

# HCAi Department of Health Care Access and Information

HOSPITAL EQUITY REPORT: MEASURES SUBMISSION GUIDE

VERSION 1.32: MARCH 10 DECEMBER 22, 2025

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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 requires California-licensed hospitals and hospital systems 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 consistent with the DDG. 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](http://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](http://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, Individual hospitals should shall also include the following information in their reports:~~

- (1) Hospital name
- (2) Hospital HCAI ID (9 digits) ~~/ Hospital system ID (to be generated by HCAI~~
- (3) Reporting ~~Organization~~ 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.

- D. No score for hospitals located in census tracts where the Healthy Places Index is unavailable.
- (7) The web address where the hospital's equity report is will be published on the hospital's website.
- (8) A health equity report as described in the [Health Equity Report](#) section of this document.

Hospital systems shall furnish a single, consolidated report that aggregates data from all of the hospital system's affiliated hospitals. For each applicable measure, the hospital system shall calculate and report the measure using data from each applicable hospital type. Hospital system equity reports shall include the numerator, denominator, and rate of each core measure broken down by each stratification category. Hospital system equity reports shall report on all hospital core measures outlined in Sections 95303. All structural measures outlined in Sections 95303 shall also be reported except for the Centers for Medicare & Medicaid Services (CMS) Hospital Commitment to Health Equity Structural (HCHE) Measure.

Hospital systems shall include the following information in their reports:

- (1) Hospital system name
- (2) Hospital system ID (to be generated by HCAI)
- (3) System description
- (4) Report period start date [January 1 of prior calendar year]
- (5) Report period end date [December 31 of prior calendar year]
- (6) Hospital HCAI IDs (9 digits) for hospitals included in the hospital system report
- (7) The web address where the hospital system's equity report will be published on the hospital system 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](mailto:hospitalequity@hcai.ca.gov).

## Structural Measures

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

- Designate an individual to lead hospital health equity activities. Hospital systems should report on this at the system level.

- Provide documentation of policy prohibiting discrimination. Hospital systems should report on this at the system level.
- 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 number 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 percentage 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 (HCHE) 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)
  - (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 and who are 18 years or older on the date they are admitted.
- (3) The percentage 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 percentage 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, 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.

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

**Exclusions:** The following patients ~~would~~ are ~~be~~ excluded from the denominator and numerator: 1) Patients who opt\_out 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 t~~ This measure is calculated as two sets of five separate ~~percentage~~ rates. The first set includes five screened positive rates that are each derived from the number of patients who screened positive for each of the five HRSNs, divided by the total number of patients 18 years or older on the date of admission who were screened for all five HRSNs, and multiplied by 100. The second set includes five received intervention rates that are each derived from the number of patients who 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 who were 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 rate 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 to question 19.
- (3) The percent rate 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 patients surveyed.
- (5) The percent rate of people patients surveyed who responded to question 19 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 4

2. HCAHPS survey: Received information and education

**Description:** The rate 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 to question 17.
- (3) The rate 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 rate percent of people surveyed who responded to the survey question 17, 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-4

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

**Description:** The rate of in-hospital deaths per 1,000 hospital discharges with a principal diagnosis of pneumonia or a principal diagnosis of sepsis with a secondary diagnosis of pneumonia present on admission, for patients ages 18 years and or 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 for patients 18 years or older that meet the inclusion and exclusion criteria for the numerator listed in the reference document.
- (2) The number of discharges for patients 18 years and or older that meet the inclusion and exclusion 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 or 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-4

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

**Description:** The rate of 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 18 to 89 years old ~~that~~ who meet the inclusion and exclusion criteria for the numerator listed in the reference document.
- (2) Discharges for patients 18 to 89 years old 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-4

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

**Description:** The rate of nNulliparous 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) multiplied by 100.

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-4

#### 6. CMQCC Vaginal Birth After Cesarean (VBAC) Rate, Uncomplicated

**Description:** The rate of vVaginal 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 100,000.

Reference: CMQCC uses [AHRQ IQI 22 Specifications](#)

**Stratification:** See Stratification Table-4

## 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-4

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

**Description:** The rate 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 or~~ older.

**Specifications:** Hospitals will provide:

- (1) The number of inpatient admissions to any acute care hospitals ~~which that~~ 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: [Methodology for Calculating All Cause, Unplanned, 30-Day Hospital Readmission Rates, California, Department of Health Care Access and Information](#)

**Stratification:** See Stratification Table-4

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

**Description:** The rate 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 years or ~~and~~ older, stratified by behavioral health diagnosis.

**Specifications:** Hospitals will provide:

- (1) The total number of all-cause 30-day unplanned readmissions ~~for~~ with:
  - a. ~~M~~Mental health disorders (MHD),
  - b. ~~S~~Substance use disorders (SUD),
  - c. ~~C~~Co-occurring disorders (CO), ~~or~~
  - d. ~~N~~No behavioral health diagnosis (NOBH).
- (2) The total number of patients who were admitted to the hospital and were 18 years or older at time of admission with:-
  - a. MHD,
  - b. SUD,
  - c. CO, or
  - d. NOBH.

(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 for patients with:-

- a. MHD
- b. SUD
- c. CO
- d. NOBH

Reference: [Methodology for Calculating All Cause, Unplanned, 30-Day Hospital Readmission Rates, California, Department of Health Care Access and Information](#)

**Stratification:** See Stratification Table-4

## Core Quality Measures for Children's Hospitals

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

**Description:** ~~Percent (rate per 100)~~Rate 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 on the pediatric experience survey.
- (2) The total number of respondents to the pediatric experience survey.
- (3) The ~~percent rate~~ 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 rate~~ 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)~~rate 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., 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: [Methodology for Calculating All Cause, Unplanned, 30-Day Hospital Readmission Rates, California, Department of Health Care Access and Information](#)

**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 (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 to question 19.
- (3) ~~Percentage~~ The rate 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~~ patients surveyed.
- (5) The ~~percent rate~~ of ~~people~~ patients ~~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-4

2. HCAHPS survey: Received information and education

**Description:** The ~~percent (rate per 100)~~ rate 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 to question 17.
- (3) ~~Percentage~~ The rate 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~~ rate 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 4

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

**Description:** The rate of in-hospital deaths per 1,000 hospital discharges with a principal diagnosis of pneumonia or a principal diagnosis of sepsis with a secondary diagnosis of pneumonia present on admission, for patients ages 18 years and or 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 for patients 18 years or older 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 or~~ 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 4

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

**Description:** The ~~percent (rate per 100)~~ rate of hospital-level, unplanned, all-cause readmissions after admission for any eligible condition within 30 days of hospital discharge for patients 18 years ~~and~~ or 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., 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: [Methodology for Calculating All Cause, Unplanned, 30-Day Hospital Readmission Rates, California, Department of Health Care Access and Information](#)

**Stratification:** See Stratification Table-4

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

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

**Specifications:** Hospitals will provide:

- (1) The total number of all-cause 30-day unplanned readmissions with:
  - a. Mental health disorders (MHD),
  - b. Substance use disorders (SUD),
  - c. Co-occurring disorders (CO), or
  - d. No behavioral health diagnosis (NOBH).
- (2) The total number of patients who were admitted to the hospital and were 18 years or older at time of admission with:
  - a. MHD,
  - b. SUD,
  - c. CO, or
  - d. NOBH.
- (3) The readmission rates calculated as the numbers from (1) divided by the number from (2) and multiplied by 100 for patients with:
  - a. MHD,

- b. SUD,
- c. CO, or
- d. NOBH.

- (1) ~~The total number of all-cause 30-day unplanned readmissions for mental health disorders (MHD), substance use disorders (SUD), 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: [Methodology for Calculating All Cause, Unplanned, 30-Day Hospital Readmission Rates, California, Department of Health Care Access and Information](#)

**Stratification:** See Stratification Table-4

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

**Description:** ~~Percent (rate per 100)~~The rate 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 the following 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~~length of stay equal to or greater than 365 days or equal to or less than three days.
- (3) The ~~rate~~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 92 of CMS IPFQR Program Manual and Appendix B: Screening for Metabolic Disorders](#) Appendix B: Screening for Metabolic Disorders

**Stratification:** See Stratification Table-4

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)~~The rate 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~~The rate 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)~~rate 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) ~~The rate~~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-4

## **Hospital System Report Data Aggregation by Measure**

The following table describes required hospital data aggregation by measures for the hospital type or types included in the hospital system report.

	<b><u>General Acute Care (GAC)</u></b>	<b><u>Children’s (C)</u></b>	<b><u>Acute Psychiatric (AP)</u></b>	<b><u>Data Aggregation</u></b>
<b><u>Structural Measures</u></b>				
<u>The Joint Commission Health Equity Leader</u>	<u>Required</u>	<u>Required</u>	<u>Required</u>	<u>No aggregation, system level</u>
<u>The Joint Commission No Discrimination Policy</u>	<u>Required</u>	<u>Required</u>	<u>Required</u>	<u>No aggregation, system level</u>
<u>The Joint Commission Preferred Language</u>	<u>Required</u>	<u>Required</u>	<u>Required</u>	<u>GAC + AP + C</u>

	<u>General Acute Care (GAC)</u>	<u>Children's (C)</u>	<u>Acute Psychiatric (AP)</u>	<u>Data Aggregation</u>
<u>CMS HCHE Measures</u>	<u>Required</u>	<u>Required</u>	<u>Required</u>	<u>Not required for hospital system</u>
<u>CMS SDOH</u>	<u>Required</u>	<u>Required</u>	<u>Required</u>	<u>GAC + AP + C</u>
<b><u>Core Quality Measures</u></b>				
<u>HCAHPS 19</u>	<u>Required</u>	<u>Not required</u>	<u>Required</u>	<u>GAC + AP</u>
<u>HCAHPS 17</u>	<u>Required</u>	<u>Not required</u>	<u>Required</u>	<u>GAC + AP</u>
<u>AHRQ Pneumonia Mortality Rate</u>	<u>Required</u>	<u>Not required</u>	<u>Required</u>	<u>GAC + AP</u>
<u>AHRQ Death Rate among Surgical Discharges</u>	<u>Required</u>	<u>Not required</u>	<u>Not required</u>	<u>GAC</u>
<u>CMQCC NTSV Rate</u>	<u>Required</u>	<u>Not required</u>	<u>Not required</u>	<u>GAC</u>
<u>CMQCC VBAC Rate</u>	<u>Required</u>	<u>Not required</u>	<u>Not required</u>	<u>GAC</u>
<u>CMQCC Exclusive Breast Milk Feeding Rate</u>	<u>Required</u>	<u>Not required</u>	<u>Not required</u>	<u>GAC</u>
<u>HCAI 30-Day Readmission Rate</u>	<u>Required</u>	<u>Required</u>	<u>Required</u>	<u>GAC + C + AP</u>
<u>HCAI 30-Day Readmission Rate by Behavioral Health Diagnoses</u>	<u>Required</u>	<u>Not required</u>	<u>Required</u>	<u>GAC + AP</u>
<u>Pediatric experience survey of willingness to recommend hospital</u>	<u>Not required</u>	<u>Required</u>	<u>Not required</u>	<u>C</u>
<u>CMS IPFQR Metabolic Disorder Screening Rate</u>	<u>Not required</u>	<u>Not required</u>	<u>Required</u>	<u>AP</u>
<u>The Joint Commission SUB- 3 and SUB-3a</u>	<u>Not required</u>	<u>Not required</u>	<u>Required</u>	<u>AP</u>

## 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~~ using 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) Include the plan in the designated field in the reporting system at [hdc.hcai.ca.gov](http://hdc.hcai.ca.gov).

### **Calculating Rate Ratios**

~~RR~~ Rate ratios are 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 multiple groups have the same lowest rate, select the group with the largest denominator as the reference group. If multiple groups have the same lowest rate and the same denominator values, report the reference group as "multiple groups." 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~~
68. 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. If multiple groups have the same highest rate, select the group with the largest denominator as the reference group. If multiple groups have the same highest rate and the same denominator values, report the reference group as “multiple groups.” 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, Uncomplicated
4. CMQCC Exclusive Breast Milk Feeding
5. Pediatric experience survey with scores of willingness to recommend the hospital
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

**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**

<b>Race and/or Ethnicity</b>	<b>PSI Death Rate (Per 1,000)</b>	<b>RR Calculation</b>	<b>RR of PSI Death Rate</b>
American Indian or Alaska 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 Pacific Islander	130.0	130.0 / 48.0	2.7
Multiracial and/or Multiethnic*	48.0	48.0 / 48.0	1.0
White	75.0	75.0 / 48.0	1.6

Multiracial and/or Multiethnic is the reference group since it has the best outcome as the (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**

<b>Preferred Language</b>	<b>PSI Death Rate (Per 1,000)</b>	<b>RR Calculation</b>	<b>RR of PSI Death Rate</b>
English Language	125.0	125.0 / 50.0	2.5
American Sign Language	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 Alaka 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 Nortfrican	250.0	350.0 / 250.0	1.4
Native Hawaiian or Paific Islander	300.0	350.0 / 300.0	1.2
Multiracial and/or Multihnic	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 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. If two or more of the top disparities have the same rate ratio value, rank the disparity with the stratification group with the largest denominator higher.

Stratification	Stratification Group	Measure	Rate Ratio	Ranking
Race and /or Ethnicity	American Indian or Alaska 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 for the hospital and hospital system level and consistent with the DDG Data De-identification Guidelines. In cases where data is only collected only for some stratification groups, the data for the groups that are missing/unknown should be reported as blank. If the DDG prohibits reporting of a stratification group, select write in "masked."suppressed". 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)	
<b>Race and/or Ethnicity</b>  Standard Used: OMB 2024 Standard and HCAI evaluation. Link: <a href="#">OMB Standards for Race and/or Ethnicity</a>	American Indian or Alaska Native
	Asian
	Black or African American
	Hispanic or Latine
	Middle Eastern or North African
	Multiracial and/or Multiethnic (two or more races)
	Native Hawaiian or Pacific Islander
White	
<b>Age (excluding maternal measures)</b>  Age refers to age at discharge. Use these age groups to the extent data is available and consistent with the DDG. 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
<b>Age (for maternal measures only)</b>  Age refers to age at discharge. Use these age groups to the extent data is available and consistent with the DDG. 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
<b>Sex Assigned at Birth</b>	Female
	Male

Standard Used: The Office of the National Coordinator (ONC) Interoperability Standards Advisory (ISA), HL7 Version 3. Link: <a href="#">USCDI Sex Assigned at Birth</a>	Unknown
<b>Expected Payer</b>  The Expected Payer 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
<b>Preferred Language</b>  Standard Used: Based on HCAI Evaluation	English Language
	Asian/ Pacific Islander Languages
	Middle Eastern Languages
	Spanish Language
	American Sign Language
	Other/Unknown
<b>Disability Status</b>  Standard Used: Federal standards from ONC ISA, HL7 Version 1.1.0 and the CDC PLACES disability measure. Link: <a href="#">HL7 Disability Status</a> Additional Resources: <a href="#">CDC PLACES Disability Measure</a>	Does not have disability
	Mobility disability
	Cognition disability
	Hearing disability
	Vision disability
	Self-Care disability
	Independent Living disability
<b>Sexual Orientation</b>  Standard Used: Federal standards from ONC ISA, SNOMED CT, HL7 Version 3 Link: <a href="#">USCDI Sexual Orientation</a>	Lesbian, gay or homosexual
	Straight or heterosexual
	Bisexual
	Something else
	Don't know
	Choose not to disclose
<b>Gender Identity</b>	Female
	Female-to-Male (FTM)/Transgender Male/Trans Man

Standard Used: Federal standards from ONC ISA, SNOMED CT, HL7 version 3. Link: <a href="#">USCDI Gender Identity</a>	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
<b>Behavioral Health Diagnosis</b>	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)	
<b>Race/Ethnicity</b>  Standard Used: OMB 2024 Standard and HCAI evaluation. Link: <a href="#">OMB Standards for Race and/or Ethnicity</a>	American Indian or Alaska Native
	Asian
	Black or African American
	Hispanic or Latino
	Middle Eastern or North African
	Multiracial and/or Multiethnic (two or more races)
	Native Hawaiian or Pacific Islander
<b>Age</b>  Age refers to age at discharge. Use these age groups to the extent data is available and consistent with the DDG. 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: <a href="#">2022 Population File for Use with 2023 AHRQ Quality Indicators</a>	White
	0–4 years
	5–9 years
	10–14 years
<b>Sex Assigned at Birth</b>  Standard Used: The Office of the National Coordinator (ONC) Interoperability Standards Advisory (ISA), HL7 Version 3. Link: <a href="#">USCDI Sex Assigned at Birth</a>	15 years and older
	Female
	Male
<b>Expected Payor</b>  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	Unknown
	Medicare
	Medicaid
	Private
	Self-Pay
<b>Preferred Language</b>  Standard Used: Based on HCAI Evaluation	Other
	English Language
	Asian/ Pacific Islander Languages
	Middle Eastern Languages
	Spanish Language
	American Sign Language
Other/Unknown	

<b>Disability Status</b>  Standard Used: Federal standards from ONC ISA, HL7 Version 1.1.0 and the CDC PLACES disability measure. Link: <a href="#">HL7 Disability Status</a> Additional Resources: <a href="#">CDC PLACES Disability Measure</a>	Does not have disability
	Mobility disability
	Cognition disability
	Hearing disability
	Vision disability
	Self-Care disability
	Independent Living disability
<b>Sexual Orientation</b>  Standard Used: Federal standards from ONC ISA, SNOMED CT, HL7 Version 3 Link: <a href="#">USCDI Sexual Orientation</a>	Lesbian, gay or homosexual
	Straight or heterosexual
	Bisexual
	Something else
	Don't know
	Choose not to disclose
<b>Gender Identity</b>  Standard Used: Federal standards from ONC ISA, SNOMED CT, HL7 Version 3 Link: <a href="#">USCDI Gender Identity</a>	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
<b>Behavioral Health Diagnosis</b>	Mental Health Disorder
	Co-Occurring Disorder
	Substance Use Disorders
	No Behavioral Health Diagnosis

## Stratification Table

<p><b><u>Race and/or Ethnicity</u></b></p> <p>Standard Used: OMB 2024 Standard and HCAI evaluation. Link: <a href="#">OMB Standards for Race and/or Ethnicity</a></p>	<p><u>American Indian or Alaska Native</u></p> <p><u>Asian</u></p> <p><u>Black or African American</u></p> <p><u>Hispanic or Latino</u></p> <p><u>Middle Eastern or North African</u></p> <p><u>Multiracial and/or Multiethnic (two or more races)</u></p> <p><u>Native Hawaiian or Pacific Islander</u></p> <p><u>White</u></p>
<p><b><u>Age (non-maternal measures):</u></b></p> <p><b><u>Core Quality Measures for General Acute Care Hospitals (1, 2, 8, and 9) and Acute Psychiatric Hospitals (1, 2, 6, and 7)</u></b></p> <p><u>Age refers to age at discharge. Use these age groups to the extent data is available and consistent with the DDG. Categories may be rolled up to meet this requirement.</u></p> <p>Standard Used: Based on HCAI Evaluation</p>	<p><u>Less than 18 years</u></p> <p><u>18 to 34 years</u></p> <p><u>35 to 49 years</u></p> <p><u>50 to 64 years</u></p> <p><u>65 years or older</u></p>
<p><b><u>Age (non-maternal measures):</u></b></p> <p><b><u>Core Quality Measures for General Acute Care Hospitals (3 and 4) and Acute Psychiatric Hospitals (3, 4, and 5)</u></b></p> <p><u>Age refers to age at discharge. Use these age groups to the extent data is available and consistent with the DDG. Categories may be rolled up to meet this requirement.</u></p> <p>Standard Used: Based on HCAI Evaluation</p>	<p><u>18 to 34 years</u></p> <p><u>35 to 49 years</u></p> <p><u>50 to 64 years</u></p> <p><u>65 years or older</u></p>
<p><b><u>Age (non-maternal measures):</u></b></p> <p><b><u>Core Quality Measures for Children’s Hospitals (1, 2)</u></b></p> <p><u>Age refers to age at discharge. Use these age groups to the extent data is available</u></p>	<p><u>0 to 4 years</u></p> <p><u>5 to 9 years</u></p> <p><u>10 to 14 years</u></p> <p><u>15 years or older</u></p>

<p><u>and consistent with the DDG. Categories may be rolled up to meet this requirement.</u></p> <p>Standard Used: Age groups from the 2022 Population File for Use with 2023 AHRQ Quality Indicators, as well as HCAI evaluation.  Link: <a href="#">2022 Population File for Use with 2023 AHRQ Quality Indicators</a></p>	
<p><b><u>Age (maternal measures):</u></b></p> <p><b><u>Core Quality Measures for General Acute Care (5, 6, 7)</u></b></p> <p><u>Age refers to age at discharge. Use these age groups to the extent data is available and consistent with the DDG. Categories may be rolled up to meet this requirement.</u></p> <p>Standard Used: Based on HCAI Evaluation</p>	<p><u>Less than 18 years</u></p> <p><u>18 to 29 years</u></p> <p><u>30 to 39 years</u></p> <p><u>40 years or older</u></p>
<p><b><u>Sex Assigned at Birth</u></b></p> <p>Standard Used: The Office of the National Coordinator (ONC) Interoperability Standards Advisory (ISA), HL7 Version 3.  Link: <a href="#">USCDI Sex Assigned at Birth</a></p>	<p><u>Female</u></p> <p><u>Male</u></p> <p><u>Unknown</u></p>
<p><b><u>Expected Payor</u></b></p> <p><u>The Expected Payor is the payer that is expected to pay the greatest share of the patient's bill.</u></p> <p>Standard Used: Based on HCAI Evaluation</p>	<p><u>Medicare</u></p> <p><u>Medicaid</u></p> <p><u>Private</u></p> <p><u>Self-Pay</u></p> <p><u>Other</u></p>
<p><b><u>Preferred Language</u></b></p> <p>Standard Used: Based on HCAI Evaluation</p>	<p><u>English Language</u></p> <p><u>Asian/ Pacific Islander Languages</u></p> <p><u>Middle Eastern Languages</u></p> <p><u>Spanish Language</u></p> <p><u>American Sign Language</u></p> <p><u>Other/Unknown</u></p>
<p><b><u>Disability Status</u></b></p>	<p><u>Does not have disability</u></p> <p><u>Mobility disability</u></p>

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

## Preferred Language Table

Preferred language groupings are taken from the HCAI Preferred Languages Spoken in California Facilities visualization and dataset ( <a href="#">link</a> )	
<b>Preferred Language</b>	<b>Languages Included</b>
<b>English Language</b>	English
<b>Asian/ Pacific Islander Languages</b>	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
<b>Middle Eastern Languages</b>	Amharic, Arabic, Armenian, Egyptian Ancient, Elamite, Hebrew, Persian, Farsi, Pashto, Tigrinya, Turkish
<b>Spanish Language</b>	Spanish
<b>Other/Unknown</b>	Any language that is not listed in any of the groups above
<b>American Sign Language (ASL)</b>	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
<b>Mental health disorders</b>	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, X72XXS, X730XXS, X731XXS, X732XXS, X738XXS, X739XXS, X7401XS, X7402XS, X7409XS, X748XXS, X749XXS, X75XXS, X76XXS, X770XXS, X771XXS, X772XXS, X773XXS, X778XXS, X779XXS, X780XXS, X781XXS, X782XXS, X788XXS, X789XXS, X79XXS, X80XXS, X810XXS, X811XXS, X818XXS, X828XXS, X830XXS, X831XXS, X832XXS, X838XXS
<b>Substance use disorders</b>	MBD017, MBD019, MBD030, MBD018, MBD028, MBD020, 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, T404X3S, T404X4S, T404X5S, T405X1S, T405X3S, T405X4S, T405X5S, T40601S, T40603S, T40604S, T40605S, T40691S,

<b>Behavioral Health Group</b>	<b>Clinical Classifications Software Refined (CCSR) Categories</b>	<b>ICD-10 Codes</b>
		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
<b>Co-occurring disorders</b>	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