

CA AB 1204 Health Equity Report and Plan

HCAI ID #: 103190315

Reporting period start date: January 1, 2024

Reporting period end date: December 31, 2024



Background

California's Assembly Bill 1204 (AB 1204), the Health Equity Disclosure Act, was created to increase transparency and accountability in reducing health disparities across the state. The law requires all licensed hospitals to prepare annual health equity reports that examine patient access, quality care, and outcomes across key demographic groups, and to develop an equity plan that outlines targeted strategies for improvement. This report is part of our hospital's commitment to meeting these statewide requirements and more importantly to advancing our mission of delivering equitable, high-quality care to every patient we serve. By analyzing our own data, identifying gaps and publicly sharing our progress, we aim to better understand the needs of the diverse communities in our service area and ensure that our improvement efforts are both responsive and measurable.

The Community We Serve

Garfield Medical Center (GMC), located at 525 N. Garfield Avenue in Monterey Park, CA, is a 210-bed general acute-care hospital. It serves a culturally diverse, densely populated urban community in the eastern Los Angeles region, particularly within Monterey Park and surrounding parts of the San Gabriel Valley. Monterey Park itself is a majority Asian (roughly 65%) with a significant Hispanic/Latino population (about 27%). The city has a relatively high proportion of foreign-born residents and is characterized by linguistic and cultural diversity.

The median household income in Monterey Park is \$68,000-\$78,000. Education attainment is mixed while a strong share holds college degrees, a notable portion of residents have lower educational levels.

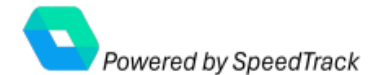
Because of these demographic and socioeconomic characteristics, GMC plays a critical role as a safety-net provider in its community. It supports a high-need, diverse population in which language barriers, cultural factors, and low-income status likely influence access to care.

In Summary, Garfield Medical Center's community is ethnically diverse, with many low and moderate income and publicly insured patients. This demographic profile underscores the importance of equity-focused efforts such as health equity reporting because disparities in language, income and access may disproportionately affect its patient population.

CA Hospital-2024 Health Equity Report

In response to the requirements of California Assembly Bill 1204, this report presents a transparent review of our patient demographics, key equity measures, and the disparities identified through our data. The Hospital Quality Improvement (HQI) provided identification of our hospital's top ten disparities using the data we submit on a quarterly basis.

HQI Top 10 Disparities
GARFIELD MEDICAL CENTER-106190315
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Disparity	Measure	Stratification	Disparity Group	Disparity Rate	Reference Group	Reference Rate	Rate Ratio	Preferred Rate
1	HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate	Age (excluding maternal measures)	50 to 64	17.9	18 to 34	3.1	5.7	Lower Rate Preferred
2	HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate	Age (excluding maternal measures)	65 and older	16.6	18 to 34	3.1	5.3	Lower Rate Preferred
3	HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate	Age (excluding maternal measures)	35 to 49	9.5	18 to 34	3.1	3.0	Lower Rate Preferred
4	HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate	Expected Payor	Medicare	17.2	Private	9.4	1.8	Lower Rate Preferred
5	HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate	Race and/or Ethnicity	Black or African American	22.0	Hispanic or Latino	13.0	1.7	Lower Rate Preferred
6	CMQCC Exclusive Breast Milk Feeding	Age (for maternal measures only)	30 to 39	14.3	18 to 29	20.9	1.5	Higher Rate Preferred
7	HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate	Preferred Language	English Language	14.7	Asian/ Pacific Islander Languages	12.4	1.2	Lower Rate Preferred
8	Agency for Healthcare Research and Quality (AHRQ) Quality Indicator Pneumonia Mortality Rate	Sex Assigned at Birth	Female	184.9	Male	164.4	1.1	Lower Rate Preferred
9	HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate	Race and/or Ethnicity	White	14.2	Hispanic or Latino	13.0	1.1	Lower Rate Preferred
10	HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate	Race and/or Ethnicity	Asian	13.6	Hispanic or Latino	13.0	1.0	Lower Rate Preferred

Disparity 1: HCAI All-caused Unplanned 30-Day Hospital Readmission Rate by Age 50-64

Measure: HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate

Stratification: Age (excluding maternal measures)

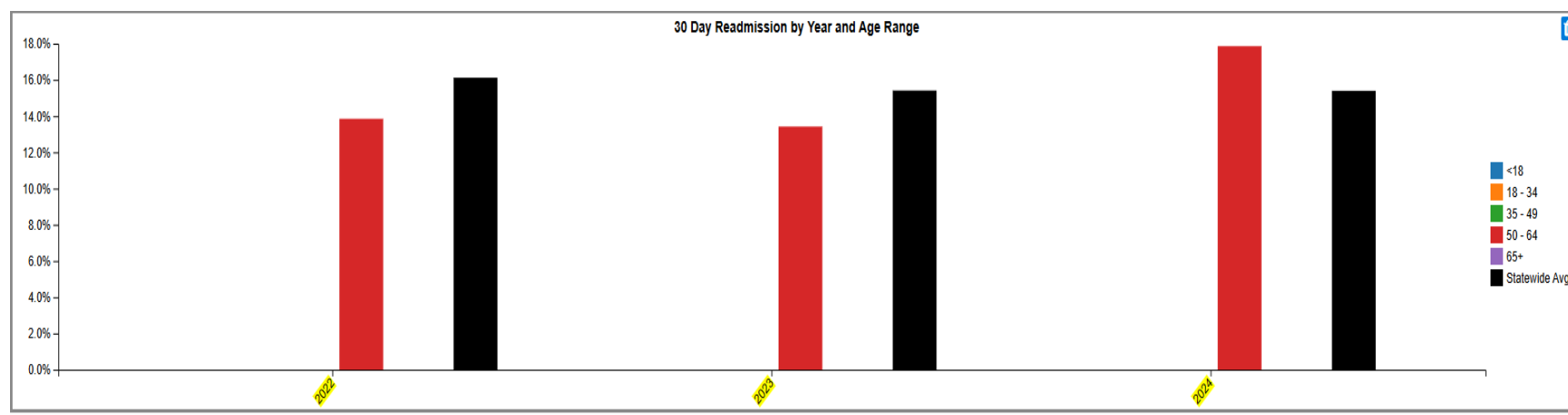
Disparity Group: 50-64

Disparity Rate: 17.9

Reference Group: 18 to 34

Reference Rate: 3.1

Rate Ratio: 5.5 Lower Rate Preferred



Disparity Data Analysis:

Age 50-64 patient group readmissions are significantly higher than other age-related disparity groups for readmission rates. The 2024 rate is compared higher than previous years. There is a slight decrease in readmission in 2023 compared to 2022. Ongoing performance improvement is focused on initiatives within Care Coordination and Care Transition.

Disparity 2: HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate by Age 65 and older

Measure: HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate

Stratification: Age (excluding maternal measures)

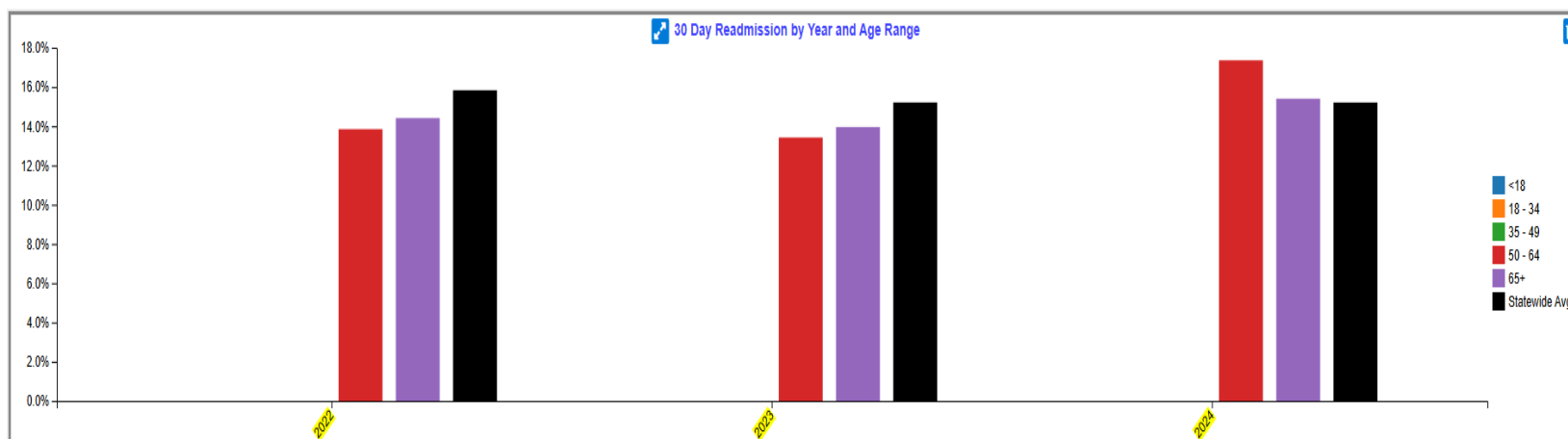
Disparity Group: 65 and older

Disparity Rate: 15.4

Reference Group: 18-34

Reference Rate: 3.1

Rate Ratio: 4.9 Lower rate preferred



Disparity Data Analysis:

Age 65 and older patient group readmission is lower than 50-64 age related disparity group in 2024. In 2022 and 2023, the 65 and older group readmissions are slightly higher than the 50-64 age group. Ongoing performance improvement is focused on initiatives within Care Coordination and Care Transition.

Disparity 3: HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate by Age 35 to 49

Measure: HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate

Stratification: Age (excluding maternal measures)

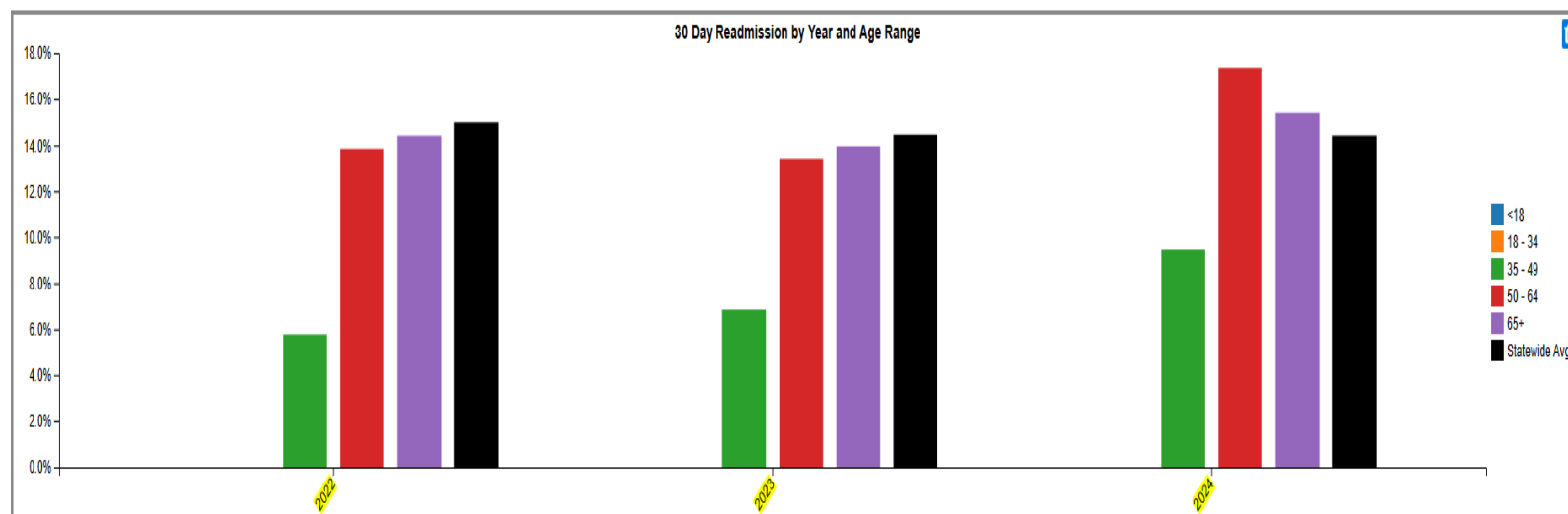
Disparity Group: 35 to 49

Disparity Rate: 9.5

Reference Group: 18 to 34

Reference Rate: 3.1

Rate Ratio: 3.0 Lower Rate preferred



Disparity Data Analysis:

Age 35-49 patient group readmissions are lower overall than 50-64 and 60 and older age-related disparity groups for readmission rates. Ongoing performance improvement is focused on initiatives within Care Coordination and Care Transition.

Disparity 1-3 Plan: Age Related Disparities (50-64, 65+, 35-49 vs. 18-34)

Population Impact: Adults 35-65+ experiencing higher unplanned readmissions compared to younger patients

Action Planned:

- Develop age-specific care transition programs (e.g. medication reconciliation, caregiver engagement and continue on follow up discharge calls)
- Focused on chronic disease self-management education
- Use of friendly patient education handout
- Employ risk assessment tool to identify patients likely to return
- Improve patient/family education with “teach-back” and focus on Rx fill and use.

Measurable Objectives: Reduce 30-day readmission rate ratio for ages 50-64 from 5.5 to 4.5, and for 65+ from 4.9 to 3.5.

Timeframe: Launch interventions on 1Q2026 and monitor annually.

Disparity 4: HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate by Expected Payor Medicare

Measure: HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate

Stratification: Expected Payor

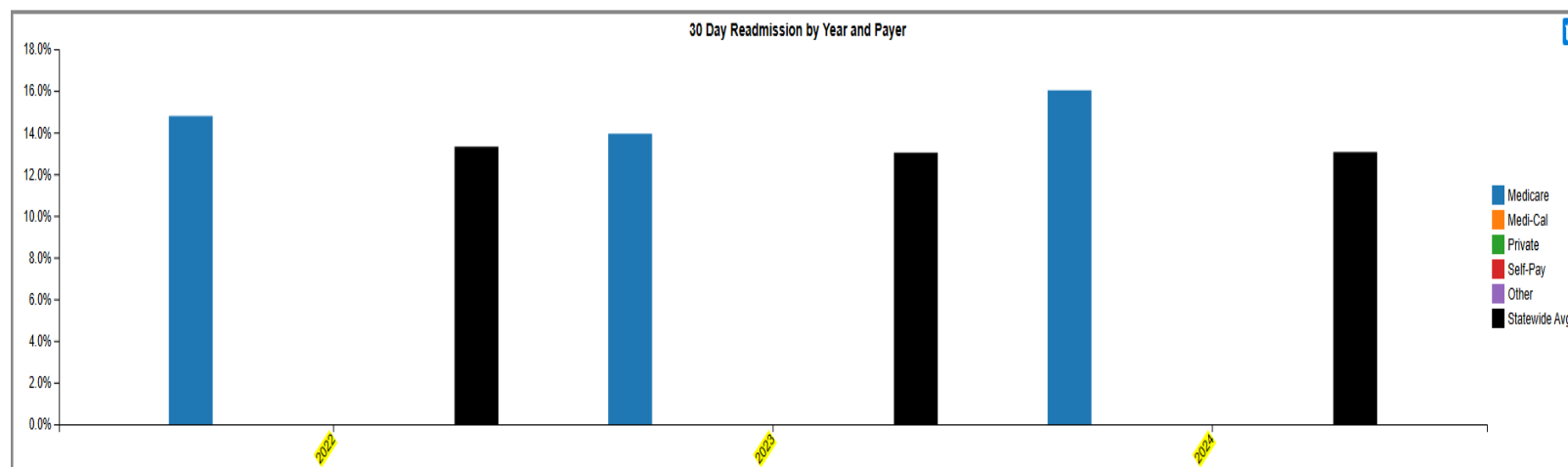
Disparity Group: Medicare

Disparity Rate: 16.0

Reference Group: Private

Reference Rate: 9.2

Rate Ratio: 1.7 Lower Rate Preferred



Disparity Data Analysis:

There are 341 Medicare out of 1,979 who has been readmitted in 2024 at 17.2% which is an increase in disparity rate as compared from 2023 that has 13.9% and 14.8% in 2022. Ongoing performance improvement is focused on initiatives within Care Coordination and Care Transition.

Disparity 4 Plan: Payer Status-Readmission (Medicare vs. Private)

Population Impact: Patients with Medicare show higher readmission rates compared to privately insured

Action Planned:

- Expand care management and social work resources for Medicare patients
- Connect patients to community-based support (transportation, medication assistance)
- Prioritize high-risk Medicare patients and follow up care teams.

Measurable Objectives: Reduce Medicare readmission rate from 17.2 to 12.0 within 24 months.

Timeframe: Implement by 1Q2026 and evaluate annually.

Disparity 5: HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate by Race and/or Ethnicity- Black or African American

Measure: HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate

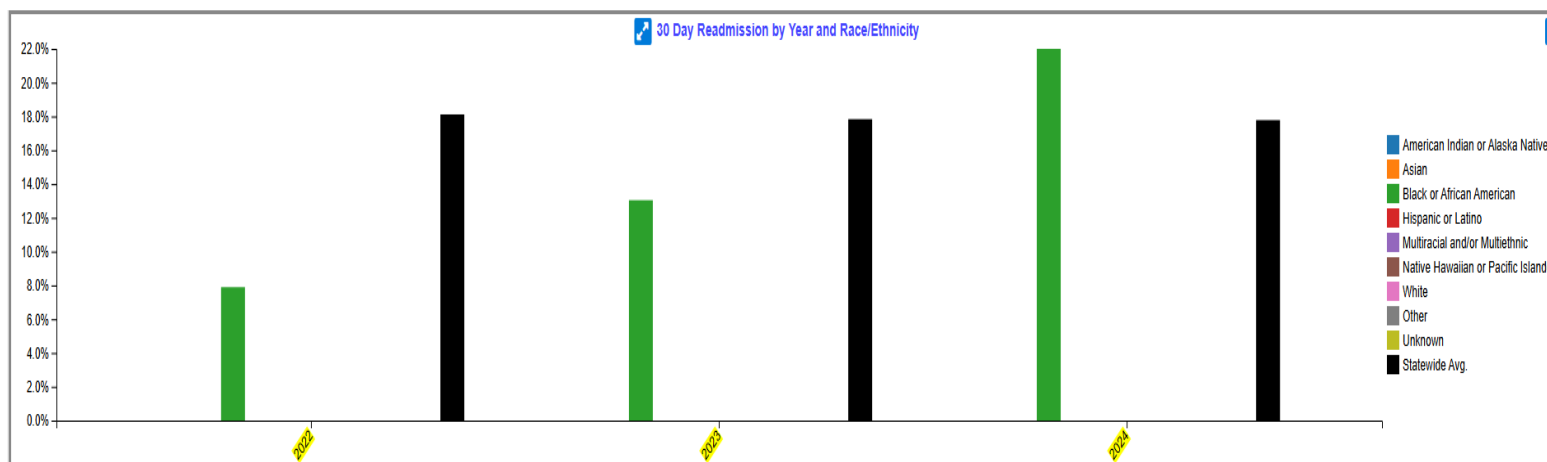
Stratification: Race and/or Ethnicity

Disparity Group: Black or African American

Disparity Rate: 22.0

Reference Group: Hispanic or Latino

Rate Ratio: 1.8 Lower Rate Preferred



Disparity Data Analysis:

In 2024, 11 patients out of 50 screened as Black or African American were readmitted. The Black or African American group has slight increase of readmission from 2022 until 2024. The percentage looks higher as compared to Hispanics due to the small number of Black/African American population that is being admitted in the hospital. Ongoing performance improvement is focused on initiatives within Care Coordination and Care Transition.

Disparity 5 Plan: HCAI All-cause unplanned 30-day readmitted rate by race and/or Ethnicity (Black/African American vs. Hispanic/Latino)

Population Impact: Black/African American patients face higher readmission rates (22 vs 12.5)

Action Planned:

- Strengthen culturally competent discharge planning and follow up
- Provide community-based health references and home visits to Black patients with chronic disease.
- Focused on chronic disease self-management education
- Use of friendly patient education handout
- Employ risk assessment tool to identify patients likely to return
- Improve patient/family education with “teach-back” and focus on Rx fill and use.

Measurable Objectives: Narrow disparity rate from 1.8 to 1.4 within 2 years.

Timeframe: Initiate by 1Q 2026 and track annually.

Disparity 6: CMQCC Exclusive Breast Milk Feeding by Age 30-39

Measure: CMQCC Exclusive Breast Milk Feeding

Stratification: Age

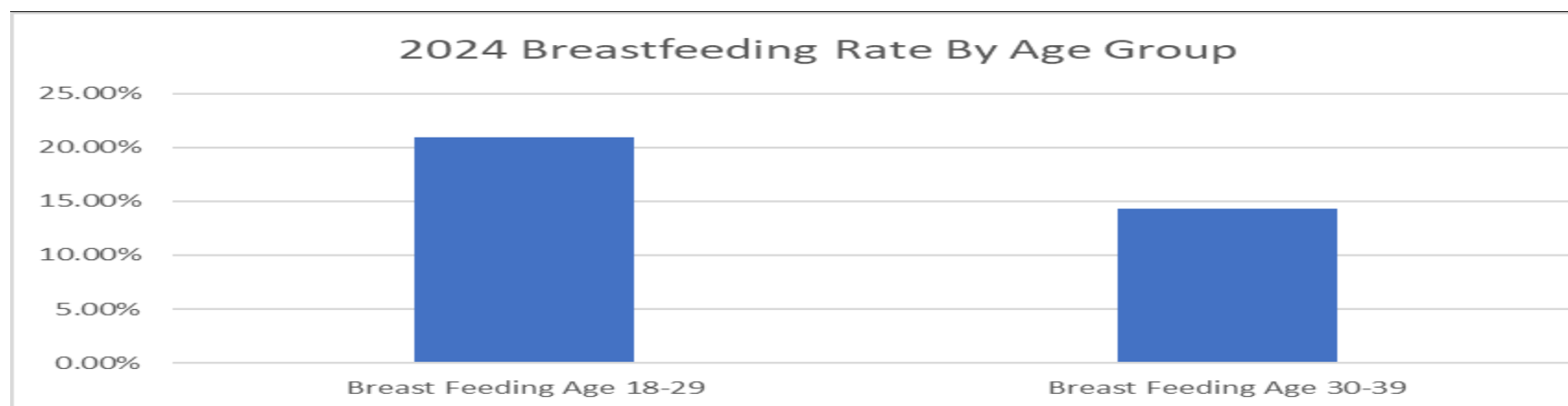
Disparity Group: 30-39

Disparity Rate: 14.3

Reference Group: 18-29

Reference Rate: 20.9

Rate Ratio: 1.5 Higher Rate Preferred



Disparity Data Analysis:

In 2024, there are 155 patients with exclusive breast feeding out of 1102 for age 30-39 and has a rate of 14.3 that is lower as compared to the age group of 18-29. Continues education on exclusive breast feeding is being implemented in the mother and baby unit.

Disparity 6 Plan: CMQCC Exclusive Breast Milk Feeding by Age 30-39

Population Impact: Age 30-39 shows lower compliance on exclusive breast milk feeding rate (14.3 vs 20.9)

Action Planned:

- Establish a multidisciplinary breastfeeding support team and designated lactation nurse to educate and support patients.
- Post-partum Director to continue to monitor progress and coordinate interventions
- Educate all staff on the importance of early initiation of breastfeeding within 1 hour of birth

Measurable Objectives: Increase exclusive breastfeeding rate from 14.3 to 20 within the next two years

Timeframe: Initiate by 1Q2026 and evaluate annually

Disparity 7: HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate by Preferred Language English

Measure: HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate by Preferred Language

Stratification: Preferred Language

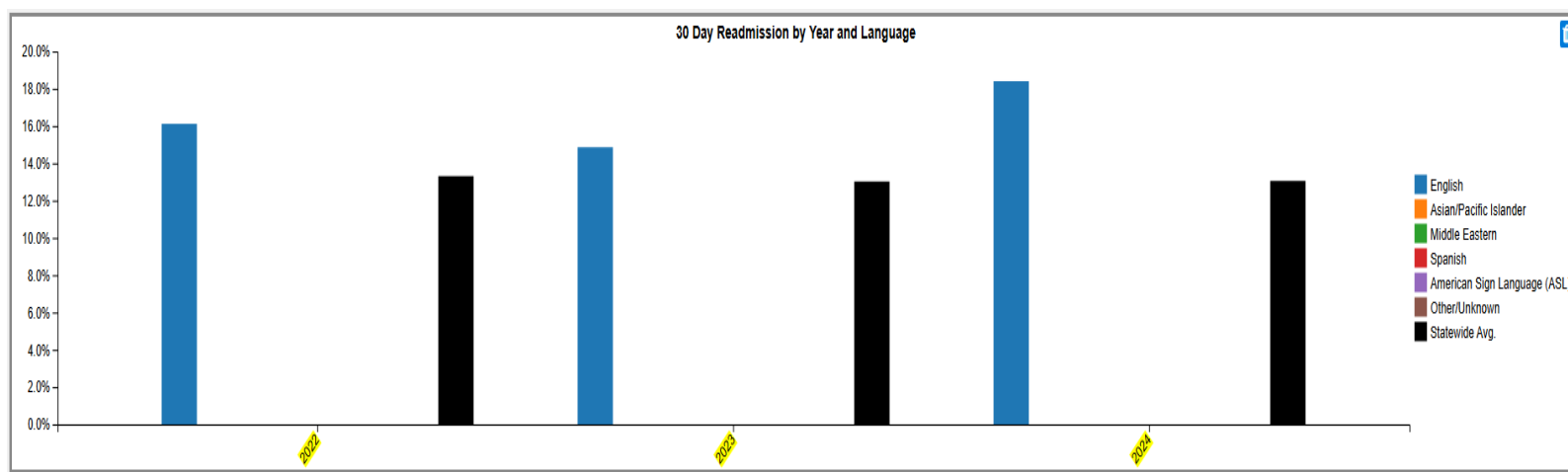
Disparity Group: English Language

Disparity Rate: 14.7

Reference Group: Asian/Pacific Islander Languages

Reference Rate: 12.4

Rate Ratio: 1.2 Lower Rate Preferred



Disparity Data Analysis:

In 2024, there are 285 out of 1,933 patients whose preferred language is English which had a higher rate of 14.7% readmission rate as compared to other patients who had other preferred languages. Ongoing performance improvement on is focused on initiatives within Care Coordination and Care Transition.

Disparity 7: HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate by Preferred Language English

Population Impact: Patients with English as preferred language shows higher rate of readmission as compared to patients with Asian/Pacific Islander Languages

Action Planned:

- Focused on chronic disease self-management education
- Use of friendly patient education handout
- Employ risk assessment tool to identify patients likely to return
- Improve patient/family education with “teach-back” and focus on Rx fill and use.

Measurable Objectives: Narrow disparity rate from 1.2 to 1.0 within 2 years.

Timeframe: Start 1Q2026 and review annually

Disparity 8: Agency for Healthcare Research and Quality (AHRQ) Quality Indicator Pneumonia Mortality Rate Sex assigned at birth

Measure: Agency for Healthcare Research and Quality (AHRQ) Quality Indicator Pneumonia Mortality Rate

Stratification: Sex at birth

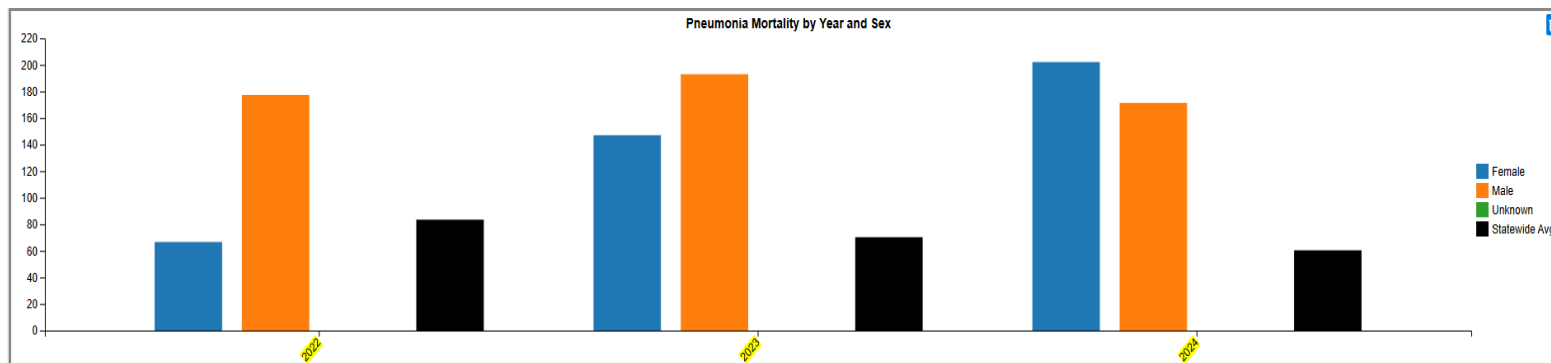
Disparity Group: Female

Disparity Rate: 184.9

Reference Group: Male

Reference Rate: 164.4

Rate Ratio: 1.1 Lower Rate Preferred



Disparity Data Analysis:

In 2024, twenty-four (24) females out of one hundred forty-six (146) or 184.9 per 1000 deaths experienced a higher mortality than the reference group of men with twenty-two (22) out of one hundred nineteen (119) or 164.4 per 1000 deaths succumbed to pneumonia. Previous years showed male has higher rate than female.

Disparity 8 Plan: Agency for Healthcare Research and Quality (AHRQ) Quality Indicator Pneumonia Mortality Rate
Sex assigned at birth (Male vs Female)

Population Impact: Female patients have slightly higher pneumonia mortality compared to male patients in 2024 (184.9 vs 164.4)

Action Planned:

- Early sepsis and pneumonia detection protocols has been implemented
- Increase female targeted preventive care campaigns
- Focused education on pneumonia patients

Measurable Objectives: Reduce mortality rate disparity ratio from 1.1 to 1.0 within a year

Timeframe: Start 1Q2026 and review annually

Disparity 9: HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate by Race and/or Ethnicity -White

Measure: HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate

Stratification: Race and/or Ethnicity

Disparity Group: White

Disparity Rate: 14.2

Reference Group: Hispanic or Latino

Reference Rate: 13.0

Rate Ratio: 1.1 Lower Rate Preferred



Disparity Data Analysis:

In 2024, 37 patients of the 260 screened as White were readmitted. There was slight increase of white patients being readmitted from 2022 to 2024. Ongoing performance improvement on is focused on initiatives within Care Coordination and Care Transition.

Disparity 9 Plan: HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate by Race and/or Ethnicity (White vs Hispanic/Latino)

Population Impact: White patients face higher readmission rate (14.2 vs 13.0)

Action Planned:

- Strengthen culturally competent discharge planning and follow up
- Provide community-based health references and home visits to Black patients with chronic disease.
- Focused on chronic disease self-management education
- Use of friendly patient education handout
- Employ risk assessment tool to identify patients likely to return
- Improve patient/family education with “teach-back” and focus on Rx fill and use.

Measurable Objectives: Narrow disparity rate from 1.1 to 1.0 within 2 years.

Timeframe: Start 1Q2026 and review annually

Disparity 10: HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate by Race and/or Ethnicity Asian

Measure: HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate

Stratification: Race and/or Ethnicity

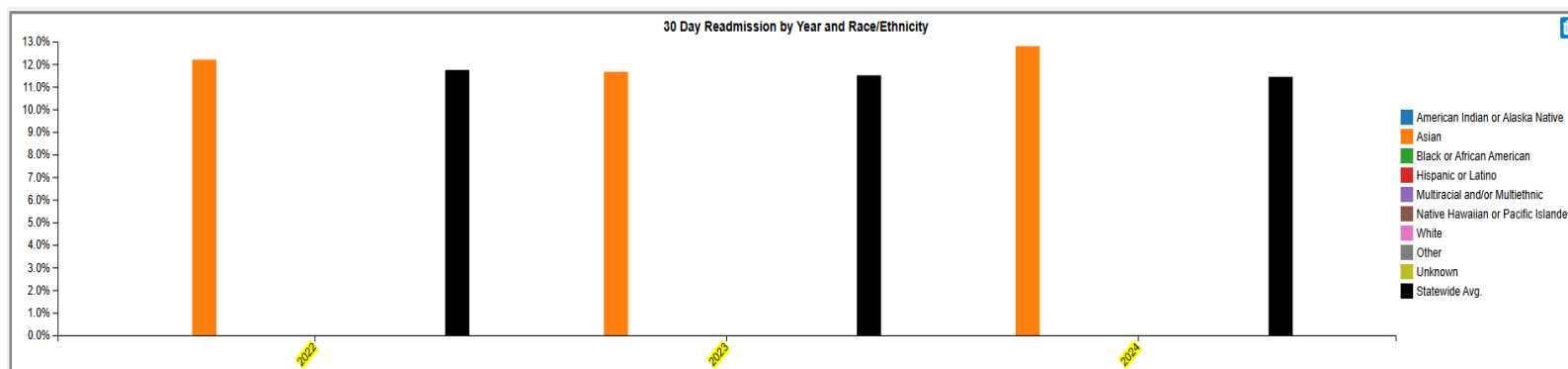
Disparity Group: Asian

Disparity Rate: 13.6

Reference Group: Hispanic or Latino

Reference rate: 13.0

Rate Ratio: 1.0



Disparity Data Analysis:

In 2024, there were 317 patients out of 2,329 patients screened as Asian race/ethnicity that were readmitted. The Asian race/ethnicity group has declined in readmission in 2023 as compared to 2022. However, increased slightly in 2024. Ongoing performance improvement is focused on initiatives within Care Coordination and Care Transition.

Disparity 10 Plan: HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate by Race and/or Ethnicity (Asian vs Hispanic/Latino)

Population Impact: Asian patients face higher readmission rate (14.2 vs 13.0)

Action Planned:

- Strengthen culturally competent discharge planning and follow up
- Provide community-based health references and home visits to Black patients with chronic disease.
- Focused on chronic disease self-management education
- Use of friendly patient education handout
- Employ risk assessment tool to identify patients likely to return
- Improve patient/family education with “teach-back” and focus on Rx fill and use.

Measurable Objectives: Narrow disparity rate from 1.0 to 0.9 within 2 years.

Timeframe: Start 1Q2026 and review annually

Monitoring and Accountability:

- Health Equity Dashboard: Quarterly reporting of disparities with stratified data by age, race/ethnicity, payer and sex at birth.
- Data result will be shared to Quality Resource Committee, Medical Executive Committee and Governing Board.
- GMC will continue to partner with community members in order to provide the appropriate needs and resource of the patient population we serve.

Conclusion:

In conclusion, our findings underscore both the progress made and the persistent inequities that continue to affect health outcomes in our community. Sustained commitment, data-driven action, and cross-sector collaboration remain essential to ensuring that every individual, regardless of race, age, language or gender has equitable access to high-quality care.

Garfield Medical Center- Health Equity Plan

Health equity is essential to delivering safe, high-quality, patient-centered care. Our hospital is committed to ensuring that every person—regardless of race, ethnicity, language, socioeconomic status, gender identity, or disability—receives equitable, culturally responsive care. Our primary goal is to identify and eliminate disparities in health outcomes, access, and patient experience across all populations we serve.

The Health Equity Plan outlines how we will integrate equity into our policies, clinical practices, data systems, workforce development, and community partnership. Through intentional and collaborative efforts, we aim to remove barriers to care and create a healthcare environment where all individuals can achieve their highest level of health.

Six (6) Health Equity Priority Areas

Priority Area 1: Person-Centered Care

- **Performance Indicator:**
 - Achieved >95% of patients receive care with language access services when needed.
 - Documentation of preferred language and cultural needs in >95% of patient records.
 - Increased referrals to community resources addressing social needs.
 - Increased participation from underrepresented groups in family conference survey and focus groups.
- **Impact:**
 - Patients receive care that honors language preference and reducing misunderstandings and improving clinical outcomes.
 - Care models reflect lived experience and community priorities, strengthening relevance, trust and equity in hospital services.

- Patients receive seamless, coordinated support that reduces barriers and improves continuity, especially for those disproportionately affected by inequities.

Priority Area 2: Patient Safety

- **Performance Indicator:**

- Annual review of safety events (falls, medication errors, pressure injuries, readmissions) stratified by race, ethnicity, language, age and insurance type.
- Completion of risk assessments (falls, skin integrity, medication risk) for all patients at admissions
- 100% of high-risk or time sensitive safety instructions (e.g. informed consent, medication instructions, discharge plans) provided in the patient's preferred language.
- 100% of patients receive culturally and linguistically appropriate discharge safety instructions.

- **Impact:**

- All patients' groups experience safer care with fewer preventable harms, ensuring that no population experiences disproportionately higher risk.
- High-reliability, standardized safety practices lead to consistent protection for all patients, narrowing gaps in adverse events.
- Patients with limited English proficiency receive clear, accurate information, reducing misunderstanding and improving adherence to safety instructions.
- Patients are safer after leaving the hospital with improved understanding of care plans and lower risk of harm or return to care.

Priority Area 3: Addressing Patient Social Determinants of Health (SDOH)

- **Performance Indicator:**

- >95% of admitted patients are screened for the key SDOH needs (housing, food insecurity, transportation, utilities, safety)
- Increase in documentation of SDOH needs in medical record across all demographic groups.
- Increased patient understanding of care plans as measured by teach-back methods

- **Impact:**

- The hospital gains a clearer understanding of social factors affecting patient health, enabling quicker and more equitable support.
- Data-driven insights allow the hospital to target resources where inequities are most significant and measure progress transparently.
- Patients are better equipped to manage their health regardless of literacy level, reducing disparities in adherence and outcomes.

Priority Area 4: Effective Treatment

- **Performance Indicator:**

- >95% adherence to clinical guidelines for all patient groups.
- >90% of targeted services delivered within established time standards for all patient populations.
- Increased use of medication reconciliation and culturally appropriate medication education.

- **Impact:**

- All patients receive timely, appropriate treatment based on best practices, reducing avoidable complications and improving outcomes for historically underserved populations.

- Patients receive prompt care regardless of background, leading to better recovery, reduced disease progression, and more equitable results.
- Patients understand and access the medications they need, decreasing preventable adverse events and improving disease control.

Priority Area 5: Care Coordination

- **Performance Indicator:**

- >95% of patients across all demographic groups receive a standardized discharge plan, including medication review, follow up appointments and discharge instructions.
- Increased follow up coordination support for high-risk patients.
- Reduction in disparities in medication errors or confusion post-discharge.
- Availability of discharge education in preferred language for all patients.

- **Impact:**

- All patients experience safe, well-supported transitions from hospital to home or other settings, reducing avoidable complications and promoting equitable recovery.
- Patients maintain continuity of care regardless of barriers, improving long term outcomes and decreasing preventable emergency visits.
- Patients leave the hospital with a clear, accurate medication plan, reducing adverse events and supporting equitable treatment adherence.
- Patients and families understand the care plan and next steps, resulting in safer transitions and fewer inequities in comprehension or adherence.

Priority Area 6: Access to Care

- **Performance Indicator:**

- Increased assistance with insurance enrollment and charity care navigation for uninsured or underinsured patients.
- Increased referrals for community programs for patients with identified needs.
- Stratification of access metrics by race, ethnicity, language and gender.

- **Impact:**

- More patients can access necessary healthcare without financial strain, reducing inequities driven by income or insurance status.
- Patients receive support that improve access, continuity and timely engagement in care.
- Data-driven action ensures the hospital targets gaps accurately and improves access for populations most affected by inequities.