Department of Health Care Access and Information

HOSPITAL EQUITY REPORT: MEASURES SUBMISSION GUIDE

~~VERSION 1.0: APRIL 15, 2024~~ VERSION 1.1: SEPTEMBER 9, 2024

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"A healthier California where all receive equitable, affordable, and quality health care"

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Introduction

California Health and Safety Code sections 127370 – 127376 ~~(Assembly Bill 1204)~~ requires California-licensed hospitals to submit an annual hospital equity report to the California Department of Health Care Access and Information (HCAI). The hospitals required to submit these reports are general acute care including children's hospitals, acute psychiatric, and special hospitals. Separate report requirements have been established for general acute, children's, and acute psychiatric hospitals due to the differences in the patient population. Special hospitals will follow the requirements of general acute care hospitals, though none are currently licensed as of the publishing of this document. The equity report consists of numerators, denominators, and rate calculations for each Hospital Equity Measure (HEM) and stratifications. Each core quality measure should be stratified by the groupings outlined in this document, to the extent that data is available and patient privacy is protected. In addition, the report must include a health equity plan to achieve disparity reduction.

Regulations to implement the Act are in the California Code of Regulations, Title 22, Division 7, Chapter 8.4, Sections 95300 - 95316.

Report Submission

The reporting period is January 1 to December 31 of the year prior to the year that a report is due.

Each hospital and hospital system report are due by September 30, with the first report due by September 30, 2025.

If the Department determines that the Department's online report submission portal at hdc.hcai.ca.gov was unavailable for data submission for one or more periods of four or more continuous supported hours during the four State working days before a due date, the Department shall extend the due date by seven days.

A hospital or hospital system may request, and the Department may grant a single 60-day extension per report period to file an equity report, pursuant to Section 127374, subdivision (b) of the Health and Safety Code. A request for extension shall be filed on or before the required due date, prescribed in this proposed regulation Section 95306, by using the extension request page available through the Department's website using the report submission portal at hdc.hcai.ca.gov.

Hospital systems report should aggregate data from their hospitals categorized by general acute care hospital, children's hospital, and acute psychiatric hospital when there is more than one hospital in a category. See each measure description for hospital system reporting requirements.

In their reports, hospitals should also include the following information:

(1) Hospital name
(2) Hospital HCAI ID (9 digit) / Hospital system ID (to be generated by HCAI)
(3) Reporting Organization (if different than hospital)
(4) Report period start date [January 1 of prior calendar year]
(5) Report period end date [December 31 of prior calendar year]
(6) Hospital in location with access to clean water and air
    A. Determined by the census tract location of the hospital and the score that the census tract received in the clean environment section of the California Healthy Places Index.
    B. A score of 50 percent or lower indicates that the hospital is not in a location with access to clean water and air.
    C. A score above 50 percent indicates that the hospital is in a location with access to clean water and air.
(7) The web address where the hospital's equity report is published on the hospital's website.
(8) A health equity report as described in the Health Equity Report section of this document.

Technical Support

Technical support and questions regarding HEMs should be sent to hospitalequity@hcai.ca.gov.

Structural Measures

1. Three structural measures based on The Joint Commission's R^3 Report: Requirement, Rational, Reference:

- Designate an individual to lead hospital health equity activities.
- Provide documentation of policy prohibiting discrimination.
- Report numerator, denominator, and percentage of patients by preferred language spoken.
  - (i) English Language
  - (ii) Asian/Pacific Islander Languages
  - (iii) Middle Eastern Languages
  - (iv) Spanish Languages
  - (v) American Sign Language
  - (vi) Other/Unknown Languages

See Preferred Language Table for language grouping details.

Specifications: Hospitals will provide:

(1) For each language group, the total of patients who report that their preferred language is in English language, Asian/Pacific Islander languages, Middle Eastern languages, Spanish languages, American Sign Language, or other/unknown languages.
(2) The total number of patients who were asked to report their preferred language.
(3) For each language group, the percent of patients by preferred language group, calculated as the number from (1) divided by the number from (2) and multiplied by 100.

2. Centers for Medicare & Medicaid Services (CMS) Hospital Commitment to Health Equity Structural (HCHE) Measure (considered one measure).

If the answer is "Yes" to all attestations within the domain, code that domain as "1" if the answer to any attestation within the domain is "No", code that domain as "0". Each domain should be coded as either "1" or "0".

This measure is not required for hospital system level reports.

- CMS HCHE Domain 1: Strategic Planning (Yes/No) ~~CMS HCHE Domain 1: Strategic Planning (Yes/No)~~
  - (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.

- CMS HCHE Domain 2: Data Collection (Yes/No)
  (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.
- CMS HCHE Domain 3: Data Analysis (Yes/No)
  (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.
- CMS HCHE Domain 4: Quality Improvement (Yes/No)
  (i) Our hospital participates in local, regional, or national quality improvement activities focused on reducing health disparities.
- CMS HCHE Domain 5: Leadership Engagement (Yes/No)
  (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.

3. CMS Screening for Social Drivers of Health and CMS Screen Positive Rate for Social Drivers of Health and intervention.

- CMS Screening for Social Drivers of Health

Description: 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):

(i) Food insecurity
(ii) Housing instability
(iii) Transportation problems
(iv) Utility difficulties
(v) Interpersonal safety

Specifications: Hospitals will provide:

(1) The number of patients admitted to the hospital who are 18 years or older at time of admission and who are screened for all five HRSNs.
(2) The total number of patients who are admitted to the hospital who are 18 years or older on the date they are admitted.
(3) The percent of patients screened for all five HRSNs, calculated as the number from (1) divided by the number from (2) and multiplied by 100.

Exclusions: The following patients will be excluded from the denominator and numerator: (a) Patients who opt- out of screening; and (b) patients who are themselves unable to complete the screening during their inpatient stay and have no legal guardian or caregiver able to do so on the patient's behalf during their inpatient stay.

Reference: Screening for Social Drivers of Health

- CMS Screen Positive Rate for Social Drivers of Health. Yes/No for each intervention item screened positive:
  (i) Food insecurity
  (ii) Housing instability
  (iii) Transportation problems
  (iv) Utility difficulties
  (v) Interpersonal safety

Description: The Screen Positive Rate for Social Drivers of Health Measure provides information on the percent (rate per 100) of patients admitted for an inpatient hospital stay who are 18 years or older on the date of admission, were screened for all five HRSNs~~HSRNs~~, and who screen positive for one or more of the following five HRSNs: Food insecurity, housing instability, transportation problems, utility difficulties, or interpersonal safety. Additionally, it tracks whether interventions were provided for patients who screened positive.

Specification: Hospitals will provide:

(1) For each of HRSNs, the number of patients admitted to the hospital who are 18 years or older at time of admission, were responded positive.
(2) The number of patients admitted to the hospital who are 18 years or older at time of admission, were screened for all five HRSNs.
(3) For each of HRSNs, the percent of patients responded positive, calculated as the number from (1) divided by the number from (2) and multiplied by 100.
(4) For each of HRSNs, the number of patients who responded positive and received intervention.
(5) For each of HRSNs, the percent of patients received intervention, calculated as the number from (4) divided by the number from (2) and multiplied by 100.

Exclusions: The following patients would be excluded from the denominator and numerator: 1) Patients who optout of screening; and 2) patients who are themselves unable to complete

the screening during their inpatient stay and have no caregiver able to do so on the patient's behalf during their inpatient stay.

Clarifying Information: The result of this measure is calculated as two sets of five separate percentage rates. The first set includes five rates each derived from the number of patients screened positive for each of the five HRSNs, divided by the total number of patients 18 years or older on the date of admission screened for all five HRSNs and multiplied by 100. The second set includes five rates each derived from the number of patients screened positive and received intervention for each of the five HRSNs, divided by the total number of patients 18 years or older on the date of admission screened for all five HRSNs and multiplied by 100.

Reference: Screening for Social Drivers of Health

Core Quality Measures for General Acute Care Hospitals

1. Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey: Would recommend hospital.

Description: The percent (rate per 100) of patients who responded, "probably yes" or "definitely yes" to question 19, "Would you recommend this hospital to your friends and family?" on the HCAHPS survey.

(i) Definitely no
(ii) Probably no
(iii) Probably yes
(iv) Definitely yes

Specifications: Hospitals will provide:

(1) The number of patients who responded "probably yes" or "definitely yes" to question 19.
(2) The total number of respondents
(3) The percent of respondents who responded, "probably yes" or "definitely yes", calculated as the number from (1) divided by the number from (2) and multiplied by 100.
(4) The total number of people surveyed.
(5) The percent of people surveyed who responded to the survey, calculated as the number from (2) divided by the number from (4) and multiplied by 100.

Reference: HCAHPS Survey and Fact Sheet

Stratification: See Stratification Table 1

2. HCAHPS survey: Received information and education

Description: The percent (rate per 100) of patients who responded "yes" to 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?" on the HCAHPS survey.

Specifications: Hospitals will provide:

(1) The number of patients who responded “yes” to question 17.
(2) The total number of respondents
(3) The percent of respondents who responded “yes”, calculated as the number from (1) divided by the number from (2) and multiplied by 100.
(4) The total number of people surveyed.
(5) The percent of people surveyed who responded to the survey calculated as the number from (2) divided by the number from (4) and multiplied by 100.

Reference**: HCAHPS Survey and Fact Sheet**

Stratification: See Stratification Table 1

3. Agency for Healthcare Research and Quality (AHRQ) Quality Indicator Pneumonia Mortality Rate

Description: 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. Excludes discharges with severe sepsis present on admission, transfers to another hospital, discharges admitted from a hospice facility, and obstetric discharges.

Specifications: Hospitals will provide:

(1) The number of deaths among discharges that meet the inclusion and exclusion criteria for the numerator listed in the reference document.
(2) The number of discharges for patients 18 and older that meet the criteria for the denominator listed in the reference document.
(3) The rate of in-hospital deaths per 1,000 hospital discharges with the 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, calculated by the number from (1) divided by the number from (2) and multiplied by 1,000.

Reference: AHRQ Quality Indicator 20 (IQI 20) Pneumonia Mortality Rate

Stratification: See Stratification Table 1

4. AHRQ Patient Safety Indicator Death Rate among Surgical Inpatients with Serious Treatable Complications

Description: In-hospital deaths per 1,000 surgical discharges, among patients ages 18 through 89 years or obstetric patients of any age~~,~~ with serious treatable complications (deep vein thrombosis/ pulmonary embolism, pneumonia, sepsis, shock/cardiac arrest, or gastrointestinal hemorrhage/acute ulcer). Excludes transfers to an acute care facility and discharges admitted from a hospice facility.

Specifications: Hospitals will provide:

(1) The number of deaths among discharges that meet the inclusion and exclusion criteria for the numerator listed in the reference document.
(2) Discharges for patients 18 to 89 or obstetric patients of any age that meet the criteria for the denominator listed in the reference document.
(3) The rate of in-hospital deaths per 1,000 hospital discharges with serious treatable complications calculated by the number from (1) divided by the number from (2) and multiplied by 1,000.

Reference**:** AHRQ Patient Safety Indicator 04 (PSI 04) Death Rate among Surgical Inpatients with Serious Treatable Complications

Stratification: See Stratification Table 1

5. California Maternal Quality Care Collaborative (CMQCC) Nulliparous, Term, Singleton, Vertex (NTSV) Cesarean Birth Rate

Description: Nulliparous women with a term (at least 37 weeks gestation), singleton baby in a vertex position delivered by cesarean birth

Specifications: Hospitals will report:

(1) The number of NTSV patients with cesarean deliveries
(2) The number of nulliparous patients delivered of a live term singleton newborn in vertex presentation.
(3) The rate generated from count data of nulliparous women with a term (at least 37 weeks gestation), singleton baby in a vertex position delivered by cesarean birth reported as a proportion calculated as the number from (1) divided by the number from (2).

Reference: NTSV Cesarean Birth Rate and The Joint Commission

Specifications Manual for Joint Commission National Quality Measures (v2024B): Appendix A ICD-10 Code Tables

Stratification: See Stratification Table 1

6. CMQCC Vaginal Birth After Cesarean (VBAC) Rate

Description: Vaginal births per 1,000 deliveries by patients with previous Cesarean deliveries. Excludes deliveries with complications (abnormal presentation, preterm delivery, fetal death, multiple gestation, or breech presentation).

Specifications: Hospitals will report:

(1) The number of vaginal deliveries among cases that meet the inclusion and exclusion criteria for the denominator listed in the reference document. Vaginal deliveries are

identified by any of the ICD-10-PCS procedure codes for vaginal delivery listed in the reference document.
(2) The number of discharges with an ICD-10-CM diagnosis code for birth delivery outcome that meet the inclusion and exclusion criteria for the denominator listed in the reference document and have listed an ICD-10-CM diagnosis code for previous Cesarean delivery listed in the reference document.
(3) The rate of VBAC per 1,000 deliveries calculated as the number from (1) divided by the number from (2) and multiplied by 1,000.

Reference: CMQCC uses AHRQ IQI 22 Specifications

Stratification: See Stratification Table 1

7. CMQCC Exclusive Breast Milk Feeding

Description: The rate of newborns per 100 who reached at least 37 weeks of gestation, or at least 3000g if gestational age is missing, and received breastmilk exclusively during their stay at the hospital.

Specifications: Hospitals will report:

(1) The number of newborn cases that were exclusively fed breast milk during their hospital stay and were at least 37 weeks gestation (or at least 3000g if gestational age is missing), did not go to the NICU, transfer, or die, did not reflect multiple gestation, and did not have codes for parenteral nutrition or galactosemia.
(2) The number of newborn cases born in the hospital that were at least 37 weeks gestation (or at least 3000g if gestational age is missing), did not go to the NICU, transfer, or die, did not reflect multiple gestation, and did not have codes for parenteral nutrition or galactosemia.
(3) The rate generated from count data of newborns who reached at least 37 weeks of gestation, or at least 3000g if gestational age is missing, and received breastmilk exclusively during their stay at the hospital reported as a proportion calculated as the number from (1) divided by the number from (2) and multiplied by 100.

Reference:

Specifications Manual for Joint Commission National Quality Measures (v2024B): Exclusive Breast Milk Feeding (PC-05)

Specifications Manual for Joint Commission National Quality Measures (v2024B): Appendix A ICD-10 Code Tables

Stratification: See Stratification Table 1

8. HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate

Description: The percent (rate per 100) 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.

Specifications: Hospitals will provide:

(1) The number of inpatient admissions to any acute care hospitals which occurs within 30 days of the discharge date of an eligible index admission. All readmissions are counted as outcomes except those that are considered planned (i.e., scheduled surgery)
(2) The total number of patients who were admitted to an acute care hospital and were 18 years or older at time of admission.
(3) The readmission rate calculated as the number from (1) divided by the number from (2) and multiplied by 100.

Reference: ~~HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate~~ Methodology for Calculating HCAI All-Cause Unplanned, 30-Day Hospital Readmission Rates

Stratification: See Stratification Table 1

9. HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate, stratified by behavioral health diagnosis

Description: The percent (rate per 100) of the hospital-level, unplanned, all-cause readmissions after admission for any eligible condition within 30 days of hospital discharge for patients aged 18 and older stratified by behavioral health diagnosis.

Specifications: Hospitals will provide:

(1) The total number of all-cause 30-day unplanned readmissions for mental health disorders (MHD), substance use disorders (SUD), ~~and~~ co-occurring disorders, and no behavioral health diagnosis.
(2) The total number of patients who were admitted to the hospital and were 18 years or older at time of admission.
(3) The readmission rates for MHD, SUD, and co-occurring disorders calculated as the numbers from (1) divided by the number from (2) and multiplied by 100.

Reference: ~~HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate~~ Methodology for Calculating HCAI All-Cause Unplanned, 30-Day Hospital Readmission Rates

Stratification: See Stratification Table 1

Core Quality Measures for Children's Hospitals

1. Pediatric experience survey with scores of willingness to recommend the hospital

Description: Percent (rate per 100) of patients or guardians who reported willingness to recommend the hospital.

Specifications: Hospitals will report:

(1) The number of patients or guardians who responded on the pediatric experience survey that they were willing to recommend the hospital.
(2) The total number of respondents
(3) The percent of respondents who responded that they were willing to recommend the hospital calculated as the number from (1) divided by the number from (2) and multiplied by 100.
(4) The total number of patients or guardians surveyed.
(5) The percent of people surveyed who responded to the survey calculated as the number from (2) divided by the number from (4) and multiplied by 100.

Stratification: See Stratification Table 2

2. HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate

Description: The percent (rate per 100) of the hospital-level, unplanned, all-cause readmissions after admission for any eligible condition within 30 days of hospital discharge for patients of all ages at children's hospitals.

Specifications: Hospitals will provide:

(1) The number of inpatient admissions to any children's hospitals which occurs within 30 days of the discharge date of an eligible index admission. All readmissions are counted as outcomes except those that are considered planned (e.g. ~~i.e.~~, scheduled surgery).
(2) The total number of patients who were admitted to a children's hospital.
(3) The readmission rate calculated as the number from (1) divided by the number from (2) and multiplied by 100.

Reference: ~~HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate~~ Methodology for Calculating HCAI All-Cause Unplanned, 30-Day Hospital Readmission Rates

Stratification: See Stratification Table 2

Core Quality Measures for Acute Psychiatric Hospitals

1. Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey: Would recommend hospital.

Description: The percent (rate per 100) of patients who responded, “probably yes” or “definitely yes” to question 19, “Would you recommend this hospital to your friends and family?” on the HCAHPS survey.

- Definitely no
- Probably no
- Probably yes
- Definitely yes

Specifications: Hospitals will provide:

(1) The number of patients who responded “probably yes” or “definitely yes” to question 19.
(2) The total number of respondents.
(3) Percentage of respondents who responded “probably yes” or “definitely yes” calculated as the number from (1) divided by the number from (2) and multiplied by 100.
(4) The total number of people surveyed.
(5) The percent of people surveyed who responded to the survey calculated as the number from (2) divided by the number from (4) and multiplied by 100.

Reference: HCAHPS Survey and Fact Sheet

Stratification: See Stratification Table 1

2. HCAHPS survey: Received information and education

Description: The percent (rate per 100) of patients who responded “yes” to 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?” on the HCAHPS survey.

Specifications: Hospitals will provide:

(1) The number of patients who responded “yes” to 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?”
(2) The total number of respondents.
(3) Percentage of respondents who responded “yes” calculated as the number from (1) divided by the number from (2) and multiplied by 100.
(4) The total number of people surveyed.
(5) The percent of people surveyed who responded to the survey calculated as the number from (2) divided by the number from (4) and multiplied by 100.

Reference: HCAHPS Survey and Fact Sheet

Stratification: See Stratification Table 1

3. Agency for Healthcare Research and Quality (AHRQ) Quality Indicator Pneumonia Mortality Rate

Description: 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. Excludes discharges with severe sepsis present on admission, transfers to another hospital, discharges admitted from a hospice facility, and obstetric discharges.

Specifications: Hospitals will provide:

(1) The number of deaths among discharges that meet the inclusion and exclusion criteria for the numerator listed in the reference document.
(2) The number of discharges for patients 18 and older that meet the criteria for the denominator listed in the reference document.
(3) The rate of in-hospital deaths per 1,000 hospital discharges with the 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, calculated by the number from (1) divided by the number from (2) and multiplied by 1,000.

Reference: AHRQ Quality Indicator 20 (IQI 20) Pneumonia Mortality Rate

Stratification: See Stratification Table 1

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

Description: The percent (rate per 100) of hospital-level, unplanned, all-cause readmissions after admission for any eligible condition within 30 days of hospital discharge for patients 18 years and older in an inpatient psychiatric facility.

Specifications: Hospitals will provide:

(1) The number of inpatient admissions to an IPF which occurs within 30 days of the discharge date of an eligible index admission. All readmissions are counted as outcomes except those that are considered planned (e.g.~~i.e~~, scheduled surgery).
(2) The total number of patients who were admitted to an IPF and were 18 years or older at time of admission.
(3) The readmission rate calculated as the number from (1) divided by the number from (2) and multiplied by 100.

Reference: ~~HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate~~ Methodology for Calculating HCAI All-Cause Unplanned, 30-Day Hospital Readmission Rates

Stratification: See Stratification Table 1

5. HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate, stratified by behavioral health diagnosis.

Description: The percent (rate per 100) 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 stratified by behavioral health diagnosis.

Specifications: Hospitals will provide:

(1) The total number of all-cause 30-day unplanned readmissions for mental health disorders (MHD), substance use disorders (SUD), ~~and~~ co-occurring disorders, and no behavioral health diagnosis.
(2) The total number of patients who are admitted to the hospital and were 18 years or older at time of admission.
(3) The readmission rates for MHD, SUD, and co-occurring disorders calculated as the number from (1) divided by the number from (2) and multiplied by 100.

Reference: ~~HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate~~ Methodology for Calculating HCAI All-Cause Unplanned, 30-Day Hospital Readmission Rates

Stratification: See Stratification Table 1

6. CMS Inpatient Psychiatric Facility Quality Reporting (IPFQR) program Screening for Metabolic Disorders.

Description: Percent (rate per 100) of patients discharged from an Inpatient Psychiatric Facility (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.

Specifications: Hospitals will report:

(1) The number of patients who received a metabolic screening in the 12 months prior to discharge, either prior to or during the index IPF stay. The screening must contain four tests: (1) body mass index (BMI); (2) blood pressure; (3) blood glucose or HbA1c; and (4) a lipid panel. The screening must have been completed at least once in the 12 months prior to the patient's date of discharge. Screenings can be conducted either at the reporting facility or at another facility for which records are available to the reporting facility. This numerator includes cases that meet the same inclusion and exclusion criteria as the denominator described in (2).
(2) The number of discharges from an IPF during the measurement period with a prescription for one or more routinely scheduled antipsychotic medications. The

measure (denominator) excludes patients for whom a screening could not be completed within the stay due to the patient's enduring unstable medical condition or enduring unstable psychological condition and patients with a LOS equal to or greater than 365 days or equal to or less than three days.

(3) The percentage of patients discharged from an IPF with a prescription for one or more antipsychotic medications for which a metabolic screening was completed within the 12 months prior to discharge calculated as the number from (1) divided by the number from (2) and multiplied by 100.

Reference:

~~Page 95 of CMS IPFQR Program Manual and Appendix B: Screening for Metabolic Disorders~~

Page 92 of CMS IPFQR Program Manual and Appendix B: Screening for Metabolic Disorders
Appendix B: Screening for Metabolic Disorders

Stratification: See Stratification Table 1

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

Description: SUB-3: The percent (rate per 100) of patients who are identified with alcohol or drug use disorder who received or refused at discharge a prescription for FDA-approved medications for alcohol or drug use disorder, or who receive or refuse a referral for addictions treatment.

Specifications: For SUB-3 hospitals will provide:

(1) The number of patients who received or refused at discharge a prescription for medication for treatment of alcohol or drug use disorder or a referral for addictions treatment.

(2) The number of hospitalized inpatients 18 years of age and older identified with an alcohol or drug use disorder.

(3) Percent of patients who are identified with having an alcohol or drug use disorder who receive or refuse at discharge a prescription for FDA-approved medications for alcohol or drug use disorder, or who receive or refuse a referral for addictions treatment calculated as the number from (1) divided by the number (2) and multiplied by 100.

Description: SUB-3a: The percent (rate per 100) of patients who were identified with alcohol or drug use disorder who received a prescription for FDA-approved medications for alcohol or drug use disorder or a referral for addictions treatment.

Specifications: For SUB-3a hospitals will provide:

(1) The number of patients who received a prescription at discharge for medication for treatment of alcohol or drug use disorder or a referral for addictions treatment.

(2) The number of hospitalized inpatients 18 years of age and older identified with an alcohol or drug use disorder.
(3) Percent of patients who are identified with having an alcohol or drug use disorder who receive a prescription for FDA-approved medications for alcohol or drug use disorder or a referral for addictions treatment calculated as the number from (1) divided by the number (2) and multiplied by 100.

Included Populations:

Patients with ICD-10-CM Principal or Other Diagnosis Code for alcohol or drug use disorder listed on Table 13.1 and 13.2 and patients with a Principal or Other ICD-10-PCS Procedure Code listed on Table 13.3 in Specifications Manual for Joint Commission National Quality Measures (2024B): Appendix A ICD-10 Code Tables referenced below.

Excluded Populations:

Patients less than 18 years of age; patient drinking at unhealthy levels who do not meet criteria for an alcohol use disorder; patients who are cognitively impaired; patients who expire; patients discharged to another hospital; patients who left against medical advice; patients discharged to another healthcare facility; patients discharged to home or another healthcare facility for hospice care; patients who have a duration of stay less than or equal to one day or greater than 120 days; patients who do not reside in the United States; patients receiving Comfort Measures Only documented.

Reference: Specifications Manual for Joint Commission National Quality Measures (v2024B): Substance Use Measures

Specifications Manual for Joint Commission National Quality Measures (v2024B): Appendix A ICD-10 Code Tables

Stratification: See Stratification Table 1

Health Equity Plan

All hospitals shall include as a part of their hospital equity report a health equity plan that includes the following:

(A) The top ten disparities identified in the data by the rate ratio (RR). The RR compares the rate between a stratification group and the reference group for each measure.

(B) A plan to address the disparities identified in (A), including population impact, measurable objectives, and specific timeframes. For each of the top 10 disparities identified in the data, the hospital will need to include the following items:

(i) What measure and stratification group shows the disparity?
(ii) What is the best performing reference group for this measure?
(iii) What is the RR of the lowest performing group, or groups, and the reference group?
(iv) What actions will the hospital take to address this disparity including population impact, measurable objectives, and specific timeframes?

(C) Performance across all the following priority areas:

(i) Person-centered care.
(ii) Patient safety.
(iii) Addressing patient social drivers of health.
(iv) Effective treatment.
(v) Care coordination.
(vi) Access to care.

(D) Explanation of methodology by indicating:

(i) Whether hospital used the methodology as outlined in the Measures Submission Guide.
(ii) If hospital did not use the Measures Submission Guide, explain what methodology was used.
(iii) Calculating Rate Ratio.

(E) Include the plan in the designated field in the reporting system at hdc.hcai.ca.gov.

RR is calculated differently for measures with preferred low rates and those with preferred high rates. RR should be calculated after applying the California Health and Human Services Agency's "Data De-Identification Guidelines (DDG)," dated September 23, 2016.

For the measures with preferred low rates, the RR is calculated as the stratification group rate divided by the reference group rate. If the reference rate is zero, use half of the lowest non-zero rate as the denominator. The measures with preferred low rates are:

1. Agency for Healthcare Research and Quality (AHRQ) Quality Indicator Pneumonia Mortality Rate

2. AHRQ Patient Safety Indicator Death Rate among Surgical Inpatients with Serious Treatable

3. California Maternal Quality Care Collaborative (CMQCC) Nulliparous, Term, Singleton, Vertex (NTSV) Cesarean Birth Rate

4. HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate

5. HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate, stratified by behavioral health diagnosis

6. Screening for metabolic disorders

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

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

For the measures with preferred high rates, the RR is calculated as the reference group rate divided by the stratification group rate. The measures with preferred high rates are:

1. Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey: Would recommend hospital

2. HCAHPS survey: Received information and education

3. CMQCC Vaginal Birth After Cesarean (VBAC) Rate

4. CMQCC Exclusive Breast Milk Feeding

5. Pediatric experience survey with scores of willingness to recommend the hospital

Steps to calculate RR for the measures with preferred low rates:

Step 1: Identify the reference group with the best outcome for each measure within each stratification category.

Step 2: Calculate the RR by dividing the rate of each stratification group by the rate of the reference group.

Example for measure with preferred low rate: AHRQ Patient Safety Indicator (PSI) Death Rate among Surgical Inpatients with Serious Treatable Complications.

AHRQ Patient Safety Indicator Death Rate among Surgical Inpatients with Serious Treatable Complications

Race and/or Ethnicity	PSI Death Rate (Per 1,000)	RR Calculation	RR of PSI Death Rate
American Indian or Alaska~~n~~ Native	128.0	128.0 / 48.0	2.7
Asian	65.0	65.0 / 48.0	1.4
Black or African American	136.0	136.0 / 48.0	2.8
Hispanic or Latino	70.0	70.0 / 48.0	1.5
Middle Eastern or North African	75.0	75.0 / 48.0	1.6
Native Hawaiian or ~~Other~~ Pacific Islander	130.0	130.0 / 48.0	2.7
~~Multi racial~~ Multiracial and/or Multiethnic*	48.0	48.0 / 48.0	1.0
White	75.0	75.0 / 48.0	1.6

~~*Multi racial*~~ *Multiracial and/or Multiethnic* is the reference group since it has the best outcome (lowest death rate).

Black or African American has the highest RR for PSI Death Rate.

Example for measure with preferred low rate and reference rate is zero: AHRQ Patient Safety Indicator Death Rate among Surgical Inpatients with Serious Treatable Complications.

Since the reference rate is zero, use half of the lowest non-zero rate as the denominator.

AHRQ Patient Safety Indicator Death Rate among Surgical Inpatients with Serious Treatable Complications

Preferred Language	PSI Death Rate (Per 1,000)	RR Calculation	RR of PSI Death Rate
English Language	125.0	125.0 / 50.0	2.5
American Sign Langu	125.0	125.0 / 50.0	2.5
Asian/ Pacific Islander Languages	110.0	110.0 / 50.0	2.2
Middle Eastern Languages	100.0	100.0 / 50.0	2.0
Spanish Language	170.0	170.0 / 50.0	3.4
Other/Unknown*	0.0	0.0 / 50.0	0.0

Other/Unknown is the reference group because it has the best readmission rate; however, since it has a rate of zero, use half of the rate for Middle Eastern Languages as the denominator.

Spanish Language is the stratification group with the highest RR.

Steps to calculate RR for the measures with preferred high rates:

Step 1: Identify the reference group with the best outcome for each measure within each stratification category.

Step 2: Calculate the RR by dividing the rate of the reference group by the rate of each stratification group.

Example for measure with preferred high rate: CMQCC Vaginal Birth After Cesarean (VBAC) Rate

CMQCC Vaginal Birth After Cesarean (VBAC) Rate

Race and/or Ethnicity	VBAC Rate (Per 1,000)	RR Calculation	RR of VBAC
American Indian or Alaska~~n~~ Native	100.0	350.0 / 100.0	3.5
Asian	290.0	350.0 / 290.0	1.2
Black	180.0	350.0 / 180.0	1.9
Hispanic	300.0	350.0 / 300.0	1.2
Middle Eastern or North African	250.0	350.0 / 250.0	1.4
Native Hawaiian or ~~Other~~ Pacific Islander	300.0	350.0 / 300.0	1.2
~~Multi-racial~~ Multiracial and/or Multiethnic	250.0	350.0 / 250.0	1.4
White*	350.0	350.0 / 350.0	1.0

White is the reference group since it is the best performing group (highest rate).

American Indian or Alaska~~n~~ Native has the highest RR for VBAC rate.

Identifying the top disparities

This example only includes the top three disparities. Hospitals are required to submit the top ten widest disparities.

Stratification	Stratification Group	Measure	Rate Ratio	Ranking
Race and /or Ethnicity	American Indian or Alaska~~n~~ Native	CMQCC Vaginal Birth After Cesarean (VBAC) Rate	3.5	1
Preferred Language	Spanish Language	AHRQ Patient Safety Indicator Death Rate among Surgical Inpatients with Serious Treatable Complication	3.4	2
Race and /or Ethnicity	Black or African American	AHRQ Patient Safety Indicator Death Rate among Surgical Inpatients with Serious Treatable Complication	2.8	3

Stratification

Measures should be stratified by the categories in the following tables to the extent that the data is available at the hospital and hospital system level. In cases where data is collected only for some stratification groups, the data for the groups that are missing/unknown should be reported as "NA". Hospital systems' report should aggregate data from their hospitals categorized by general acute care hospital, children's hospital, and acute psychiatric hospital when there is more than one hospital in a category.

Stratification Table 1

*Applies to Core Quality Measures for General Acute Care Hospitals (1,2,3,4,5,6,7,8,9) and for Acute Psychiatric Hospitals (1,2,3,4,5,6,7)	
Race and/or Ethnicity Standard Used: OMB 2024 Standard and HCAI evaluation. Link: OMB Standards for Race and/or Ethnicity	American Indian or Alaska~~n~~ Native
	Asian
	Black or African American
	Hispanic or Latino
	Middle Eastern or North African
	~~Multi-racial~~ Multiracial and/or Multiethnic (two or more races)
	Native Hawaiian or ~~Other~~ Pacific Islander
	White
Age (excluding maternal measures) Age refers to age at discharge. Use these age groups to the extent data is available and patient privacy is protected. Categories may be rolled up to meet this requirement. Standard Used: Based on HCAI Evaluation	Less than 18
	18 to 34
	35 to 49
	50 to 64
	65 and older
Age (for maternal measures only) Age refers to age at discharge. Use these age groups to the extent data is available and patient privacy is protected. Categories may be rolled up to meet this requirement. Standard Used: Based on HCAI Evaluation	Less than 18
	18 to 29
	30 to 39
	40 and older

Sex Assigned at Birth Standard Used: The Office of the National Coordinator (ONC) Interoperability Standards Advisory (ISA), HL7 Version 3. Link: USCDI Sex Assigned at Birth	Female
	Male
	Unknown
Expected Payor The Expected Payor is the payer that is expected to pay the greatest share of the patient's bill. Standard Used: Based on HCAI Evaluation	Medicare
	Medicaid
	Private
	Self-Pay
	Other
Preferred Language Standard Used: Based on HCAI Evaluation	English Language
	Asian/ Pacific Islander Languages
	Middle Eastern Languages
	Spanish Language
	American Sign Language
	Other/Unknown
Disability Status Standard Used: Federal standards from ONC ISA, HL7 Version 1.1.0 and the CDC PLACES disability measure. Link: HL7 Disability Status Additional Resources: CDC PLACES Disability Measure	Does not have disability
	Mobility disability
	Cognition disability
	Hearing disability
	Vision disability
	Self-Care disability
	Independent Living disability
Sexual Orientation Standard Used: Federal standards from ONC ISA, SNOMED CT, HL7 Version 3 Link: USCDI Sexual Orientation	Lesbian, gay or homosexual
	Straight or heterosexual
	Bisexual
	Something else
	Don't know
	Choose not to disclose

Gender Identity Standard Used: Federal standards from ONC ISA, SNOMED CT, HL7 version 3. Link: USCDI Gender Identity	Female
	Female-to-Male (FTM)/Transgender Male/Trans Man
	Male
	Male-to-Female (MTF)/Transgender Female/Trans Woman
	Identifies as non-conforming gender, Genderqueer, neither exclusively male nor female, non-binary gender
	Additional gender category or other
	Choose not to disclose
Behavioral Health Diagnosis	Mental Health Disorder
	Co-Occurring Disorder
	Substance Use Disorder
	No Behavioral Health Diagnosis

Stratification Table 2

*Applies to measures for Children's Hospitals (1 and 2)	
Race/Ethnicity Standard Used: OMB 2024 Standard and HCAI evaluation. Link: OMB Standards for Race and/or Ethnicity	American Indian or Alaska~~n~~ Native
	Asian
	Black or African American
	Hispanic or Latino
	Middle Eastern or North African
	~~Multi-racial~~ Multiracial and/or Multiethnic (two or more races)
	Native Hawaiian or ~~Other~~ Pacific Islander
	White
Age Age refers to age at discharge. Use these age groups to the extent data is available and patient privacy is protected. Categories may be rolled up to meet this requirement. Standard Used: Age groups from the 2022 Population File for Use with 2023 AHRQ Quality Indicators, as well as HCAI evaluation. Link: 2022 Population File for Use with 2023 AHRQ Quality Indicators	0–4 years
	5–9 years
	10–14 years
	15 years and older
Sex Assigned at Birth Standard Used: The Office of the National Coordinator (ONC) Interoperability Standards Advisory (ISA), HL7 Version 3. Link: USCDI Sex Assigned at Birth	Female
	Male
	Unknown
Expected Payor The Expected Payor is the payer that is expected to pay the greatest share of the patient's bill. Standard Used: Based on HCAI Evaluation	Medicare
	Medicaid
	Private
	Self-Pay
	Other
Preferred Language Standard Used: Based on HCAI Evaluation	English Language
	Asian/ Pacific Islander Languages
	Middle Eastern Languages
	Spanish Language
	American Sign Language
	Other/Unknown

Disability Status Standard Used: Federal standards from ONC ISA, HL7 Version 1.1.0 and the CDC PLACES disability measure. Link: HL7 Disability Status Additional Resources: CDC PLACES Disability Measure	Does not have disability
	Mobility disability
	Cognition disability
	Hearing disability
	Vision disability
	Self-Care disability
	Independent Living disability
Sexual Orientation Standard Used: Federal standards from ONC ISA, SNOMED CT, HL7 Version 3 Link: USCDI Sexual Orientation	Lesbian, gay or homosexual
	Straight or heterosexual
	Bisexual
	Something else
	Don't know
	Choose not to disclose
Gender Identity Standard Used: Federal standards from ONC ISA, SNOMED CT, HL7 Version 3 Link: USCDI Gender Identity	Female
	Female-to-Male (FTM)/Transgender Male/Trans Man
	Male
	Male-to-Female (MTF)/Transgender Female/Trans Woman
	Identifies as non-conforming gender, Genderqueer, neither exclusively male nor female, non-binary gender
	Additional gender category or other
	Choose not to disclose
Behavioral Health Diagnosis	Mental Health Disorder
	Co-Occurring Disorder
	Substance Use Disorders
	No Behavioral Health Diagnosis

Preferred Language Table

Preferred language groupings are taken from the HCAI Preferred Languages Spoken in California Facilities visualization and dataset (link)	
Preferred Language	**Languages Included**
English Language	English
Asian/ Pacific Islander Languages	Assamese, Bengali, Burmese, Chamorro, Chinese, Chuukese, Mandarin, Fijian, Filipino, Gujarati, Hiligaynon, Hindi, Hmong, Ilocano or Iloko, Indonesian, Mien or Iu Mien, Javanese, Japanese, Korean, Lao, Malayalam, Marathi, Mon-Khmer, Mongolian, Nepali, Panjabi or Punjabi, Sinhalese, Samoan, Telugu, Tagalog, Thai, Tonga, Urdu, Vietnamese, Cantonese, or Yue Chinese
Middle Eastern Languages	Amharic, Arabic, Armenian, Egyptian Ancient, Elamite, Hebrew, Persian, Farsi, Pashto, Tigrinya, Turkish
Spanish Language	Spanish
Other/Unknown	Any language that is not listed in any of the groups above
American Sign Language (ASL)	American Sign Language

Behavioral Health Groupings

ICD-10 codes and CCR categories were adopted from the Massachusetts Center for Health Information and Analysis, Massachusetts Acute Care Hospital Emergency Department Data – Quarterly Update October 2018 to September 2023

Mental health disorders and substance use disorders are determined using the Clinical Classifications Software Refined (CCSR) Categories which is an aggregation of over 70,000 ICD-10-CM diagnosis codes placed into over 530 clinically relevant categories.

Behavioral Health Group	Clinical Classifications Software Refined (CCSR) Categories	ICD-10 Codes
Mental health disorders	MBD002, MBD003, MBD004, MBD005, MBD006, MBD007, MBD012, MBD027, MBD001, MBD009, MBD008, MBD010, MBD011, MBD013	All ICD-10 codes within the CCSR categories column
	MBD026 (include only ICD-10 codes listed in ICD-10 codes column)	F304, F3170, F3172, F3174 F3176, F3178, F325, F3340, F3342
	MBD034 (include only ICD-10 codes listed in ICD-10 codes column)	T1491XS, T360X2S, T361X2S, T362X2S, T363X2S, T364X2S, T365X2S, T366X2S, T367X2S, T368X2S, T3692XS, T370X2S, T371X2S, T372X2S, T373X2S, T374X2S, T375X2S, T378X2S, T3792XS, T380X2S, T381X2S, T382X2S, T383X2S, T384X2S, T385X2S, T386X2S, T387X2S, T38802S, T38812S, T38892S, T38902S, T38992S, T39012S, T39092S, T391X2S, T392X2S, T39312S, T39392S, T394X2S, T398X2S, T3992XS, T400X2S, T401X2S, T402X2S, T403X2S, T40412S, T40422S, T40492S, T404X2S, T405X2S, T40602S, T407X2S, T40712S, T40722S, T408X2S, T40902S, T40992S, T410X2S, T411X2S, T41202S, T41292S, T413X2S, T4142XS, T415X2S, T420X2S, T422X2S, T423X2S, T424X2S, T425X2S, T426X2S, T4272XS, T428X2S, T43012S, T43022S, T431X2S, T43202S, T43212S, T43222S, T43292S, T433X2S, T434X2S, T43502S, T43592S, T43602S, T43612S, T43622S, T43632S, T43642S, T43692S, T438X2S, T4392XS, T440X2S, T441X2S, T442X2S, T443X2S, T444X2S,

Behavioral Health Group	Clinical Classifications Software Refined (CCSR) Categories	ICD-10 Codes
		T445X2S, T446X2S, T447X2S, T448X2S, T44902S, T44992S, T450X2S, T451X2S, T452X2S, T453X2S, T454X2S, T45512S, T45522S, T45602S, T45612S, T45622S, T45692S, T457X2S, T458X2S, T4592XS, T460X2S, T461X2S, T462X2S, T463X2S, T464X2S, T465X2S, T466X2S, T467X2S, T468X2S, T46902S, T46992S, T470X2S, T471X2S, T472X2S, T473X2S, T474X2S, T475X2S, T476X2S, T477X2S, T478X2S, T4792XS, T480X2S, T481X2S, T48202S, T48292S, T483X2S,T484X2S, T485X2S, T486X2S, T48902S, T48992S, T490X2S, T491X2S, T492X2S, T493X2S, T494X2S, T495X2S, T496X2S, T497X2S, T498X2S, T4992XS, T500X2S, T501X2S, T502X2S, T503X2S, T504X2S, T505X2S, T506X2S, T507X2S, T508X2S, T50902S, T50912S, T50992S, T50A12S, T50A22S, T50A92S, T50B12S, T50B92S, T50Z12S, T50Z92S, T510X2S, T511X2S, T512X2S, T513X2S, T518X2S, T5192XS, T520X2S, T521X2S, T522X2S, T523X2S, T524X2S, T528X2S, T5292XS, T530X2S, T531X2S, T532X2S, T533X2S, T534X2S, T535X2S, T536X2S, T537X2S, T5392XS, T540X2S, T541X2S, T542X2S, T543X2S, T5492XS, T550X2S, T551X2S, T560X2S, T561X2S, T562X2S, T563X2S, T564X2S, T565X2S, T566X2S, T567X2S, T56812S, T56892S, T5692XS, T570X2S, T571X2S, T572X2S, T573X2S, T578X2S, T5792XS, T5802XS, T5812XS, T582X2S, T588X2S, T5892XS, T590X2S, T591X2S, T592X2S, T593X2S, T594X2S, T595X2S, T596X2S, T597X2S, T59812S, T59892S, T5992XS, T600X2S, T601X2S, T602X2S, T603X2S, T604X2S, T608X2S, T6092XS, T6102XS, T6112XS, T61772S, T61782S, T618X2S, T6192XS, T620X2S, T621X2S, T622X2S, T628X2S, T6292XS, T63002S, T63012S, T63022S, T63032S, T63042S, T63062S, T63072S, T63082S,

Behavioral Health Group	Clinical Classifications Software Refined (CCSR) Categories	ICD-10 Codes
		T63092S, T63112S, T63122S, T63192S, T632X2S, T63302S, T63312S, T63322S, T63332S, T63392S, T63412S, T63422S, T63432S, T63442S, T63452S, T63462S, T63482S, T63512S, T63592S, T63612S, T63622S, T63632S, T63692S, T63712S, T63792S, T63812S, T63822S, T63832S, T63892S, T6392XS, T6402XS, T6482XS, T650X2S, T651X2S, T65212S, T65222S, T65292S, T653X2S, T654X2S, T655X2S, T656X2S, T65812S, T65822S, T65832S, T65892S, T6592XS, T71112S, T71122S, T71132S, T71152S, T71162S, T71192S, T71222S, T71232S, X710XXS, X711XXS, X712XXS, X713XXS, X718XXS, X719XXS, X72XXXS, X730XXS, X731XXS, X732XXS, X738XXS, X739XXS, X7401XS, X7402XS, X7409XS, X748XXS, X749XXS, X75XXXS, X76XXXS, X770XXS, X771XXS, X772XXS, X773XXS, X778XXS, X779XXS, X780XXS, X781XXS, X782XXS, X788XXS, X789XXS, X79XXXS, X80XXXS, X810XXS, X811XXS, X818XXS, X828XXS, X830XXS, X831XXS, X832XXS, X838XXS
Substance use disorders	MBD017, MBD019, MBD030, MBD018, MBD028, MDB020, MBD021, MBD029, MBD032	All ICD-10 codes within the CCSR categories column
	MBD026 (include only ICD-10 codes listed in ICD-10 codes column)	F1011, F1021, F1111, F1121, F1211, F1221, F1311, F1321, F1411, F1421, F1511, F1521, F1611, F1621, F1811, F1821, F1911, F1921
	MBD034 (include only ICD-10 codes listed in ICD-10 codes column)	T400X1S, T400X3S, T400X4S, T400X5S, T401X1S, T401X3S, T401X4S, T402X1S, T402X3S, T402X4S, T402X5S, T403X1S, T403X3S, T403X4S, T403X5S, T40411S, T40413S, T40414S, T40415S, T40421S, T40423S, T40424S, T40425S, T40491S, T40493S, T40494S, T40495S, T404X1S,

Behavioral Health Group	Clinical Classifications Software Refined (CCSR) Categories	ICD-10 Codes
		T404X3S, T404X4S, T404X5S, T405X1S, T405X3S, T405X4S, T405X5S, T40601S, T40603S, T40604S, T40605S, T40691S, T40693S, T40694S, T40695S, T407X1S, T407X3S, T407X4S, T407X5S, T40711S, T40712S, T40713S, T40714S, T40721S, T40722S, T40723S, T40724S, T408X1S, T408X3S, T408X4S, T40901S, T40903S, T40904S, T40905S, T40991S, T40993S, T40994S, T40995S, T410X1S, T410X3S, T410X4S, T410X5S, T426X1S, T426X3S, T426X4S, T426X5S, T4271XS, T4273XS, T4274XS, T4275XS, T43205S, T43601S, T43603S, T43604S, T43605S, T43611S, T43613S, T43614S, T43615S, T43621S, T43623S, T43624S, T43625S, T43631S, T43633S, T43634S, T43635S, T43641S, T43643S, T43644S, T43691S, T43693S, T43694S, T43695S
Co-occurring disorders	Patient has at least one code from the mental health disorder group and at least one code from the substance use disorder group	Patient has at least one code from the mental health disorder group and at least one code from the substance use disorder group