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Hospital Equity Measures Advisory Committee (HEMAC)

Draft Meeting Minutes for April 8, 2026

Members Attending In-Person: Dr. Ash Amarnath, California Association of Public Hospitals and Health Systems; Elia Gallardo, Department of Health Care Access and Information (HCAI); Dr. Amy Sitapati, University of California (UC) San Diego.

Members Attending Remotely: Dr. Amy Adome, Sharp Healthcare; Joan Allen, Service Employees International Union; Denny Chan, Justice in Aging; Dr. Neil Maizlish, Public Health Alliance of Southern California; Cary Sanders, California Pan-Ethnic Health Network; Kristine Toppe, National Committee for Quality Assurance; Silvia Yee, Disability Rights Education & Defense Fund.

Members Absent: Dannie Ceseña, California LGBTQ Health and Human Services Network.

State Partners Attending In-Person: Dr. Anna Flynn, California Department of Public Health (CDPH).

State Partners Attending Remotely: Nathan Nau, California Department of Managed Health Care (DMHC); Dr. Jeff Norris, California Department of Health Care Services (DHCS); Kelly Saephan, Covered California.

Presenters: Dr. Ash Amarnath, HEMAC Chair, Chief Medical Officer, California Association of Public Hospitals and Health Systems; Bruce Spurlock, MD, President & CEO, Convergence Health Consulting; Elia Gallardo, JD, Chief Equity Officer, HCAI; Elizabeth Ballart, Attorney IV, HCAI; Christopher Krawczyk, PhD, Chief Analytics Officer, HCAI; Michael Valle, MPA, Deputy Director and Chief Data Officer, HCAI; Shannon Conroy, PhD, MPH, Research Scientist Supervisor II; Ying Yang, Research Scientist Supervisor, HCAI.

Public Attendance: 41

Agenda Item #1: Call to Order, Welcome, and Meeting Minutes

Dr. Ash Amarnath, HEMAC Chair, delivered opening remarks, welcoming meeting participants and reaffirming the committee's mission to advance health equity and increase transparency across California. He highlighted a major milestone: this was the first year that hospital equity data had been successfully submitted, analyzed, and reviewed, reflecting several years of collaborative

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work by the committee. Over 440 hospitals and 33 health systems across the state participated in this initial reporting effort.

Dr. Ash Amarnath also welcomed new state partners to the committee, including Kelly Saephan from Covered California, Dr. Jeff Norris from DHCS, and Dr. Anna Flynn from CDPH. He expressed appreciation for former members Peg Carpenter, Sarah Lahidji, and Julie Nagasako for their service and contributions.

Elia Gallardo, Chief Equity Officer, HCAI, welcomed everyone and called the meeting to order with a roll call of committee members and state partners. The committee reviewed and approved the meeting minutes from the September 3, 2025, HEMAC meeting. The motion was made by Dr. Ash Amarnath and seconded by Kristine Toppe and Cary Sanders. The following members voted to approve the minutes: Dr. Ash Amarnath, Dr. Amy Adome, Joan Allen, Cary Sanders, Dr. Amy Sitapati, Kristine Toppe, Silvia Yee. Committee member Denny Chan abstained from voting. Committee member Dr. Neil Maizlish was present but was experiencing technical difficulties at the time of the roll-call vote and did not vote.

The motion to approve the minutes was carried by a vote of seven.

Questions/Comments from the Committee:

There were no questions or comments from the committee about this agenda item.

Public Comment:

There were no public comments on this agenda item.

Agenda Item #2: September 3, 2025, Meeting Recap

Elia Gallardo, provided a recap of the September meeting, noting that Hospital Equity Measure (HEM) reports were due September 30, with an optional 60-day extension. The September meeting also covered submission requirements and mentioned available resources such as QuickStart guides, webinars, and recordings. Additional updates included efforts on data quality assurance, de-identification validation, and technical assistance on data masking and risk assessment, along with webinars attended by over 230 participants and ongoing one-on-one hospital support. The committee also reviewed hospital use of reporting tools, including the hospital equity data toolkit and the Hospital Quality Institute's Platform (HQIP) for draft report generation. Additional support from the California Maternal Quality Care Collaborative was highlighted, particularly for perinatal measures and partially stratified reports.

Questions/Comments from the Committee:

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There were no questions or comments from the committee about this agenda item.

Public Comment:

There were no public comments on this agenda item.

Agenda Item #3: Chief Data Officer Updates

Michael Valle, Deputy Director and Chief Data Officer, HCAI, highlighted the significance of the meeting as a major milestone, noting that the first HEM reports are now publicly available. He thanked the committee for its extensive contributions over 15 meetings since July 2022, estimating over 600 collective hours of effort, and acknowledged HCAI staff and leadership for their work in launching the program. He also thanked the hospital community for their contributions to the program. He emphasized that this is the first year of an ongoing annual reporting process, with lessons learned expected to improve data quality and usability over time. He also noted that analyses presented were based on available submissions at the time, with most reports now published, though a small number of hospitals failed to submit. He referenced recent regulatory updates for the 2026 cycle and reminded the committee of its mandate under Assembly Bill 1204 to make additional program improvement recommendations by September 2027.

Questions/Comments from the Committee:

The committee expressed appreciation for the committee's work and the presentation and stated that they look forward to reviewing and engaging further with the reports.

Public Comment:

There were no public comments on this agenda item.

Agenda Item #4: Initial Review of the 2025 Hospital Equity Measures Reporting Data

Christopher Krawczyk, Chief Analytics Officer, HCAI, highlighted the completion of the first year of HEM reporting as a major milestone. He emphasized the importance of collaboration between HCAI, the advisory committee, hospitals, and stakeholders, noting that the program is grounded in partnership, transparency, and continuous improvement rather than simple data submission. He highlighted core guiding principles, including improving data quality over time, raising hospital capacity through technical assistance, carefully balancing de-identification with usability to avoid masking meaningful disparities, and building toward long-term actionability of equity data. He

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acknowledged early implementation challenges such as staffing limitations and the complexity of de-identification, while underscoring that the submitted data is already producing valuable insights.

Ying Yang, Research Scientist Supervisor, HCAI, presented preliminary analysis of hospital equity reports, noting that 448 of 456 hospitals and 33 of 35 hospital systems submitted reports, with 320 approved for analysis. She reviewed findings showing that most hospitals met CMS health equity attestation domains, while psychiatric hospitals had some gaps in data collection. She also presented early results on social drivers of health (SDOH) screening, noting masking and missing data concerns due to sensitivity and re-identification risks.

Ying Yang summarized early disparity findings, showing that 30-day readmission and remission measures were most frequently identified as key disparities across hospital types, with variations by stratification categories such as age, payer, and race/ethnicity. She concluded by outlining projected next steps, including expanded analyses using the full dataset, development of a technical assistance plan, analytic tools, and dashboards to support future reporting, interpretation, and improvement efforts.

Questions/Comments from the Committee:

Committee members provided a summary of their extensive independent analysis of the published public dataset, highlighting data quality issues including high levels of missing and masked data, limited subgroup representation, and concentration of usable data in familiar measures like 30-day readmissions and traditional stratifications (age, payer, race). The committee emphasized the importance of defining a clear baseline to track improvement. The committee raised concerns about information bias, interpretability of top disparities, and recommended multi-year data pooling, stronger data quality, having a reasonable data quality improvement timeline, and better alignment between hospital equity plans and reported findings.

HCAI thanked the committee and agreed that their analysis supports the program's goal of identifying lessons learned. HCAI expressed interest in the committee members' offer to share a R coding for HCAI staff to review and build upon to support future efforts. HCAI noted its limited current authority in law, which only allows the department to receive aggregated, de-identified data from hospitals. HCAI also noted its state staffing constraints. HCAI also clarified methodological points, including that stratifications are currently analyzed independently by measure, not combined across measures, which limits interpretation of findings such as age disparities. HCAI noted that many issues stem from data quality and completeness. HCAI will continue providing technical assistance, strengthening partnerships across HCAI, stakeholders, and hospitals, and exploring future regulatory changes. HCAI emphasized resource constraints and the need for partnership, while noting that some limitations may require legislative action, and confirmed that deeper disparities analysis is a priority as staffing increases.

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The committee emphasized the importance of understanding underlying causes of disparities, particularly around language data, for example, American Sign Language reporting. The committee also expressed concerns about age-based comparisons, emphasizing that the intent is not to equate all ages but to identify inequitable treatment and systemic assumptions about older adults and people with disabilities, for example, not offering appropriate care because of age-related stereotypes. The committee encouraged continued improvement in disability-related data collection and cited progress in Washington State as an example of improvement over time.

The committee echoed prior concerns about data actionability and emphasized the importance of leveraging existing structures such as Joint Commission accreditation work. The committee also raised questions about California Maternal Quality Care Collaborative (CMQCC) maternal measures, noting unexpectedly low reporting and suggesting further validation and clarification of denominators. HCAI agreed to have its team re-examine the denominator used for the maternal measures and to follow up with the committee with revised figures if a correction is warranted.

The committee expressed appreciation for the accessibility of the presentation and urged deeper interpretation of equity plan submissions, particularly when hospitals identify age or Medicare as top disparities. The committee emphasized the need for clearer follow-up actions and requested a timeline for deeper analysis of both quantitative data and qualitative equity plans.

The committee raised concerns about how age is being used analytically, noting that comparing younger versus older populations within a single hospital will almost always show disparities and may not be meaningful without broader context. The committee also inquired about the value of system-level aggregation when hospitals serve very different populations. The committee asked whether the current reference group is appropriate, suggesting alternatives such as comparing each group with the highest-performing hospitals, and asked that this be captured for the committee's future recommendations. HCAI agreed it warranted further consideration.

The committee highlighted that while summaries show age as a top disparity, more granular data reveals nuanced patterns, for example, disparities in ages 35 to 49 rather than just 65 and over, suggesting that important insights may be lost in aggregation, and encouraged deeper exploration of raw data.

HCAI reiterated appreciation for all input and reinforced that the program is in an early stage. HCAI also emphasized ongoing technical assistance, future analysis expansion, and opportunities for collaboration in improving both data quality and interpretability going forward.

Public Comment:

In response to the committee's inquiry regarding clarification of the denominators for maternal measures, a CMQCC representative provided public comment that, since there are only 200 birthing hospitals in California, 200 should have been used as the denominator rather than 400 plus.

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A public commentor acknowledged the responsiveness and technical support from HCAI, given their organization had challenges with their data collection. The support received helped tremendously with providing timely guidance to their respective state hospitals. The commentor also expressed interest in talking with the HCAI team about some of the core quality metrics and the assigned ratio calculations like the preferred high rates and low rates, their applicability for their hospitals, and how specific guidance language could be considered for updates.

Agenda Item #5: Review of the Equity Report Evaluation Framework

Bruce Spurlock, MD, President & CEO, Convergence Health Consulting, presented a semi-qualitative evaluation of a diverse sample of 34 hospital health equity plans using a developed structured rubric. The analysis was not intended to rank hospitals, but rather to better understand hospital planning practices and evaluate the completeness, accuracy, and depth of hospital health equity planning. Hospitals were blinded and not named in the analysis. Convergence Health Consulting developed a structured rubric to assess five domains, including SDOH screening practices, accuracy and completeness of disparities reporting, health equity plan content, specificity of interventions and engagement strategies, and performance within six priority areas. Hospitals were scored using a simple 0–2 scale based on whether criteria were fully addressed, partially addressed, or not addressed.

The evaluation revealed wide variation in performance. While some hospitals scored well in planning elements, they often demonstrated lower performance in priority implementation areas. A key finding was the lack of alignment between identified disparities and action planning within reports, with many hospitals relying on general rather than targeted interventions. Common themes across equity plans included efforts to reduce 30-day readmissions through transitional care and discharge planning, as well as SDOH screening, language access, patient education, care coordination, community partnerships, medication management, and governance strategies.

Bruce Spurlock concluded that while the rubric offers a useful and transparent starting point, stronger guidance that supports improved linkage between disparities and interventions, and better data accuracy and validation are needed to make health equity plans more actionable.

Questions/Comments from the Committee:

The committee commended the rubric but noted that hospitals vary in data infrastructure and analytic capacity and cautioned that a “Top 10 Disparities” requirement may be too restrictive.

The committee emphasized the need for flexibility to address locally meaningful disparities even when they are not high-volume metrics. The committee referenced a lived experience at a local public hospital, where a challenge related to maternal and child health outcomes among Haitian Creole–speaking mothers was actively addressed. Although not high-volume, the intervention produced significant qualitative impact, including improved patient communication and

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strengthened cultural competency, as well as informing hiring practices and service delivery.

The committee echoed concerns about the plans, noting inconsistencies between reported disparities and proposed actions, overuse of templated language, limited acknowledgment of statistical uncertainty or confounding, and some troubling cases where hospitals claimed no disparities due to lack of data collection or misused statistical significance to dismiss findings.

The committee emphasized strengthening expectations around data quality improvement, suggesting hospitals explicitly address how they will improve data collection when data are missing or incomplete.

Public Comment:

Public comments raised concerns about how external pressures and measurement design affect health equity reporting. A public commentor noted that fear of potential federal repercussions led hospitals to use more general language in their plans.

A public commentor praised the rubric and its usefulness and highlighted that certain requirements, such as SDOH metrics focused on patients over 18 years of age, do not fit pediatric settings, where most patients are younger.

In response, Bruce Spurlock, MD, President & CEO, Convergence Health Consulting, acknowledged these limitations, noting that a single general rubric does not fit all hospital types and should be adapted in the future for pediatric, critical access, and psychiatric hospitals to better reflect their different populations and data realities.

Agenda Item #6: Key Insights from the First Year of the Program Implementation Process and Next Steps

Shannon Conroy, Research Scientist Supervisor II, HCAI, explained that a major lesson from the first year was how deadline extensions compressed timelines, leaving less time for HCAI to review and correct reports. She noted that hospitals valued HCAI's extensive technical assistance and communication; approximately 150 hours of technical assistance and 400 hours of review were provided. She clarified that about 100 hospitals had data masked or reports approved as submitted because they did not respond to HCAI's requests or declined revisions despite repeated outreach, documented and notified in all cases. These maskings and non-responses, rather than an absence of disparities, account for some reports showing limited or no identified disparities.

Christopher Krawczyk, Chief Analytics Officer, HCAI, discussed the complexity of data de-identification, where the goal was to protect patient privacy while still preserving useful data. Due to time constraints a simplified masking approach was adopted, such as masking counts below a certain threshold (for example, less than 11). He noted that combining variables, like preferred

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language with other factors, often increased the amount of masked data, and future updates to guidelines present an opportunity for improvement. He explained that HCAI had chosen a more precise “scalpel” approach to the data de-identification guidelines (DDG), rather than a simpler approach masking all cells below a set number, to reduce re-identification risk while maximizing usable data and avoiding over-masking the groups often experiencing the greatest disparities. He further noted that a new version of the California Health and Human Services Agency DDG had been released, and that future regulations would present an opportunity to revisit the masking approach.

Elizabeth Ballart, Attorney IV, HCAI, outlined proposed regulatory updates aimed at clarifying and streamlining the process to improve guidance, reduce confusion and ensure compliance. For example, hospital systems previously had to submit multiple reports due to unclear rules, so the new proposal requires a single consolidated report. She also clarified proposed timelines, such as requiring hospitals to post reports within 15 business days after HCAI posts them and allowing 30 days for corrections if errors are found. Another example of proposed regulatory updates is removing the requirement to list a CEO in system reports since not all systems have one.

Michael Valle, Deputy Director and Chief Data Officer, HCAI, emphasized that the first year revealed successes and continued collaboration among HCAI, hospitals, and the committee will drive improvements. He noted that the current proposed regulatory changes are mostly technical, such as clarifying timelines and report formats, but there is potential for more broad regulatory updates in the future, based on feedback from the committee, hospitals and the public, including modifying the measures themselves or making recommendations to the Legislature for larger-scale reforms to the program.

Questions/Comments from the Committee:

The committee inquired about creating a shared, public-facing platform, similar to collaborative models like a wiki or GitHub, where data and analyses can be openly refined and built upon collectively, rather than repeatedly recreated from scratch.

The committee highlighted the challenge of encouraging the public to provide sensitive data, such as sexual orientation and gender identity, especially in a tense political climate where individuals may hesitate to disclose information and organizations may act cautiously due to perceived funding risks.

HCAI responded by pointing to the existing Hospital Equity Measures Toolkit as a resource for outreach, assessment, and iterative improvement. HCAI also responded that although no relevant laws have changed, the broader federal climate is creating a “chilling effect,” making stakeholders wary; however, HCAI is actively monitoring guidance, staying aligned with legal standards, and encouraging open communication with hospitals while acknowledging these concerns.

The committee emphasized the need to explicitly address data quality in reporting, consider phased timelines for mandatory data collection, and tackle challenges like small sample sizes and

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low-frequency outcomes through strategies such as multi-year data pooling or alternative measures. The committee also raised the importance of longitudinal reporting so progress can be tracked year over year rather than forcing the public to piece together changes.

The committee reinforced the need for accountability and continuous improvement by warning against hospitals simply reusing prior submissions with minor updates; and suggested reviewing submissions for originality and using feedback tools like rubrics to push hospitals to meaningfully improve their data completeness and planning each year.

Public Comment:

There were no public comments on this agenda item.

Agenda Item #7: Committee Wrap Up

Dr. Ash Amarnath, HEMAC Chair, recapped the meeting by noting it was productive, and covered updates from the chief data officer, an initial review of the 2025 HEM reporting data, review of the equity report evaluation framework, lessons from the program's first year, and discussion of proposed regulatory amendments and implementation progress. Looking ahead, Dr. Amarnath outlined items for the next advisory meeting, including providing program updates, continuing to gather committee feedback, and reviewing qualitative data as suggested by a committee member. He concluded by reminding attendees that the next meeting is scheduled for July 14, 2026, from 9:00 AM to 1:00 PM.

Questions/Comments from the Committee:

There were no questions or comments from the committee about this agenda item.

Public Comment:

There were no public comments on this agenda item.

Agenda Item #8: Public Comment for Items Not on the Agenda

Public Comment:

A public commentor raised a concern about whether current data efforts adequately track frequent or excessive emergency department (ED) use, noting it as a major challenge for hospital systems. He shared an example from the Sacramento region, where a study found 272 individuals averaging five ED visits per month, suggesting this may be a statewide issue. He also pointed out

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complications such as communication barriers and privacy constraints and suggested that better analysis of frequent ED use could benefit future data and planning. In response, HCAI noted that there are existing data products on this topic, and encouraged the public to email HCAI at dataandreports@hcai.ca.gov, for available relevant products and information.

Agenda Item #9: Adjournment

Dr. Ash Amarnath, HEMAC Chair, adjourned the meeting at 12:10 p.m.