safe setting where structured care is provided. Routine evaluations and individualized treatment plans are tailored to the unique needs of each individual. The commitment categories of patients treated at DSH-Napa are Lanterman-Petris-Short (LPS) Act, Incompetent to Stand Trial (PC 1370), Offenders with Mental Health Disorders (PC 2972), and Not Guilty by Reason of Insanity (PC 1026).

In addition to providing psychiatric care, DSH-Napa plays a role in the broader mental health system by emphasizing rehabilitation and community reintegration. Treatment is provided by a multidisciplinary team consisting of psychiatrists, psychologists, social workers, rehabilitation therapists, and a variety of nursing classifications.

DSH-Napa is licensed by the California Department of Public Health to provide three levels of care: Intermediate (ICF), Acute, and Skilled (SNF). Approximately 2,600 staff work at the hospital, and DSH-Napa is the largest employer in Napa County. Administrative staff classifications include hospital police officers, dietetics, custodial, warehouse, and Information Technology staff, as well as many other positions that serve to support the large hospital infrastructure.

The hospital is accredited by the Joint Commission on Accreditation of Healthcare Organizations. The Joint Commission conducts unannounced surveys of this hospital at least every three years. The purpose of the survey is to evaluate the hospital's compliance with nationally established Joint Commission standards. The survey results are used to determine whether accreditation should be awarded and under what conditions that happens. Joint Commission standards deal with organizational quality, safety of care issues and the safety of the environment in which care is provided.

Our mission is to provide high quality, compassionate mental health care safely, responsibly, and equitably across a continuum of care and settings.

Organization Name: Department of State Hospitals – Napa

Reporting Period: January 1 – December 31, 2025

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SECTION 2 — DATA LIMITATIONS & CONTEXT

DSH- Napa still relies on paper copies of patient documents but also uses separate software programs to collect and store data.

Paper-based documentation such as handwritten Interdisciplinary Notes (IDNs), signed consent forms, or printed test results are collected and stored in a patient's chart. Data collection and analysis from these are still very limited.

However, the facility also uses different software applications to capture, organize and store operational data. Examples such as the utilization of the Incident Management Module within the Wellness and Recovery Model Support System (WaRMSS), which is the approved method for reporting unexpected or undesirable incidents. Another software is the ADT (Admission, Discharge, and Transfer) system, that manages the movement of patients from arrival to discharge or transfer. Data collection and reports from this software are accessible for analysis.

SECTION 3 — IDENTIFICATION OF DISPARITIES

Methods Used to Identify Disparities:

The review used the applicable rate-ratio methodology and demographic and social-factor stratification. Based on the hospital's application of the applicable HCAI reporting criteria, no reportable disparities were identified for this reporting period. All results in the supplied prioritized table were masked. Therefore, the findings do not establish either confirmed disparities or equivalent outcomes among all patient groups. The masked results will be monitored as potential signals and reviewed further where permitted.

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-Napa is committed to providing care and treatment for patients that are centered on their individual needs, culture and goals.

Key Practices and Metrics:

- The Dialectical Behavior Therapy (DBT) Program – DBT at DSH - Napa consists of a comprehensive program across the entire hospital as well as intensive programs embedded in three units in the facility. The evidence-based treatment is provided by psychiatric technicians, psychiatric technician assistants, registered nurses, rehabilitation therapists, social workers, psychologists, and psychiatrists. The DBT Program at DSH-Napa continues to lead the way for other DSH sites in DBT implementation, longevity, and adaptability to changes in the patient population and institutional demands. **Metrics**: Semi-annually, DBT Coordinator reports to the facility's Quality Council the number of patients enrolled in the program as well as the significant development seen to the patients.

- Trauma-Informed Care (TIC) - The number of patients screened for trauma is a performance indicator on the DSH Strategic Plan. DSH-Napa continues to complete trauma screenings using the PCL-5 (PTSD Checklist for DSM-5) across most programs, with ongoing efforts to increase trauma-related diagnoses. **Metrics:** PCL-5 and diagnosis data are collected via Wellness and Recovery Model Support System (WaRMSS). Data is presented to Quality Council semi-annually.

2. Patient Safety

DSH-Napa is committed to identifying and managing patient safety events which are incidents that could or did result in harm.

Key Practices and Metrics:

- Morning Meetings: A daily meeting consisting of leadership and health service specialists across all departments that review patient incidents in the last 24 hours as reported in WaRMSS and in the Nurse-On-Duty (NOD) logs. **Metrics**: Meetings conducted daily and NOD Log sent daily.

- Risk Management Committees: The Risk Management structure supports the policy that staff is to ensure that a standardized procedure utilizing a hierarchy of

interventions is used when addressing identified risk, behavioral and medical incidents. Timely interventions are developed and implemented to prevent or minimize harm. Risk Management Committees continue to address individual patient issues relating to aggression. All programs are actively using Program Review Committee (PRC) and Enhanced Trigger Review/ Psychology Specialist Services Committee (ETRC/PSSC) meetings. **Metrics:** Semi- Annually, the number of PRC and ETRC/PSSC cases are reviewed and reported to Quality Council. Data between different programs is being identified. Data comparison from previous to current reporting periods are also being tracked and analyzed.

3. Addressing Social Drivers of Health (SDOH)

DSH-Napa addresses social drivers of health by embedding rehabilitation, vocational, and educational supports into its mental health care model, and focusing on equitable, community-integrated outcomes for patients. This approach tackles both clinical and social determinants, aiming to improve not just symptom management but also patients' ability to thrive in their communities.

Key Practices and Metrics:

- Vocational Services: The purpose of Vocational Services is to facilitate and enhance vocational opportunities that enable the patient to select and prepare for occupations, thereby gaining self-esteem and confidence through meaningful work experiences. Vocational Services also provides an environment for the patient to recover previous employment skills and knowledge. **Metrics:** Vocational Rehabilitation Assessment Tool (VRAT) is used to assess all patients referred to Vocational Services. Vocational Services managers/supervisors review the recommendations and determine placement.

- Education (Academic) Services: The purpose of the Education Services is to improve the quality of life for DSH-Napa patients by providing educational opportunities for those that are eligible. **Metrics:** Focus 9 in the patient's individualized Treatment Plans tracks educational needs. Data that includes attendance, education personnel credentials, student testing, budgetary information, course descriptions and schedules, Contracts/Agreements with and billing for community education agencies and other required hospital-wide education information are maintained by Phoenix Adult School. CASAS (Comprehensive Adult Student Assessment Systems) testing is also being conducted. Reports are submitted to the CA Department of Education.

- Rehabilitation Mall Services: This service is designed to ensure that each patient receives intensive and individualized services to promote their increased wellness and ability to thrive in the world. Services facilitated through the mall include courses and activities designed to help with symptom management,

personal skills development, and life enrichment. **Metrics**: Provision of Treatment hours are measured and reported to the Quality Council quarterly.

4. Effective Treatment

It is the policy of DSH – Napa to outline a system for the provision of adequate, appropriate, and timely preventive, routine, urgent and emergent medical and psychiatric care to all patients in need of such services, consistent with the generally accepted professional standard of care.

Key Practices and Metrics:

- Individualized Treatment Plans –Treatment Teams monitor patient progress through the continuum of care toward both short and long-term goals of successful discharge. **Metrics:** Treatment Plans are created within 7 days of admission and updated after 30 days and quarterly thereafter. Treatment plans are audited monthly. Twenty percent of quarterly conferences due monthly (approximately 60 Treatment Plans, 12 per program) are audited by the program seniors. Standards Compliance provides a Quantitative Profile Data Report to the Medical Director's Office, Service Chiefs, Clinical Administrator, and Nurse Administrator to identify patterns and trends and provide corrective action as necessary.

5. Care Coordination

DSH - Napa integrates care coordination into its daily operations through structured treatment planning, multidisciplinary team involvement, and engagement with the community in patient's care from admission to discharge.

Key Practices and Metrics:

- Discharge Planning**:** As part of the Treatment Plan, this section documents the list of criteria and long-term goals and status of the patients towards achieving this goal. It also includes what stakeholders (e.g., Conservator, CONREP, legal counsel, county, parole officer, treatment team) require the patient to do to leave the hospital. **Metrics:** Discharge criteria and long- term goals are reviewed as part of the Treatment Plans audit monthly. Twenty percent of quarterly conferences due monthly (approximately 60 Treatment Plans, 12 per program) are audited by the program seniors. Standards Compliance provides a Quantitative Profile Data Report to the Medical Director's Office, Service Chiefs, Clinical Administrator, and Nurse Administrator to identify patterns and trends and provide corrective action as necessary.

6. Access to Care

DSH–Napa shall provide services 24 hours, seven days a week to ensure that all patients receive timely and appropriate routine, urgent, and emergent medical and psychiatric care to ensure their safety and wellness, including preventive health screenings, assessment, and management of risk factors for significant complications, and the appropriate documentation of this care. All patients who have medical problems that require a level of care, evaluation, diagnosis, or treatment not available at the hospital shall be referred to medical specialists, outside consultants, clinics, and/or acute care hospitals/other facilities. Coordinated and documented communication between nursing and medical staff shall serve as the foundation for the provision of medical services. Integration of medical service needs and psychiatric service needs shall be reflected in the Treatment Plan.

Key Practices and Metrics:

- Admission Physical Examination and Assessments: The Admission History and Physical (H&P) Form is used to document the admission physical exam and assessment. This assessment is completed within 24 hours of admission. No part of the physical exam may be deferred unless the patient refuses. The admission H&P may be done by a Nurse Practitioner or the Primary Care Provider (PCP).

- Annual Physical Examination and Assessments: The History and Physical Form (MH-C 9021) is also used to document the annual physical exam and assessment.

- Ongoing Medical Care: The Chief Physician and Surgeon/Designee shall assign PCPs to specific units/programs. The PCPs are responsible for providing ongoing medical care to the patients on the assigned units/programs. The patient's medical appointments, including outside hospital appointments, are maintained as scheduled.

  Metrics:

  - The Chief of Primary Care Services (PCS), in coordination with the hospital's Department of Medicine Peer Review Committee, established procedures for objective data collection relevant to the provision of medical care to patients. A randomized sample of each provider's cases is used to determine adherence to this policy and identify improvement opportunities. The Department of Medicine Peer Review Committee, the Chief of PCS, and the Medical Director receive aggregate and provider specific data in order to evaluate provider specific performance, as well as departmental needs for process improvements, training, and/or education, pursuant to the mandate of the Medical Staff Bylaws.

SECTION 5 — CONTRIBUTING FACTORS

- Legal Commitment of Patients
  - Due to difference in legal commitments of patients admitted at DSH – Napa, different approaches are integrated in relation to patient autonomy, treatment outcomes, and risk management.

- Level of Care
  - DSH – Napa's different levels of care such as Skilled Nursing Facility (SNF), Acute Psychiatric Hospital (APH) and Intermediate Care Facility (ICF) can drive significant data disparity due to differences in standard reporting requirements and regulatory mandates.

- Availability of Data
  - Most patient information is still hardcopy format, maintained in a Patient chart. Individual software applications are used depending on the need such as ADT, WaRMSS, POS, etc. Implementation of the Electronic Health Record is still pending.

- Staffing Constraints
  - DSH- Napa still faces staffing limitations that affect some of the facility's current disciplines.

SECTION 6 — SPECIFIC, MEASURABLE, ACHIEVABLE, RELEVANT and TIME BOUND (S.M.A.R.T) EQUITY GOALS

Because no reportable disparities were identified under the applicable HCAI reporting criteria for this reporting period, DSH–Napa's goals focus on preventive monitoring, review of the masked SUB-3a findings, documentation quality, and maintenance of equitable access to services.

Goal 1: Review Masked SUB-3a Findings

Baseline: At the beginning of this improvement cycle, 0% of the listed masked SUB-3a findings will have been formally reviewed and documented through this new monitoring process.

Target: By September 2027, the Substance Recovery Services will ensure that 100% of the listed masked SUB-3a findings have been reviewed and their disposition documented. Where available and permitted, the review will include:

- Numerators and denominators;
- Demographic group and reference-group rates;
- Patient eligibility and clinical appropriateness;
- Whether treatment or referral was offered;
- Patient acceptance or refusal;

- Language-assistance needs and services; and
- Documentation completeness.

Progress, findings, responsible follow-up actions, due dates, and final dispositions will be reviewed and presented quarterly to the Quality Council.

Goal 2: Improve SUB-3a Documentation

Baseline: The provisional baseline for complete documentation of SUB-3a eligibility, treatment or referral offered, and patient acceptance or refusal is 80%. The Substance Recovery Services will validate this baseline through medical record review and report quarterly to the Quality Council.

Target: DSH–Napa will achieve and maintain at least 90% complete SUB-3a documentation by September 2027. Performance will be measured through a standardized medical record review and presented quarterly to the Quality Council.

If the first audit establishes a baseline different from 80%, the validated baseline and any approved adjustment to the target will be documented in the Quality Council minutes and reflected in the plan.

Goal 3: Continue Stratified Equity Monitoring

Baseline: No quarterly reviews have been completed under this new monitoring cycle at the start of the plan period.

Target: By September 2027, the Substance Recovery Services will complete and document four quarterly reviews of applicable quality measures stratified by available demographic and social factors.

Recurring, worsening, or newly reportable findings and findings indicating material access, documentation, patient-safety, or discrimination concern will be referred through the hospital's approved quality-improvement process. Each referral will identify the finding, responsible owner, required action, due date, follow-up measurement, and final disposition.

SECTION 7 — INTERVENTIONS & ACTION PLAN

- <u>The Dialectical Behavior Therapy (DBT) Program</u>
    - Strengthening of the DBT program. Recommendations include continuing the Behavioral Mileu Coach pilot on the first unit and looking to finalize its initiation to the other 2 units by Quarter 4 of 2026.
    - Continued partnership with the Intensive Substance Recovery Unit and art therapists specializing in murals in making DBT available to more patients

and emphasizing the importance of using patient-centered approaches in treatment.

- Trauma Informed Care (TIC)
    - Encourage leaders to incorporate the Culture Compass tool regularly in meetings to model trauma-informed values and cultural humility.
    - TIC Committee to review policies and include input from staff and people with lived experience where possible.
    - Continue to provide ongoing support for sensory rooms and sensory tools
    - Increase access to calming spaces
    - Increase multidisciplinary involvement in the TIC Committee
    - Provide additional training and resources to staff to improve their understanding of Stage 1 trauma treatment
    - Enhance compliance with completing tracking logs through refresher trainings and engaging Unit Supervisors to gain support and encourage active involvement in promoting the use of the tracking logs.

In addition to maintaining the existing programs described above, DSH–Napa will implement the following actions related to the SMART equity goals in Section 6:

- Conduct quarterly standardized medical-record audits of SUB-3a documentation.
- Review the masked SUB-3a findings, including eligibility, clinical appropriateness, whether treatment or referral was offered, patient acceptance or refusal, language assistance, and documentation completeness.
- Document identified findings, responsible owners, corrective actions, due dates, and follow-up results.
- Refer recurring, worsening, or newly reportable findings and material access, documentation, patient-safety, or discrimination concerns to the appropriate hospital quality-improvement process.
- Continue existing clinical programs while monitoring their approved performance measures. These programs will not be described as reducing disparities unless that outcome is measured and supported by the hospital's data.

SECTION 8 — MONITORING & EVALUATION PLAN

Substance Recovery Services will review implementation of the Health Equity Plan quarterly through September 2027. Monitoring will include:

- Progress toward the Section 6 baselines and targets;
- Completion and results of SUB-3a documentation audits;
- Disposition of masked SUB-3a findings;
- Available demographic and social-factor stratification;
- Status of assigned corrective actions and overdue items; and
- Follow-up measurements used to determine whether interventions were effective.

Additional investigation will occur when a finding becomes reportable under the applicable HCAI criteria, recurs or worsens, indicates a material access or documentation concern, or involves a serious patient-safety or discrimination concern.

Each required action will identify the finding, responsible owner, action to be completed, due date, evidence of completion, follow-up measurement, and final disposition. An action will be closed only after completion evidence is reviewed and the approved effectiveness target is achieved, or the Quality Council documents another appropriate disposition.

In addition, DSH- Napa continuously monitors key performance indicators across different disciplines. Standards Compliance Department conducts, receives, audits and prepares monthly reports to ensure compliance. Reports are submitted to Department Heads/ Chiefs to identify patterns and trends and address corrective actions as needed. Current Monitoring plan includes:

- Standards Compliance
    - Admissions
    - Seclusion, Restraints and Walking Restraints
- Central Nursing Services
    - Nursing Care Plans
    - Outside Hospitalizations
    - Nursing Weekly Progress Notes
    - RN Progress Notes
    - Purposeful Rounds
    - Falls Documentation
    - Mealtime Monitoring
- Medical Ancillary Services
    - Medical Transfers
- Pharmacy
- Dietetics
- Health and Safety
- Medical Director
    - Treatment Plans
- Psychiatry
- Psychology
- Social Work
- Rehabilitation Therapy
- Public Health

SECTION 9 — IMPLEMENTATION TIMELINE OF THE PLAN

Year	Action Items	Lead Department	Timeline
2026	Preparation for EHR Implementation	Hospital- Wide	Q3 – Q4
2026	Facility Projects/ Construction	Plant Operations	Q3 – Q4
2026	Validate the provisional 80% SUB-3a documentation baseline through the first standardized medical-record audit and achieve at least 90% complete documentation	Substance Recovery Services	Baseline validated at the first quarterly review; 90% target by September 2027
2026	Review and document the disposition of 100% of the listed masked SUB-3a findings	Substance Recovery Services	September 2027
2026	Complete stratified equity monitoring	Substance Recovery Services	September 2027

SECTION 10 — CORE AND STRUCTURAL MEASURES

Core Measures:

Measure	Description	Target	Stratification	Example Value
HBIPS-1: Admission Screening	Measures suicide risk, substance use, violence risk, and psychological trauma history upon admission.	100%	Review by available race, age, sex, and preferred-language categories, where appropriate and supported by sufficient data.	No validated baseline is currently available. The Substance Recovery Services will establish the baseline through the first quarterly medical-record audit following plan approval
SUB-3a: Treatment Provided or Offered at Discharge and Patient Acceptance	Measures whether eligible patients were provided or offered treatment at discharge and whether the treatment was accepted.	Validate the provisional 80% documentation baseline through the first quarterly medical-record audit; achieve at least 90% complete documentation; and review and document the disposition of 100% of the listed masked SUB-3a findings by September 2027.	Race, age, sex, and preferred language, as available.	All listed SUB-3a findings were masked. The 80% documentation baseline is provisional and pending validation through the first quarterly review.

Structural Measures:

Measure	Description	Status	Notes
EHR Implementation	NetSmart Discovery Sessions	In Progress	Meeting with Subject Matter Experts (SMEs) from all departments in the facility
Interpreter Availability	The presence of dedicated, certified medical interpreters for patients with limited English proficiency.	Fully Implemented	

SECTION 11 — PATIENT AND COMMUNITY ENGAGEMENT

- Cooperative Advisory Council: The committee is responsible for identifying issues that are relevant and/or common to all patients within the facility. The committee members gather input from unit representatives and develop systems for resolution of these issues. Managers support the council by participation when invited to provide information on requested topics.

- Health and Wellness Committee: The committee is to make recommendations to the Executive Policy Team (EPT) regarding improving the health and wellness of patients and staff. In addition, the Committee shall be responsible for the creation, planning, implementation and evaluation of health and wellness initiatives approved by EPT.

- LGBTQIA+ (Lesbian, Gay, Bisexual, Transsexual, Queer, Intersex, Asexual) Committee: The charge of the committee is to foster inter-departmental dialogue and coordinated care and raise awareness of LGBTQIA culturally responsive care among patients, staffs, and our larger community, and to contribute to the improvement of DSH-Napa policies and procedures with regard to LGBTQIA patients and staff, as well as to support efforts to comply with DSH policies of non-discrimination.

- Transgender Treatment Advisory Committee (TTAC): This interdisciplinary committee, which also includes Patients' Rights advocates, serves to advise, educate, and support patients and all staff about strategies to support gender affirming care for transgender and gender diverse patients. TTAC helps inform housing decisions, supports teams to identify how to provide gender affirming care in complex cases, makes recommendations about medical interventions, and nurtures gender affirming treatment milieus for staff and patients.

- Family and Friends Support Group: Our Executive Policy Team meets every month with this group made up of family members, friends, and other loved ones of our patients. This group allows family and others to ask questions about Administration and observe presentations on hospital policies and initiatives. The group is run by patient families and is advertised in our visiting centers and on our website.

SECTION 12 — NO DISPARITIES IDENTIFIED

The hospital's review of available core and structural measures did not identify reportable disparities under the applicable HCAI reporting criteria for this reporting period. Certain subgroup results were based on small numbers of events or cases, limiting the conclusions that can be drawn. These findings do not establish that all demographic groups experienced equivalent outcomes.

Actions to Maintain Equity:

1. Continue monitoring equity measures quarterly.
2. Obtain health-equity input, when permitted, through forensic-appropriate processes such as direct patient feedback, Patient Rights, grievances, surveys, interpreter concerns, and treatment-team observations.
3. Review and update applicable policies when monitoring, patient feedback, regulatory guidance, or hospital findings identify a need for change.
4. Implement equity-focused quality improvement projects when a specific need is identified. Each project will include a baseline, measurable target, responsible owner, timeline, monitoring method, and effectiveness measure.
5. Investigate findings that recur, worsen, become HCAI-reportable, or indicate a material access, documentation, patient-safety, or discrimination concern.

SECTION 13 — LEADERSHIP REVIEW & APPROVAL

Prepared By: Tennille Tune, Standards Compliance Director

Signature: _____ Date: 9.28.26

Approved By: Jennie Clay, Executive Director

Signature: _____ Date: 9/28/26

Approved By: Adam Kleinhenz, Clinical Administrator

Signature: _____ Date: 9/28/26

Approved By: Dr. Seth Judd, Medical Director

Signature: _____ Date: 9/28/26