DSH California Department of
State Hospitals

Healthcare Equity Action Plan

DSH- Atascadero 2025

ORGANIZATION INFORMATION

Organization Name: Department of State Hospitals – Atascadero

Reporting Period: 2025

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Introduction and Background
The Department of State Hospitals (DSH) manages the California state hospital system, which provides mental health services to patients admitted into DSH facilities. The department strives to provide effective treatment in a safe environment and in a fiscally responsible manner.

DSH oversees five state hospitals – Atascadero, Coalinga, Metropolitan (in Los Angeles County), Napa and Patton, with approximately 5500 long-term and short-term beds, providing both medical and psychiatric treatment for upwards of 10,000 patients annually.

The Department of State Hospitals-Atascadero (DSH-A) is a secure forensic hospital located in San Luis Obispo County, California. It opened in 1954 and is a psychiatric hospital constructed within a secure perimeter. The majority of the primarily male patient population is remanded for treatment by county superior courts or by the Department of Corrections and Rehabilitation (CDCR). The hospital does not accept voluntary admissions. The hospital has approximately 1,184 beds. The commitment categories of patients treated at DSH-Atascadero are: Incompetent to Stand Trial (Penal Code 1370); Offenders with a Mental Health Disorder (Penal Code 2962/2972); Mentally Ill Prisoners transferred from CDCR (Penal Code 2684); Not Guilty by Reason of Insanity (Penal Code 1026); and Lanterman-Petris-Short (LPS) Act. Patients stay longer than 120 days based on their legal commitment through the legal system.

Authority and Purpose
In June 2022, The Joint Commission approved a new Leadership Standard (LD.04.03.08) to identify and reduce healthcare disparities. In 2025, this leadership standard was upgraded to a National Performance Goal 4 with 6 Elements of Performance. Additionally, the California Health and Safety Code Section 127370-127376 as amended by The Medical Equity Disclosure Act (AB 1204) requires hospitals to submit a plan to prioritize and address disparities for vulnerable patient populations identified in the report for measures on patient access, quality, and outcomes by socioeconomic demographic factors, submitted to the Department of Health Care Access and Information (HCAI). Last, The California Health & Safety Code Section 1279.6 (as amended by AB 3161 Health Facilities Patient Safety and Antidiscrimination Act) provides authority that a hospital's patient safety plan includes a process for addressing discrimination,

including but not limited to racism, and its impacts on patient health and safety. This process includes monitoring socioeconomic disparities in patient safety events and developing interventions to remedy known disparities as indicated.

This charged DSH with developing their individual hospital-wide action plan for reducing healthcare disparities for the patients served. The Atascadero Healthcare Equity Plan was developed through a collaborative process that actively engaged stakeholders and staff within the hospital.

Organizational Commitment to Health Equity

DSH Strategic Plan: DSH 2024-2029 Strategic Plan carries forward key elements on DSH approach to the care and services DSH provides. The additional core value of Equity is introduced in the current plan.

Equity: Welcoming a variety of perspectives, lived experience, cultures, identities and abilities so team members and patients feel included and valued. Treating everyone with courtesy and respect. Improving equitable access and outcomes for all.

Data Limitations & Context: Patients at DSH-Atascadero 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 1: Structure and Leadership

1.1 Health Care Equity Lead and Designation
Individual/Team Designated: DEI Committee

Authority and Responsibilities: DEI committee will work with Standards & Compliance to assist with implementing a local policy regarding health care equity with data collection and report to Executive Team. Documentation will align with TJC measurements.

1.2 Reporting Structure
Standards & Compliance/DEI Committee will report data quarterly to the Utilization/Risk Management Committee.

Section 2: Data Collection Methodology

2.1 Sociodemographic Categories for Stratification
- Age
- Race: White, Black/African American, Asian, Native Hawaiian/Pacific Islander, American Indian/Alaska Native, Other)
- Ethnicity (Hispanic/Latino, Non-Hispanic/Latino)
- Sex (Male, Female, Non-binary, Other, prefer not to disclose)
- Gender Identity
- Sexual Orientation
- Preferred Language/Language Spoken:

- Payor (Medicare, Medicaid, Commercial, Uninsured, Self, Other)
- Disability Status
- Other

2.2   Data Sources Used

Patient Charts, WaRMSS, PaRTS, ADT, Plato. At this time, DSH does not have an EHR to address data collection. Patient records are paper based at this time. DSH is working on implementing an EHR in the near future.

2.3   Health Related Social Needs (HRSN) Assessment

(Joint Commission NPG 4, EP#2 Requirement)

2.3.1   Health Related Social Needs Assessment/Screening Tool Used:

DEI will implement a social needs assessment screening tool. Current plan is to review Health & Physical assessment, Psychiatrist Assessment, 30-Day Psychosocial Assessment, and other assessments done upon admission,

2.3.2   Screening Implementation

Target Population: Black, Asian, and Hispanic/Latino

Screening Setting: Admission units

Frequency: Admission

2.3.3   HRSN Assessed:

- Transportation access
- Food security/insecurity
- Housing stability/instability
- Insurance coverage adequacy
- Education and health literacy
- Employment status
- Utility assistance needs
- Safety concerns
- Social isolation/support

Hospital Process, Resources and Referrals

Process	Resources
Food Assistance	Refer to County Behavioral Health, Parole, or Conditional Release Program (CONREP)
Housing Support	Based on patient commitment: CDCR, Conditional Release Program (CONREP), Parole, County Behavioral Health, family/collateral contact, CARE Court.
Financial	Parole, Medi-Cal, SSI application
Transportation	Based on commitment to Parole, CONREP, directly to the community, bus or train.
Referral Agencies	Utilize referral source based on commitments such as CDCR, CONREP, County Behavioral Health such as Full-Service Partnerships, CARE Court.

Section 3: Data Stratification for Quality Measures and Action Plan Development

3.1 HCAI Structural and Core Quality Measures Report
DSH-Atascadero had fewer than l0 disparities and no 30-day readmissions at the facility. All data submitted to HCAI were reviewed and approved internally

3.2 Medications related to substance abuse diagnosis.
Specifically, Black, Hispanic, and White were the groups with the disparities compared to the reference group Asian. In addition, Age groups 18-34, 35-49, & >65 Y/O had SUB-3 treatment disparities compared to the reference group 50-64 Y/O. No 30-day readmissions were identified.

Figure 1: Substance abuse diagnosis and/or referral for substance abuse treatment for patients

Rank	Stratification	Reference Group	Reference Rate	Rate Ratio
1	Age	50-64	***	***
2	Race	Asian	0.0	***
3	Age	50-64	***	***
4	Race	Asian	0.0	***
5	Race	Asian	0.0	***
6	Age	50-64	***	***

3.3 Analysis and Findings
Lifespan:
The >65 age group has the highest treatment rate (***), making it the greatest disparity group.
The 18–34 age group has the lowest treatment rate, making it the best-performing group.

Race/Ethnicity:
The White group has the highest treatment rate (***), making it the disparity group.
The Asian group has the lowest treatment rate (***) making it the best-performing group.

3.4 Measurable Goals
A. Address Age-Related Disparities (RR *** & ***)
Objective: Achieve a 10% reduction in the disparity gap in "SUB3a Treatment Accepted" rates between the reference group (50-64 age group) and the high-disparity age groups within 12 months.
Timeframe: By end of Q4 2026.

B. Address Race-Related Disparities (RR ***, ***, ***)
Objective: Achieve a 10% reduction in the disparity gap in "SUB3a Treatment Accepted" rates for racial groups within 18 months.
Timeframe: By end of Q2 2027.

Section 4: Action Plans to Address Disparities

4.1 Performances across priority areas as described by HCAI:
Person-centered care - care that is respectful of and responsive to patient preferences, needs and values. Work on incorporating audit tools to identify specific race/ethnicity. An EHR would help gather data once it is implemented.

Patient Safety - preventing harm to patients during the process of health care delivery.

Continue to provide resources such as suicide prevention flyers to all patients upon discharge. Implementing an EHR to capture documentation of patient safety referrals. Furthermore, DSH Atascadero will continue to provide group treatment and education.

Social Drivers of Health - identifying and addressing social, economic, and environmental factors that influence health outcomes. Continue to utilize assessments in all areas. Report on patient's self-determination and identify resources that would best support patients upon discharge to the community. Continue to provide as much information to CDCR, County Behavioral Health, Parole, CONREP, and family systems who provide the continuum of care.

Effective Treatment - providing services based on evidence-based or scientific knowledge to all who could benefit and refrain from providing services to those not likely to benefit. Continue to provide group and individual treatment as specified on the patient's treatment plan. Treatment teams will work with patients on determining treatment during their treatment at DSH-Atascadero.

Care Coordination - organizing patient care activities and sharing information among all participants with patient care. Continue to provide as much documentation and case presentation to the receiving parties such as CDCR, Parole, County Behavioral Health, CONREP, and families. All within the patient's willingness to their self-determination and release of information.

4.2   Interventions

Intervention: Implement a mandatory, evidence-based, and culturally responsive communication training program for all clinical staff by Q3 2026.

Intervention: Create and standardize the implementation of the DSH approved Health Related Social Needs (HRSN) Assessment/Screening Tool across all admissions by Q1 2026.

Intervention: Integrate a formal, DSH wide resource guide and referral process into the patient's individualized treatment plan for those screening positive for high-priority HRSNs.

Intervention: Update and formalize the hospital's Patient Safety Plan to include ongoing, quarterly monitoring and analysis of identified health disparities data by the Risk Management Committee, effective Q1 2026.

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Section 5: HCAI Priority Areas and Linked Disparities:

5.1　HCAI Priority Areas:
HCAI Priority Area Linked Disparities (Rank, Relative Risk, & Group Implied)

Person-Centered Care
Rank 2 (RR ***, Non-Asian groups), Rank 4 (RR ***, Non-Asian groups), and Rank 5 (RR ***, Non-Asian groups).

Patient Safety
Ranks 1-6 (All disparities are monitored as KPIs: RRs ***, ***, ***, ***, ***, ***).

Addressing Patient Social Drivers of Health (SDOH)
Rank 1 (RR ***, age groups <50 or >64) and Rank 3 (RR ***, age groups <50 or >64).

Effective Treatment
Ranks 1-6 (All RRs are targeted by interventions to improve treatment acceptance rates).

Care Coordination
Rank 1 (RR ***) and Rank 3 (RR ***), linked to post-discharge support needs.

Access to Care
Ranks 1-6 (All RRs where cultural, communication, or social barriers impede the ability to accept treatment).

5.2　Disparities & Contributing Factors:
Disparity (Rank & Group Implied)

Rank 1 (likely age groups <50 or >64)
Contributing Factor: Socioeconomic Status/Income: Lower income likely correlates with lack of resources for post-discharge care.

Rank 2 (likely non-Asian groups)
Contributing Factor: Language and English Proficiency: Barriers affect communication of treatment protocols and understanding.

Rank 3 (likely age groups <50 or >64)　　* Education Level: Affects health literacy and the ability to navigate complex referral processes.
Contributing Factor: Access to Primary Care: Gaps in primary care relationships can lead to less coordinated care and support systems.
Contributing Factor: Socioeconomic Status: Inability to afford support systems or resources post-discharge.

Rank 4 (likely non-Asian groups) * Quality of Care/Systemic Discrimination: Implicit bias leading to different treatment options offered or perceived.
Contributing Factor: Stigma and Mistrust: Historical mistrust of the medical system causes hesitancy in accepting treatment.
Contributing Factor: Race and Ethnicity: Explicit stratification variable showing disparity.

Rank 5 (likely non-Asian groups)
Contributing Factor: Geographic Location: Limited availability of local services that are culturally competent.
Language and English Proficiency: Communication gaps impacting patient understanding and

agreement.

Rank 6 (likely age groups <50 or >64)
Contributing Factor: Socioeconomic Status: General economic factors influencing overall health decisions and capacity to accept treatment.

5.3   HCAI Priority Areas Linked to Disparities:

HCAI Priority Area	Linked Disparities (Rank, Relative Risk, & Group Implied)
Person-Centered Care	Rank 2 (RR ***, Non-Asian groups), Rank 4 (RR ***, Non-Asian groups), and Rank 5 (RR ***, Non-Asian groups).
Patient Safety	Ranks 1-6 (All disparities are monitored as KPIs: RRs ***, ***, ***, ***, ***, ***).
Addressing Patient Social Drivers of Health (SDOH)	Rank 1 (RR ***, age groups <50 or >64) and Rank 3 (RR ***, age groups <50 or >64).
Effective Treatment	Ranks 1-6 (All RRs are targeted by interventions to improve treatment acceptance rates).
Care Coordination	Rank 1 (RR ***) and Rank 3 (RR ***), linked to post-discharge support needs.
Access to Care	Ranks 1-6 (All RRs where cultural, communication, or social barriers impede the ability to accept treatment).

Section 6: Monitoring and Evaluation Plan

The Clinical Risk Management Committee is responsible for the ongoing quarterly monitoring and analysis of all identified health disparities data (RRs ***, ***, ***, ***, ***, ***), which are tracked as Key Performance Indicators (KPIs). The effectiveness of interventions will be specifically evaluated against the measurable goals: achieving a 10% reduction in the age-related disparity gap by the end of Q4 2026 and achieving a 10% reduction in the race-related disparity gap by the end of Q2 2027.

Health Disparity: Prescribers writing medication orders related to substance abuse diagnosis when clinically indicated.				
Priority Populations(s): Black, Asian, Hispanic/Latino				
Goals	Action Steps	Resources & Key Stakeholders	Metrics	Measurable Outcomes/Impact

Short-Term Goal	Review audit process for psychiatrist RCCP on medications related to substance abuse/or alcohol diagnosis Review Psychiatrist RCCP Work with pharmacy on a tracking system to prompt prescribing physician Audits will be updated by 1/5/26.	Standards Compliance Psychiatry Pharmacy	Audit 5 Psychiatrist RCCP's	DEI Committee will report quarterly to Quality Council (QC)
Long-Term Goal EHR	An EHR would be an easier way to collect data without manual input as current practice.	TSD	To be determined	Utilize an EHR

Community Engagement: Patients, families, CDCR, CONREP, County Behavioral Health, full-service partnerships, peer support teams, and community advocates. Semiannual stakeholder listening sessions implemented. DSH-Atascadero has limitations on recording data to HCAI's standards. Patients are admitted through the legal system and stay longer than 120 days.

SECTION 7 — LEADERSHIP REVIEW & APPROVAL

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Signature: _Dante Karas, AED_ Date: 3/5/2026_____