



California Department of
State Hospitals

Department of Healthcare
Access and Information
(HCAI) Health Equity Plan
**Department of State
Hospitals- Napa
2025**

HCAI HEALTH EQUITY PLAN TEMPLATE

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, 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: 2025

Primary Contact:

Name: Tennille Tune
Title: Standards Compliance Director
Email: DSHOmbudsman@dsh.ca.gov
Phone: (707) 253-5000

Secondary Contact:

Name: Blair Cliff
Title: Staff Services Manager
Email: DSHOmbudsman@dsh.ca.gov
Phone: (707) 253-5000

SECTION 2 — DATA LIMITATIONS & CONTEXT

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

DSH-Napa serves mostly forensic psychiatric patients with very long lengths of stay >120 days.

Medication Assisted Treatment (MAT) continuation data comes only from patients admitted on MAT, resulting in very small sample sizes.

MAT is not initiated for patients who were not admitted on MAT; this limits equity analysis for treatment offers or initiation metrics.

Many patients discharge to correctional institutions, reducing visibility into post-discharge outcomes

SECTION 3 — IDENTIFICATION OF DISPARITIES**Methods Used to Identify Disparities:**

- Analysis of SUB3a Treatment Accepted stratified by race and age.
- Review of MAT continuation and naloxone at discharge data for eligible patients.
- Ranking disparities based on relative ratios.

Ranked List of Identified Disparities:

Rank	Measure	Stratification	Reference Group	Reference Rate	Rate Ratio	Disparity Group
1	SUB3a_Treatment_Accepted	Race	Hispanic	0	***	White
2	SUB3a_Treatment_Accepted	Age	18_34	0	***	35–49
3	SUB3a_Treatment_Accepted	Age	18_34	0	***	50–64
4	SUB3a_Treatment_Accepted	Language	Spanish	***	***	English
5	SUB3a_Treatment_Accepted	Language	Spanish	***	***	Other

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

Performance Summary:

- Patients already on MAT are continued on MAT according to preference.
- No formal process exists to discuss MAT initiation with patients *not* admitted on MAT.

Equity Gaps:

- Treatment acceptance disparities exist across race, age, and language groups.
- No documented process ensuring all Substance Use Disorder (SUD) patients receive equitable MAT evaluation or education

Planned Improvements:

- Implement standardized MAT education and discussion script during intake (Q3 2026).
- Translate MAT materials into top four languages (Q4 2026).

2. Patient Safety

Performance Summary:

- Strong adherence to MAT administration safety protocols.
- Diversion prevention policies heavily limit MAT initiation.

Equity Gaps:

- Limited availability of MAT initiation may disproportionately affect patients who develop SUD needs while hospitalized

Planned Improvements:

- Review feasibility of expanding MAT initiation programs (Q2 2026).

3. Addressing Social Drivers of Health (SDOH)**Performance Summary:**

- Naloxone offered at discharge for eligible patients leaving to community settings.
- Most patients return to correctional facilities where MAT availability varies.

Equity Gap(s):

- Treatment acceptance disparities may compound post-discharge SUD vulnerability

Planned Improvements:

- Strengthen coordination with correctional health systems to support continuity (Q4 2026).

4. Effective Treatment (Linked to Disparity 2, 3)**Performance Summary:**

- SUB3a acceptance shows disparities across race, age, and language.
- MAT initiation is not offered; only continuation occurs.

Equity Gaps:

- Lack of culturally responsive models.
- Limited flexibility in engagement strategies for adults 50-64.

Planned Improvements:

- Initiate a pilot program to address the SUB3a treatment acceptance rate disparity between the highest-performing and lowest-performing demographic aiming to reduce the gap by at least 20% through the initial implementation of targeted outreach strategies in one service area or unit (Q4 2026).

5. Care Coordination**Performance Summary:**

- Coordination for MAT continuation is strong for patients already receiving treatment.

Equity Gaps:

- No process for coordinating MAT initiation for patients newly identified with SUD.

Planned Improvements:

- Increase the overall facility wide SUB3a treatment acceptance rate by 7.5% through enhanced staff training on shared decision-making practices and the standardization of the substance use disorder screening (Q4 2026).

6. Access to Care (Linked to Disparity 1, 4, 5)**Performance Summary:**

- Only patients arriving on MAT have access.
- Disparities identified in SUB3a acceptance suggest differential engagement or structural limitations.

Equity Gaps:

- Lack of MAT offering limits access for many patients.

Planned Improvements:

- Integrate MAT eligibility review into the admission assessments Q2 2026.

SECTION 5 — CONTRIBUTING FACTORS**Disparity 1: White patients, SUB3a Acceptance**

Contributing Factor: Small sample size.

Disparity 2: Age 35–49, SUB3a Acceptance

Contributing Factor: Small sample size.

Disparity 3: Age 50–64, SUB3a Acceptance

Contributing Factor: Small sample size.

Disparity 4: MHD_ English speakers, SUB3a Acceptance

Contributing Factor: Small sample size.

Disparity 5: “Other” language patients, SUB3a Acceptance

Contributing Factor: Small sample size.

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

Disparity 1 — White Patients (Race), SUB3a Acceptance

Factor: Small sample size and inconsistent documentation of treatment discussions.

SMART Goal:

- **Specific:** Improve documentation consistency for MAT treatment discussions for White patients to reduce data gaps.
- **Measurable:** Reduce documentation-related missing data by 50% from 2025 baseline.
- **Achievable:** Staff retraining
- **Relevant:** Reduces measurement distortions; improves equity monitoring.
- **Time-Bound / Target Completion:** December 31, 2026

Disparity 2 — Age 35–49, SUB3a Acceptance

Factor: Working-age adults may have more ambivalence or treatment preferences.

SMART Goal:

- **Specific:** Increase targeted MAT education and discussion for patients ages 35–49.
- **Measurable:** Increase documented MAT education encounters to 90% of eligible patients.
- **Achievable:** Implement intake education script + automated reminders.
- **Relevant:** Addresses acceptance differences due to understanding or ambivalence.
- **Time-Bound / Target Completion:** December 31, 2026

Disparity 3 — Age 50–64, SUB3a Acceptance

Factor: Lower awareness of MAT benefits among older patients.

SMART Goal:

- **Specific:** Provide age-tailored MAT education highlighting safety and benefits for older adults.
- **Measurable:** Increase acceptance or documented refusal rates by 30% in this group.
- **Achievable:** Geriatric-focused educational handouts and clinician training.
- **Relevant:** Addresses unique informational needs of older patients.
- **Time-Bound / Target Completion:** December 31, 2026

Disparity 4 — English Speakers, SUB3a Acceptance

Factor: Possible documentation differences; may access more treatment options earlier.

SMART Goal:

- **Specific:** Standardize documentation workflow for English-speaking patients to reduce variation.
- **Measurable:** Achieve 95% SUB3a documentation completeness for English speaking patients.
- **Achievable:** Workflow updates, and staff reinforcement.
- **Relevant:** Ensures accurate measurement and reduces artificial inflation of disparities.
- **Time-Bound / Target Completion:** December 31, 2026

Disparity 5 — Other Language Patients, SUB3a Acceptance

Factor: Interpreter gaps; cultural differences in MAT acceptance.

SMART Goal:

- **Specific:** Ensure interpreter availability and translated MAT materials for top 4-5 non-English languages.
- **Measurable:** Deliver interpreter-supported MAT education to 95% of non-English-speaking SUD patients.
- **Achievable:** Translation rollout and interpreter workflow improvements.
- **Relevant:** Directly addresses communication-related barriers to MAT acceptance.
- **Time-Bound / Target Completion:** December 31, 2026

SECTION 7 — INTERVENTIONS & ACTION PLAN

Disparity 1 — Race: White patients have higher SUB3a Treatment Accepted

DSH-Napa will ensure all White patients are evaluated equitably for MAT using a standardized MAT discussion checklist at admission. Staff will be trained on implicit bias and culturally responsive counseling to support acceptance of MAT among this population. Quarterly equity reports will monitor progress, and any gaps will be addressed with targeted interventions, including focused counseling sessions.

Disparity 2 — Age: 35–49 years have higher SUB3a Treatment Accepted

Patients aged 35–49 will be offered age-specific peer support and education programs to increase engagement with MAT. Staff training will emphasize the unique needs of working-age adults, including flexible scheduling and counseling approaches. Progress will be monitored quarterly through the equity report and/or dashboard, and interventions adjusted based on uptake and feedback.

Disparity 3 — Age: 50–64 years have higher SUB3a Treatment Accepted

For patients aged 50–64, DSH-Napa will provide targeted education, counseling, and peer support to improve MAT acceptance. Age-appropriate materials and one-on-one counseling sessions will be prioritized. Equity reports and/or dashboards will be used to track acceptance rates quarterly, and any persistent gaps will trigger additional staff coaching or tailored interventions.

Disparity 4 — Language: English speakers have higher SUB3a Treatment Accepted

English-speaking patients will receive standardized MAT education and counseling during admission, with staff trained on communication strategies to address potential barriers. Implementation of the MAT checklist ensures that all English-speaking patients are consistently evaluated and offered treatment. Equity reports and/or dashboards will monitor progress each quarter.

Disparity 5 — Language: Other languages have higher SUB3a Treatment Accepted

Patients speaking languages other than English will receive MAT educational materials in their preferred language and access to qualified interpreters during all counseling sessions. Staff will be trained on culturally responsive approaches for non-English-speaking populations. Progress will be monitored quarterly via equity reports and/or dashboards, and gaps will be addressed through additional interpreter support or enhanced educational resources.

Quarterly Action Plan (All Disparities)

- **Q1 2026:** Develop and approve standardized MAT discussion checklist, identify top non-English languages for translation, and produce baseline equity report.
- **Q2 2026:** Conduct staff training on implicit bias, equitable MAT evaluation, and culturally- and age-responsive counseling. Begin translation and production of educational materials.
- **Q3 2026:** Implement the MAT checklist in intake workflow, distribute translated educational materials, and launch age-specific peer support programs. Provide interpreter-supported counseling for non-English speakers.
- **Q4 2026:** Conduct quarterly equity audits for SUB3a Treatment Accepted, provide feedback to leadership, adjust interventions as needed, and ensure full implementation of educational materials, peer support, and checklist usage. Complete work on equity dashboard.

SECTION 8 — MONITORING & EVALUATION PLAN

- SUB3a Treatment Accepted stratified by race, age, language
- MAT continuation rates
- MAT eligibility screening rates
- Naloxone-at-discharge rates

SECTION 9 — IMPLEMENTATION TIMELINE OF THE PLAN

Phase	Action Items	Lead Department	Timeline
1	Develop MAT screening tools	Psychiatry/Standard Compliance Department	Q2 2026
2	Conduct training on SUB3a and MAT equity	Clinical Training	Q3 2026
3	Launch dashboard	Standard Compliance	Q4 2026
4	Evaluate early outcomes	Leadership	Q1 2027

SECTION 10 — CORE AND STRUCTURAL MEASURES

Core Measures:

Measure	Target	Stratification	Current Value
SUB3a_Treatment_Accepted	Maximum rate of 0.002	Race, Age, Language	>0.002
MAT Continuation	100%	N/A	Met
Naloxone Distribution	100%	N/A	Limited to community discharges

Structural Measures:

Measure	Description	Status	Notes
Standardized MAT Evaluation	All SUD patients evaluated for MAT regardless of demographics or admission status	Implemented	Quarterly audits to ensure compliance
MAT Discussion Checklist	Document MAT offer, patient preference, and counseling	Implemented	Chart reviews conducted quarterly
Staff Training	Implicit bias, equitable MAT evaluation, culturally- and age-appropriate counseling	Ongoing	Track completion via HR/Training system
Patient Education Materials	Translated materials for non-English languages	In progress	Distribution monitored quarterly

SECTION 11 — PATIENT AND COMMUNITY ENGAGEMENT

- Substance Recovery Services (SRS) provides comprehensive treatment to patients recovering from addiction. The program integrates medical, psychological, and social support to create a pathway to recovery. Services include assessment and individualized treatment planning, individual counseling, group therapy, and peer support. The hospital also has an Intensive Substance Recovery Unit (ISRU) which provides services to patients most vulnerable to substance use.
- Patients receiving MAT are assessed by SRS for diagnosis, treatment recommendations, and continuity of care to address substance recovery needs.
- All patients receiving MAT participate in weekly individual meetings with an SRS counselor, which include a focus on relapse prevention.
- Treatment groups focused on coping skills, triggers, the biology of substance abuse, education on co-occurring disorders, and relapse prevention are available to all patients with substance use disorders.
- Community based support services (12 step meetings, SMART Recovery, etc.) are available to all patients with a substance use disorder.
- Treatment conferences are held at routine intervals and provide a forum where the patient and their treatment team can discuss treatment options. The treatment plan serves as the guiding document for the patient's care and captures progress towards short and long-term goals.
- Client Advisory Council is composed of current patients across the hospital who collectively work together to address their care needs and improve the quality of services during hospitalization. The group serves as a bridge between patients and hospital leadership and contributes to identifying areas for improvement, ensuring clinical practices remain patient-focused, and tailoring services to better meet patient needs.
- The Friends and Family Support Group meets with the hospital executive team monthly. This provides an opportunity for loved ones of patients to come together, share experiences and insights, and find comfort knowing they are not alone in supporting someone with mental health challenges. Sessions are a mix of structured presentations by hospital staff and open sharing afterwards.