Monrovia Memorial Hospital

MMH Health Equity Report 2026

Our analysis of quality and patient experience data for calendar year 2025 included stratification by key demographic characteristics, including age, sex, race, ethnicity, preferred language, disability status, sexual orientation, gender identity, and payer source. No significant disparities were identified across the core quality measures reviewed. These results reflect our ongoing commitment to providing individualized, patient-centered care and maintaining robust quality monitoring and performance improvement processes. While no disparities were identified during the reporting period, we remain committed to advancing health equity through continuous monitoring of demographic and outcome data, adherence to applicable state and federal requirements, and implementation of targeted interventions should emerge trends or disparities be identified.

Person-centered care

Person-centered care serves as the foundation of our clinical and operational approach, ensuring that each patient's individual needs, preferences, values, and goals are respected and incorporated into care planning and delivery.

Initiatives:
Upon admission, we collect information regarding each patient's preferred language, cultural considerations, communication needs, and other relevant social and demographic factors. This information is documented in the electronic health record and communicated to the interdisciplinary care team to support individualized, culturally responsive care throughout the patient's stay.

Monitoring and Outcomes:
We routinely monitor patient experience and satisfaction measures, including patients' likelihood to recommend our hospital, and analyze these outcomes across demographic groups. During the current reporting period, no significant disparities were identified, reflecting a consistently positive patient experience and equitable delivery of care across the populations served.

Future Focus:
We remain committed to strengthening person-centered care through ongoing enhancement of patient communication practices, patient engagement strategies, and staff education. Continued training in cultural humility, diversity, equity and inclusion principles, and unconscious bias awareness will support our efforts to provide equitable, respectful, and high-quality care for all patients. Additionally, we will continue to monitor

patient experience data and implement targeted improvements as needed to address emerging needs or potential disparities.

Patient safety

Patient safety is a fundamental priority and integral to our commitment to providing equitable, high-quality care for all patients. We maintain comprehensive safety processes designed to prevent harm, promote positive outcomes, and ensure that all patients receive safe and effective care regardless of age, race, ethnicity, language, disability status, gender identity, sexual orientation, or payer source.

Initiatives:
We actively monitor, track, and report healthcare-associated infections (HAIs) and other patient safety indicators in accordance with California Department of Public Health (CDPH) and National Healthcare Safety Network (NHSN) requirements. In addition, we maintain policies that promote a safe, respectful, and non-discriminatory environment for patients, visitors, and staff. Ongoing staff education, performance improvement activities, and interdisciplinary collaboration support our efforts to reduce patient harm and enhance patient safety.

Monitoring and Outcomes:
Patient safety data, including infection rates, patient falls, and other quality and safety indicators, are regularly reviewed through our quality and patient safety committees. Data are analyzed and stratified by relevant demographic characteristics to identify potential disparities in outcomes. During the current reporting period, no significant disparities were identified, demonstrating consistent safety performance and equitable care delivery across patient populations.

Future Focus:
We will continue to implement evidence-based patient safety practices, strengthen surveillance and reporting processes, and monitor outcomes to identify opportunities for improvement. Ongoing evaluation of safety metrics and demographic trends will support early identification of emerging risks and potential disparities. We remain committed to fostering a culture of safety and ensuring that all patients, particularly vulnerable populations, receive safe, equitable, and high-quality care.

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Addressing patient social drivers of health

We recognize that social drivers of health (SDOH) play a critical role in influencing health outcomes, access to care, and overall well-being. As part of our commitment to advancing health equity, we proactively identify and address health-related social needs (HRSNs) that may affect a patient's ability to achieve optimal health outcomes.

Initiatives:
We screen eligible patients for the five core health-related social needs identified by the Centers for Medicare & Medicaid Services (CMS): food insecurity, housing instability, transportation barriers, utility assistance needs, and interpersonal safety concerns. Patients who screen positive are assessed by appropriate members of the care team and connected with available internal resources, community-based services, and support programs to help address identified needs.

Monitoring and Outcomes:
We monitor screening completion rates, positive screening rates across each HRSN domain, and the timeliness and effectiveness of interventions provided. These data are routinely reviewed and analyzed by demographic characteristics to identify potential disparities in screening, referral, or intervention processes. During the current reporting period, no significant disparities were identified, reflecting equitable implementation of our screening and intervention practices across patient populations.

Future Focus:
We will continue to strengthen our efforts to identify and address social drivers of health through ongoing staff education, process improvement, and collaboration with community partners. Our clinical social worker and interdisciplinary care team will take a proactive approach to the early identification of health-related social needs, facilitating timely assessment, resource coordination, and intervention. We will continue to evaluate program effectiveness and enhance referral processes to ensure patients receive appropriate support and services to address barriers that may impact their health outcomes.

Effective treatment

Delivering effective, high-quality care is central to our mission and commitment to health equity. We strive to provide evidence-based treatment plans tailored to the complex medical needs of our Long-Term Acute Care Hospital (LTACH) patient population while ensuring that all patients have equitable access to appropriate clinical interventions and services.

Initiatives:
Our clinical pathways, treatment protocols, and interdisciplinary care planning processes are standardized, regularly reviewed, and aligned with current evidence-based practices. These processes are designed to support consistent, high-quality care while addressing the unique clinical, cultural, and communication needs of diverse patient populations. Interdisciplinary collaboration among physicians, nursing staff, rehabilitation services, respiratory therapy, case management, and social services helps ensure individualized treatment planning and optimal patient outcomes.

Monitoring and Outcomes:
We routinely monitor key clinical outcome measures, including ventilator weaning success, functional improvement, infection prevention outcomes, readmission rates, and discharge to a lower level of care. Outcome data are analyzed and stratified by demographic and social factors to evaluate treatment effectiveness and identify potential disparities. During the current reporting period, no significant disparities were identified, indicating consistent treatment outcomes and equitable care delivery across the populations we serve.

Future Focus:
We will continue to leverage data-driven performance improvement initiatives to evaluate treatment effectiveness, optimize clinical outcomes, and promote health equity. Ongoing review of clinical outcomes and demographic trends will support the early identification of potential disparities and opportunities for improvement. We remain committed to implementing evidence-based practices, enhancing interdisciplinary collaboration, and ensuring all patients receive effective, equitable, and patient-centered care.

Care coordination

Effective care coordination is essential in the Long-Term Acute Care Hospital (LTACH) setting, particularly during transitions between levels of care. Our goal is to ensure seamless, patient-centered transitions that promote continuity of care, reduce barriers to treatment, and support optimal outcomes for all patients.

Initiatives:
Our interdisciplinary care team coordinates each patient's care throughout the continuum of their hospitalization, beginning at admission and continuing through discharge to home, a skilled nursing facility, an acute rehabilitation setting, or another appropriate level of care. Care coordination activities include comprehensive discharge planning, medication reconciliation, patient and family education, and timely communication with post-acute

providers and community resources. Language preferences, health literacy needs, cultural considerations, and individualized patient goals are incorporated into the discharge planning process to support equitable and effective transitions of care.

Monitoring and Outcomes:
We routinely monitor care coordination and transition-related metrics, including hospital readmission rates, discharge outcomes, patient experience feedback, and the effectiveness of discharge planning processes. These measures are analyzed across demographic and social factors to identify potential disparities in care transitions and access to post-discharge resources. During the current reporting period, no significant disparities were identified, indicating consistent care coordination practices and successful transitions across the patient populations we serve.

Future Focus:
We will continue to strengthen our care transition and discharge planning processes through interdisciplinary collaboration, patient and family engagement, and ongoing evaluation of care coordination outcomes. Efforts will focus on ensuring patients and their support systems are well prepared for transitions in care, have access to necessary resources and services, and receive appropriate follow-up support. We remain committed to promoting equitable, safe, and seamless transitions of care for all patients.

Access to care

Ensuring equitable access to care is a core component of our commitment to health equity and high-quality patient care. As a Long-Term Acute Care Hospital (LTACH), we strive to provide timely access to specialized services for all eligible patients while promoting fair and consistent admission practices that are free from discrimination or bias.

Initiatives:
Our admission criteria are applied consistently and objectively to all patients referred for LTACH services. We collaborate closely with referring providers, acute care hospitals, patients, and families to facilitate appropriate placement and timely access to care. Information regarding our services, patient rights, and admission processes is made available in multiple languages and through interpreter services as needed to support effective communication and informed decision-making.

Monitoring and Outcomes:
We routinely monitor referral, evaluation, admission, and payer data to assess access to care and identify potential barriers that may affect patient populations. Data are analyzed across demographic factors, including race, ethnicity, preferred language, disability status, and payer source, to evaluate equitable access to services. During the current reporting

period, no significant disparities were identified, indicating equitable access to LTACH services among the populations we serve.

Future Focus:
We will continue to monitor access-to-care metrics and evaluate referral and admission patterns to ensure equitable access to our specialized services. Ongoing collaboration with referral partners, community organizations, and healthcare providers will support timely identification of eligible patients and promote awareness of available LTACH resources. We remain committed to reducing barriers to care, enhancing communication and outreach efforts, and ensuring that all eligible patients have the opportunity to access the specialized care and services they need.

We will continue to educate staff, medical staff, board members, and other care providers on the principles of health equity, diversity, cultural competence, and inclusive care practices. Health equity and diversity topics will be incorporated into annual education and competency programs to promote awareness, reduce barriers to care, and support equitable health outcomes for all patients.