Health Equity Plan

2026

Department of State Hospitals – Patton

September 22, 2026

Health Equity Plan

Signature indicates that a copy of the plan has been provided, has been approved, and responsibility to implement the plan is understood.

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DSH-Patton Treatment and Programs

Department of State Hospitals – Patton (DSH-Patton) is a forensic psychiatric hospital that provides 24-hour inpatient care for persons with mental health disorders, including medical, nursing, rehabilitative, pharmacy, and dietary services. DSH-Patton is licensed as an Acute Psychiatric Hospital (APH) by the California Department of Public Health – Licensing and Certification Unit governed by the provisions of the Health and Safety Code of California and its rules and regulations to operate and maintain Acute Psychiatric Care and Intermediate Care bed classifications.

All treatment programs at DSH-Patton utilize the recovery philosophy offering a broad spectrum of treatment, while fully endorsing the hospital's mission to provide comprehensive clinical services within the context of a biopsychosocial rehabilitation model within an environment of safety and security for all patients, staff and the community in an atmosphere of dignity and respect. As part of our treatment philosophy, we ensure that diversity and cultural needs are consistently integrated into all aspects of mental health care. DSH-Patton recognizes the importance of addressing the unique needs of the patient population by assessing both mental health and psychosocial risk factors that contribute to hospitalizations.

Health Equity Plan Overview:

DSH-Patton's annual Health Equity Plan (HEP) outlines a proactive, hospital-wide approach for identifying and addressing the top ten health disparities identified amongst the hospital's patient population. The plan adheres to Health and Safety Code Sections 127370-127376, reporting annually to the Department of Health Care Access and Information (HCAI), measuring patient access, quality, and outcomes by demographic stratification and addressing performance across six priority areas: person-centered care, patient safety, addressing patient social drivers of health, effective treatment, care coordination, and access to care.

Performance Data - Top 10 Disparities:

The 2025 performance dataset (January through December 2025) was stratified by demographic stratification. Disparities for each equity measure were assessed by comparing the rate ratios across stratification groups. Rate ratios are calculated with appropriate methods for measures with preferred low or high rates that followed the California Health and Human Services Agency's "Data De-Identification Guidelines (DDG)," dated September 23, 2016.

Overall Analysis:

The 2025 analysis identified 14 calculated, masked findings involving the SUB-3a Treatment Accepted measure across certain language, race, age, and sex categories. Because the supplied table did not include the underlying group and reference rates, numerators, denominators, masking reasons, or statistical-test information, these findings do not independently establish confirmed disparities or equivalent outcomes across groups. No reportable disparities were identified based on the applicable HCAI reporting criteria for this reporting period.

DSH-Patton will review all policies related to discharge planning, community reintegration, acceptance of substance abuse treatment at discharge, and prescribing practices to ensure equitable access to care for all patients at the facility. Leadership will identify and document any policy gaps, assign responsible parties and due dates, and track policy review, approval, implementation, effectiveness, escalation, and closure.

Action Plan:

DSH-Patton continues to provide treatment focused on addressing the social and cultural disparities that may affect a patient's transition and reintegration. The treatment model is client-centered and grounded in the values of empowerment and self-determination. Patients are active participants in their treatment planning though a multidisciplinary treatment approach.

All patients are admitted to DSH-Patton on an involuntary basis following an adjudication process. Some patients are deemed Incompetent to Stand Trial (IST) while others are admitted under Not Guilty by Reason of Insanity (NGRI) or other forensic and civil commitments. Discharge for majorities of patients also requires an adjudication process and depending on the court's determination, a patient may be returned to jail, transferred to a conditional release program, or discharged directly into the community.

When discharges occur at DSH-Patton, there is a very involved planning process and coordination with community partners or stakeholders. For all patients directly discharged back into the community, a 30-day medication supply is provided, including Narcan. Discharge summaries include notes from psychiatrists, social workers, and nursing staff. DSH-Patton collaborates closely with community and county agencies to address needs such as housing, medical and psychiatric follow-up, financial support, family engagement and continuity of care. This includes clinical handoffs to receiving agencies, family members or residential facilities as appropriate.

Patients with Opioid Use Disorder that are on medication(s) when they are admitted will continue to receive medication(s) throughout their stay and upon discharge, unless the patient

chooses to discontinue use. As of April 2025, Narcan is added to the discharge medication supplies to ensure Narcan is available to our patients' post-discharge, out in the community.

DSH–Patton participates in a statewide DSH Health Care Equity Workgroup that supports coordinated review of health-care-equity data, priorities, and improvement opportunities across DSH hospitals. DSH–Patton will use applicable statewide findings and recommendations to inform its hospital-specific Health Equity Plan and will submit relevant local findings and proposed actions to the DSH–Patton Quality Council for review and oversight.

In addition, DSH-Patton leadership has chartered a Health Equity Workgroup that convenes monthly or more often to support the hospital's commitment to fair and consistent patient care. The workgroup systematically gathers and analyzes data to identify potential disparities in clinical outcomes and patient experiences. Findings are used to formulate informed recommendations to the Quality Council, strengthening accountability and continuous improvement across the hospital.

DSH-Patton remains committed to identifying and addressing potential inequities in care delivery. The hospital will use validated data, documented patient perspectives, and ongoing monitoring to evaluate equity. This commitment does not, by itself, establish equal care or outcomes across demographic groups. Patton will identify and verify any practices described as evidence-based, recovery-oriented, culturally responsive, or designed to reduce bias.

Performance Priority Areas:

DSH-Patton will continue to address disparities through reviewing existing processes, improving data analysis to address accuracy and identify disparities, and will continue to evaluate and develop measurable goals and objectives with a multidisciplinary approach. Currently, DSH-Patton addresses equity practices in the following six (6) performance priority areas.

1. Person Centered Care

DSH-Patton delivers care that prioritizes patients' unique needs, values, and preferences. DSH-Patton welcomes a variety of perspectives, lived experiences, cultures, identities, and abilities so team members and patients feel included and valued. DSH-Patton's core values include treating everyone with courtesy and respect and improving equitable access and outcomes for all. The goal is to provide a structured, safe, and equitable process for transitioning forensic patients from inpatient care to the community or lower levels of care, ensuring legal compliance, continuity of treatment and protection of the public and the

patient.

The interdisciplinary teams at DSH-Patton apply a biopsychosocial-spiritual treatment orientation to provide high-quality evidence base treatment. The care starts with individualized treatment planning for each patient. Mental health professionals develop individual treatment plans based on each patient's history, culture and cognitive capacity. The treatment modalities such as psychosocial groups help patients develop an understanding of their mental illness and the recovery process, which incorporate elements of the patient's culture, language and beliefs systems that affect a patient's understanding of their illness. In addition, the hospital provides an Activity (supplemental/milieu) Program that also includes multi-cultural events/activities. These are opportunities outside of core treatment groups that include evening, weekends, and special events. This holistic approach helps patients view their illness within a familiar cultural context to reduce stigma and decrease isolation.

Trauma informed treatment is an important treatment perspective for DSH-Patton. The clinicians recognize the deterministic nature of people's lives and acknowledge that past trauma (personal, cultural, societal) impacts a person's life today. DSH-Patton makes an effort to train staff to manage these factors so they can create an environment that does not retraumatize patients.

Patient engagement is a key principle in our practice. The treatment team involves the patient and their support systems in the decision process such as therapy approaches, medication options, lifestyle changes, symptom management and overall self-empowerment in deciding their treatment goals. Each patient who is discharged directly into the community from DSH-Patton is provided with a comprehensive list of community resources and emergency contact numbers, including suicide prevention and crisis intervention hotlines. As part of the discharge process, social workers and DSH-staff prepare individualized discharge plans in collaboration with the patient and incorporate the Wellness Recovery Action Plan (WRAP). The WRAP identifies personal triggers, high-risk situations, coping strategies, available resources, and specific actions to be taken in the event of a crisis.

DSH-Patton upholds the principle of self-determination, respecting each patient's autonomy in decision-making regarding their treatment and recovery. The Treatment Team emphasizes the importance of patient education and empowerment, enabling individuals to make informed choices, and developing strategies to reduce the occurrence of rehospitalization.

2. Patient Safety

DSH-Patton's mission is to provide evaluation and treatment for individuals with complex

behavioral health needs in a safe, equitable, and responsible manner, by leading innovation and excellence across a continuum of care. Our goal is to foster a therapeutic system of care that addresses the physical, emotional, and environmental needs of patients and team members.

It is the policy of DSH-Patton to have a Safety Program in effect to provide a safe, secure, clean, healthy, therapeutic, and functional environment for staff, patients, and visitors. Patient injury and illness prevention shall be among the first considerations in the achievement of effective and efficient management of all programs, departments, and work activities. Each employee is responsible for staff and patient safety by knowing and following all safety policies and procedures.

An important part of the discharge planning process is ensuring safety for both the patients and the community. The key factors that DSH-Patton takes into consideration when developing a discharge plan for safety include, but are not limited to, completing a risk assessment, incorporate the Wellness Recovery Action Plan (WRAP) to identify triggers, high risk situations, coping strategies, actions to be taken in the event of a crisis, and coordination with community resources.

Interdisciplinary teams evaluate the patient's risk for violence, self-harm, or relapse, and take into consideration environmental risks of the discharge location. The discharge process covers medication management, clear instructions for ongoing treatment, and contacts and resources to utilize in the event of a mental health crisis. When appropriate, communication among healthcare providers, legal authorities, and supportive networks is initiated to reduce adverse events and ensure a safe transition back into the community.

DSH-Patton is committed to fostering strong partnerships and effective collaborations with community stakeholders to ensure successful transitions of forensic patients into the community. Through monthly meetings with the Public Guardian's Office and County Mental Health Services, DSH-Patton engages in joint case reviews to evaluate patient needs, prioritize medical, psychosocial and psychiatric care, and identify appropriate community placements. This collaborative approach promotes continuity of care, supports recovery and reintegration, and ensures that patients receive the necessary resources and support for long-term stability and safety in the community.

3. Addressing Patient Social Drivers of Health

DSH is working to develop and improve data collection on social drivers of health to address disparities. DSH is in the process of implementing an Electronic Health Record (EHR) to address the various data collection related issues. DSH is establishing a standardized methodology within the Patient Reservation Tracking System (PaRTS) internal platform to address the current lack of a centralized data collection system for key patient

demographics, specifically sexual orientation/sex assigned at birth, by gathering this information during patient admissions via the initial patient screenings.

As part of the hospital quality improvement activities, DSH-Patton has developed a Healthcare Equity workgroup to meet The Joint Commission (TJC) Hospital National Performance Goal (NPG) #4, which aims to prioritize healthcare equity. This workgroup is designed to review patients' health-related social needs (HSRNs), identify health care disparities within the patient population through stratifying quality and safety data based on sociodemographic characteristics, and develop a targeted action plan to achieve improvement in health care equity. At least quarterly, the workgroup reports its progress to the Quality Council.

4. Effective Treatment

Upon admission, each patient is assigned to a multidisciplinary Treatment Team consisting of treating Psychiatrist, Psychologist, Rehabilitation Therapists (RT), Clinical Social Worker (CSW), Registered Nurse (RN), and Psychiatric Technician (PT). When clinically indicated, additional providers will be included as part of the treatment team (e.g., teacher, dietitian, therapist, etc.). Treatment Team members regularly assess patient conditions, provide clinical interventions, and respond to patient needs.

Treatment planning includes forensic evaluations, incorporating evidence-based practices across the continuum of care to improve patient outcomes. Treatment goals include fostering an inclusive environment and trauma-informed treatment culture that promote equity, autonomy, resilience, transparency and empowerment. In addition, treatment planning focuses on optimizing the quality of forensic evaluations by applying best practices, debiasing strategies, and cultural competence and humility.

5. Care Coordination

At DSH-Patton, discharge planning begins upon admission and includes an assessment of the patient's needs and identification of available resources and supports which are reassessed and updated throughout the patient's hospitalization. Discharge planning is a joint effort of the Treatment Team, patient, authorized family or significant others, Discharge Planning and Community Integration Department (DPCID), Forensic Evaluation Department (FED) and relevant agencies involved in the patient's treatment. When applicable according to commitment type, treatment teams in conjunction with the CONREP liaisons and CONREP will establish initial discharge criteria in the Initial Collaboration meeting.

The discharge Social Workers collaborate closely with the other members of the interdisciplinary treatment team, the patient, their family (when available) and county mental health agencies in the receiving community. Depending on the court's determination and commitment status, a patient may return to county jail, transfer to CONREP or another appropriate setting, or discharge directly into the community. For applicable direct-community discharges, the record will document coordination of housing, benefits, follow-up care, community referrals, transportation, and medication continuity. It will also document whether applicable clothing, the authorized spending allowance, prescribed medications including Narcan when indicated and required discharge materials were provided or why an exception occurred. Protected information will be shared only as authorized and legally permitted.

6. Access to Care

DSH-Patton is committed to ensuring timely and equitable access to care by our patients upon discharge which is influenced by multiple factors including commitment codes, availability of services, and coordination of care.

DSH-Patton engages with community partners to ensure proper and safe community transition. For example, our Transitional Level of Care (TLOC) meeting is a collaboration between DSH-Patton, the County Public Guardian's Office (PG) and the County Department of Mental Health (DMH) aimed at increasing the referrals and discharges for LPS patients to a lower level of care. DSH-Patton collaborates with the LPS Liaison on ways to remove systemic barriers between our agencies and to help improve discharge rates and processes of our LPS population.

DSH-Patton also engages in the Community Assistance, Recovery, and Empowerment (CARE) Act Program. This is a collaborative initiative between DSH and County Behavioral Health (CBH) departments. The program provides coordinated, community-based services to individuals diagnosed with schizophrenia, schizoaffective disorder, or other psychotic disorders. The overarching objective of the CARE Act is to reduce recidivism and strengthen discharge planning for individuals transitioning from state hospitals to community settings during their first-year of post-hospitalization.

Whenever possible and with patient authorization, a clinical hand-off is conducted with any receiving agency, group home, family member, or county partner to promote continuity of care and ensure a coordinated transition to the next level of support.