

Hospital Equity Report User Input Template

This template lists the fields that require manual user input to complete the HCAI Hospital Equity Reports using HQI's AB 1204 Equity Report Solution. Just type or click your responses below for easy copying and pasting into the Equity Report section of HQIP when you are ready to generate your final csv report for uploading HCAI's HDC Portal.

The Equity Report section of HQIP is also where you will find the Top 10 Disparities identified for your hospital/system available for download and companion use with this template.

The HQIP Hospital Equity Report - User Guide on HQI's AB 1204 Hospital Equity Reporting Support page helps you navigate the HQIP Equity Reporting process: <https://hqinstitute.org/support-for-mandatory-health-equity-reporting/>

For questions or problems completing this template, email The HQI Analytics Team: hqianalytics@hqinstitute.org

Report Web Address & The Joint Commission Yes/No Structural Measures

Type or select your response to each item in the field provided.

Note: HCAI marked these fields as required for all hospital types and hospital systems.

1. Web Address: What is the web address where your hospital/system equity report will be published on your website? (200 characters max)	
https://palomarhealthdistrict.org	
2. Health Equity Lead: Does your hospital/system have a designated individual who leads hospital/system health equity activities? (Yes/No)	☒ Yes ☐ No
3. Discrimination Policy: Does your hospital/system provide documentation of your policy prohibiting discrimination? (Yes/No)	☒ Yes ☐ No

Health Equity Plan and Performance across Six Priority Areas

Type your response to each item in the field provided.

Note: HCAI marked these fields as required for all hospital types and hospital systems.

4. Heath Equity Plan: What actions will your hospital/system take to address *each* of your Top 10 disparities, including population impact, measurable objectives, and specific timeframes? (5000 characters max)

Palomar noted that the disparities for Palomar Poway were readmissions by age, race, and financial grouping. Based on readmissions from data from 2024 and the continued disparity for readmissions for 2025 the team reviewed the CMS Guide for reducing disparities in readmissions from 2024 to help guide their improvement process.

Palomar will apply a system wide approach based on the CMS guidelines from 2024.

Readmission Disparity:

Key actions: The disparity for readmissions was shared with the Regulatory/Equity Committee members and further recommendations from that committee were made. Our initial action included reviewing the discharge planning process by nursing, providers and the coordination of post - discharge services by our Case Management team. Palomar has a multifaceted discharge planning process that includes medication reconciliation, patient and family education, and post discharge follow-up. Palomar has been tracking the initial Case Management assessment process for a year based on our action plan from last year's readmission opportunities. We have made steady improvements in overall compliance with identification within 48 hours of patient admission the need for either follow-up care and referrals as needed for services; to include home health or other outpatient services that would support the patient's recovery. The RNs continue to provide education to the SNFs on continuity of care to ensure that the next level of care is able to facilitate recommended care to avoid a readmission. Palomar Medical Center has worked with their SDOH screening and data infrastructure for referrals for patients that have been identified as having a social or economic disparity that may affect their recovery. As discharge appropriate referrals are placed with community resources to ensure that the patient receives the continuity of care needed to fully recover and to prevent readmission.

Palomar Poway will continue to identify patients risk factors early in their admission to allow for early intervention to help prevent readmissions. Palomar Poway will continue to provide discharge material in an easily readable manner that has been individualized for the patient. The RN will continue to use the teach-back method during their discharge instruction process

Palomar Poway will continue to engage the patients' caregivers as they understand the patient's unique needs and will help to ensure the discharge instructions are understood

Palomar Poway will continue to engage community resources for those patients who require health care access to community help

Palomar Poway will continue to conduct medication reconciliation upon discharge to ensure continuity of care with the patient's home medications.

Time frame and Objectives for readmission:

Reduce readmissions in disparity groups by greater than or equal to the disparity group by 3% in 12 months, and narrow the rate ratio gap by greater than or equal to 1% over 24 months

Improve initial CRM assessment within 48 hours to 95% within a year.

5. Person-Centered Care: Describe your hospital's/system's performance in this priority area. (5000 characters max)

Person-Centered Care for the identified top 10 disparities:

The role of the professional nurse incorporates both the function of ensuring that patients' needs are met across settings and providers and facilitating the delivery of quality care. Professional nurses have the potential for significant contributions to patient-centered, and cost-effective care through care coordination for Palomar. Patients access the services of Palomar Medical Center(s) over their life span as they move through the wellness and illness/injury health care continuum. Palomar Medical Center(s) have health care providers that are able to coordinate the complete preventive and episodic needs of patients as they require throughout the continuum of their care. The primary goals for patient care, at Palomar Medical Center(s) continuum of care are as follows:

Match the individual patient's and family's needs with the appropriate level of preventive care, medical intervention and/or psycho-social services.

Coordinate care through integration of all systems such as wellness care, acute hospitalization, skilled nursing as well as home health and hospice care referrals as appropriate.

Provide seamless transfers within the Palomar Medical Center facilities:

Palomar Medical Center, Poway nursing model for patient centered care is relationship-based care and nursing effectively communicates with patients when providing care, treatment, and services following this model. The nursing staff at Palomar Medical Center(s) have chosen the Relationship-Based Care model as its model of care because it best reflects the manner in which care is delivered to patients and their family members across the continuum. Relationship-Based Care is comprised of three crucial relationships:

The care provider's relationship with patients and families

The care provider's relationship with self

The care provider's relationship with colleagues

The provider relationship is one in which the care provider consistently maintains the patient and the family as his or her central focus. Compassion and care are conveyed through touch, a kind act, through competent clinical interventions, or through listening and seeking to understand the others experience. Relationship-Based Care refers to a philosophical foundation of the model and its operational framework. Healthcare is provided through relationships. All care practices visibly demonstrate the mission and values of Palomar, including those of clinicians and staff members from all disciplines, departments and services.

The patient and family are at the center of the Relationship-Based Care model. The following elements of the model promotes organizational health, clinical safety and quality, patient and family satisfaction, physician and staff satisfaction, and effective recruitment and retention:

The initial phase of relationship-based care is performed through the nursing assessment, which is performed within 24 hours of admission. Nursing identifies the patient's oral and written communication needs, including the patient's preferred language for discussing health care. This communication includes the need for personal devices such as hearing aids or glasses, language interpreters, communication boards, and translated or plain language materials. The nursing staff communicates with the patient during initial nursing assessment and provides the patient treatment, and services in a manner that meets their oral and written communication needs. Palomar Medical Center(s) medical record contains information that reflects the patient's care, treatment, services, race and ethnicity. Palomar Medical Center respects, protects, and promotes patient rights.

Palomar nursing standards also require care plans that are to be completed within 8 hours of admission and these care plans are individualized by the interdisciplinary team that contain specific, actionable information for staff across multiple care settings. These care plans promote communication and continuity of care/patient centered /relationship by suggesting communication strategies, treatment plans, and psychosocial resources.

Palomar Medical Center(s) Regulatory / Equity Committee reviews patient equity data to determine if they experience less safe or lower quality of care or poorer health outcomes associated with their race, ethnicity, language, disability, or sexual orientation. The Regulatory/Equity Committee reviews other factors, to document if these disparities in health care could be caused by cultural or language barriers that impair communication with caregivers, impeded access to care, or fear of discrimination. The goal of the Regulatory/Equity Committee is to address cultural, communication, mobility, SDOH, and other patient needs during their patient admission.

Goal and Time Frame:

Document teach back at discharge; ≥95%; patient/caregiver preferences integrated and documented by greater than or equal to 95% of the time maintain 12 months at 100%.

Increase care plan individualization per disparity group by greater than or equal to 95% of the time within 12 months and maintain 100%.

6. Patient Safety: Describe your hospital's/system's performance in this priority area. (5000 characters max)

Palomar Medical Center, Poway conducts a patient safety survey every other year and participates in Leap Frog. Palomar Medical Center Poway received a grade B from Leap Frog for their data and processes for Spring of 2026. Palomar Medical Center Poway has reviewed the opportunities that were identified and are working on process improvements related to surgical site infections and urinary tract infections. The overall data continued to show improvement in retained foreign items, accidental rents and tears in the procedural areas, respiratory issues, and kidney failures following procedures. For the safety related questions Palomar performed within the average hospital range for all the measures. The other measures Poway performed within the expected average for all hospitals participating in Leap frog. Palomar reviews overall readmission data at their Quality Committee quarterly. This information is shared with the care team and includes readmissions, reason for readmissions, and rate. Part of the discussions for how to reduce readmissions includes, medication reconciliation, access to care, were clear instructions provided, was discharge planning started on the first day of the admission, timely follow-up by providers, and access to a post

discharge contact/what does the patient need to look for and who do they call. Palomar will continue to improve follow-up after hospital discharge to include connecting patients with community-based services, providers, and other treatment modalities to help prevent readmissions. The discharge paperwork and process were updated to include community resources, phone numbers, individualized education plan, and as needed referrals for outpatient services. The Case Management team developed a report that is sent via email to the leadership team to help provide oversight to ensure appropriate discharge planning is occurring.

Goal and Time Frame:

Palomar Health Poway will ensure that the 10 top priorities, which include readmissions, meet all the requirements for Leapfrog's 30 national performance measures by the beginning of 2027 and that the measures put into place for safety at surgery will improve the Leap Frog score for Spring 2027 back to an A.

Initial Case Management referral / interview within 48 hours for all patients readmitted. Goal is 95% of all readmissions within 6 months and reduce the rate ratio by 1% for all reference groups in 12 months.

7. Addressing Patient Social Drivers of Health: Describe your hospital's/system's performance in this priority area. (5000 characters max)

The patient's (SDOH) such as but not limited to access to transportation, difficulty paying for prescriptions or medical bills, education and literacy, food insecurity, and housing insecurity will be assessed on all patients. The process that is used to monitor and report progress is the Prapare form which was added to the initial nursing assessment. This process also is included in the Outpatient Departments to ensure that patients with limited resources have the support that they need. Once a positive result is documented by nursing there is an automatic referral process sent to the Case Management team. The Case Management ("CRM") team are able to interview the patient and determine what resources are needed for the patient's continuity of care. The Case Management team and nursing team worked with information technology and developed an electronic drop down of community resources and after care instructions that are tailored to meet the needs of the patient at discharge. The Case Management leadership team conduct monthly reviews to ensure consistent and individualized discharge planning is based on the patient's needs and diagnosis.

Goal and Time Frame:

Initial Case Management referral / interview within 48 hours for all patients readmitted. Goal is 95% of all readmissions within 6 months and reduce the rate ratio by 1% for all reference groups in 12 months.

8. Effective Treatment: Describe your hospital's/system's performance in this priority area. (5000 characters max)

Palomar Medical Center Poway has reviewed their process with care transitions from one setting to another setting within the facility. The nursing team determined that there are potential gaps when transferring patients care from one level of care to another, which include within the facility or to a SNF. The nursing staff has worked with the information technology team to improve their documentation for the following:

Identify patients at risk for ineffective transitions of care

Document within the EMR the transition assessment and hand off

Perform medication reconciliation for transitions of patient care and communicate to next care provider

Individualize a nursing care plan that addresses all care across the continuum

Communicate essential care to next level and to other team members to include CRM to help facilitate effective discharge planning to help to prevent readmissions

The readmission data has helped improve the care transitions from acute care to the ambulatory setting and enabled the CRM team to set up pre-discharge interventions with a patient, ensure patient/family education is in place and done, post discharge interventions done/to include outreach community programs, and ensuring medications are reconciled at discharge.

Goal and Time Frame:

Initial Case Management referral / interview within 48 hours for all patients readmitted. Goal is 95% of all readmissions within 6 months and reduce the rate ratio by 1% for all reference groups in 12 months.

9. Care Coordination: Describe your hospital's/system's performance in this priority area. (5000 characters max)

Palomar Medical Center, Poway will include the following processes for care coordination for the top 10 priorities.

Palomar Medical Center, Poway's EMR has a robust discharge planning and patient education process that is addressed in their "adult inpatient standards".

Teach-back method: Nurses ensure the patient and caregivers understand their care plan, medications, and warning signs by having them repeat the information in their own words.

Clear instructions: Discharge instructions are provided in simple, understandable language, and provided in both written and digital formats.

Shared decision-making: Involve patients in their care from the time of admission to help them prepare for a smooth transition home.

Medication reconciliation: A medical staff-led review of all medications before discharge is performed to prevent missed, duplicate, or incorrect dosages, which can cause adverse events.

Adherence support: The CRM (Case Management team) initiate communication with the patient to ensure patients can access and adhere to their medication schedules, which can be done through pharmacist phone calls, automated reminders, and financial assistance.

Post-discharge support and communication

Timely follow-up: The CRM and or nursing staff will schedule follow-up appointments with primary care providers (PCPs) or specialists within one week of discharge. This is performed at the time of discharge

Post-discharge contact: Depending on patient needs, there is a follow-up phone call from a nurse within 24–72 hours of discharge can assess the patient's condition and reinforce discharge instructions.

Goal and Time Frame:

Initial Case Management referral / interview within 48 hours for all patients readmitted. Goal is 95% of all readmissions within 6 months and reduce the rate ratio by 1% for all reference groups in 12 months.

10. Access to Care: Describe your hospital's/system's performance in this priority area. (5000 characters max)

CRM at Palomar provides follow-up for timely care, provides clear discharge instructions, and coordinated post-acute support from community resources. The CRM team continue to offer the patient:

Follow-up appointment made by CRM

Medication reconciliation and home medications

Social inequities which would make it difficult to continue with recovery, i.e., housing, rides, caregivers. CRM connects the patient to community resources

Education to include what to do and whom to call for worsening symptoms

Goal and Time Frame:

Initial Case Management referral / interview within 48 hours for all patients readmitted. Goal is 95% of all readmissions within 6 months and reduce the rate ratio by 1% for all reference groups in 12 months.

System Description (only applies to system reports)

11. System Description: Describe your hospital system. Information reported may include but not limited to, providing an overview of your organizational structure, services, capacity, overall role within the healthcare landscape, ownership, geographic location, the full range of clinical and support services offered, and any distinguishing features that define the system's mission and impact. (5000 characters max)

Despite efforts to improve healthcare access and quality, hospitals continue to face challenges in achieving health equity. Disparities based on socioeconomic status, race, ethnicity, language, and other social determinants persist, leading to differential healthcare outcomes among patient populations. Factors such as structural racism, implicit bias, inadequate cultural competency, and limited resources contribute to these disparities, posing significant challenges to equitable healthcare delivery. Palomar will play a crucial role in providing healthcare services to diverse populations. Achieving health equity will require identifying and addressing the systemic barriers that contribute to these disparities. Therefore, Palomar will document any patient's (SDOH) which may include, but not limited to, access to transportation, difficulty paying for prescriptions or medical bills, education and literacy, food insecurity, and housing insecurity will be assessed on inpatients. Palomar will include, but not be limited to, high-risk population of patients with diabetes, pregnant women, or homeless. If SDOH are identified, the patient will be provided information about community resources and support activities. Patients that have been screened for these social needs may have obstacles to high quality care which could contribute to poor health. Screening for these social determinants of health will be performed by nursing staff for inpatient admissions which will include the Obstetrical Unit. Palomar will use available data from the Prapare Screening Tool to help identify health care disparities in its patient population and prioritize which population(s) on which to focus. Palomar will conduct a

stratification analysis using social demographic characteristics such as age, gender, preferred language, or race and ethnicity to better understand the specific disparities that may exist for the patient population.

Social Determinants PRAPARE section is addressed on the OB Admission History and Adult Inpatient History form

The RN fills out all the required fields within the form.

If the stratified analyses show differences across groups, Palomar will work to understand the root cause of the differences

Equitable Access to Healthcare Services: Ensuring that all individuals have equitable access to healthcare services.

Cultural Competence and Linguistic Access: Promoting cultural competence and linguistic access within healthcare settings to ensure that healthcare providers can effectively communicate.

Community Engagement and Partnership: Engaging communities and partnering with community organizations, stakeholders, and policymakers to develop and implement strategies for promoting health equity.

Data Collection and Monitoring: Improving data collection and monitoring systems to track health disparities

Palomar will evaluate and revise their action plan as necessary. Leaders, providers, and staff will be informed at least annually on the progress to reduce identified health disparities.

Social Determinants PRAPARE section was added to the following outpatient areas for any patient over the age of 18:

Emergency Department, Infusion Therapy, Radiation Oncology, Wound Care and Hyperbaric therapy, Cardiac Rehab, Perinatal Services, Physical Therapy, Occupational Therapy, Speech/OP, Interventional Radiology, Cardiac Cath lab, and, OP OB Triage

Department of Health care Access and Information: Palomar, Poway will collect hospital screening data for all patients that are 18 years or older for all five-health related social needs.

The number of patients admitted to the hospital who are 18 years or older at time of admission and who screened for all SDOH identified

The total number of patients who are admitted to the hospital who are 18 years or older on the date they are admitted

The percent of patients screened for all SDOH identified

Palomar Medical Center, Poway does review data quarterly

Age Friendly Measures:

Eliciting Patient Healthcare Goals

This domain focuses on obtaining patients' health-related goals and treatment preferences which will inform shared decision-making goal concordant care

Responsible Medication Management

This domain aims to optimize medication management through monitoring of the pharmacological record for drugs that may be considered inappropriate in older adults due to increased harm

Frailty Screening and Interventions (i.e. Mobility, Mentation, and Malnutrition)

This domain aims to screen patients for geriatric issues related to frailty including cognitive impairment/delirium, physical function/mobility, and malnutrition for the purpose of early detection and intervention where appropriate

Social Vulnerability (social isolation, economic insecurity, ageism, limited access to healthcare, caregiver stress, elder abuse)

This domain seeks to ensure that hospitals recognize the importance of social vulnerability screening of older adults and have systems in place to ensure that social issues are identified and addressed as part of the care plan

Palomar has set goals to create health processes that ensure every older adult receives the best care possible and:
 is not harmed by care
 is satisfied with the care they receive
 Palomar will screen patients ≥ 65 years of age for
 Medication, Mentation, Nutrition, and Mobility &
 Provide resource when patients meet screening criteria

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

The CMS Hospital Commitment to Health Equity (HCHE) Structural Measure consists of five Domains, each of which have from 1-5 attestations. Read all attestations for each domain. If **all** attestations within a domain are true for your hospital, select ‘**Yes**’ for the Domain (Yes/No). If **any** attestation within a domain is not true for your hospital, select “**No**” for the Domain (Yes/No).

Note: HCAI marked these fields as required for all hospital types, the CMS HCHE Structural Measure is not required for hospital systems.

12. CMS HCHE Domain 1: Strategic Planning

Attestations

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

Domain 1: Strategic Planning (Yes/No)

☒ Yes ☐ No

13. CMS HCHE Domain 2: Data Collection

Attestations

- i. Our hospital collects demographic information, including self-reported race and ethnicity, and/or social determinant of health information on the majority of our patients.
- ii. Our hospital has training for staff in culturally sensitive collection of demographics and/or social determinant of health information.
- iii. 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.

Domain 2: Data Collection (Yes/No)

☒ Yes ☐ No

14. CMS HCHE Domain 3: Data Analysis

Attestation

- i. 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.

Domain 3: Data Analysis (Yes/No)

☒ Yes ☐ No

15. CMS HCHE Domain 4: Quality Improvement

Attestation

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

Domain 4: Quality Improvement (Yes/No)

☒ Yes ☐ No

16. CMS HCHE Domain 5: Leadership Engagement

Attestations

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

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

Domain 5: Leadership Engagement (Yes/No)

☒ Yes ☐ No

CMS Screening for Social Drivers of Health (SDOH) and CMS Screen Positive Rate for SDOH and Intervention

The CMS Screening for Social Drivers of Health measure assesses whether a hospital implements screening for all patients that are 18 years or older at time of admission for all of the five-health-related social needs (HRSNs) including Food insecurity, Housing instability, Transportation problems, Utility difficulties, and Interpersonal safety. HQI will calculate the *rates* based on the numerators and denominators you provide. **If a value is unavailable or unknown, type '0' in the field.**

Note: HCAI marked these fields as required for all hospital types and hospital systems.

CMS SDOH Overall Screened	
17. Overall Screened Numerator: Number of patients admitted to an inpatient hospital stay who were 18 years or older on the date of admission and were <u>screened for all five HRSNs</u> . (9 digits max)	3,221
18. Overall Screened Denominator: Number of patients who were admitted to a hospital inpatient stay and who were 18 years or older on the date of admission. (9 digits max)	3,400
CMS SDOH Food Insecurity	
19. Food Insecurity Positives: Number of patients positive for food insecurity. (9 digits max)	45
20. Food Insecurity Interventions: Number of interventions provided for food insecurity. (9 digits max)	45

CMS SDOH Housing Instability	
21. Housing Instability Positives: Number of patients positive for housing instability. (9 digits max)	169
22. Housing Instability Interventions: Number of interventions provided for housing instability. (9 digits max)	169

CMS SDOH Transportation Problems	
23. Transportation Problems <u>Positives</u>: Number of patients positive for transportation problems. <i>(9 digits max)</i>	78
24. Transportation Problems <u>Interventions</u>: Number of interventions provided for transportation problems. <i>(9 digits max)</i>	78
CMS SDOH Utility Difficulties	
25. Utility Difficulties <u>Positives</u>: Number of patients positive for utility difficulties. <i>(9 digits max)</i>	29
26. Utility Difficulties <u>Interventions</u>: Number of interventions provided for utility difficulties. <i>(9 digits max)</i>	29
CMS SDOH Interpersonal Safety	
27. Interpersonal Safety <u>Positives</u>: Number of patients positive for interpersonal safety. <i>(9 digits max)</i>	46
28. Interpersonal Safety <u>Interventions</u>: Number of interventions provided for interpersonal safety. <i>(9 digits max)</i>	46