Hospital Equity Measures Report

General Information

Report Type:	Hospital Equity Measures Report
Year:	2024
Hospital Name:	RESNICK NEUROPSYCHIATRIC HOSPITAL AT UCLA
Facility Type:	Acute Psychiatric Hospital
Hospital HCAI ID:	106190930
Report Period:	01/01/2024 - 12/31/2024
Status:	Submitted
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Hospital Location with Clean Water and Air:	
Hospital Web Address for Equity Report:	https://www.uclahealth.org/community-equity

Overview

Assembly Bill No. 1204 requires the Department of Health Care Access and Information (HCAI) to develop and administer a Hospital Equity Measures Reporting Program to collect and post summaries of key hospital performance and patient outcome data regarding sociodemographic information, including but not limited to age, sex, race/ethnicity, payor type, language, disability status, and sexual orientation and gender identity.

Hospitals (general acute, children's, and acute psychiatric) and hospital systems are required to annually submit their reports to HCAI. These reports contain summaries of each measure, the top 10 disparities, and the equity plans to address the identified disparities. HCAI is required to maintain a link on the HCAI website that provides access to the content of hospital equity measures reports and equity plans to the public. All submitted hospitals are required to post their reports on their websites, as well.

Laws and Regulations

For more information on Assembly Bill No. 1204, please visit the following link by copying and pasting the URL into your web browser:
https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202120220AB1204

Hospital Equity Measures

Joint Commission Accreditation

Acute psychiatric hospitals are required to report three structural measures based on the Commission Accreditation's Health Care Disparities Reduction and Patient-Centered Communication Accreditation Standards. For more information on these measures, please visit the following link by copying and pasting the URL into your web browser:
https://www.jointcommission.org/standards/r3-report/r3-report-issue-36-new-requirements-to-reduce-health-care-disparities/

The first two structural measures are scored as "yes" or "no"; the third structural measure comprises the percentages of patients by five categories of preferred languages spoken, in addition to one other/unknown language category.

Designate an individual to lead hospital health equity activities (Y = Yes, N = No).

Y

Provide documentation of policy prohibiting discrimination (Y = Yes, N = No).

Y

Number of patients that were asked their preferred language, five defined categories and one other/unknown languages category.

1692

Table 1. Summary of preferred languages reported by patients.

Languages	Number of patients who report preferring language	Total number of patients	Percentage of total patients who report preferring language (%)
English Language	1621	1692	95.8
Spanish Language	suppressed	1692	suppressed
Asian Pacific Islander Languages	suppressed	1692	suppressed
Middle Eastern Languages	suppressed	1692	suppressed
American Sign Language	suppressed	1692	suppressed
Other Languages	suppressed	1692	suppressed

Centers for Medicare & Medicaid Services (CMS) Hospital Commitment to Health Equity Structural (HCHE) Measure

There are five domains that make up the CMS Hospital Commitment to HCHE measures. Each domain is scored as "yes" or "no." In order to score "yes," a acute psychiatric hospital is required to confirm all the domain's attestations. Lack of one or more of the attestations results in a score of "no." For more information on the CMS Hospital Commitment to HCHE measures, please visit the following link by copying and pasting the URL into your web browser: https://data.cms.gov/provider-data/topics/hospitals/health-equity

Centers for Medicare & Medicaid Services (CMS) Hospital Commitment to Health Equity Structural (HCHE) Measure Domain 1: Strategic Planning (Yes/No)

- Our hospital strategic plan identifies priority populations who currently experience health disparities.
- Our hospital strategic plan identifies healthcare equity goals and discrete action steps to achieve these goals.
- Our hospital strategic plan outlines specific resources that have been dedicated to achieving our equity goals.
- Our hospital strategic plan describes our approach for engaging key stakeholders, such as community-based organizations.

Y

CMS HCHE Measure Domain 2: Data Collection (Yes/No)

- Our hospital strategic plan identifies healthcare equity goals and discrete action steps to achieve these goals.
- Our hospital has training for staff in culturally sensitive collection of demographics and/or social determinant of health information.

• Our hospital inputs demographic and/or social determinant of health information collected from patients into structured, interoperable data elements using a certified electronic health record (EHR) technology.

Y

CMS HCHE Measure Domain 3: Data Analysis (Yes/No)

• Our hospital stratifies key performance indicators by demographic and/or social determinants of health variables to identify equity gaps and includes this information in hospital performance dashboards.

Y

CMS HCHE Measure Domain 4: Quality Improvement (Yes/No)

• Our hospital participates in local, regional or national quality improvement activities focused on reducing health disparities.

Y

CMS HCHE Measure Domain 5: Leadership Engagement (Yes/No)

• Our hospital senior leadership, including chief executives and the entire hospital board of trustees, annually reviews our strategic plan for achieving health equity.

• Our hospital senior leadership, including chief executives and the entire hospital board of trustees, annually review key performance indicators stratified by demographic and/or social factors.

Y

Centers for Medicare & Medicaid Services (CMS) Social Drivers of Health (SDOH)

Acute psychiatric hospitals are required to report on rates of screenings and intervention rates among patients above 18 years old for five health related social needs (HRSN), which are food insecurity, housing instability, transportation problems, utility difficulties, and interpersonal safety. These rates are reported separately as being screened as positive for any of the five HRSNs, positive for each individual HRSN, and the intervention rate for each positively screened HRSN. For more information on the CMS SDOH, please visit the following link by copying and pasting the URL into your web browser:
https://www.cms.gov/priorities/innovation/key-concepts/social-drivers-health-and-health-related-social-needs

Number of patients admitted to an inpatient hospital stay who are 18 years or older on the date of admission and are screened for all of the five HRSN

865

Total number of patients who are admitted to a hospital inpatient stay and who are 18 years or older on the date of admission

1279

Rate of patients admitted for an inpatient hospital stay who are 18 years or older on the date of admission, were screened for an HRSN, and who screened positive for one or more of the HRSNs

43.2

Table 2. Positive screening rates and intervention rates for the five Health Related Social Needs of the Centers of Medicare & Medicaid Services (CMS) Social Drivers of Health (SDOH).

Social Driver of Health	Number of positive screenings	Rate of positive screenings (%)	Number of positive screenings who received intervention	Rate of positive screenings who received intervention (%)
Food Insecurity	216	25.0	0	
Housing Instability	229	26.5	0	
Transportation Problems	133	15.4	0	
Utility Difficulties	53	6.1	0	
Interpersonal Safety	411	47.5	0	

Core Quality Measures for General Acute Psychiatric Hospitals

There are two quality measures from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey. For more information on the HCAHPS survey, please visit the following link by copying and pasting the URL into your web browser: https://hcahpsonline.org/en/survey-instruments/

Patient Recommends Hospital

The first HCAHPS quality measure is the percentage of patients who would recommend the hospital to friends and family. For this measure, acute psychiatric hospitals provide the percentage of patient respondents who responded "probably yes" or "definitely yes" to whether they would recommend the hospital, the percentage of the people who responded to the survey (i.e., the response rate), and the inputs for the percentages. The percentages and inputs are stratified by race and/or ethnicity, non-maternal age categories, sex, payer type, preferred language, disability status, sexual orientation, and gender identity. The corresponding HCAHPS question number is 19.

Number of respondents who replied "probably yes" or "definitely yes" to HCAHPS Question 19, "Would you recommend this hospital to your friends and family?"

NA

Total number of respondents to HCAHPS Question 19

NA

Percentage of total respondents who responded "probably yes" or "definitely yes" to HCAHPS Question 19

NA

Total number of people surveyed on HCAHPS Question 19

NA

Response rate, or the percentage of people who responded to HCAHPS Question 19

NA

Table 3. Patient recommends hospital by race and/or ethnicity, non-maternal age categories, sex, payer type, preferred language, disability status, sexual orientation, and gender identity.

Race and/or Ethnicity	Number of "probably yes" or "definitely yes" responses	Total number of responses	Percent of "probably yes" or "definitely yes" responses (%)	Total number of patients surveyed	Response rate of patients surveyed (%)
American Indian or Alaska Native					
Asian					
Black or African American					
Hispanic or Latino					
Middle Eastern or North African					
Multiracial and/or Multiethnic (two or more races)					
Native Hawaiian or Pacific Islander					
White					

Age	Number of "probably yes" or "definitely yes" responses	Total number of responses	Percent of "probably yes" or "definitely yes" responses (%)	Total number of patients surveyed	Response rate of patients surveyed (%)
Age < 18					
Age 18 to 34					
Age 35 to 49					
Age 50 to 64					
Age 65 Years and Older					

Sex assigned at birth	Number of "probably yes" or "definitely yes" responses	Total number of responses	Percent of "probably yes" or "definitely yes" responses (%)	Total number of patients surveyed	Response rate of patients surveyed (%)
Female					
Male					
Unknown					

Payer Type	Number of "probably yes" or "definitely yes" responses	Total number of responses	Percent of "probably yes" or "definitely yes" responses (%)	Total number of patients surveyed	Response rate of patients surveyed (%)
Medicare					
Medicaid					
Private					
Self-Pay					
Other					

Preferred Language	Number of "probably yes" or "definitely yes" responses	Total number of responses	Percent of "probably yes" or "definitely yes" responses (%)	Total number of patients surveyed	Response rate of patients surveyed (%)
English Language					
Spanish Language					
Asian Pacific Islander Languages					
Middle Eastern Languages					
American Sign Language					
Other/Unknown Languages					

Disability Status	Number of "probably yes" or "definitely yes" responses	Total number of responses	Percent of "probably yes" or "definitely yes" responses (%)	Total number of patients surveyed	Response rate of patients surveyed (%)
Does not have a disability					
Has a mobility disability					
Has a cognition disability					
Has a hearing disability					
Has a vision disability					
Has a self-care disability					
Has an independent living disability					

Sexual Orientation	Number of "probably yes" or "definitely yes" responses	Total number of responses	Percent of "probably yes" or "definitely yes" responses (%)	Total number of patients surveyed	Response rate of patients surveyed (%)
Lesbian, gay or homosexual					
Straight or heterosexual					
Bisexual					
Something else					
Don't know					
Not disclosed					

Gender Identity	Number of "probably yes" or "definitely yes" responses	Total number of responses	Percent of "probably yes" or "definitely yes" responses (%)	Total number of patients surveyed	Response rate of patients surveyed (%)
Female					
Female-to-male (FTM)/ transgender male/trans man					
Male					
Male-to-female (MTF)/ transgender female/trans					
Non-conforming gender					
Additional gender category or other					
Not disclosed					

Patient Received Information in Writing

The second HCAHPS quality measure is the percentage of patients who reported receiving information in writing on symptoms and health problems to look out for after leaving the hospital. Acute psychiatric hospitals are required to provide the percentage of patient respondents who responded "yes" to being provided written information, the percentage of the people who responded to the survey (i.e., the response rate), and the inputs for these percentages. These percentages and inputs are stratified by race and/or ethnicity, non-maternal age categories, sex, payer type, preferred language, disability status, sexual orientation, and gender identity. The corresponding HCAHPS question number is 17.

Number of respondents who replied "yes" to HCAHPS Question 17, "During this hospital stay, did you get information in writing about what symptoms or health problems to look out for after you left the

hospital?"

NA

Total number of respondents to HCAHPS Question 17

NA

Percentage of respondents who responded "yes" to HCAHPS Question 17

NA

Total number of people surveyed on HCAHPS Question 17

NA

Response rate, or the percentage of people who responded to HCAHPS Question 17

NA

Table 4. Patient reports receiving information in writing about symptoms or health problems by race and/or ethnicity, non-maternal age categories, sex, payer type, preferred language, disability status, sexual orientation, and gender identity.

Race and/or Ethnicity	Number of "yes" responses	Total number of responses	Percentage of "yes" responses (%)	Total number of patients surveyed	Response rate of patients surveyed (%)
American Indian or Alaska Native					
Asian					
Black or African American					
Hispanic or Latino					
Middle Eastern or North African					
Multiracial and/or Multiethnic (two or more races)					
Native Hawaiian or Pacific Islander					
White					

Age	Number of "yes" responses	Total number of responses	Percentage of "yes" responses (%)	Total number of patients surveyed	Response rate of patients surveyed (%)
Age < 18					
Age 18 to 34					
Age 35 to 49					
Age 50 to 64					
Age 65 Years and Older					

Sex assigned at birth	Number of "yes" responses	Total number of responses	Percentage of "yes" responses (%)	Total number of patients surveyed	Response rate of patients surveyed (%)
Female					
Male					
Unknown					

Payer Type	Number of "yes" responses	Total number of responses	Percentage of "yes" responses (%)	Total number of patients surveyed	Response rate of patients surveyed (%)
Medicare					
Medicaid					
Private					
Self-Pay					
Other					

Preferred Language	Number of "yes" responses	Total number of responses	Percentage of "yes" responses (%)	Total number of patients surveyed	Response rate of patients surveyed (%)
English Language					
Spanish Language					
Asian Pacific Islander Languages					
Middle Eastern Languages					
American Sign					
Other/Unknown Languages					

Disability Status	Number of "yes" responses	Total number of responses	Percentage of "yes" responses (%)	Total number of patients surveyed	Response rate of patients surveyed (%)
Does not have a disability					
Has a mobility disability					
Has a cognition					
Has a hearing disability					
Has a vision disability					
Has a self-care					
Has an independent living disability					

Sexual Orientation	Number of "yes" responses	Total number of responses	Percentage of "yes" responses (%)	Total number of patients surveyed	Response rate of patients surveyed (%)
Lesbian, gay or homosexual					
Straight or heterosexual					
Bisexual					
Something else					
Don't know					
Not disclosed					

Gender Identity	Number of "yes" responses	Total number of responses	Percentage of "yes" responses (%)	Total number of patients surveyed	Response rate of patients surveyed (%)
Female					
Female-to-male (FTM)/ transgender male/trans man					
Male					
Male-to-female (MTF)/ transgender female/ trans woman					
Non-conforming gender					
Additional gender category or other					
Not disclosed					

Agency for Healthcare Research and Quality (AHRQ) Indicators

Acute psychiatric hospitals are required to report on two indicators from the Agency for Healthcare Research and Quality (AHRQ). For general information about AHRQ indicators, please visit the following link by copying and pasting the URL into your web browser: https://qualityindicators.ahrq.gov/

Pneumonia Mortality Rate

The Pneumonia Mortality Rate is defined as the rate of in-hospital deaths per 1,000 hospital discharges with a principal diagnosis of pneumonia or a principal diagnosis of sepsis with a secondary diagnosis of pneumonia present on admission for patients ages 18 years and older. Acute psychiatric hospitals report the Pneumonia Mortality Rate by race and/or ethnicity, non-maternal age categories, sex, payer type, preferred language, disability status, sexual orientation, and gender identity. The corresponding AHRQ Inpatient Quality Indicator is 20. For more information about this indicator, please visit the following link by copying and pasting the URL into your web browser: https://qualityindicators.ahrq.gov/Downloads/Modules/IQI/V2023/TechSpecs/IQI_20_Pneumonia_Mortality_Rate.pdf

Number of in-hospital deaths with a principal diagnosis of pneumonia or a principal diagnosis of sepsis with a secondary diagnosis of pneumonia present on admission

NA

Total number of hospital discharges with a principal diagnosis of pneumonia or a principal diagnosis of sepsis with a secondary diagnosis of pneumonia present on admission

NA

Rate of in-hospital deaths per 1,000 hospital discharges with a principal diagnosis of pneumonia or a principal diagnosis of sepsis with a secondary diagnosis of pneumonia present on admission

NA

Table 5. Pneumonia Mortality Rate by race and/or ethnicity, non-maternal age categories, sex, payer type, preferred language, disability status, sexual orientation, and gender identity.

Race and/or Ethnicity	Number of in-hospital deaths that meet the inclusion/exclusion criteria	Number of hospital discharges that meet the inclusion/exclusion criteria	Rate of in-hospital deaths per 1,000 hospital discharges that meet the inclusion/exclusion criteria (%)
American Indian or Alaska Native			
Asian			
Black or African American			
Hispanic or Latino			
Middle Eastern or North African			
Multiracial and/or Multiethnic (two or more			
Native Hawaiian or Pacific Islander			
White			

Age	Number of in-hospital deaths that meet the inclusion/exclusion criteria	Number of hospital discharges that meet the inclusion/exclusion criteria	Rate of in-hospital deaths per 1,000 hospital discharges that meet the inclusion/exclusion criteria (%)
Age < 18			
Age 18 to 34			
Age 35 to 49			
Age 50 to 64			
Age 65 Years and Older			

Sex assigned at birth	Number of in-hospital deaths that meet the inclusion/exclusion criteria	Number of hospital discharges that meet the inclusion/exclusion criteria	Rate of in-hospital deaths per 1,000 hospital discharges that meet the inclusion/exclusion criteria (%)
Female			
Male			
Unknown			

Payer Type	Number of in-hospital deaths that meet the inclusion/exclusion criteria	Number of hospital discharges that meet the inclusion/exclusion criteria	Rate of in-hospital deaths per 1,000 hospital discharges that meet the inclusion/exclusion criteria (%)
Medicare			
Medicaid			
Private			
Self-Pay			
Other			

Preferred Language	Number of in-hospital deaths that meet the inclusion/exclusion criteria	Number of hospital discharges that meet the inclusion/exclusion criteria	Rate of in-hospital deaths per 1,000 hospital discharges that meet the inclusion/exclusion criteria (%)
English Language			
Spanish Language			
Asian Pacific Islander Languages			
Middle Eastern Languages			
American Sign Language			
Other/Unknown Languages			

Disability Status	Number of in-hospital deaths that meet the inclusion/exclusion criteria	Number of hospital discharges that meet the inclusion/exclusion criteria	Rate of in-hospital deaths per 1,000 hospital discharges that meet the inclusion/exclusion criteria (%)
Does not have a disability			
Has a mobility disability			
Has a cognition disability			
Has a hearing disability			
Has a vision disability			
Has a self-care disability			
Has an independent living disability			

Sexual Orientation	Number of in-hospital deaths that meet the inclusion/exclusion criteria	Number of hospital discharges that meet the inclusion/exclusion criteria	Rate of in-hospital deaths per 1,000 hospital discharges that meet the inclusion/exclusion criteria (%)
Lesbian, gay or homosexual			
Straight or heterosexual			
Bisexual			
Something else			
Don't know			
Not disclosed			

Gender Identity	Number of in-hospital deaths that meet the inclusion/exclusion criteria	Number of hospital discharges that meet the inclusion/exclusion criteria	Rate of in-hospital deaths per 1,000 hospital discharges that meet the inclusion/exclusion criteria (%)
Female			
Female-to-male (FTM)/ transgender male/trans man			
Male			
Male-to-female (MTF)/ transgender female/trans woman			
Non-conforming gender			
Additional gender category or other			
Not disclosed			

HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate

Acute psychiatric hospitals are required to report several HCAI All-Cause Unplanned 30-Day Hospital Readmission Rates, which are broadly defined as the percentage of hospital-level, unplanned, all-cause readmissions after admission for eligible conditions within 30 days of hospital discharge for patients aged 18 years and older. These rates are first stratified based on any eligible condition, mental health disorders, substance use disorders, co-occurring disorders, and no behavioral health diagnosis. Then, each condition-stratified hospital readmission rate is further stratified by race and/or ethnicity, non-maternal age categories, sex, payer type, preferred language, disability status, sexual orientation, and gender identity. For more information on the HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate, please visit the following link by copying and pasting the URL into your web browser:
https://hcai.ca.gov/wp-content/uploads/2024/10/HCAI-All-Cause-Readmission-Rate-Exclusions_ADA.pdf

HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate in an Inpatient Psychiatric Facility (IPF)

Number of inpatient admissions to an IPF which occurs within 30 days of the discharge date of an eligible index admission and were 18 years or older at time of admission

46

Total number of patients who were admitted to an IPF and were 18 years or older at time of admission

244

Rate of hospital-level, unplanned, all-cause readmissions after admission for any eligible condition within 30 days of hospital discharge for patients aged 18 and older

18.9

Table 6. HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate for any eligible condition by race and/or ethnicity, non-maternal age categories, sex, payer type, preferred language, disability status, sexual orientation, and gender identity.

Race and/or Ethnicity	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
American Indian or Alaska Native			
Asian	suppressed	suppressed	suppressed
Black or African American	suppressed	suppressed	suppressed
Hispanic or Latino	suppressed	suppressed	suppressed
Middle Eastern or North African			
Multiracial and/or Multiethnic (two or more races)	suppressed	suppressed	suppressed
Native Hawaiian or Pacific Islander			
White	23	129	17.8

Age	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Age 18 to 34	suppressed	suppressed	suppressed
Age 35 to 49	19	65	29.2
Age 50 to 64	14	54	25.9
Age 65 Years and Older	suppressed	suppressed	suppressed

Sex assigned at birth	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Female	21	130	16.2
Male	25	114	21.9
Unknown			

Payer Type	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Medicare	13	76	17.1
Medicaid	24	95	25.3
Private	suppressed	suppressed	suppressed
Self-Pay	suppressed	suppressed	suppressed
Other	suppressed	suppressed	suppressed

Preferred Language	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
English Language	suppressed	suppressed	suppressed
Spanish Language	suppressed	suppressed	suppressed
Asian Pacific Islander Languages			
Middle Eastern Languages			
American Sign Language			
Other/Unknown Languages			

Disability Status	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Does not have a disability			
Has a mobility disability			
Has a cognition disability			
Has a hearing disability			
Has a vision disability			
Has a self-care disability			
Has an independent living disability			

Sexual Orientation	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Lesbian, gay or homosexual			
Straight or heterosexual			
Bisexual			
Something else			
Don't know			
Not disclosed			

Gender Identity	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Female			
Female-to-male (FTM)/transgender male/ trans man			
Male			
Male-to-female (MTF)/transgender female/ trans woman			
Non-conforming gender			
Additional gender category or other			
Not disclosed			

HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate - Mental Health Disorders

Number of inpatient admissions to an IPF which occurs within 30 days of the discharge date for mental health disorders and were 18 years or older at time of admission

19

Total number of patients who were admitted to an IPF and were 18 years or older at time of admission

148

Rate of hospital-level, unplanned, all-cause readmissions after admission for mental health disorders within 30 days of hospital discharge for patients aged 18 and older

12.8

Table 7. HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate for mental health disorders by race and/or ethnicity, non-maternal age categories, sex, payer type, preferred language, disability status, sexual orientation, and gender identity.

Race and/or Ethnicity	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
American Indian or Alaska Native			
Asian	suppressed	suppressed	suppressed
Black or African American	suppressed	suppressed	suppressed
Hispanic or Latino	suppressed	suppressed	suppressed
Middle Eastern or North African			
Multiracial and/or Multiethnic (two or more races)	suppressed	suppressed	suppressed
Native Hawaiian or Pacific Islander			
White	suppressed	suppressed	suppressed

Age	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Age 18 to 34	suppressed	suppressed	suppressed
Age 35 to 49	suppressed	suppressed	suppressed
Age 50 to 64	suppressed	suppressed	suppressed
Age 65 Years and Older	0	19	0.0

Sex assigned at birth	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Female	suppressed	suppressed	suppressed
Male	suppressed	suppressed	suppressed
Unknown			

Payer Type	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Medicare	suppressed	suppressed	suppressed
Medicaid	suppressed	suppressed	suppressed
Private	suppressed	suppressed	suppressed
Self-Pay	suppressed	suppressed	suppressed
Other	suppressed	suppressed	suppressed

Preferred Language	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
English Language	suppressed	suppressed	suppressed
Spanish Language	suppressed	suppressed	suppressed
Asian Pacific Islander Languages			
Middle Eastern Languages			
American Sign Language			
Other/Unknown Languages			

Disability Status	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Does not have a disability			
Has a mobility disability			
Has a cognition disability			
Has a hearing disability			
Has a vision disability			
Has a self-care disability			
Has an independent living disability			

Sexual Orientation	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Lesbian, gay or homosexual			
Straight or heterosexual			
Bisexual			
Something else			
Don't know			
Not disclosed			

Gender Identity	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Female			
Female-to-male (FTM)/transgender male/ trans man			
Male			
Male-to-female (MTF)/transgender female/ trans woman			
Non-conforming gender			
Additional gender category or other			
Not disclosed			

HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate - Substance Use Disorders

Number of inpatient admissions to an IPF which occurs within 30 days of the discharge date for substance use disorders and were 18 years or older at time of admission

NA

Total number of patients who were admitted to an IPF and were 18 years or older at time of admission

NA

Rate of hospital-level, unplanned, all-cause readmissions after admission for substance use disorders within 30 days of hospital discharge for patients aged 18 and older

NA

Table 8. HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate for substance use disorders by race and/or ethnicity, non-maternal age categories, sex, payer type, preferred language, disability status, sexual orientation, and gender identity.

Race and/or Ethnicity	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
American Indian or Alaska Native			
Asian			
Black or African American			
Hispanic or Latino			
Middle Eastern or North African			
Multiracial and/or Multiethnic (two or more races)			
Native Hawaiian or Pacific Islander			
White			

Age	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Age 18 to 34			
Age 35 to 49			
Age 50 to 64			
Age 65 Years and Older			

Sex assigned at birth	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Female			
Male			
Unknown			

Payer Type	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Medicare			
Medicaid			
Private			
Self-Pay			
Other			

Preferred Language	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
English Language			
Spanish Language			
Asian Pacific Islander Languages			
Middle Eastern Languages			
American Sign Language			
Other/Unknown Languages			

Disability Status	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Does not have a disability			
Has a mobility disability			
Has a cognition disability			
Has a hearing disability			
Has a vision disability			
Has a self-care disability			
Has an independent living disability			

Sexual Orientation	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Lesbian, gay or homosexual			
Straight or heterosexual			
Bisexual			
Something else			
Don't know			
Not disclosed			

Gender Identity	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Female			
Female-to-male (FTM)/transgender male/ trans man			
Male			
Male-to-female (MTF)/transgender female/ trans woman			
Non-conforming gender			
Additional gender category or other			
Not disclosed			

HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate - Co-occurring disorders

Number of inpatient admissions to an IPF which occurs within 30 days of the discharge date for co-occurring disorders and were 18 years or older at time of admission

27

Total number of patients who were admitted to an IPF and were 18 years or older at time of admission

94

Rate of hospital-level, unplanned, all-cause readmissions after admission for co-occurring disorders within 30 days of hospital discharge for patients aged 18 and older

28.7

Table 9. HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate for co-occurring disorders by race and/or ethnicity, non-maternal age categories, sex, payer type, preferred language, disability status, sexual orientation, and gender identity.

Race and/or Ethnicity	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
American Indian or Alaska Native			
Asian	suppressed	suppressed	suppressed
Black or African American	suppressed	suppressed	suppressed
Hispanic or Latino	suppressed	suppressed	suppressed
Middle Eastern or North African			
Multiracial and/or Multiethnic (two or more races)	suppressed	suppressed	suppressed
Native Hawaiian or Pacific Islander			
White	suppressed	suppressed	suppressed

Age	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Age 18 to 34	suppressed	suppressed	suppressed
Age 35 to 49	suppressed	suppressed	suppressed
Age 50 to 64	suppressed	suppressed	suppressed
Age 65 Years and Older	suppressed	suppressed	suppressed

Sex assigned at birth	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Female	suppressed	suppressed	suppressed
Male	suppressed	suppressed	suppressed
Unknown			

Payer Type	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Medicare	suppressed	suppressed	suppressed
Medicaid	suppressed	suppressed	suppressed
Private	suppressed	suppressed	suppressed
Self-Pay			
Other	suppressed	suppressed	suppressed

Preferred Language	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
English Language	suppressed	suppressed	suppressed
Spanish Language			
Asian Pacific Islander Languages			
Middle Eastern Languages			
American Sign Language			
Other/Unknown Languages			

Disability Status	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Does not have a disability			
Has a mobility disability			
Has a cognition disability			
Has a hearing disability			
Has a vision disability			
Has a self-care disability			
Has an independent living disability			

Sexual Orientation	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Lesbian, gay or homosexual			
Straight or heterosexual			
Bisexual			
Something else			
Don't know			
Not disclosed			

Gender Identity	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Female			
Female-to-male (FTM)/transgender male/ trans man			
Male			
Male-to-female (MTF)/transgender female/ trans woman			
Non-conforming gender			
Additional gender category or other			
Not disclosed			

HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate - No Behavioral Health Diagnosis

Number of inpatient admissions to an IPF which occurs within 30 days of the discharge date with no behavioral diagnosis and were 18 years or older at time of admission

suppressed

Total number of patients who were admitted to an IPF and were 18 years or older at time of admission

suppressed

Rate of hospital-level, unplanned, all-cause readmissions after admission with no behavioral diagnosis within 30 days of hospital discharge for patients aged 18 and older

suppressed

Table 10. HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate with No Behavioral Diagnosis by race and/or ethnicity, non-maternal age categories, sex, payer type, preferred language, disability status, sexual orientation, and gender identity.

Race and/or Ethnicity	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
American Indian or Alaska Native			
Asian			
Black or African American			
Hispanic or Latino			
Middle Eastern or North African			
Multiracial and/or Multiethnic (two or more races)			
Native Hawaiian or Pacific Islander			
White	suppressed	suppressed	suppressed

Age	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Age 18 to 34			
Age 35 to 49			
Age 50 to 64			
Age 65 Years and Older	suppressed	suppressed	suppressed

Sex assigned at birth	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Female	suppressed	suppressed	suppressed
Male	suppressed	suppressed	suppressed
Unknown			

Payer Type	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Medicare	suppressed	suppressed	suppressed
Medicaid			
Private	suppressed	suppressed	suppressed
Self-Pay			
Other			

Preferred Language	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
English Language	suppressed	suppressed	suppressed
Spanish Language			
Asian Pacific Islander Languages			
Middle Eastern Languages			
American Sign Language			
Other/Unknown Languages			

Disability Status	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Does not have a disability			
Has a mobility disability			
Has a cognition disability			
Has a hearing disability			
Has a vision disability			
Has a self-care disability			
Has an independent living disability			

Sexual Orientation	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Lesbian, gay or homosexual			
Straight or heterosexual			
Bisexual			
Something else			
Don't know			
Not disclosed			

Gender Identity	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Female			
Female-to-male (FTM)/transgender male/ trans man			
Male			
Male-to-female (MTF)/transgender female/ trans woman			
Non-conforming gender			
Additional gender category or other			
Not disclosed			

CMS Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program Screening for Metabolic Disorders

Acute psychiatric hospitals are required to report the rate of structured screenings for metabolic disorders among patients with a prescription for one or more routinely scheduled antipsychotic medications. The structured screenings must contain (1) body mass index (BMI), (2) blood pressure, (3) blood glucose or HbA1c, and (4) a lipid panel, and be completed at least once in the 12 months prior to the patient's date of discharge. The rate of patient screenings for metabolic disorders are stratified by race and/or ethnicity, non-maternal age categories, sex, payer type, preferred language, disability status, sexual orientation, and gender identity. For more information on the structured screenings for metabolic disorders, please see page 92 of the report by visiting the following link by copying and pasting the URL into your web browser: https://www.qualityreportingcenter.com/globalassets/2021/05/iqr/ipfqr_programmanualv7.0_final508.pdf

Number of patients with a prescription for one or more routinely scheduled antipsychotic medications who received a metabolic screening in the 12 months prior to discharge, either prior to or during the index IPF stay

NA

Number of discharges from an IPF during the measurement period with a prescription for one or more routinely scheduled antipsychotic medications

NA

Rate of patients discharged from an IPF with a prescription for one or more routinely scheduled antipsychotic medications for which a structured metabolic screening was completed in the 12 months prior to discharge, either prior to or during the index IPF stay

NA

Table 11. Rate of patients who received structured metabolic screenings with a prescription for a routinely scheduled antipsychotic medication by race and/or ethnicity, non-maternal age categories, sex, payer type, preferred language, disability status, sexual orientation, and gender identity.

Race and/or Ethnicity	Number of eligible patients who received metabolic screening	Total number of eligible discharges	Rate of eligible patients who received metabolic screening (%)
American Indian or Alaska Native			
Asian			
Black or African American			
Hispanic or Latino			
Middle Eastern or North African			
Multiracial and/or Multiethnic (two or more races)			
Native Hawaiian or Pacific Islander			
White			

Age	Number of eligible patients who received metabolic screening	Total number of eligible discharges	Rate of eligible patients who received metabolic screening (%)
Age < 18			
Age 18 to 34			
Age 35 to 49			
Age 50 to 64			
Age 65 Years and Older			

Sex assigned at birth	Number of eligible patients who received metabolic screening	Total number of eligible discharges	Rate of eligible patients who received metabolic screening (%)
Female			
Male			
Unknown			

Payer Type	Number of eligible patients who received metabolic screening	Total number of eligible discharges	Rate of eligible patients who received metabolic screening (%)
Medicare			
Medicaid			
Private			
Self-Pay			
Other			

Preferred Language	Number of eligible patients who received metabolic screening	Total number of eligible discharges	Rate of eligible patients who received metabolic screening (%)
English Language			
Spanish Language			
Asian Pacific Islander Languages			
Middle Eastern Languages			
American Sign Language			
Other/Unknown Languages			

Disability Status	Number of eligible patients who received metabolic screening	Total number of eligible discharges	Rate of eligible patients who received metabolic screening (%)
Does not have a disability			
Has a mobility disability			
Has a cognition disability			
Has a hearing disability			
Has a vision disability			
Has a self-care disability			
Has an independent living disability			

Sexual Orientation	Number of eligible patients who received metabolic screening	Total number of eligible discharges	Rate of eligible patients who received metabolic screening (%)
Lesbian, gay or homosexual			
Straight or heterosexual			
Bisexual			
Something else			
Don't know			
Not disclosed			

Gender Identity	Number of eligible patients who received metabolic screening	Total number of eligible discharges	Rate of eligible patients who received metabolic screening (%)
Female			
Female-to-male (FTM)/transgender male/ trans man			
Male			
Male-to-female (MTF)/transgender female/ trans woman			
Non-conforming gender			
Additional gender category or other			
Not disclosed			

The Joint Commission SUB-3: Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge

Acute psychiatric hospitals are required to report the rate of structured screenings for metabolic disorders among patients with a prescription for one or more routinely scheduled antipsychotic medications. The structured screenings must contain (1) body mass index (BMI), (2) blood pressure, (3) blood glucose or HbA1c, and (4) a lipid panel, and be completed at least once in the 12 months prior to the patient's date of discharge. The rate of patient screenings for metabolic disorders are stratified by race and/or ethnicity, non-maternal age categories, sex, payer type, preferred language, disability status, sexual orientation, and gender identity. For more information on the structured screenings for metabolic disorders, please see page 92 of the report by visiting the following link by copying and pasting the URL into your web browser: https://www.qualityreportingcenter.com/globalassets/2021/05/iqr/ipfqr_programmanualv7.0_final508.pdf

Number of hospitalized inpatients 18 years of age or older with an alcohol or drug use disorder who received or refused a prescription medication for the disorder or a referral for addictions treatment

NA

Total number of hospitalized inpatients 18 years of age and older identified with an alcohol or drug use disorder

NA

Rate of hospitalized inpatients 18 years of age or older with an alcohol or drug use disorder who received or refused a prescription medication for the disorder or a referral for addictions treatment

NA

Table 12. Rate of eligible patients who received or refused prescription or referral for treatment by race and/or ethnicity, non-maternal age categories, sex, payer type, preferred language, disability status, sexual orientation, and gender identity.

Race and/or Ethnicity	Number of eligible patients who received or refused prescription or referral for treatment	Total number of hospitalized patients at least 18 years or older identified with an alcohol or drug use disorder	Rate of eligible patients who received or refused prescription or referral for treatment (%)
American Indian or Alaska Native			
Asian			
Black or African American			
Hispanic or Latino			
Middle Eastern or North African			
Multiracial and/or Multiethnic (two or more races)			
Native Hawaiian or Pacific Islander			
White			

Age	Number of eligible patients who received or refused prescription or referral for treatment	Total number of hospitalized patients at least 18 years or older identified with an alcohol or drug use disorder	Rate of eligible patients who received or refused prescription or referral for treatment (%)
Age 18 to 34			
Age 35 to 49			
Age 50 to 64			
Age 65 Years and Older			

Sex assigned at birth	Number of eligible patients who received or refused prescription or referral for treatment	Total number of hospitalized patients at least 18 years or older identified with an alcohol or drug use disorder	Rate of eligible patients who received or refused prescription or referral for treatment (%)
Female			
Male			
Unknown			

Payer Type	Number of eligible patients who received or refused prescription or referral for treatment	Total number of hospitalized patients at least 18 years or older identified with an alcohol or drug use disorder	Rate of eligible patients who received or refused prescription or referral for treatment (%)
Medicare			
Medicaid			
Private			
Self-Pay			
Other			

Preferred Language	Number of eligible patients who received or refused prescription or referral for treatment	Total number of hospitalized patients at least 18 years or older identified with an alcohol or drug use disorder	Rate of eligible patients who received or refused prescription or referral for treatment (%)
English Language			
Spanish Language			
Asian Pacific Islander Languages			
Middle Eastern Languages			
American Sign Language			
Other/Unknown Languages			

Disability Status	Number of eligible patients who received or refused prescription or referral for treatment	Total number of hospitalized patients at least 18 years or older identified with an alcohol or drug use disorder	Rate of eligible patients who received or refused prescription or referral for treatment (%)
Does not have a disability			
Has a mobility disability			
Has a cognition disability			
Has a hearing disability			
Has a vision disability			
Has a self-care disability			
Has an independent living disability			

Sexual Orientation	Number of eligible patients who received or refused prescription or referral for treatment	Total number of hospitalized patients at least 18 years or older identified with an alcohol or drug use disorder	Rate of eligible patients who received or refused prescription or referral for treatment (%)
Lesbian, gay or homosexual			
Straight or heterosexual			
Bisexual			
Something else			
Don't know			
Not disclosed			

Gender Identity	Number of eligible patients who received or refused prescription or referral for treatment	Total number of hospitalized patients at least 18 years or older identified with an alcohol or drug use disorder	Rate of eligible patients who received or refused prescription or referral for treatment (%)
Female			
Female-to-male (FTM)/transgender male/trans man			
Male			
Male-to-female (MTF)/transgender female/trans woman			
Non-conforming gender			
Additional gender category or other			
Not disclosed			

The Joint Commission SUB-3: Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge

Acute psychiatric hospitals are required to report the rate of patients 18 years of age or older with an alcohol or drug use disorder who received or refused a prescription medication for the disorder or a referral for addictions treatment. This rate is stratified by race and/or ethnicity, non-maternal age categories, sex, payer type, preferred language, disability status, sexual orientation, and gender identity. For more information on the rate calculation and inclusion/exclusion criteria, please visit the following link by copying and pasting the URL into your web browser: https://manual.jointcommission.org/releases/TJC2024B/MIF0221.html

Number of hospitalized inpatients 18 years of age or older with an alcohol or drug use disorder who received or refused a prescription medication for the disorder or a referral for addictions treatment

NA

Total number of hospitalized inpatients 18 years of age and older identified with an alcohol or drug use disorder

NA

Rate of hospitalized inpatients 18 years of age or older with an alcohol or drug use disorder who received or refused a prescription medication for the disorder or a referral for addictions treatment

NA

Table 13. Rate of patients who received or refused prescription or referral for treatment by race and/or ethnicity, non-maternal age categories, sex, payer type, preferred language, disability status, sexual orientation, and gender identity.

Race and/or Ethnicity	Number of patients who received or refused prescription or referral for treatment who meet inclusion/ exclusion criteria	Total number of identified with an alcohol or drug use disorder who meet inclusion/ exclusion criteria	Rate of eligible patients who received or refused prescription or referral for treatment who meet inclusion/ exclusion criteria (%)
American Indian or Alaska Native			
Asian			
Black or African American			
Hispanic or Latino			
Middle Eastern or North			
Multiracial and/or Multiethnic (two or more races)			
Native Hawaiian or Pacific Islander			
White			

Age	Number of patients who received or refused prescription or referral for treatment who meet inclusion/ exclusion criteria	Total number of identified with an alcohol or drug use disorder who meet inclusion/ exclusion criteria	Rate of eligible patients who received or refused prescription or referral for treatment who meet inclusion/ exclusion criteria (%)
Age 18 to 34			
Age 35 to 49			
Age 50 to 64			
Age 65 Years and Older			

Sex assigned at birth	Number of patients who received or refused prescription or referral for treatment who meet inclusion/ exclusion criteria	Total number of identified with an alcohol or drug use disorder who meet inclusion/ exclusion criteria	Rate of eligible patients who received or refused prescription or referral for treatment who meet inclusion/ exclusion criteria (%)
Female			
Male			
Unknown			

Payer Type	Number of patients who received or refused prescription or referral for treatment who meet inclusion/ exclusion criteria	Total number of identified with an alcohol or drug use disorder who meet inclusion/ exclusion criteria	Rate of eligible patients who received or refused prescription or referral for treatment who meet inclusion/ exclusion criteria (%)
Medicare			
Medicaid			
Private			
Self-Pay			
Other			

Preferred Language	Number of patients who received or refused prescription or referral for treatment who meet inclusion/ exclusion criteria	Total number of identified with an alcohol or drug use disorder who meet inclusion/ exclusion criteria	Rate of eligible patients who received or refused prescription or referral for treatment who meet inclusion/ exclusion criteria (%)
English Language			
Spanish Language			
Asian Pacific Islander Languages			
Middle Eastern Languages			
American Sign Language			
Other/Unknown Languages			

Disability Status	Number of patients who received or refused prescription or referral for treatment who meet inclusion/ exclusion criteria	Total number of identified with an alcohol or drug use disorder who meet inclusion/ exclusion criteria	Rate of eligible patients who received or refused prescription or referral for treatment who meet inclusion/ exclusion criteria (%)
Does not have a disability			
Has a mobility disability			
Has a cognition disability			
Has a hearing disability			
Has a vision disability			
Has a self-care disability			
Has an independent living disability			

Sexual Orientation	Number of patients who received or refused prescription or referral for treatment who meet inclusion/ exclusion criteria	Total number of identified with an alcohol or drug use disorder who meet inclusion/ exclusion criteria	Rate of eligible patients who received or refused prescription or referral for treatment who meet inclusion/ exclusion criteria (%)
Lesbian, gay or homosexual			
Straight or heterosexual			
Bisexual			
Something else			
Don't know			
Not disclosed			

Gender Identity	Number of patients who received or refused prescription or referral for treatment who meet inclusion/ exclusion criteria	Total number of identified with an alcohol or drug use disorder who meet inclusion/ exclusion criteria	Rate of eligible patients who received or refused prescription or referral for treatment who meet inclusion/ exclusion criteria (%)
Female			
Female-to-male (FTM)/ transgender male/trans man			
Male			
Male-to-female (MTF)/ transgender female/trans woman			
Non-conforming gender			
Additional gender category or other			
Not disclosed			

Health Equity Plan

All acute psychiatric hospitals report a health equity plan that identifies the top 10 disparities and a written plan to address them.

Top 10 Disparities

Disparities for each hospital equity measure are identified by comparing the rate ratios by stratification groups. Rate ratios are calculated differently for measures with preferred low rates and those with preferred high rates. Rate ratios are calculated after applying the California Health and Human Services Agency's "Data De-Identification Guidelines (DDG)," dated September 23, 2016.

Table 14. Top 10 disparities and their rate ratio values.

Measures	Stratifications	Stratification Group	Stratification Rate	Reference Group	Reference Rate	Rate Ratio
HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate in an Inpatient Psychiatric Facility (IPF).	Expected Payor			Medicare	17.1	1.5
HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate in an Inpatient Psychiatric Facility (IPF).	Sex Assigned at Birth			Female	16.2	1.4
HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate in an Inpatient Psychiatric Facility (IPF).	Age (excluding maternal measures)			50 to 64	25.9	1.1

Plan to address disparities identified in the data

UCLA Health is committed to advancing the health and wellbeing of every patient in the broad and diverse communities we serve. Through the Office of Health Equity and Inclusive Excellence and the DGSOM Office of Inclusive Excellence, we work to eliminate inequities and foster a culture of belonging in care, education, and research. The Office of Community builds partnerships across Los Angeles to advance health and wellness. Our LGBTQ+ Health initiatives offer services for patients of all identities, while the Homeless Healthcare Collaborative delivers free, mobile, trauma-informed medical and behavioral health care to people experiencing homelessness.

In 2024, UCLA Health—inclusive of Resnick Neuropsychiatric Hospital—became the first health system in California to earn the Joint Commission's Health Care Equity Certification, affirming that equity is embedded within our structures of governance, clinical care, and continuous improvement.

UNPLANNED READMISSIONS HEALTH EQUITY ACTION PLAN

When patients leave the hospital, we know they need support successfully returning to their community to avoid unexpected re-hospitalization. To support patients during their transition after hospitalization, the RNPH provides highly coordinated care, daily interdisciplinary review, structured social work reassessments, equity-focused review of safety practices, and tailored post-discharge services. Health equity analyses reveal modest differences in readmission rates across demographic groups: Sex (M vs. F disparity: 1.2), Age (35-49 vs. 50-64 disparity: 1.1), and Payor (Medi-Cal vs. Medicare disparity: 1.3). Addressing these differences is central to our commitment to exceptional quality and safety of care for all patients.

RNPH has several practices in place that create a strong platform for delivering excellent and equitable readmissions outcomes. First, for the past five years, the Post-Acute Psychiatry Clinic has provided outpatient follow-up for patients within seven days of discharge from the inpatient unit, regardless of age or insurance coverage. This ensures that patients using Medi-Cal, Medicare, or

commercial insurance, and patients with no insurance, have equal access to care after an inpatient stay. Licensed therapists in this clinic provide both short-term psychotherapy and case management, linking patients to long-term mental health care in the community. Patients seen in this clinic are considerably less likely to experience an unplanned readmission within 30 days, with a rate of less than 5% as compared to about 12% for all patients discharged from RNPH and more than 30% for all Medi-Cal beneficiaries in Los Angeles County.

Second, daily interdisciplinary safety huddles actively track readmissions in real time. Readmissions are discussed within 48 hours, allowing interdisciplinary leaders and frontline staff to identify immediate opportunities for intervention.

While these structures provide a strong foundation, more work is needed to specifically identify and address inequities. We aim to maintain or improve overall psychiatric readmission outcomes while eliminating inequities among patient populations, including payor, age, and sex. By strengthening our existing practices with deeper equity analyses, targeted interventions, and ongoing measurement, UCLA Psychiatry will advance toward more equitable care transitions and improved long-term recovery for all patients.

IMPROVEMENT STRATEGIES AND MEASURABLE OBJECTIVES:
Maintain existing best practices to prevent unplanned readmissions:
1. Post-acute Psychiatry Clinic Access: Continue ensuring that all discharged patients are offered appointments within seven days of discharge.
2. Daily Monitoring of Readmissions: Maintain structured discussion of all readmissions during Active Daily Management huddles, including attention to demographic factors that may influence outcomes.

By the end of 2026, we will analyze the root causes of inequities in unplanned readmissions:
1. Build and monitor dynamic displays for post-discharge follow-up completion rates across all patients and among relevant populations.
2. Investigate root causes of unexpected variations in outcomes and routinely report findings to psychiatry quality forums.

By the end of 2027, we will implement tailored interventions to improve inequities in unplanned readmissions:
1. Publish an updated equity action plan that integrates findings from follow-up completion, daily huddle monitoring, and social work reassessment reviews, with concrete recommendations tailored to closing the identified inequities.
2. Develop tailored interventions and improvement plans to address significant inequities identified through continuous performance monitoring.
3. Implement targeted interventions to address drivers of inequity in readmissions.

Performance in the priority area

Acute psychiatric hospitals are required to provide hospital equity plans that address the top 10 disparities by identifying population impact and providing measurable objectives and specific timeframes. For each disparity, hospital equity plans will address performance across priority areas: person-centered care, patient safety, addressing patient social drivers of health, effective treatment, care coordination, and access to care.

Person-centered care

At UCLA Psychiatry, person-centered care is the foundation of our clinical and organizational practice. Our performance in this area reflects a commitment to collaboration, respect, cultural humility, and equity. We integrate these principles into every stage of care, from treatment planning to discharge, ensuring that patients and families experience the hospital not only as a place of safety but also as an active partner in recovery.

COLLABORATIVE TREATMENT PLANNING AND SHARED DECISION-MAKING

Treatment planning is structured as an interactive process rather than a top-down directive. Treatment teams design clinical plans informed by patient values and goals. With patient consent, family members or other key supports are included so that the recovery plan is understood and reinforced across care settings. A weekly shared decision-making group, led by clinicians, provides education and practice in communicating with the treatment team, ensuring that patients are equipped to participate meaningfully in decisions about their care. Daily interdisciplinary rounds bring together psychiatry, nursing, social work, occupational therapy, and the patient ensuring that diverse professional perspectives align with the patient's goals.

TRAUMA-INFORMED CARE

Our staff receive ongoing training in trauma-informed principles like safety, trust, empowerment, collaboration, and choice, and are coached to embed these values in daily practice. Clinicians ask permission before entering rooms, explain procedures in plain language, and emphasize patient choice whenever possible. We have demonstrated a measurable decline in escalated events requiring restraint or seclusion, with patients experiencing care as more transparent and collaborative.

BOARD CERTIFIED BEHAVIOR ANALYST (BCBA)

Person-centered care on our inpatient units is further strengthened by the presence of a BCBA who specializes in treating patients with autism and developmental differences. The BCBA collaborates with patients, families, and the treatment team to design individualized strategies that reduce distress, promote communication, and build adaptive skills. Interventions are tailored to each patient's unique sensory, behavioral, cognitive, and learning needs.

PEER INVOLVEMENT

UCLA RNPH has partnered with peer-based organizations in the community. Persons with lived experience of mental illness offer peer-to-peer support groups four times a week across the units at RNPH. Their presence normalizes recovery, provides role modeling, and instills hope. Patients frequently report that peer interactions make them feel understood.

PATIENT AND FAMILY ADVISORY COUNCIL

Patient and family input is systematically sought and incorporated into service improvements. The Patient and Family Advisory Council (PFAC) provides a formal structure for patients and families to shape policy, inform program development, and guide aspects of daily operations. The council meets monthly, and each meeting generates actionable recommendations. Progress on these action plans is tracked and reported back on a monthly basis, ensuring accountability and transparency in how feedback informs change.

COMPREHENSIVE INTERDISCIPLINARY CARE

Every admitted patient is assigned a psychiatrist, nurse, social worker, and rehabilitation therapist (occupational therapist and/or recreational therapist). Spiritual care is available to all patients as needed, and hospital chaplains offer spiritual care groups to patients each week. This

comprehensive, interdisciplinary model ensures that care is medically sound and also responsive to psychosocial, functional, and cultural needs.

CONCLUSION

Person-centered care in UCLA Psychiatry is not a single program but a culture that spans treatment planning, trauma-informed practice, peer involvement, and active use of patient feedback. By embedding these principles into our daily operations, we reduce stigma, improve patient and family experience, and strengthen equity across populations.

Patient safety

At the Resnick Neuropsychiatric Hospital at UCLA (RNPH), we want every patient to not only be safe, but to feel safe. The RNPH prioritizes therapeutic collaboration and shared decision making with patients and recognizes that patients, staff, and visitors expect exceptional, safe, and error-free care. The organization uses a proactive approach to the identification and mitigation of errors and responds quickly, effectively, and appropriately when errors occur. All departments within the organization are responsible for reporting health care safety events, and these reports are monitored through the organizational leadership structure.

The RNPH supports the concept that errors occur due to a breakdown in systems and processes, not individual mistakes; therefore, our approach focuses on improving systems and processes. The organization has implemented an electronic event reporting system to address unexpected and adverse events, including events with the perception of discrimination. The RNPH promotes a culture of safety in its management of errors and occurrences. All personnel have avenues to report suspected and identified health care errors without fear of retaliation. Summary data from the event reporting system is aggregated and presented periodically to the Performance Improvement and Patient Safety Council and to the Professional Staff Executive Committee, who may recommend further risk reduction activities. The Zero Harm Committee reviews significant events that caused or could cause patient harm and identifies opportunities to improve processes that impact patient safety systemwide.

The Performance Improvement and Patient Safety Council (PIPSC) ensures health care quality and patient safety through the ongoing prioritization, design, implementation, monitoring, and analysis of performance improvement initiatives. PIPSC assesses staff opinions regarding their perceptions of risks to patients, the culture of the health care environment to facilitate safe practices, and their suggestions for improving patient safety and clinical outcomes through the culture of safety surveys. Additionally, the Council evaluates access to care, the patient experience, and health outcomes to assess and improve mental health care.

The Vice Chancellor of UCLA Health Sciences serves as the Governing Body for UCLA Hospital and Clinics and has executive responsibility for the PIPSC. The Professional Staff Executive Committee, the UCLA Hospital System President and CEO, and the PIPSC ensure an integrated program.

The Zero Harm Committee oversees the Health System's efforts and initiatives to implement highly reliable practices to reduce medical errors and health care-acquired conditions (HACs) toward the goal of zero harm, providing a systematic, coordinated and continuous approach to:

* Serve as a system-wide decision-making body for identifying and aligning ongoing patient and staff safety initiatives to foster the growth of the organization's culture of safety
* Plan and prioritize ongoing patient and staff safety initiatives
* Identify and mitigate barriers to becoming a high reliability organization

* Review and address:
  - High-risk patient and staff safety opportunities across the health system
  - Patterns of HACs and patient safety indicators, including any health care inequities
  - Opportunities based on Leapfrog's bi-annual Hospital Patient Safety Grade
* Administer and analyze the hospital's culture of safety survey and support department-specific and system-wide action plans as needed

Addressing patient social drivers of health

UCLA Health established a systemwide social drivers of health (SDOH) program to address the profound impact that daily needs like food, housing, transportation, and finances have on people's overall health and wellbeing.

The SDOH Program seeks to elevate the patient's role as the leader in their care and honor social care team members as "support travel companions" for patients and health care providers using a learning health system quality improvement approach to promote enhanced, whole-person care. The SDOH program supplies dedicated end-to-end program and project management support, develops and monitors process and outcome key performance indicators, participates in thought leadership collaborations, and contributes to relevant governance bodies across UCLA Health. The SDOH program is directly aligned with the UCLA Health institutional goals and population health strategy with oversight by the Population Health Equity Committee (chaired by the Population Health Medical Director) and the UCLA Health Population Health Steering Committee (chaired by the President of the Faculty Practice Group). The program is also accountable to the University of California Medical Centers' Population Health SDOH Committee and participates in local, regional, and national groups.

A key effort led by the SDOH Program includes universal SDOH risk screening with validated tools, full psychosocial assessment with enhanced documentation, and intervention for health-related social needs. The program standardized processes, documentation, and electronic data display to facilitate better-informed medical care and better social care services delivery. Patients' health-related social needs are evaluated through interprofessional collaborations during interdisciplinary rounds. When patient needs are identified, a social worker meets the patient to assess their needs directly and to offer them resources and support that are appropriate for their situation. When resources are available within UCLA Health, they are provided directly at the point of service. Referrals to community-based organizations (CBOs) for relevant services are made when the patient consents.

Universal risk screening identifies needs related to eight SDOH domains: housing, food, finance, medical bills including prescriptions, utilities, transportation, social isolation and interpersonal safety. An electronic community resource search platform integrated into the EMR streamlines and centralizes data sharing with CBOs. These resources are also publicly available for any community member who is interested in finding local community resources for health related social needs.

Staff are thoroughly trained on SDOH screening processes. We continually monitor screening processes. Screening rates for each domain consistently exceed the CMS 2024 published threshold of 64% and include SDOH domains beyond those required by CMS.

The SDOH Program is leading the development and implementation of a Community Partnerships Prioritization Scorecard, a community care collaborative with other regional organizations, a community care hub with physical space allocation, and a preferred network of community-based organizations to service UCLA Health patient's health-related social needs. The SDOH Program

cultivates relationships with community-based organizations that can provide resources or interventions outside of UCLA Health, such as food delivery programs or financial strain resource information bundles.

Performance in the priority area continued

Performance across all of the following priority areas.

Effective treatment

The Resnick Neuropsychiatric Hospital at UCLA (RNPH) delivers effective treatment through an integrated framework that combines evidence-based clinical practice, rigorous quality oversight, equity-driven measurement, and investment in workforce and community partnerships.

DATA-DRIVEN QUALITY FRAMEWORK

Our systemwide quality framework is anchored by our quality strategy, which tracks clinical outcomes related to mortality, outcomes, high value care, patient experience, readmissions, and safety measures. The quality strategy tracks and aggregates nationally reported quality indicators with internal performance targets, providing leaders and frontline teams with actionable data to identify opportunities, reduce unexpected variation, and drive improvement. To ensure treatment is both excellent and equitable, we have developed health equity analytic tools to monitor state-mandated measures, overall and across patient populations, to detect unexpected variations in outcomes and guide targeted interventions.

CLINICAL GOVERNANCE AND OVERSIGHT

Oversight of clinical care and operations is provided through integrated committee structures:

* The Professional Staff Executive Committee (PSEC) oversees the quality and safety of medical care, reviewing aggregate performance data and recommending action.
* The Performance Improvement Patient Safety Council (PIPSC) aligns safety, quality, and performance improvement activities with organizational priorities, focusing attention on areas of greatest opportunity.
* The Equitable Care Committee sets systemwide clinical equity strategy, monitors outcomes across all populations, and develops policies and practices that support the organization in delivering equitable care and treatment.
* The Health Equity Informatics Insights and Innovations Taskforce (HEI^3) advances equity in health information technology by defining data standards, standardizing population health analytics, and cultivating innovations that integrate equity principles into clinical informatic systems.
* The Health Literacy Workgroup promotes clear, compassionate clinical communication by aligning care, education, and counseling with each patient's language, literacy, and communication needs.

These governance bodies ensure that performance monitoring and accountability are embedded in day-to-day operations, supporting a culture of transparency and continuous improvement.

STRATEGIC FRAMEWORK FOR EFFECTIVE TREATMENT

Our work is guided by six interconnected strategies:

1. Applying principles of quality and equity to deliver evidence-based and innovative psychiatric treatment
2. Fostering a healthy, engaged, and safe workforce that is equipped to provide high-quality care

3. Meeting unique and complex patient needs through compassion, creativity, and individualized planning
4. Using real-time data to drive measurable improvements in outcomes and safety
5. Delivering leading-edge education to train future leaders in mental health care
6. Investing in our communities through service, advocacy, and collaboration

KEY STRATEGIC PROJECTS DEMONSTRATING PERFORMANCE

Data-Driven Care & Measurement-Based Practice

* Data Center of Excellence: Developing infrastructure for real-time clinical decision-making, predictive analytics, and systematic outcomes tracking.

* Seclusion and Restraint Reduction Initiative: A multidisciplinary effort to reduce both the frequency and duration of restrictive interventions. Through trauma-informed care, early intervention, and training by a Board-Certified Behavior Analyst, staff are better equipped to interpret patient behaviors and prevent escalation.

Workforce & Culture

* Turnover Reduction Efforts: Departmental and unit-level strategies to strengthen retention through onboarding, peer recognition, and workload management. Stable staffing directly improves consistency and continuity of patient care.

* Staff Engagement Strategy: Surveys, listening sessions, and action plans create feedback loops that ensure staff feel valued, included, and aligned with the hospital's mission. Engaged staff provide more effective, compassionate care.

PERFORMANCE AND IMPACT

Together, these initiatives create a culture of care that is evidence-based, data-driven, person-centered, and equity-focused. RNPH demonstrates measurable performance in the delivery of effective treatment. We are reducing unexpected variations in outcomes, improving the timeliness and safety of interventions, and advancing toward equitable care across patient populations. Our governance structures ensure that the highest standards of safety and quality are consistently applied, while our analytic platforms and workforce strategies support continual learning and improvement, ensuring that exceptional care is delivered to every patient, without exception.

Care coordination

Care coordination is a cornerstone of person-centered, equitable psychiatric care at UCLA RNPH. Given the complexity of behavioral health needs, effective coordination requires seamless collaboration among interdisciplinary staff, patients and families, community partners, and peer-led organizations. Our performance in this priority area demonstrates both a structured approach to discharge planning and an innovative model for linking patients with resources that extend beyond hospitalization.

ASSIGNMENT OF SOCIAL WORKERS

Every patient admitted to UCLA RNPH is assigned a dedicated social worker. Social workers serve as the primary coordinators of care, integrating clinical treatment with discharge planning, community connections, and family engagement. This one-to-one assignment promotes continuity, timely communication, and discharge plans tailored to each patient's unique needs. Social workers ensure that every patient leaves the hospital with a scheduled appointment to see a licensed mental health clinician in the community within seven days of discharge. Licensed social workers in the Post-Acute Care Psychiatry Clinic are also available to support patients with follow-up linkages after hospitalization. In developing discharge plans, social workers carefully consider potential barriers to care including transportation, access to electronics, language, insurance, and other factors so that each patient has the best chance of a successful transition.

COORDINATION WITH SYSTEMS OF CARE

Many of our patients with developmental disabilities receive services through California's Regional Centers. UCLA Psychiatry holds weekly standing meetings with Regional Center representatives to streamline care planning, coordinate funding and housing resources, and ensure that patients with complex developmental and psychiatric needs experience continuity of services after discharge. This partnership reduces duplication of effort and aligns discharge planning with the long-term supports available in the community. In addition, social workers regularly collaborate with other community systems to address the diverse needs of patients and families. These include the Department of Children and Family Services, Adult Protective Services, County Departments of Mental Health, the criminal justice system, and school districts. By engaging with these systems, social workers help ensure that care transitions are safe, coordinated, and responsive to each patient's unique circumstances.

IN-SERVICES WITH COMMUNITY PROGRAMS

UCLA RNPH hosts 6-10 in-service sessions with community-based organizations each month, allowing staff to remain up to date on the range of resources available to patients and families. These sessions strengthen referral pathways to housing programs, mental health and substance use services, vocational supports, and culturally specific resources. By keeping the clinical case management team informed about evolving community options, patients benefit from more accurate and individualized discharge planning.

PFAC COLLABORATION IN DISCHARGE PLANNING

The Patient and Family Advisory Council (PFAC) collaborates closely with the social work team to improve discharge planning practices. Feedback from patients and families has been used to revise discharge education materials, adjust timing of family meetings, and develop clearer explanations of community-based services. The PFAC meets monthly, and action items related to discharge planning are tracked and reported out to ensure accountability and responsiveness.

PARTNERSHIPS WITH PEER-LED ORGANIZATIONS

We partner with organizations such as National Alliance on Mental Illness West Los Angeles (NAMI WLA) and The Painted Brain to extend support networks for patients and families. NAMI provides family education, peer-to-peer support, and advocacy resources that help patients and families navigate services and remain engaged after discharge. The Painted Brain, a peer-run social enterprise, offers creative groups and community-building opportunities that combat isolation and stigma. These partnerships reinforce recovery as a process and provide patients with hope and belonging beyond hospitalization.

CONCLUSION

Care coordination at UCLA Psychiatry is designed to ensure that no patient leaves the hospital without a clear, connected path forward. By assigning social workers to every patient, building structured bridge services, maintaining standing partnerships with Regional Centers, collaborating with PFAC, and leveraging community and peer-led organizations such as NAMI and Painted Brain, we have created a model that integrates hospital-based treatment with community recovery. Our performance in this area reflects a commitment to reducing fragmentation, enhancing continuity, and supporting patients and families as full partners in care.

Access to care

UCLA Health is committed to advancing equitable access to high-quality health care for the diverse communities we serve. Our comprehensive approach ensures timely, patient-centered care for all populations and patients.

To enhance access, UCLA Health is expanding clinical capacity for both new and returning patients by building a new psychiatric hospital, which will increase inpatient bed capacity from 74 to 119. This expansion will allow UCLA Psychiatry to reduce wait times for admission, meet the growing demand for specialized psychiatric services, and better serve patients across the lifespan. The new hospital is designed to provide not only more beds, but also updated facilities that support modern models of care, including expanded space for group therapies, family meetings, and recovery-oriented programming.

Special emphasis is placed on urgent and same- or next-day appointment availability to meet immediate psychiatric needs efficiently. Continuity of care is also prioritized, particularly for patients transitioning from inpatient settings, many of whom experience vulnerabilities related to financial constraints, chronic conditions, or limited support systems. Strengthened follow-up protocols—including the Post-Acute Psychiatry Clinic and the Bridge Program—aim to improve post-discharge outcomes and reduce preventable readmissions. These services ensure that patients are seen within days of discharge, minimizing gaps in medication access, therapeutic engagement, and psychosocial stabilization.

To reduce structural barriers, UCLA Health continues to expand its portfolio of virtual care services, including a new Specialty Psychiatric Outpatient Clinic. These services enhance convenience for patients who may face transportation challenges, inflexible work schedules, or caregiving responsibilities. Virtual visits are available across multiple service lines, from medication management to psychotherapy, creating a continuum of care that reaches patients in their homes and communities. To ensure equitable digital access, the organization provides multilingual support and digital literacy assistance for patients navigating virtual platforms.

Recognizing the significant impact of social determinants of health on access and outcomes, the population health teams are integrating these factors into program design and care delivery. Patients are routinely screened for needs such as housing instability, food insecurity, and lack of transportation. Those with identified needs are referred to appropriate social service resources through a coordinated system that facilitates navigation and follow-up. This whole-person care model aims to reduce non-clinical barriers for all patients and communities.

UCLA Health also actively partners with community-based organizations, local health departments, and trusted community leaders to extend care beyond traditional clinical settings. Initiatives include mobile health units and the Homeless Healthcare Collaborative, which bring psychiatric and primary care directly to individuals experiencing homelessness throughout Los Angeles. In addition, partnerships with peer-led organizations such as NAMI and Painted Brain create access to education, support groups, and recovery communities that reduce stigma and expand opportunities for long-term recovery. These efforts are designed to meet patients and families where they are and build trust with the communities we serve.

To ensure that access is inclusive for all patients, UCLA Health provides accommodations for individuals with disabilities, including accessible facilities, auxiliary aids, and adaptive communication supports. The health system also prioritizes culturally and linguistically appropriate services, with expanded interpreter resources and translated materials available across multiple languages. Staff are trained to deliver care that is responsive to cultural needs, language preferences, and diverse abilities, creating a more inclusive and supportive environment for patients and their families.

Through these coordinated efforts, UCLA Health and RNPH are building a system of psychiatric care that is accessible, equitable, compassionate, and recovery-oriented. The organization remains firmly committed to promoting health equity and continually refines strategies to meet the evolving needs of the populations it serves.

Methodology Guidelines

Did the hospital follow the methodology in the Measures Submission Guide? (Y/N)

Y