BOARD OF TRUSTEES MEETING

WEDNESDAY, MAY 14, 2025
5:00pm to 9:00pm

Conference Center at Highland Care Pavilion
1411 East 31st Street Oakland, CA 94602
Ronna Jojola Gonsalves, Clerk of the Board
(510) 535-7515

LOCATION:

Open Session, In Person: HCP Conference Center, see above address

ZOOM Meeting Link:[1]

https://alamedahealthsystem.zoom.us/j/9361457125?pwd=4JnAmhDnBaLqY4GWf4PQBwp3w0Puy2.1&omn=88652793776
Meeting ID: 936 145 7125
Meeting Password: 20200513

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MEMBERS

Alan E. Fox	Greg Garrett
Lilavati Indulkar, MD	Donna Linton
Nicholas Moss, MD	Nely Obligacion
David Sayen	Sblend A. Sblendorio

[1] Log into the meeting at www.zoom.com. You will be directed to download the meeting app (free) if you have not used ZOOM previously. ZOOM meetings may be accessed on computers and portable devices.

BOARD OF TRUSTEES REGULAR MEETING AGENDA

SPECIAL NOTE: Per Brown Act requirements, Trustees of the Alameda Health System will attend board and committee meetings in person at the location(s) noticed on this agenda. Staff and members of the public may attend either in person at the location noticed on this agenda, or remotely via Zoom, using the link included on this agenda.

Public Comment Instructions
If you attend the meeting in person and wish to address the Board or Committee regarding an item on the agenda or in their purview, please see the Clerk of the Board to sign up.

If you attend the meeting remotely and wish to address the Board of Trustees or Committee regarding an item on the agenda or in their purview, send an email to cob@alamedahealthsystem.org prior to the start of the meeting, or via Zoom chat during the meeting. Your comment will be heard at the appropriate time.

Each speaker, whether in person or remote, will be allotted between one and three minutes to speak, depending on the number of speakers present.

OPEN SESSION / ROLL CALL

PUBLIC COMMENT

A. CEO REPORT
James E.T. Jackson, Chief Executive Officer

B. MEDICAL STAFF REPORTS

AHS Medical:	Berenice Perez, MD, Chief of Medical Staff
AH Medical:	Catherine Pyun, DO, Chief of Medical Staff

C. COMMITTEE AND TRUSTEE REPORTS

C1. Human Resources Committee: April 16, 2025
David Sayen, Committee Chair

C2. Quality Professional Services Committee: April 23, 2025

C3. Finance Committee (no quorum): May 7, 2025
Alan Fox, Committee Chair

D. CONSENT AGENDA: ACTION

D1. Approval of the Minutes from the April 9, 2025 Board of Trustees Meetings

D2. Approval of the System Wide Policies and Standardized Procedures listed below:

- HR SECTION 2.00 - POLICY 2.20 HOLIDAYS
- HR SECTION 1.00 - POLICY 1.81 EMPLOYEE PREFERRED NAME

- HR SECTION 3.00 POLICY 3.25 Compliance Non-Retaliation and Non-Retribution

D3. Recommendation from the Quality Professional Services Committee to approve the policies listed below:

- Surgical and Procedural Area Attire Policy
- Patient Complaints and Grievances Policy
- Healthcare Industry Representative Relations Policy and Procedure
- Teaching Physician Billing Policy
- Medications: Hazardous Drugs Preparation and Handling in Pharmacy
- Use of Echocardiography Contrast Imaging Agents
- Patients own Medications Storage, Security, Handling and Administration
- Medication Therapeutic Interchange Policy
- Pharmaceutical Company Representative Policy
- System Medication Samples Policy
- Medications: Inpatient Medication Dispensing Policy
- Critical Value Policy – Nursing
- Standards of Nursing Practice

D4. Recommendation from the Quality Professional Services Committee to approve the AHS Medical Staff Policies and Procedures listed below:

AHS and AH Medical Staff:

- Medical Staff Access to Medical Staff Records
- Medical Staff Credentialing and Privileging of Providers
- Medical Staff Ongoing Monitoring and Evaluation of actions Related to Providers

END OF CONSENT AGENDA

E. ACTION / DICUSSION: Contracts

E1. Amendment with Virtual Radiologic Professionals of California, P.A. to renew terms of our remote imaging services agreement. The term of this amendment is July 1, 2025 through July 1, 2026 auto-renewing each year after unless prior written notice is provided no less than 120 days prior to the end of the initial term. The estimated impact of this amendment is $3,197,097.
Elizabeth Mahler, Chief Medical Officer

E2. Amendment with East Bay Foundation for Graduate Medical Education to renew our surgical residency program. The term of this amendment is July 1, 2025 through June 30, 2026. The estimated impact of this amendment is $4,325,956.
Elizbeth Mahler, Chief Medical Officer

E3. New agreement with Strata Decision Technology, LLC for provision of financial and budgeting software services. The term of this agreement is June 1, 2025 through May 31, 2030. The estimated impact of this agreement is $2,491,181.
Kimberly Miranda, Chief Financial Officer

F. ACTION/DISCUSSION (60 min)

F1. DISCUSSION/ACTION: Bylaws Update
Ahmad Azizi, General Counsel

F2. DISCUSSION: Highland Labor and Delivery Update
LanNa Lee, MD, Chair Obstetrics, Midwifery, and Gynecology

G. DISCUSSION: Board Calendar and Tracking

H. STAFF REPORTS (Written)

H1. Chief Financial Officer Report, February Financial Report
Kimberly Miranda, Chief Financial Officer

H2. Public Affairs and Community Engagement Report
Alice Kinner, Administrative Director

CLOSED SESSION

1. **CONFERENCE WITH LEGAL COUNSEL - EXISTING LITIGATION**
   (Paragraph (1) of subdivision (d) of Gov. Code § 54956.9)
   Case name unspecified: Disclosure would jeopardize settlement negotiations
   Ahmad Azizi, General Counsel

2. **Conference with Labor Negotiators**
   [Government Code Section 54957.6]
   AHS Designated Representatives: Ulysses Madison, Director of People Operations
   Employee Organization: CNA/ILWU Local 6/SEIU 1021/ACMEA

3. **Regulatory Affairs, Risk Management, Patient Safety**
   [Health and Safety Code 101850(ai)(1)]

(Reconvene to Open Session)

General Counsel Report on Action Taken in Closed Session

TRUSTEE COMMENTS

ADJOURNMENT

Our Mission
Caring, Healing, Teaching, Serving All

Strategic Vision

AHS will be recognized as a world-class patient and family centered system of care that promotes wellness, eliminates disparities and optimizes the health of our diverse communities.

Values

Compassion, Commitment, Teamwork, Excellence, Integrity, and Respect.

Meeting Procedures

All items appearing on the agenda are subject to action by the Board of Trustees. Staff recommendations are subject to action and change by the Board of Trustees.

The Board of Trustees is the Policy Body of the Alameda Health System. The Board has several standing Committees where Board matters are the subject of discussion at which members of the public are urged to testify. Board procedures do not permit: 1) persons in the audience at a Committee meeting to vocally express support or opposition to statements by Board Members or by other persons testifying; 2) ringing and use of cell phones, pagers, and similar sound-producing electronic devices; 3) signs to be brought into the meeting or displayed in the room; 4) standing in the meeting room. Citizens are encouraged to testify at Committee meetings and to write letters to the Clerk of the Board or to its members, 1411 East 31st Street Oakland, CA 94602.

Members of the public are advised that all Board and Committee proceedings are recorded (audio), including comments and statements by the public in the course of the meetings. Copies of the audio recordings will be made available to the public. Copies of the agendas and supporting documents can be found here: http://www.alamedahealthsystem.org/meeting-agendas-and-minutes/**. By attending and participating in Board/Committee meetings, members of the public consent to audio recording of any statements they may make during the proceedings.**

Disability Access

To request accommodation or assistance to participate in the meeting please contact the Clerk of the Board. Requests made at least 48 hours in advance of the meeting will help to ensure availability.

In order to accommodate persons with severe allergies, environmental illness, multiple chemical sensitivity or related disabilities, attendees at public meetings are reminded that other attendees may be sensitive to perfumes and various other chemical-based scented products. Please help us to accommodate these individuals.

The AHS Board of Trustees is committed to protecting the private health information (PHI) of our patients. We ask that speakers refrain from disclosing or discussing the PHI of others. Please also know that, should you decide to disclose your PHI, the Trustees will still likely refer your matter, to the extent it involves PHI, to the executive staff for a confidential review of the facts and for confidential handling. If you would like more information regarding the confidentiality of PHI as it relates to the Health Insurance Privacy and Accountability Act, please refer to 45CFR Section 164.101, et.seq.

B. MEDICAL STAFF REPORTS

ALAMEDA HEALTH SYSTEM

Alameda Hospital Medical Executive Committee (MEC)
and
Alameda Health System Medical Executive Committee (MEC)
Report to the Alameda Health System Board of Trustees

SUBJECT: **Agenda Item:** B

Meeting Date: May 14, 2025

Item Description: AHS and AH MEC Combined Report

FROM: Berenice Perez, M.D., Alameda Health System Chief of Staff
Catherine Pyun, D.O., Alameda Hospital Chief of Staff

The report below is being submitted from the Alameda Health System (AHS) and Alameda Hospital (AH) Medical Executive Committee(s) to the AHS Board of Trustees.

1. **The combined Medical Executive Committee (MEC) was presented an overview of California Assembly Bill 40 (AB40) by Rebeca Rozen, Regional Vice President of the Hospital Council and Dr. Andrea Wu, MD.** AB40 requires 90% Ambulance Patient Offload Times (APOT) within 30 minutes of arriving at the Emergency Department (ED). Hospitals that consistently fail to achieve target off-load times may face suspension of their specialty designation for myocardial infarction, strokes and cardiac arrest care. HGH ED and SL ED meet the target APOT about 70% of the time, while AH ED consistently meets the target. Meeting the APOT time is impacted by ED boarding and hospital throughput.

2. **Resources and Engagement After Care in the Hospital (REACH) Project**
   Dr. Evan Rusoja, MD PhD initiated this program to help patients with transitional care post hospital discharge. Pilot 2.0 will assess multiple outreach models a) provider outreach with escalation to nurse or CHW, b} nurse outreach with escalation to provider, c) CHW outreach with escalation to provider. Pilot 2.0 is supported by the AHS ED, AHS Complex Care Team and the Bridge Clinic FQHC platform.

3. **AHS Medical Staff Quality & Safety Committee**
   - **Quality Objectives and Key Results Dashboards (Feb 2025)** — ED Boarding time for admitted patients slightly increased to 16.56 hours at HGH;3.2 hours at SLH, below the goal of 3.5 hours.
   - **Patient experience**—Likelihood to recommend: HGH 57th percentile, SLH 64th percentile. Highland ED likely to recommend: 56th percentile, San Leandro ED: 59th percentile. Factors impacting scores: patient being discharged from the waiting room, and feelings of not seeing a provider.

- **Stroke Program Certification Survey**—Increase in number of stroke patients transported by EMS to HGH ED. In February, 55% of stroke patients boarded in the ED more than 24 hours; average time spent in the ED 23:25 hours which is longer than expected.

4. **Reports from Medical Staff and Hospital Committees**—The following committees reported on their metrics goals and performance. Their reports were approved by the Medical Executive Committee and included in the report to QPSC.
   - Critical Care Committee
   - Transfusion Committee
   - Infection Prevention and Control Committee
   - SLH Patient Care Services
   - Environmental Services
   - Rehabilitation Services (PT/OT/SLP)
   - Patient Safety Committee
   - Health Information Management
   - Utilization Management Committee

5. **AHS Clinical Practice Committee** — Several policies and physician order sets were reviewed approved by the Medical Executive Committee and were included in the QPSC consent agenda for board approval.

6. **AH Department of Medicine Report**
   Dr. William Lowery, MD provided the annual report highlighting the Department's Quality and Patient Safety focus.
   Patient Experience
   - Monthly Patient Centeredness Report
   - Provider-specific HCAHPS measures and opportunities to enhance the overall care experience.
   - HCAHPS Survey Mode returned to phone-based surveying. The CMS digital mixed mode (email & mail) was causing reporting issues and data delays for Alameda Health.
   - Survey Awareness Efforts including survey awareness posters in high-visibility areas.

   Quality and Patient Safety
   - Stroke Program
   - Leapfrog Rating "A"
   - Medical Record Completion
   - Ongoing Survey Readiness

7. **AH care experience results, facility update, hospital performance and services were provided.**
    - The ORKs for patient experience were shared including those above goal and below goal.
    - Urgent/emergent procedures are performed at AH.

8. **AH Leapfrog Ratings for the Fall of 2023 and Fall of 2024 were presented including the contributors to the improvement grade.** The grades are comprised of two groups (process and outcome measures). The projection grade for the Fall of 2025 is a decline to a "B" score due to a decline in patient experience and the outcome measures HAIs due to a denominator that is too small to be used. Most of the outcomes are not surgical related so there is no impact from the reduction in elective surgeries at AH.

D1. Approval of the Minutes from the April 9, 2025 Board of Trustees Meetings

BOARD OF TRUSTEES MEETING

WEDNESDAY, APRIL 9, 2025
5:00pm to 9:00pm

Conference Center at Highland Care Pavilion
1411 East 31st Street Oakland, CA 94602
Ronna Jojola Gonsalves, Clerk of the Board
(510) 535-7515

LOCATION:
Open Session, In Person: HCP Conference Center, see above address

MEMBERS

Alan E. Fox	Greg Garrett
Donna Linton	Nicholas Moss, MD
Nely Obligacion	David Sayen
Sblend A. Sblendorio	

THE MEETING WAS CALLED TO ORDER AT 5:02 pm

ROLL CALL WAS TAKEN AND THE FOLLOWING TRUSTEES WERE PRESENT: Alan Fox, Greg Garrett, Donna Linton, Nicholas Moss, MD, Nely Obligacion, and David Sayen

ABSENT: Sblend Sblendorio, excused

PUBLIC COMMENT:

A. CEO REPORT
James E.T. Jackson, Chief Executive Officer

Trustee Garrett said the surveying of providers felt like a disconnect given that the providers said they felt they were not being updated on the progress of and status of improvement efforts. They were saying that they were not informed. Dr. Mahler said currently, improvements were made on an individual department by department basis. They were trying to connect the work the organization was doing on quality and safety, which was the heart of the SCORE survey, to improve the culture.

Trustee Sayen asked if they were going to study why the response rate to the SCORE survey was so high this year. Mr. Jackson said it might be good to have Darshan come to talk about this. They had a process where they shared the results of the survey with staff and then talked with them about how they could start to fix the issues that staff identified. He thought that process could be how they have sustained and grown engagement.

Trustee Obligacion said the physician response rate was under 50%. She asked if it was just because the physicians were busy and focused on what the priorities were. Mr. Jackson said that was a big part of it. He never wanted to take them from that work. Given the work Dr. Perez and Dr. Mahler were doing he was excited about the trajectory of how they were interfacing with the Medical Staff. Dr. Perez said physicians have told her they would like the survey tied to what happens afterwards. They fill out the survey but then they don't know what happens after, so why fill it out.

B. MEDICAL STAFF REPORTS

AHS Medical: Berenice Perez, MD, Chief of Medical Staff
AH Medical: Catherine Pyun, DO, Chief of Medical Staff

Trustee Linton asked about the low occupancy rate of licensed inpatient beds at Alameda and San Leandro. If the average was 60% there appeared to be capacity to absorb the 6-7 patients a day who were boarding. She asked if the Doc of the Day and other strategies mentioned earlier, would better match capacity with availability. Dr. Perez said the Doc of the Day program would help identify potential transfer candidates earlier. What they needed was staffed beds and District planning to create safe places for the patients to land. Dr. Mahler said it wasn't so much about figuring out how to staff reliably to a higher volume but rather how to predictably deliver that volume. They were working with everyone in operations, nursing, bed management, etc.

C. COMMITTEE AND TRUSTEE REPORTS

C1. Audit and Compliance Committee: March 19, 2025
Sblend Sblendorio, Committee Chair

C2. Quality Professional Services Committee: March 26, 2025
Greg Garrett, Trustee

C3. Finance Committee: April 2, 2025
Alan Fox, Committee Chair

Trustee Garrett asked about the negotiations with the County regarding John George reimbursements. Ms. Miranda said that once the County had a good understanding of what they were going to get paid, they would be able to adjust what AHS could get paid. She had not pushed too hard as AHS was getting paid, the County was just withholding a piece of the contract. Trustee Garrett asked if she believed the County's understanding of their reimbursement situation would be finalized by the end of this fiscal year. Ms. Miranda said they had to. They could not take a hit down to $40M.

Trustee Linton asked if they were anticipating getting the contract amendment to increase up to the $72M projected. Ms. Miranda said they hoped to. Her understanding was they were working on it and that this will happen.

Trustee Sayen said the presentations from Pharmacy and Laboratory were really good and showcased the remarkable teams. Mr. Jackson noted that one of the items discussed was the urine analyzer being at the end of life. Within 24-hours the Foundation President, Preston Walton, committed to acquiring that unit for them.

D. CONSENT AGENDA: ACTION

Trustee Sayen asked if there was any public comment on the consent agenda. Ms. Jojola Gonsalves said there was not.

Ms. Jojola Gonsalves said staff was pulling the HR Compliance Enforcement and Discipline policy below, and there were three small administrative changes to the minutes to correct typos.

D1. Approval of the Minutes from the March 12, 2025 Board of Trustees Meetings

D2. Approval of the System Wide Policies and Standardized Procedures listed below

- HR SECTION 5.00 - POLICY 5.12 Employee Safety and Security
- HR_ SECTION 1.00 - POLICY 1.80 EMPLOYEE DATA CHANGES
- HR SECTION 3.00 - POLICY 3.12 SEXUAL HARASSMENT
- HR SECTION 3.00 - POLICY 3.17 OUTSIDE EMPLOYMENT
- HR_ SECTION 3.00 - POLICY 3.16 PROTECTION OF TRADE SECRETS_NON-DISCLOSURE OF AHS INFORMATION
- ~~HR SECTION 3.00 POLICY 3.24 Compliance Enforcement and Discipline~~
- Records Retention Policy
- Information Systems Access Policy
- Information Systems Activity Review Policy
- Remote Access Policy
- AHS Facility Access Policy
- AHS Acceptable Use Policy
- AHS Information Security Risk Management Policy

Recommendation from the Quality Professional Services Committee to approve the policies listed below.

- VANCOMYCIN PHARMACY DOSING PROTOCOL
- Quality Assurance and Improvement Plan 2025
- Probate Conservatorship
- Medicare Outpatient Observation Policy
- Temporary Shelter for Discharging Patients Policy
- System Wide Care Management Discharge Planning Policy
- Secondary Review Process Policy
- Care Management for Unidentified Patients

D3. Recommendation from the Quality Professional Services Committee to approve the AHS Medical Staff Policies and Procedures

AHS and AH Medical Staff:

- Medical Staff credentialing and Privileging Providers
- Medical Staff Ongoing Monitoring and Evaluation of Actions Related to Providers
- Medical Staff Ongoing Monitoring of expiring Items
- Telemedicine credentialing by Proxy

AHS Medical Staff:
- Medical Staff Committees

AH Medical Staff:
- Medical Staff Committees

D4. Contracts

D4a. Amendment with Metropolis California, LLC to reflect service adjustments and associated funding increase for provision of parking services. The term of his amendment is October 1, 2024 through December 31, 2025. The estimated impact of this amendment is $2,258,508.59.
Mark Fratzke, Chief Operating Officer

Moved by Trustee Fox, seconded by Trustee Linton to approve the consent agenda.

ACTION: A motion was made and seconded to approve the consent agenda. A roll call was taken, and the motion passed.
AYES: Trustees Fox, Garrett, Linton, Moss, Obligacion, Sayen
NAYS: None
ABSTENTION: None

E. ACTION/DISCUSSION

E1. DISCUSSION: Sexual Assault Awareness Presentation
Concepcion Topete, Supervisor SARRT
Dawn Dougherty, SARRT Coordinator

Trustee Fox asked how they funding this program. Ms. Topete said they were funded through California Emergency Services and AHS supported the program with a 20% match. The total program cost was $1.1M.

Trustee Fox asked if they were at risk of Federal funds. Ms. Topete said they were at risk. In the last five years, funding has been cut from $1.7M to $1.1M. She said they were impacted by 25% of their grants this year. Trustee Fox asked if they would need to cut services. Ms. Topete said they were a small and mighty team doing everything they can, but they were having to slowly cut services a little at a time.

Trustee Linton asked if they were cutting staff or services. Ms. Topete said they have not cut staff or services yet. They did not know what the full impact would be yet. They didn't want to start by cutting services though.

E2. DISCUSSION: Public Affairs and Community Engagement (PACE)
Alice Kinner, Vice President, PACE

Trustee Garrett asked why Ms. Kinner thought it was brave to film documentaries at AHS. Ms. Kinner said they lose control. They can't, in a documentary setting, reject what's being

filmed because of the way the content is framed. The PACE team is always with the film crews. Trustee Garrett asked if they should be more concerned and potentially not approve documentaries. Ms. Kinner said documentaries provide an authentic voice, and right now, that mattered. Influencer marketing worked because people are less interested in overly polished pieces. She felt more protective than ever about AHS due to the potential funding threats and took every opportunity she could to share the work the clinicians were doing.

E3. DISCUSSION: St. Rose Update

Mario Harding, CAO St. Rose
Kimberly Miranda, Chief Financial Officer

Trustee Sayen asked if St. Rose lost a lot of staff with the new leadership. It could be scary for people when the organization they work for undergoes such changes. Mr. Harding said that, with the exception of Labor and Delivery staff losses as a result of shutting the unit down, they haven't lost a great deal of staff.

Trustee Fox, reviewing the slide "FY 25 Approved Budget + SCA's DHLP Cash Flow Projection," asked if it was correct that AHS has not committed to make a line of credit available at the levels listed on the slide? Ms. Miranda said that was correct. They had only committed to the $15M. The IGT funding was expected in May so they should be able to pay the $12M back.

Trustee Fox asked if submitting the CHFFA loan modification application communicated to the State that AHS would provide this additional credit. Ms. Miranda said this was not set in stone. They had to put something with viability together. They needed to increase volume and they needed to get the synergy with AHS, which would take time.

Trustee Fox asked if, as they get questions from the State, they would have an opportunity to say this has not been formally committed. Ms. Roberg said the consulting firm they worked with has other clients that they submitted applications for. The firm instructed AHS that what CHFFA was primarily looking at was the financial ratios. They had thresholds with the values, and St. Rose's ratios were below what they would require. The performance was not good, even if they were making the assumption that AHS would lend St. Rose the money.

Trustee Linton asked if the consultant indicated that they had a good chance of getting the loan forgiveness. Mr. Fratzke confirmed they had. Trustee Linton asked if they had contemplated options if the loan was not forgiven. She had concerns about next fiscal year for the whole health system given the current external environment with the State and Federal Government. There was a lot of potential risk. Then when St. Rose was considered, it caused a great deal of consternation about how much it may be a drag on the entire health system. Mr. Fratzke said Mr. Jackson has requested an internal workgroup to consider and lay out all the different scenarios.

Trustee Linton asked if the budget that they would adopt would include the scenario they are most comfortable with as well as the risks that are posed and how they might be able to adjust. Mr. Fratzke said the budget will be their best prediction for the next fiscal year.

Beyond that they could probably give some scenarios regarding different external impacts that could affect the budget.

Trustee Moss asked if the workgroup would be specific to St. Rose. Mr. Fratzke said it would include St. Rose. They had a lot to work out. A $10M reduction was much different than a $100M reduction. They have to figure it all out the best they can and be prepared.

E4. DISCUSSION: Board Assessment Results Discussion
David Sayen, President

Trustee Sayen said he wanted to see if he could get a couple of Trustees to work with him on both a plan for addressing areas the survey indicated they were coming up short on as well as planning for the retreat.

F. DISCUSSION: Board Calendar and Tracking

Trustee Linton said the goal was for the AHS Board to meet with the County Supervisors three times a year. She asked if they had a mechanism for communicating AHS's budget needs while the County was developing their budget. Mr. Jackson said they did not at this time have a meeting scheduled and they did not previously have a reciprocal conversation regarding their budget. The CFO had regular meetings with her counterpart at the County and that might be the place to bring this up. Trustee Sayen said the AHS bylaws called for three meeting with the Supervisors, but as we don't control their agenda, it could sometimes be a challenge to get that scheduled. Trustee Linton said that if they wanted to make a case for getting more Measure A funds, for example, they would want to sync up with the County's budget process to make that argument. Ms. Miranda said that 75% of the Measure A funds come to AHS, and the County has committed to continue with the $7M for St. Rose. Typically, they haven't received general fund dollars from the County. But she did share how they were doing with the budget.

Trustee Garrett said there was also Measure W funds, which raised sales tax for the homeless. But they learned there was a clause that allowed for other general operating expenses. The County has been accruing these funds for three years because it's been in litigation. They had $500M accrued so far and then annually an additional $150M. He wanted to know if they could get their foot in the door for some of the $500M. Ms. Dong said they had been having conversations around Measure C. Measure W was still in litigation. The Alameda County Taxpayers Association has appealed to the State Supreme Court. There was debate about whether this general tax revenue could be used for other things.

G. STAFF REPORTS (Written)

G1. Chief Financial Officer Report, February Financial Report
Kimberly Miranda, Chief Financial Officer

G2. Public Affairs and Community Engagement Report
Alice Kinner, Administrative Director

Truste Obligacion recused herself from agenda item 1, as an employee of SEIU. She requested they hear agenda item 1 last.

Mr. Azizi said the Board would meet in closed session to discuss the items set forth on the agenda.

CLOSED SESSION

1. **Conference with Labor Negotiators**
   [Government Code Section 54957.6]
   AHS Designated Representatives: Ulysses Madison, Director of People Operations
   Employee Organization: CNA/ILWU Local 6/SEIU 1021/ACMEA

2. **Regulatory Affairs, Risk Management, Patient Safety**
   [Health and Safety Code 101850(ai)(1)]

(Reconvene to Open Session)

General Counsel Report on Action Taken in Closed Session

Mr. Azizi said the Board met in closed session and there was no reportable action.

ADJOURNMENT: pm

This is to certify that the foregoing is a true and correct copy of the minutes of the meeting of April 9, 2025 as approved by the Board of Trustees on May 14, 2025.

_____
Ronna Jojola Gonsalves
Clerk of the Board

APPROVED AS TO FORM:

Reviewed by: _____
Ahmad Azizi
General Counsel

D2 & D3 Approval of the System Wide Policies and Standardized Procedures listed below_

Alameda Health System			CPC Executive Summary to AHS and AH Medical Executive Committee(s) – April 2025			
Policies and Procedures				Chair: Dr. Bullard and Dusty Gilleland, RN		
TOPIC or TITLE OF POLICY	**Document Owners**	**Summary of Changes**	**Last Approved Date**	**Next review date after BOT approval**	**Purpose**	**History of Review Committee**
AHS System Wide Policies & Procedures						
HR SECTION 2.00 - POLICY 2.20 HOLIDAYS	Sara McElfresh Arleen Gomez	• Revised • Updated template • Added Juneteenth Holiday, • updated to gender inclusive language		04/2028		• CPC 4/3/2025 • MEC 4/16/2025
HR SECTION 1.00 - POLICY 1.81 EMPLOYEE PREFERRED NAME	Sara McElfresh Arleen Gomez	• New • This was created so employees can use their preferred name first name, rather than their legal name, which we have set up and are setting up capabilities for use across various systems (IT, Lawson (HR), and ID Badging).		04/2028		• CPC 4/3/2025 • MEC 4/16/2025
HR SECTION 3.00 POLICY 3.25 Compliance Non-Retaliation and Non-Retribution	Sara McElfresh Arleen Gomez	• Revised		04/2028		• CPC 4/3/2025 • MEC 4/16/2025
Surgical and Procedural Area Attire Policy	Dusty Gilleland Jaimie Weber	• Revised •		04/2028		• CPC 4/3/2025 • MEC 4/16/2025
Patient Complaints and Grievances Policy	Darshan Grewal Jan Robertson	• Revised • To comply with new CMS language for the definitions around complaints and grievances • To comply with AHS's contractual agreements with payors. (rather than AAH) • To provide patients with one single phone number to call to file a complaint rather than facility wide numbers; Patient Safety Department will handle all incoming calls regarding complaints and grievances		04/2028		• CPC 4/3/2025 • MEC 4/16/2025

Alameda Health System			CPC Executive Summary to AHS and AH Medical Executive Committee(s) - April 2025			
Policies and Procedures				Chair: Dr. Bullard and Theresa Cooper		
TOPIC or TITLE OF POLICY	**Document Owners**	**Summary of Changes**	**Last Approved Date**	**Next review date after BOT approval**	**Purpose**	**History of Review Committee**
Healthcare Industry Representative Relations Policy and Procedure	Doug Johnson Dusty Gilleland	• Revised • Added language related to appropriate wear in the OR and Cath Lab, and updated the stoplight badging requirements.		04/2028		• CPC 4/3/2025 • MEC 4/16/2025
Teaching Physician Billing Policy	Akemi Renn	• New • This policy is intended to comply with Federal, State and CMS Claims Processing Manual requirements for teaching physician services.		04/2028		• CPC 4/3/2025 • MEC 4/16/2025
Medications: Hazardous Drugs Preparation and Handling in Pharmacy	Priya Patel, PharmD	• Revise policy to align with new USP 800 guidelines. • System P&T approved 3/2025 • Consent Item – PolicyTech		04/2028		• P&T 3/2025 • CPC 4/3/2025 • MEC 4/16/2025
Use of Echocardiography Contrast Imaging Agents	Julie Sheu	• Revision to include registered cardiac sonographers per scope of practice • System P&T approved 3/2025 • Consent Item – Policy/Protocol		04/2028		• P&T 3/2025 • CPC 4/3/2025 • MEC 4/16/2025
Patients own Medications Storage, Security, Handling and Administration	Priya Patel, PharmD	• TJC Triennial review – no changes • System P&T approved 3/2025 • Consent Item – PolicyTech		04/2028		• P&T 3/2025 • CPC 4/3/2025 • MEC 4/16/2025
Medication Therapeutic Interchange Policy	Priya Patel, PharmD	• TJC Triennial review – no changes • System P&T approved 3/2025 • Consent Item – PolicyTech		04/2028		• P&T 3/2025 • CPC 4/3/2025 • MEC 4/16/2025
Pharmaceutical Company Representative Policy	Priya Patel, PharmD	• TJC Triennial review – no changes • System P&T approved 3/2025 • Consent Item – PolicyTech		04/2028		• P&T 3/2025 • CPC 4/3/2025 • MEC 4/16/2025
System Medication Samples Policy	Priya Patel, PharmD	• TJC Triennial review – no changes • System P&T approved 3/2025 • Consent Item – PolicyTech		04/2028		• P&T 3/2025 • CPC 4/3/2025 • MEC 4/16/2025

Alameda Health System			CPC Executive Summary to AHS and AH Medical Executive Committee(s) - April 2025			
Policies and Procedures				Chair: Dr. Bullard and Theresa Cooper		
TOPIC or TITLE OF POLICY	**Document Owners**	**Summary of Changes**	**Last Approved Date**	**Next review date after BOT approval**	**Purpose**	**History of Review Committee**
Medications: Inpatient Medication Dispensing Policy TJC Triennial review –	Priya Patel, PharmD	• minor change to align with practice on when to tube medication for those sites with the tubing system • System P&T approved 3/2025 • Consent Item – PolicyTech		04/2028		• P&T 3/2025 • CPC 4/3/2025 • MEC 4/16/2025
Critical Value Policy - Nursing	Dusty Gilleland	• Revised • No changes from previous version		04/2028		• CPC 4/3/2025 • MEC 4/16/2025
Standards of Nursing Practice	Dusty Gilleland	• Revised • No changes from previous version		04/2028		• CPC 4/3/2025 • MEC 4/16/2025

ALAMEDA HEALTH SYSTEM	Policy	
	HR SECTION 2.00 – POLICY 2.20 HOLIDAYS	**Reference # tbd**
	LEVEL ☐ System ☐ Site	EFFECTIVE DATE: 5/2025 NEXT REVIEW DATE: 5/2028

POLICY STATEMENT
To provide eligible employees with paid time off for holidays. Holidays for employees covered by an MOU are determined through the bargaining process and administered in accordance with the provisions of the MOU. To the extent this policy conflicts with an MOU provision, the MOU will prevail.

PURPOSE
To provide policy and practices for the administration of paid holidays.

SCOPE
All regular full-time and part-time employees are entitled to the holiday benefit as set forth below.

DEFINITIONS
Recognized Holidays. AHS recognizes the following paid holidays: New Year's Day (January 1), Dr. Martin Luther King, Jr. Birthday (Third Monday in January), President's Day (Third Monday in February), Memorial Day (Last Monday in May), Juneteenth (June 19), Independence Day (July 4), Labor Day (First Monday in September), Veteran's Day (November 11), Thanksgiving Day (Fourth Thursday in November), Day After Thanksgiving, Christmas Day (December 25).

Float Holidays. See applicable MOUs.

Holiday Shift. When an assigned shift overlaps two calendar days, a "holiday shift" occurs when the majority of work, excluding overtime, is performed or scheduled on the holiday.

Value of a Holiday. The value of a holiday which falls during a pay period is 1/10th of an employee's time spent in paid status during such pay period, excluding overtime. The maximum value of a holiday is 8 hours for a classification normally scheduled to work 80 hours per pay period. The value of a holiday will vary for employees covered by an Alternative Workweek Schedule (e.g. 12-hour shifts).

Holidays To Be Observed on Workdays. In the event that January 1; July 4; November 11, known as "Veterans Day"; or December 25 shall fall on a Saturday, the holiday shall be observed on the preceding Friday. If any of these holidays fall on a Sunday, the holiday shall be observed on the following Monday. When November 11, December 25, January 1 or July 4 occur on a Saturday or Sunday when a weekend worker is scheduled to work, the employee shall observe the holiday on the actual day.

PROCEDURES
Holidays Not Worked. Holidays not worked by full-time employees shall be compensated at straight time. Part time employees shall be compensated at straight time, prorated each pay period in which a holiday occurs, based upon a proration of the hours which would have been worked within the pay period, but for the holiday, to the normal full-time period for the job classification. A part-time employee may, in writing, with a minimum of seven calendar days' notice to their manager/supervisor, elect to use accrued vacation and/or compensatory time off to replace a decrease experienced in their regular biweekly salary due to a prorated holiday.

Holiday Worked. Regular full-time and part-time employees who are required to work one of these holidays will be paid time and one-half for the first 12 hours and double-time for hours in excess of twelve. See MOUs for holiday pay for 12 and 10 hours shift employees. Services-as-needed employees shall be compensated only for hours worked on holidays at one and one-half times the normal hourly rate.

In Lieu Day Off. When a holiday falls on an employee's regularly scheduled day off, such employee may be given an in-lieu day off (a less than full-time employee will receive a prorated in-lieu day off) within 26 pay periods to be scheduled by mutual agreement of the employee and the manager/supervisor, or the manager/supervisor may compensate the employee in cash. Should an in-lieu day off not be taken within 26 pay periods, the employee shall be compensated in cash.

When the manager/supervisor determines that it will be necessary to fill such a position on a holiday, the incumbent employee shall be offered such work before it is offered to another employee, provided that the holiday occurs on the incumbent employee's regular workday. If the employee chooses to work the holiday, he/she shall receive an in-lieu day off in conjunction with their regularly scheduled day(s) off within 26 pay periods to be scheduled by mutual agreement of the employee and the manager/supervisor or by mutual agreement of the employee and the manager/supervisor the employee may be compensated in cash. Should an in-lieu day off not be taken with 26 pay periods, the employee shall be compensated in cash.

	Policy	
ALAMEDA HEALTH SYSTEM	**HR Section 1.00 – Policy 1.81 Employee Preferred Name**	**Reference # TBD**
	LEVEL ☐ System ☐ Site	**EFFECTIVE DATE: 5/2025** **NEXT REVIEW DATE: 5/2028**

POLICY STATEMENT

Alameda Health System has established this policy that allows preferred first names to appear in our systems of records, even if individuals have not changed their legal names, except where the use of the official legal name is required by Alameda Health System business or legal obligation or where limited by software or IT systems.

***Note**: Preferred names refer to first names only; changes to last names still require legal documentation.*

PURPOSE

As an inclusive workplace, Alameda Health System recognizes that employees may wish to use a name other than their given first name as recorded on official documents and records. A preferred name may reflect an individual's gender identity, the use of a nickname, the use of a name that reflects a cultural, religious, or familial preference or practice, or to distinguish oneself from someone with a similar name, among others. A preferred name is a valuable component of a person's identity and impact their ability to successfully navigate within the organization.

SCOPE

This policy applies to Alameda Health System employees.

DEFINITIONS

Family/Last Name: The name officially recorded in onboarding documents upon new hire. This name can only be changed by submission of appropriate legal documentation that authorizes such a change.

Given Name: Also commonly known as first name or legal first name, AHS acknowledges that the given name is what is recorded as the official name.

Legal Name: A "legal name" is the name recorded on one's legal identification (i.e., passport, birth certificate, Social Security card) and used on official Alameda Health System records. The name of the employee that is generated from the employment application, which is shown on the Social Security card and is the official name of record.

Preferred Name: The first and/or middle name by which the employee prefers to be known. An alternative to the individual's legal name as designated by the individual. A self-chosen personal and/or professional name used instead of a legal name.

Inappropriate preferred name: Names deemed vulgar or offensive, violates Alameda Health System policies, used for commercial or promotional purposes, or seek to avoid legal obligations. Inappropriate preferred names are determined by the Human Resources Office.

RESPONSIBILITIES

- All Alameda Health System employees must comply with policies and procedures.
- Human Resources is responsible for maintaining policies regarding employee data.

	Policy	
ALAMEDA HEALTH SYSTEM	**HR Section 1.00 – Policy 1.81 Employee Preferred Name**	**Reference # TBD**
	LEVEL ☐ System ☐ Site	**EFFECTIVE DATE: 5/2025** **NEXT REVIEW DATE: 5/2028**

PROCEDURES

Employees may add or change their "preferred name" through My Passport (the AHS Employee Self Service Portal). Employees can enter their preferred name by which the employee wants to be known within Alameda Health System in the My Passport system.

The use of a preferred name is used solely for Alameda Health System internal systems and does not change the legal name within Alameda Health System. Official records, such as but not limited to, transcripts, W-2 forms, employee payroll or mailings, will show the legal name of the employee.

Preferred first names will be used in the following systems and records:

- Employee Badge (ID cannot be used as official identification outside of Alameda Health System)
  - An AHS ID Badge Request Agreement must be completed & submitted.
- Employee Email and Zoom account
  - Submit a ticket to IT Service Now to request a change for email and network ID – This process may take up to 14 days and is not handled by the HR Department
- Alameda Health System's employee directory

Legal names will continue to be used for official records including, but not limited to the following:

- Legal documents and reports produced by the Alameda Health System
- Employment documents
- Employment verifications
- I-9 forms, visa/immigration documentation
- Paychecks, W2s, and other payroll documents
- Benefits enrollment (health insurance, retirement, etc.)
- Any HR HRIS-related databases or related information

Preferred names may consist of a first and/or middle name and are limited to alphabetical characters, a hyphen, and/or a space.

Alameda Health System retains the right to evaluate each request on a case-by-case basis and reserves the right to deny preferred name requests that are deemed inappropriate including but not limited to avoiding a legal obligation, fraud, offensive language, or misrepresentation used for criminal or misrepresentation purposes, may be harmful to the reputation or interests of Alameda Health System. Preferred first names may not be used for commercial or promotional purposes and thus may not be a company name, group name, or message. Preferred first names shall not include numerical characters and may contain hyphens. Abuse or misuse of this policy and process may result in disciplinary action.

REFERENCES

Fair Employment and Housing Act (FEHA), California State

ALAMEDA HEALTH SYSTEM	Policy	
	HR SECTION 3.00 POLICY 3.25 Compliance Non-Retaliation and Non-Retribution	**Reference # tbd**
	LEVEL ☐ System ☐ Site	EFFECTIVE DATE: 5/1/2025 NEXT REVIEW DATE: 5/2028

POLICY STATEMENT

It is the policy of Alameda Health System (AHS) that all AHS employees and its affiliate practitioners are encouraged to report concerns about actual or potential violations of law, regulations or AHS policies. No AHS employee, supervisor, manager or executive shall engage in retaliation, retribution or any form of harassment directed against an AHS employee and its affiliate practitioner who reports a possible wrong-doing – including an infringement of law, regulations, or AHS policy – in accordance with the procedures outlined in the Code of Conduct.

Retaliation is defined as any adverse employment action taken against an applicant or employee because that person engaged in activity protected under this policy or reasonably thought to be protected under this policy. Protected activities may include, but are not limited to, reporting or assisting in reporting suspected violations of this policy and/or cooperating in investigations or proceedings arising out of a violation of this policy.

Adverse employment action is conduct or an action that materially affects the terms and conditions of the applicant's or employee's employment status or is reasonably likely to deter the person from engaging in protected activity. Even actions that do not result in a direct loss of compensation or in termination may be regarded as an adverse employment action when considered in the totality of the circumstances.

Examples of retaliation under this policy include, but are not limited to: demotion; suspension; reduction in pay; denial of a merit salary increase; failure to hire or consider for hire; refusing to promote or consider for promotion because of reporting a violation of this policy; harassing another employee for filing a complaint; denying employment opportunities because of making a complaint or for cooperating in an investigation; changing someone's work assignments for identifying harassment or other forms of discrimination in the workplace; treating people differently such as denying an accommodation; or not talking to an employee when otherwise required by job duties; or excluding the employee from job-related activities because of engagement in activities protected under this policy.

PURPOSE

There are two purposes for the adoption of this policy. First, this policy is designed to encourage AHS employees and its affiliate practitioners to report possible violations of law, regulations, or policies (including, the AHS Code of Conduct) in accordance with the procedures outlined in the Code of Conduct. Second, it is designed to prevent any improper retaliation, harassment or retribution for making such reports.

RESPONSIBILITIES

Responsibility to Report

1. AHS is committed to a policy that encourages timely disclosure of compliance concerns and prohibits any action directed against an AHS employee and its affiliate practitioner for making a good faith report of a concern.

2. AHS employees and its affiliate practitioners have the responsibility to report, in good faith, concerns regarding actual, potential or perceived wrongdoing in accordance with the guidelines contained in the Standards for Business Conduct.

3. Retaliation for good faith reporting of perceived or suspected violations of law, regulation, AHS policy and procedure, and the Standards for Business Code of Conduct, or for participation in an investigation of an alleged violation is strictly prohibited. Any employee, supervisor, manager or executive who commits or condones any form of retaliation, retribution or harassment against a reporting AHS employee and its affiliate practitioner shall be subject to appropriate discipline up to and including termination.

Effect of Self-Reporting

A prompt disclosure by an AHS employee and its affiliate practitioner will be considered positively, even if the wrongdoing resulted from malfeasance or inadequate performance by the person making the report. However, the making of the report will not exempt the AHS employee and its affiliate practitioner from the consequences of the employee's and its affiliate practitioner's malfeasance or inadequate performance.

Duty to Investigate

All claims of retaliation, retribution or harassment against reporting AHS employees and its affiliate practitioners will be brought to the immediate attention of the Director of People Operations. who will investigate and, if appropriate, recommend actions to the CEO of the organization where the wrongful retaliation occurred.

Conflict of Interest

If there is a valid conflict of interest or valid concern regarding the objectivity of either the responsible Director, People Operations or Designee or the CEO of the organization where the retaliation occurred, which might affect their ability to take appropriate disciplinary steps, the VP of Internal Audit and Compliance shall serve in the affiliate Director, People Operations role and the Senior Executive or Designee to whom the CEO reports shall fulfill the CEO's role in the disciplinary process.

Discipline

AHS employees or management personnel and its affiliate practitioners who are found to have engaged in retaliation, retribution, or harassment are subject to discipline up to and including termination of employment. In addition, any person who intentionally provides false information may be subject to disciplinary action up to and including termination.

PROCEDURES

1. Managers (includes Executives, Directors, Managers, and Supervisors) shall:
    a. Take appropriate measures to safeguard AHS employees and its affiliate practitioners

against retaliation. At a minimum, the following actions should be taken and become an on-going aspect of the management process:

i. Maintain an "open door" policy to support and encourage the AHS employees' and its affiliate practitioners' reporting of work-related issues or concerns;
ii. Encourage "speak up" culture.

iii. Ensure that AHS employees and its affiliate practitioners understand that they may, without fear of retaliation, report violations and concerns directly to the Compliance Department

iv. Meet regularly with subordinates and discuss the main points of this policy and other applicable compliance program policies;

b. Ensure that reports of actual or potential violations are handled as confidentially as possible;
c. Focus on the issue raised and not the individual(s) involved;
d. Report immediately to the Compliance Department or Confidential Message Line any known or suspected instances of retaliation, harassment or retribution.
e. The Compliance Department shall:
f. Develop and maintain a system to document and track reported instances of retaliation;
g. Be responsible for the prompt investigation and follow-up of any reported retaliation.

REFERENCES

- Civil Rights Department Discrimination, Harassment, and Retaliation Prevention Sample EEO Policy December 2022
- AHS Code of Conduct

ALAMEDA HEALTH SYSTEM

ATTIRE FOR RESTRICTED AND SEMI-RESTRICTED PROCEDURAL AREAS

Site	Alameda Health System	***Previous Revision Dates***	2/2017, 5/2025
Effective Date	3/2017	***Date Revised***	
Document Owner	DIR, PERIOPERATIVE NURSING SVC	***Next Scheduled Review***	5/2028
Executive Responsible	CHIEF ADMINISTRATIVE OFFICER		

Purpose

To provide guidance to perioperative personnel about surgical attire, including scrub apparel, shoes, and head coverings, worn in the semi-restricted and restricted areas. Guidance is also provided for managing personal items and electronic devices taken into the semi-restricted and restricted areas. The expected outcome is that the patient will be free from signs and symptoms of infection.

Policy

1. Clean surgical attire will be worn in semi-restricted and restricted areas.

2. Individuals who enter semi-restricted and restricted areas will wear scrub attire that has been provided by the facility and laundered at the health care-accredited laundry facility; or wear single-use scrub attire provided by the facility and intended for use within peri-operative and procedural areas.
    a. The scrub attire must cover any other garment that remains on the individual, whichis not part of the facility provided scrub attire.
    b. Visitors entering the semi-restricted or restricted area should don either clean surgical attire or a single-use attire (e.g., coveralls, bunny suit, repscrubs) designed to completely cover personal apparel. Vendors must wear single-use surgical attire (per “vendor relations” policy) when in the semi-restricted and restricted areas.

3. Laundered scrub apparel will be protected from contamination during transport to the health care facility and during storage.

4. The health care worker’s arms may be covered during performance of preoperative patient skin antisepsis.
    a. Arms may be covered with long sleeves (facility laundered jacket or disposable jacket) during performance of preoperative patient skin antisepsis.
    b. Personal long-sleeved shirts may not be worn unless covered by

facility laundered or approved single-use disposable attire.

5. Clean cloth or disposable head coverings that cover the scalp and hair will be worn by personnel who enter the semi-restricted and restricted areas.
    a. Personal cloth head covers (scrub caps) may be worn but must be laundered daily.
    b. Personal cloth head covers must be made of a low linting and tightly woven fabric.
    c. Remove head coverings at the end of the shift or when contaminated.Facial hair is to be covered when entering the restricted area and while preparing and packing items in the clean assembly section of the sterile processing area.

6. Scrub attire that has been penetrated by blood, body fluids, or other potentially infectiousmaterials must be removed immediately, or as soon as possible, and replaced with clean attire.
    a. When extensive contamination of the body occurs, a shower or bath will be takenbefore the clean attire is donned.

7. Cover apparel (e.g., lab coats, warm-up jackets) worn over scrub attire will be clean, changed daily and provided by the facility. Individually owned cover apparel is not allowed in the restricted areas.

8. Cover gowns are not required when leaving the department.

9. Disposable, high filtration efficiency masks must always be worn when in the presence of opened sterile items.
    a. The mask must cover the mouth and nose entirely and be tied securely.
    b. Masks must be either “on” or “off”. They must never hang around the neck.

10. Jewelry that cannot be contained or confined within the scrub attire will not be worn in thesemi-restricted or restricted areas.
    a. Hand and wrist jewelry (rings, watches, and bracelets) will not be worn.

11. Shoes worn within the perioperative environment will be clean and meet the health care organization’s safety requirements.
    a.
    b. Shoe covers may be worn to protect shoes and reduce risk of exposure to potentially infective materials. They should be changed whenever they become torn or soiled. Shoe covers should be removed immediately after use and discarded, and hand hygiene performed.
    c. Shoe covers are optional for Shoes dedicated for use within the Perioperative area.
    d. Shoe covers or boots must be worn in instances when gross contamination can reasonably be anticipated (e.g., some orthopedic surgery).

e. Personal items brought into the semi-restricted and restricted areas will be cleaned and disinfected or contained.Clean and disinfect briefcases, backpacks, and other personal items taken into the semi-restricted or restricted areas or place them in a clean disposable bag.
f. Clean and disinfect cell phones, tablets, and other personal communication or handheld electronic equipment according to the manufacturer's instructions for use before taking these items into the OR, and perform frequent hand hygiene after using the devices.

Laundering

1) Remove attire that has been penetrated by blood, body fluids, or other potentially infectious materials immediately or as soon as possible and replace with clean attire.
2) Bag or containerize the contaminated, soiled, or wet attire and leave it at the location where it was used. Do not rinse or sort the attire.
3) After each daily use, leave scrub apparel at the health care facility to be laundered per facility policy.
4) Remove surgical attire before leaving the health care facility.
5) Store laundered scrub apparel in enclosed carts, cabinets, or dispensing machines

Identification Badges

1. Secure identification badges in a visible location on the scrub attire top or long-sleevedjacket.
2. Identification badges, access cards, and lanyards will be cleaned and disinfected on a regular basis and when contaminated.
3. Badges and Lanyards should be secured so as not to interfere with a prepared sterile field.

Stethoscopes

1) Stethoscopes will be cleaned and disinfected before each patient use.
   a) Cloth or fabric covers are not to be used.

a. **Competency**
   a. Perioperative personnel working in semi-restricted and restricted areas of the facility will receive education and complete competency verification activities on surgical attire worn in the perioperative areas.

b. **Quality**

a. Perioperative personnel working in semi-restricted and restricted areas of the facility will participate in quality assurance and performance improvement activities related to surgical attire worn in the perioperative areas.

c.

References

AORN Syntegrity® Solution. AORN Syntegrity® On-line Companion Guide.

Guideline for surgical attire. In: Guidelines for Perioperative Practice. Denver, CO: AORN, Inc. 2024

Approvals

Departmental	**Date: 2/2017, 10/2021, 3/2025**
Clinical Practice Council	**Date: 3/2017, 01/2022, 4/2025**
Medical Executive Committee	**Date: 4/2017, 01/2022, 4/2025**
Board of Trustees	**Date: 5/2017, 03/2022, 5/2025**

Old Headers			
Department	Perioperative, IR, Cath Lab, etc.	***Effective Date***	5/2017
Campus	AHS System	***Date Revised***	2/2017
Unit	Perioperative Services	***Next Scheduled Review***	2/2020
Manual	Perioperative Services	***Author***	Director, Perioperative Services
Replaces the following Policies:		***Responsible Person***	Chief Administrative Officer

ALAMEDA HEALTH SYSTEM

PATIENT COMPLAINTS/GRIEVANCES

Effective Date	Not Set	***Date Revised***	03/2025
Document Owner	DARSHAN GREWAL (DIR, PATIENT SAFETY)	***Next Scheduled Review***	04/2028
Executive Responsible	Director, Patient Safety		

Printed copies are for reference only. Please refer to electronic copy for the latest version.

Purpose

To facilitate effective, consistent management of patient complaints and grievances, to enhance the patient experience and to maintain quality patient care and service throughout Alameda Health System. (AHS).

To provide a procedure for visitors, patients or patient representatives to register a complaint regarding care, treatment or services.

To provide a reliable, accurate and timely system of receiving, documenting, resolving and responding to patient complaints and grievances.

To systematically communicate patient complaints and grievances to leaders and medical staff.

To comply with CMS Conditions of Participation.

To comply with AHS's contractual agreements with payors.

Definition

1. Per CMS CoPs, a **"patient grievance"** is a formal or informal written or verbal complaint that is made to the hospital by a patient, or the patient's representative, regarding the patient's care (when the complaint is not resolved at the time of the complaint by staff present), abuse or neglect, issues related to the hospital's compliance with the CMS Hospital Conditions of Participation (CoPs), or a Medicare beneficiary billing complaint related to rights and limitations provided by 42 CFR 489. "**Staff present" i**ncludes any hospital staff present at the time of the complaint or who can quickly be at the patient's location (i.e., nursing, administration, nursing supervisors, patient advocates, etc.) to resolve the patient's complaint. If a patient care complaint cannot be resolved at the time of the complaint by staff present, is postponed for later resolution, is referred to other staff for later resolution, requires investigation, and/or requires further actions for resolution, then the complaint is a grievance for the purposes of these requirements. A complaint is considered resolved when the patient is satisfied with the actions taken on their behalf.
2. • **Billing issues** are not usually considered grievances for the purposes of these requirements. However, a Medicare beneficiary billing complaint related to rights and limitations provided by 42 CFR 489 is considered a grievance.

3. A written complaint is always considered a grievance. This includes written complaints from an inpatient, an outpatient, a released/discharged patient, or a patient's representative regarding the patient care provided, abuse or neglect, or the hospital's compliance with CoPs. For the purposes of this requirement, an email or fax is considered "written."

4. Information obtained from patient satisfaction surveys usually does not meet the definition of a grievance. If an

identified patient writes or attaches a written complaint on the survey and requests resolution, then the complaint meets the definition of a grievance. If an identified patient writes or attaches a complaint to the survey but has not requested resolution, the hospital must treat this as a grievance if the hospital would usually treat such a complaint as a grievance.

5. Patient complaints that are considered grievances also include situations where a patient or a patient's representative telephones the hospital with a complaint regarding the patient's care or with an allegation of abuse or neglect, or failure of the hospital to comply with one or more CoPs, or other CMS requirements. Those post-hospital verbal communications regarding patient care that would routinely have been handled by staff present if the communication had occurred during the stay/visit are not required to be defined as a grievance.

6. All verbal or written complaints regarding abuse, neglect, patient harm, or hospital compliance with CMS requirements are considered grievances for the purposes of these requirements.

7. Whenever the patient or the patient's representative requests that his or her complaint be handled as a formal complaint or grievance or when the patient requests a response from the hospital, the complaint is considered a grievance, and all the requirements apply.

8. • Data collected regarding patient grievances, as well as other complaints that are not defined as grievances (as determined by the hospital), must be incorporated in the hospital's Quality Assessment and Performance Improvement (QAPI) Program.

Policy

1. It is the policy of AHS to ensure that patient complaints registered by or on behalf of a patient, are investigated, acted upon and responded to appropriately.
    a. The hospital's governing body is responsible for the effective operation of the grievance process.
    b. The Board delegates the responsibility (in writing) to review and resolve grievances to the Patient Safety Department (formerly Risk Management).

2. Patients are informed of their right to file a complaint.

3. Presentation of a complaint will not compromise a patient's care or future access to care. Patients can freely voice complaints and recommend change without being subject to coercion, discrimination, retaliation, or unreasonable interruption of care, treatment or services.

Procedure

1. Patients calling to file a complaint or grievance should be directed to the Patient Safety Department- Patient Relations Team at 510-437-8484.

2. For complaints received in a patient care area, every attempt will be made to resolve patient/family concerns immediately by staff present through effective service recovery: listening, empathizing, acknowledging and providing resolution.

3. If unable to resolve the complaint immediately, the chain of command should be activated to involve the supervisor/ manager/ director/ or designee.

4. The immediate supervisor/manager/director (or designee) will attempt to resolve the complaint to the patient's satisfaction.

5. Resolved and unresolved complaint details and supervisor/manager/director/or designee follow up actions should be entered into the electronic Safety Alert System (SAS), also known as MIDAS, as a Patient Relations event.

6. Upon receipt of a Patient Relations Safety Alert, managers are required to investigate and provide follow up actions to the Patient Safety Department **within 5 business days** unless otherwise specified by the Patient Safety Department.

7. If the electronic Safety Alert System is down for > 4 hours, complaints, grievances and manager follow up actions should be emailed to PatientSafety@alamedahealthsystem.org .
8. AHS Patient Complaint Forms (PCFs) Appendix A are available:

    a. On the AHS Intranet >Web Apps>Forms on Demand
    b. As an attachment to this policy
9. The PCF is for patient or patient representative/family use only.
10. The PCF is to be provided to patients upon request and is for patient/family use only. Upon completion of a PCF, patients are instructed to return the form directly to AHS Patient Safety Department but they may choose to return the form to any AHS Representative. AHS is required to make available Alameda Alliance For Health Member Grievances Forms to Alameda Alliance patients who may express dissatisfaction with the Plan or it's offered benefits. The forms should be available onsite. The Forms are available in multiple languages and as attachment to this policy, Appendix B.

11. Any AHS Representative who receives a completed PCF should immediately inform their Supervisor and forward the PCF to the Patient Safety Department immediately via fax 510-338-4161 or scan to PatientSafety@alamedahealthsystem.org
12. Written correspondence from patients, insurance companies or any other outside agency or entity related to patient grievances, received directly by an AHS facility/campus, should be immediately forwarded via fax/scan to the Patient Safety Department for processing.

13. Upon receipt of a PCF or a patient grievance, the Patient Safety Department will:
    a. Log the event into the Safety Alert System
    b. AHS will notify Alameda Alliance Member Services Department (or other payor if indicated) of any member's grievances
    c. Send an acknowledgement letter to the patient/complainant within 7 days
    d. Forward the grievance to the appropriate Department Manager (if not already done)
    e. Provide a written response to the patient within 30 days
    f. Complicated grievance cases may require additional time to resolve and communication with the patient may be ongoing

14. The grievance response will include:
    a. The name of the hospital contact person
    b. The steps taken on behalf of the individual to investigate the complaint
    c. The results of the process
    d. The date of completion of the complaint process

15. The Patient Safety Department will forward physician related complaints to the Department Chair and/or designee for review and follow up. The medical leader will investigate the concern, provide a prompt, responsible solution to the problem(s) identified, and communicate this information to the Patient Safety Department. The Patient Safety Department will send a response letter to the patient within 30 days.

16. Written grievances related to the professional competence or professional conduct of a physician or podiatrist require the following (per Title 22):

    a. Inform the complainant that the Medical Board of California or the California Board of Podiatric Medicine, are the only authorities in the state that may take disciplinary action against the provider's license.
    b. Give the complainant the address and toll-free phone number of the applicable state board.
    c. NOTE: there is no requirement that the preceding steps be taken in response to a verbal complaint about a physician.

17. The Patient Safety Department will refer to the following areas as appropriate during the grievance investigation/resolution period:
    a. Ethics Committee
    b. Legal Counsel
    c. Quality Review Committees/Quality Outcomes Department
    d. Department Chair/Chief/ Medical Director/or designee
    e. Department Manager/Director
    f. Medical Staff
    g. Case Management (premature discharge complaint)
    h. A multidisciplinary group will meet to discuss and address events not resolved using the Standard Process.

18. The Patient Safety Department will retain all grievance and resolution information on file for a period of five (5) years.

19. Data from the complaints and grievances process is referred up to the governing body via the Quality and Safety Committee, the Medical Executive Committee and the Board of Trustees.

20. Other resources for complaint resolution include:
    a. The California Department of Public Health Services – (800) 554-0352
    b. Alameda County Long-term Care Ombudsman Program (SNF) – (510) 638-6878
    c. The Joint Commission – (800) 994-6610 or complaint@jointcommission.org
    d. For Alameda Alliance Patients only: Alameda Alliance for Health Member Services (510) 747-4567 or 1(877) 371-2222

Attachments:

Appendix A: AHS Patient Complaint Form

Appendix B: Alameda Alliance for Health Grievance Forms:

a) English
b) Spanish
c) Chinese
d) Vietnamese

Approvals:

APPROVALS		System	Alameda	AHS Core	San Leandro
Committee Name: System P and T	**Date:**				
Patient Care Leadership Team	**Date:**	**10/26/2018 3/2025**			
Clinical Practice Council	**Date:**	**11/1/2018 4/2025**			
Medical Executive Committee	**Date:**	**4/2025**	**11/2018**	**11/2018**	**11/2018**
Board of Trustees	**Date:**	**01/2019 5/2025**			

ALAMEDA HEALTH SYSTEM	Policy	
	Document Title **Healthcare Industry Representative Relations Policy**	**Reference #** **Version 8**
	Level X System ☐ Site	**Effective Date:** Effective Date **Last Review Date**: Last Periodic Review Date01/2023
	Document Owner: System Vice President Supply Chain	

POLICY STATEMENT

It is the policy of Alameda Health System (AHS) to ensure that all sales representatives, vendors and visitors with whom AHS or its providers and staff conducts business are correctly identified and have completed the appropriate training and compliance certifications. In order to comply with AHS policy and HIPAA requirements, all sales representatives, vendors and visitors must follow the AHS Healthcare Industry Representative Relations Policy and the procedures below.

PURPOSE

Sales and vendor relations are important to providing excellent patient care and service. To ensure beneficial relations a protocol has been established to monitor Health Care Industry Representative Relations (HCIR) activities. This is necessary to safeguard patient confidentiality and property, monitor products and contractual issues, protect business interests, establish standardized processes and protocol, maintain our commitment to compliance and business ethics, and to maintain quality medical care. It is the policy of Alameda Health System to manage access to its facility in a manner that will protect the rights of patients as well as employees.

To ensure safe and high-quality patient care delivery by assuring contracted Alameda Health System business partners are in compliance with AHS policies, procedures and requirements as related to vendor orientation, qualification, and/or job-related competency.

Health care industry representatives (HCIR) by virtue of their training, knowledge, and expertise, can provide valuable assistance to AHS staff. This assistance can expedite the procedure/treatment and facilitate desired patient outcomes. HCIR may be more familiar with their system, device, procedure, or drug than the physician and the healthcare team.

This policy will be provided through the Symplr Vendor Management System. An Acknowledgement of Receipt and acceptance will be kept on record. Failure of the HCIR to comply with these guidelines may result in further restrictions, non-payment, or termination of visitation privileges with the organization.

SCOPE

This Policy applies to all healthcare industry representatives, Alameda Health System staff, providers, facilities and locations.

ALAMEDA HEALTH SYSTEM	Policy	
	Document Title **Healthcare Industry Representative Relations Policy**	**Reference #** **Version 8**
	Level X System ☐ Site	**Effective Date:** Effective Date **Last Review Date**: Last Periodic Review Date01/2023
	Document Owner: System Vice President Supply Chain	

DEFINITIONS

Health Care Industry Representative (HCIR): A Health Care Industry Representative is a generic term used to refer to a sales professional or other individual who represents a company or companies to healthcare clients, including physicians, nurses, buyers, and general users of the company's product. HCIR represent manufacturers, distributors, service companies, and other organizations. HCIR perform marketing activities, manage contract sales, generate other sales, provide quotes, demonstrate products, solve problems, advise, clients on matters, or perform many other duties generally associated with representing their company.

RESPONSIBILITIES

- It is the responsibility for all healthcare industry representatives follow the registration, credentialling, and access stoplight badge procedure.
- It is the responsibility of all AHS staff and providers to challenge any healthcare industry representative who do not have a Green or Yellow stoplight bade and report them to Security.
- It is the responsibility of Department Leaders to on occasion provide a variance to the stoplight badge requirement, but it is not acceptable to allow this behavior to continue.

POLICY TEXT

It is the policy of AHS that all HCIRS conducting business with Alameda Health System

- Will comply with the policies, procedures, and guidelines of Alameda Health System including vaccination policies.
- Will comply with, and remain in compliance with, all State and Federal laws and regulations which currently or may hereafter apply.
- Will comply with the Joint Commission and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) standards that apply to Alameda Health System and any other standards and regulations promulgated hereafter.

ATTACHMENTS

Health Care Industry Representative Procedures.

Health Care Industry Representative Procedure

Visitation:

1. Prior to gaining vendor access to AHS, representatives must register through the internet at www.symplr.com. Registration is required on an annual basis.

2. Appointments are required. Once registered, vendor account representatives are seen by appointment only. To make an appointment, representative shall contact the department directly.

3. Upon entry into AHS, vendor representatives must stop at designated Symplr check-in points to obtain an identification badge. Kiosks are located at the OR in Alameda and main entrances at Alameda and San Leandro hospitals and at the Wilma Chan Highland Hospital near the K-Building Garage entrance, in the Materials Management Receiving Department and in the OR lobby. Badges must be worn at all times while on premises.

4. Representatives shall limit their visits to only the departments where a confirmed appointment was made for the purpose of providing information and servicing the account.

5. No distribution of sample product is allowed without prior approval of the Value Analysis Committee.

6. New supplies or equipment shall neither be presented nor offered within the Alameda Health System without prior approval of the Value Analysis Committee.

7. Equipment must be delivered 24 hours prior to required use to allow time for electrical safety check to be performed.

8. In general, all product deliveries are to be made during regular business hours to the Receiving Department. Deliveries of pre-approved items specific to a patient or a case shall be delivered directly to the ordering department. The products must be clearly identified with the department name, the department phone and the Physician or ordering party's name. For Bill Only deliveries, the packing slip is to be attached to the Purchase Requisition. All other packing slips are to be immediately sent to the facility's Receiving Department.

9. After hours deliveries are to be coordinated directly with Supply Chain or the ordering department to prevent deliveries from being misplaced.

10. Representatives are not allowed in any patient care area or ancillary department unless they are providing pre-approved and scheduled education or training on supplies, equipment, or services.

11. Badging: Some HCIR may be issued an Alameda Health System identification badge. This badge must be worn while on AHS premises. It is not a substitute for the Symplr stoplight label. When visiting any clinical areas, both must be worn. All AHS staff are authorized and empowered to stop representatives who do not have a Symplr stoplight label.

Compliance Requirements

AHS HCIR registration and certification process is accessed through the internet at www.symplr.com on an annual basis. In order to ensure safe and quality patient care, Alameda Health System may require that HCIR complete the following requirements:

a. Verification of company training and documentation of training.
b. Evidence and verification of background check
c. Date and results of annual TB test
d. Evidence of Mumps, Measles, Rubella (MMR) immunity or documentation of 2 doses of the MMR vaccine
e. evidence of varicella immunity or 2 doses of the adult varicella vaccine
f. Evidence of Hep B Booster Series or declination
g. Documentation of product and general liability insurance
h. Evidence of Training in HIPAA and patient privacy
i. Evidence of Training in Bloodborne Pathogen Education (if applicable)
j. Evidence of Training in Operating Room Protocols and Etiquette (if applicable).
k. Review and acknowledgment of hospital and departmental policy and procedures
l. Evidence of Covid-19 vaccination and booster
m. AHS Vendor Attestation on Roles and Responsibilities

Requirements are determined based upon the HCIR specific role and access to patient care areas at AHS and as determined by the California Department of Public Health (CDPH).

Non-Compliance

1. Upon entry into Alameda Health System, all individuals providing care, treatment or service must wear assigned badges and stoplight labels while on premises.

2. All HCIR agree to follow all applicable Alameda Health System policies, procedures, and requirements while on the premises.
    a. An HCIR's failure to comply with Alameda Health System's policies, procedures and requirements may result in the individual being asked to leave the premises.

3. HCIR will not have access to medical records or any other records, regardless of media or format, containing Protected Health Information (PHI), except as expressly stated in a valid, signed Business Associate Agreement. If a Business Associate Agreement is not in place and a HCIR incidentally gains access to PHI during the course of any site visit, such PHI shall be kept confidential.

4. Non-compliance shall result in the HCIR being escorted from the premises. Repeated violations may result in a ban from Alameda Health facilities.

Valid Purchase Commitments:

The AHS Purchasing department is the central agency responsible for obtaining the maximum value in the purchase of equipment, supplies, and services for AHS. Purchase orders are required for all purchases. The Purchasing department staff members are the only agents authorized to make purchases on behalf of AHS.

1. Any order or purchase request submitted to a vendor without a valid purchase order from AHS Purchasing Department will be considered invalid and is not binding.
2. Deliveries arriving without a valid purchase order number or with a packing slip listing a name in place of a purchase order number will be returned to sender. AHS is not responsible for deliveries left in the receiving area or loading dock without an appropriate signature from Supply Chain Receiving personnel.
3. All requests for bids should originate in the AHS Purchasing Department or the Non-Physicians Contracts Department. All bids will remain confidential and will not be shared with competitors. In the event a department manager solicits a quotation, a copy must also be sent to the AHS Purchasing Department.

4. Priority will be given to those HCIR who have national GPO agreements with AHS GPO or local Alameda Health System independent agreements. Local contracts and agreements may be negotiated for products and/or services not addressed by GPO agreements, or in the rare occurrence where compliance is not feasible or is in the best interest of Alameda Health System to do so.

5. All price agreements, letters of commitment, purchase contracts and/or lease agreements must be approved by the appropriate department including AHS Non-Physician Contracting (NPC), Purchasing Department, VP Supply Chain and signed by the appropriate Executive Officer in accordance with AHS contracting policy. A contract or agreement signed by unauthorized personnel will be considered invalid.

Invoicing

1. All invoices must be sent to:

   Alameda Health System ATTN: Accounts Payable 15400 Foothill Boulevard San Leandro, CA 945578

   OR invoices may be e-mailed to apinvoices@alamedahealthsystem.org (preferred method)

2. Invoices must reference a valid purchase order number.

Product Introduction and Evaluation:

HCIR are prohibited from bringing samples and new products directly to AHS staff, physicians and other clinicians.

AHS has an active Value Analysis Program. New products considered for use must be reviewed and approved by the Value Analysis Committee prior to use (including trials) within the organization. Products provided as samples must be coordinated through Supply Chain and shall be provided at "no charge" to the organization. The AHS Purchasing department will issue a "No Charge" purchase order for tracking purposes. HCIR must also provide evaluation forms, "Hold Harmless" agreements, and in servicing as necessary. Products should be delivered to the Supply Chain Department for distribution unless other arrangements have been made and agreed to by AHS Supply Chain.

Cath Lab and Surgical Services:

1. Appropriate attire: Any HCIR entering the Cath Lab procedure rooms or the OR core and operating suites must wear appropriate attire. AHS has contracted with RepScrubs for all HCIR to obtain the appropriate attire. Under no circumstances are HCIR allowed to wear clothing in from the street. On rare occasion, AHS managers may allow HDIR to wear AHS scrubs. The RepScrubs vending machines are linked to our Symplr Vendor Management System and reports are generated daily to confirm an

HCIR credentials and compliance with AHS Policy.

2. Surgical implants must be reviewed and approved by the OR Director prior to introduction and use. Items provided to AHS without prior authorization by the OR Director will not be paid for and will be considered a donation to the organization.

3. All implanted devices that are shipped to AHS must have a purchase order number assigned in advance. For implants carried in by a vendor representative it is the vendor representative's responsibility to provide detailed paperwork for all implants, including physician's name, date of service, and accurate pricing within 48 hours or the next business day to avoid delays in payment.

4. AHS will not accept nor pay any charges for loaner fees, delivery charges on instrument sets, delivery charges for items from prosthetics banks, or any other specialized equipment with disposable components.

Solicitation, Display, Promotion, and Educational Programs:

1. Solicitations, displays, demonstrations, promotions, gifts, educational programs for new products, meal functions and distribution of materials are prohibited without prior approval of the System Vice President Supply Chain.

HCIR Acknowledgement - AHS HCIR Policy and Compliance Requirements

Vendor Representative Signature	Name of Company	Date
Name of Representative Supervisor	Phone Number of Supervisor	

Approvals

Reference:

- AAHS Facility Access Policy
- Value Analysis Policy
- Medication Drug Recall (33558-1)
- Pharmaceutical Company Representative Policy

POLICY STATEMENT

This policy is intended to comply with Federal, State and CMS Claims Processing Manual requirements for teaching physician services.

PURPOSE

The purpose of this document is to provide a unified Provider Practice Plan policy regarding submission of bills to third-party carriers for teaching physician services where residents and fellows are involved with the provision of these services.

SCOPE

Code of Federal Regulations, 42 CFR 415.172(b), 42 CFR 415.170, CFR 415.174 and California Code of Regulations, 22 CCR 51503(j), Physician Services

DEFINITIONS

"Approved Graduate Medical Education (GME) Program" means a residency program approved by the Accreditation Council for Graduate Medical Education (ACGME) of the American Medical Association or the equivalent entity for osteopathy, dentistry, or podiatry or a program that may count towards certification of the participant in a specialty or subspecialty listed in the Annual Report by the American Board of Medical Specialties (ABMS). (Note that the ABMS listing is not mentioned in the Medicare teaching physician rules except by incorporating existing language in another longstanding regulation concerning cost reporting by hospitals).

"*Direct Supervision*" means the Teaching Physician must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the service. It does not mean that the Teaching Physician must be present in the room when the service is performed.

"*Critical or Key Portion*" means that part (or parts) of a service that the Teaching Physician determines is (are) a critical or key portion(s).

"*Immediately Available*" has not been defined by CMS, however, as a matter of AHS policy, the Teaching Physician should, at a minimum, remain In the Building and not become involved in other scheduled patient care. The Teaching Physician may perform rounds, check on patients in recovery, review charts in his or her office, and even begin another procedure. The Teaching Physician may not see previously scheduled patients in a clinic unless such patients are seen on an urgent or emergent basis of short duration, or for a pre-operative visit.

"*In the Building*" means within the operating structure of a Hospital or Clinic. For example, a physician is not "immediately available" in the Clinic if rounding in the Hospital, even if the Clinic shares physical space in the Hospital. As another example, a surgeon is not

"immediately available" in the Hospital Operating Room while in the Ambulatory Surgery Center and vice versa.

"*Medical Student*" means an individual who participates in an accredited educational program, such as medical school, that is not an Approved GME Program.

"Metropolitan Statistical Area (MSA)" is a geographic region that includes a city and its surrounding communities. MSAs have at least one urbanized area of 50,000 or more population, plus adjacent territory that has a high degree of social and economic integration with the core as measured by commuting ties.

"*Non-Provider Setting*" means a setting other than a hospital, skilled nursing facility, home health agency, or comprehensive outpatient rehabilitation facility in which residents furnish services. This could include, but is not limited to, family practice or multi-specialty clinics or physician offices.

"*Physically Present*" means that the Teaching Physician is located in the same room (or partitioned or curtained area, if the room is subdivided to accommodate multiple patients) as the patient and/or performs a face-to-face service.

"*Resident*" means an individual who participates in an approved GME program, including programs in osteopathy, dentistry, and podiatry. For the purpose of federal rules includes interns and fellows, as well as residents.

"Resident" also includes a physician who is not in an approved GME program, but who is authorized to practice only in a hospital setting, i.e., physicians with temporary or restricted licenses or unlicensed graduates of foreign medical schools.

"*Teaching Physician*" means a physician (other than another resident) who involves residents in the care of his or her patients.

"*Teaching Setting*" means any provider, hospital-based provider, or non-provider setting in which Medicare payment for resident services is made under the Part A direct GME payment.

RESPONSIBILITIES

Physicians who provide teaching physician services at Alameda Health System (AHS).

POLICY

At Alameda Health System (AHS), the policies and procedures set forth in this document are applicable not only to Medicare patients, but to all patients, regardless of payer source,

except to the extent that specific requirements of a particular payer would not be fully satisfied by compliance with these general policies and procedures, which are based upon the Medicare rules. For example, claims may not generally be submitted to Medi-Cal unless the Teaching Physician directly provided the service.

Under the CMS Teaching Physician Billing Requirements, services provided in a teaching setting are payable if the services are:

- Physicians, not residents, personally provide the service (42 CFR 415.170(a)).
- Residents provide the service when teaching physicians are physically present during critical or key service parts (42 CFR 415.172(a)). This includes telehealth services through 2-way, interactive, audio-video telehealth in residency training sites outside a metropolitan statistical area (MSA).
- Teaching physicians providing evaluation and management (E/M) services with a graduate medical education (GME) program granted a primary care exception may bill for lower- and mid-level E/M services provided by residents (42 CFR 415.174).

Through the Medi-Cal program, California Code of Regulations Title 22 Section 51503(j), no professional fees are payable for services provided independently by resident or students in a teaching setting. Services provided in a teaching setting are payable when directly provided by teaching physicians and when:

(1) They are performed for necessary treatment of the patient:

(2) They are not an exercise of teaching supervision without direct patient care services being provided;

(3) They do not duplicate any medical services billed by any other provider; and

(4) The teaching physician is not on salary or contract to the hospital for the direct patient care services provided.

“Directly provided” for Medi-Cal billing is a service by the teaching physician that is more than passive supervision, but active participation in the patient’s care, such as contributing to the plan of care. This means the teaching physician’s documentation must show:

(1) The Teaching Physician saw the patient;

(2) The Teaching Physician reviewed the resident’s note and agreed with or revised the findings; and

(3) The Teaching Physician actively participated in the patient's care, by either documenting involvement in the development of the plan or by changing the plan.

Nothing in this policy shall be construed to eliminate the necessity of complying with specific practice and documentation requirements imposed by particular payers, including Medi-Cal.

For details on documentation requirements in this policy, see *Attachment I*: **Acceptable Documentation Templates for Compliance with Provider Practice Plan Teaching Physician Billing Policy.**

PROCEDURE

1. Major Surgical Procedures

A. Physical Presence: The teaching physician must be present during all key (critical) portions of the procedure and be immediately available to furnish services during the entire procedure.

Since there will be variations in what constitutes the key and critical portions of particular procedures, teaching physicians have the flexibility in defining the key and critical portions of each procedure. Generally, teaching physician presence is not required during the opening and closing of the surgical field. However, for some procedures, the closing may actually be the key portion of the procedure (e.g., plastic and reconstructive surgeries). For such procedures, the teaching physician must be present for the closing.

B. Definition of Immediately Available: The teaching physician must be immediately available during all non-key portions of a surgical procedure. Immediately available is defined as being able to immediately return to the patient if necessary (i.e., teaching physician cannot be performing another procedure). If the teaching physician leaves the operating room, before or after the key portions of the procedure to become involved in another surgical procedure, he or she must arrange for another physician to be immediately available to intervene in the original procedure.

C. Two surgical overlapping procedures: In order to bill for two overlapping procedures, a teaching physician must be present during the critical or key portions of both procedures. The key portions of the procedures cannot overlap.

D. Three or more overlapping surgical procedures: In the case of three concurrent surgical procedures, the role of the teaching surgeon in each of the cases is classified

as a supervisory service to the hospital rather than a physician service to an individual patient and is not billable.

E. Global Surgical Package: For major surgical procedures that are a part of global payment packages, the teaching physician must personally perform or observe the resident perform the post-operative visit(s) considered by the teaching physician to be key visits during the post-operative period. If the post-operative period extends beyond the patient's discharge and the teaching physician (and/or a member of the teaching physician's specialty) is not providing the patient's follow-up care, then the teaching physician should not bill the full global package.

For Medi-Cal patients, unless there is documentation in the medical record that the teaching physician directly provided services in connection with the pre-operative and a post-operative visit on each day of a patient's inpatient stay, and as required, outpatient care during the remainder of the post-operative follow-up period, payment is to be reduced from the otherwise allowable global fee.

F. Documentation: Documentation should indicate what the teaching physician views as the critical or key portion and should indicate that the teaching physician was present for the critical or key portion of the procedure. It should also indicate that the physician was immediately available for the non-key portions of the surgical procedure. If the teaching physician was not immediately available for the non-key portions of the procedure, the medical record or other supporting documentation (i.e. back-up schedule) should clearly identify which teaching physician was immediately available.

For single surgical episodes (non-overlapping) the teaching physician, resident or other staff can document the teaching physician's presence.

In the case of overlapping/concurrent procedures, the teaching physician must document presence in his/her own note. The teaching physician must personally document the key portion of each of the overlapping procedures performed using patient-specific terms to describe the personal services provided or observed and that the teaching physician or another physician was immediately available to return to either procedure in the event of complication.

The teaching physician shall prepare a personal note for each key post-surgical follow-up visit for which physician was present. The teaching physician's note for post-surgical follow-up visits does not need to satisfy the criteria for an E/M

service, but must be a clinically relevant entry in the medical record. This may be a brief note, but "Seen, examined, agreed" or similar entries are not sufficient.

2. **Minor Procedure** (Procedures with less than 5 minutes duration):

   A. Physical Presence: The teaching physician must be present during the entire procedure.

   B. Documentation: The documentation must show that the teaching physician was present during the entire procedure. The documentation may be provided by either the resident, the nurse, or personally by the teaching physician.

3. **Endoscopies** (Excluding endoscopic surgery. Refer to the requirements for major procedures for endoscopic surgery.)

   A. Physical Presence: The teaching physician must be present during the entire "viewing" portion of the procedure. The viewing portion is defined as insertion, viewing and withdrawal of the scope. Viewing via a monitor from a remote location or at a later time is not acceptable.

   B. Documentation: The documentation must show that the teaching physician was present during the entire viewing. The teaching physician may document his/her presence personally. The documentation may be made by a resident, nurses, or an attestation statement and must be countersigned by the teaching physician.

4. **Maternity**

   A. Physical Presence: The teaching physician must be present during all key (critical) portions of the maternity procedures and follow the same guidelines previously noted for major surgical procedures.

   In addition, the teaching physician must provide direct patient care during all deliveries, including normal deliveries. The mere presence of a teaching physician is not sufficient to justify a bill for professional services by the teaching physician.

   B. Documentation: The documentation must show the teaching physician's active involvement in the patient's care, and not just presence and availability at the time of delivery.

5. **Discharge Day Management**

Generally, on the day of a patient's discharge, the physician spends an added amount of time with the patient and the family communicating instructions to be followed upon discharge, future medical visits, and medication management. In addition to any final reviews of progress notes and the patient's physical condition, the amount of time spent with the patient and family discussing discharge instructions should be noted.

6. Interpretation of Diagnostic Radiology and Other Diagnostic Tests:

A. Physical Presence: The teaching physician must personally review both the test, image, or study and review or interpret the test results.

B. Documentation: The interpretation report may be dictated by either the teaching physician or the resident/fellow. If a resident or fellow prepares and signs the interpretation, the teaching physician must indicate the test, image, or study was reviewed and the resident's interpretation and either agrees with it or edits the findings. A countersignature of the resident's interpretation by the teaching physician is insufficient documentation, unless there is accompanying attestation of the above. For pathology consultative services, documentation must include the name of the requesting physician, and the nature of the request.

7. Interventional Radiology and/or Other Complex, High-Risk Procedures

High-Risk procedures for which Medicare policy or the CPT description indicates that the procedure requires personal supervision of its performance by a physician. Examples: interventional radiological and cardiology supervision and interpretation codes, cardiac catheterization, cardiovascular stress tests, and transesophageal echocardiography.

A. Physical Presence: The teaching physician must be present with the patient during all critical and key portions and remain immediately available to furnish services for the duration of the entire procedure. Key portions of two procedures being performed may not overlap. Observation via a monitor from another location is not acceptable to satisfy the presence requirement. Immediately available means that the teaching physician must be in the area and not engaged in the key portion of an overlapping or concurrent procedure. The same rules for major procedures for single and overlapping cases apply to interventional procedures.

When the descriptor of the CPT billing code states "supervision and interpretation" (S&I), the teaching physician must be present during the entire radiologic portion

of the interventional procedure, that portion of the procedure that is reflected in the wording of the procedure code or in accordance with the "supervision and interpretation" requirements as specified in the CPT code description.

B. Documentation: If the teaching physician performs both the surgical and radiologic portions of the procedure, the documentation must indicate that the teaching physician was present during the key/critical portions of the procedure. If the teaching physician is billing an S&I code, the documentation must indicate that the teaching physician was present during the surgical and radiologic portion of the procedure before moving on to another procedure. A co-signature to a report prepared by the resident is insufficient documentation by the teaching physician. For single procedures, a resident, nurse or teaching physician may document the teaching physician's presence. For overlapping procedures, the documentation must be completed by the teaching physician indicating their presence and key portions of the procedure. In addition, there must be documentation by the teaching physician or a signed attestation that the teaching physician reviewed the films and confirm (or revised) the interpretation.

8. Anesthesia

A. Physical Presence: If the teaching physician is present during the key portion of the procedure, including induction, emergence, and any other critical parts of the procedure and immediately available to furnish services during the entire procedure, a bill can be submitted based on the unreduced fee schedule. The teaching physician's physical presence during only the preoperative or postoperative visits with the patient is not sufficient to bill for the service.

B. Concurrent procedures: If the teaching physician is involved in concurrent procedures with more than one resident (maximum of 4 residents) or with a resident and a non-physician anesthetist (CRNA), payment will be for *medical direction*.

C. Medical Direction Requirements: An anesthesiologist must ***meet all seven*** of these requirements for every case the teaching physician is concurrently medically directing:

1. Perform a pre-anesthetic examination and evaluation.
2. Prescribe the anesthesia plan.
3. Personally participate in the most demanding procedures in the anesthesia plan, including induction and emergence.

4. Ensure a qualified individual performs any procedures in the anesthesia plan that the anesthesiologist does not personally perform.
5. Monitor the course of anesthesia administration at frequent intervals.
6. Remain physically present for all key and critical portions of the procedure and be available for immediate diagnosis and treatment of emergencies.
7. Provide post-anesthesia care as indicated.

D. Pre- and post-operative visits: The teaching physician's presence is not required during pre-operative or post-operative visits with the patient, as long as the visits are made by either the resident or CRNA.

E. Documentation: If the service is performed with one resident, the teaching physician must personally document his/her presence with the patient during the key portions of the procedure, including induction and emergence, or regional anesthesia and any other key portion of the procedure. The teaching physician must also document his/her immediate availability during the entire procedure. When a medical student or other student is involved, the teaching physician must also document the pre- and post-anesthesia evaluation and care.

9. Psychiatry

A. Physical Presence: For time-based counseling codes, the physical presence requirement can be met by remote, simultaneous observation and immediate consultation with the resident or fellow. Audio-only equipment does not satisfy the physical presence requirement. The teaching physician should only bill on the basis of the time spent observing the session. Evaluation and Management services and procedures provided in Psychiatry need to comply with the same physical presence requirements of other Evaluation and Management services and procedures. The teaching physician supervising the resident must be a physician. The Teaching Physician Billing Policy does not apply to psychologists who supervise psychiatry residents.

During the service, the teaching physician can be present through a 1-way mirror, video equipment, or like devices. In residency training sites outside an MSA, teaching physicians may be present through audio-video telehealth during the service when they involve residents. Medical records must show the teaching physician took part in the psychiatric services.

B. Documentation: The teaching physician must document the time spent and a description of the involvement in observing the service. The teaching physician should only bill for the time directly observing the service. Documentation of Evaluation and Management services must comply with Evaluation and Management requirements listed in the Evaluation and Management section of this policy. Procedures must comply with procedure documentation requirements.

10. Time-Based Codes

A. Physical Presence: The teaching physician must be present for the period of time for which the claim is made. Time for resident services in the absence of the teaching physician cannot be billed.

B. Documentation: The documentation must show the length of time the teaching physician was directly involved with the service to the patient and a brief description of the service provided.

11. Evaluation and Management Service

A. General Rule: In a teaching setting, the services must meet 1 of these criteria:
   a. Physicians, not residents, personally provide the service (42 CFR 415.170).
   b. Residents provides the service when the teaching physicians are physically present during critical or key service parts (42 CFR 415.172). This includes telehealth services through audio/video real-time technology in residency training sites outside a Metropolitan Statistical Area (MSA).
   c. Teaching physicians providing Evaluation and Management (E/M) services with a Graduate Medical Education (GME) program are granted a primary care exception and may bill Medicare for the lower and mid-level E/M services provided by residents (42 CFR 415.174).

B. Evaluation and Management (E/M) visit level selected is based on the level of medical decision making (MDM) or the amount of time spent by the physician or resident. For some types of visits (such as emergency department visits and critical care), in accordance with their CPT codes, physicians do not have this choice and will use only MDM or only time to bill. The CPT E/M Guidelines for MDM apply.

   For all E/M visits, history and physical exam must be performed in accordance with code descriptors, but history and exam no longer impact visit level selection. When

time is used to select visit level, the full time must be completed; the general CPT rule regarding the midpoint for certain timed services does not apply.

Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of an E/M visit code. It would not be medically necessary or appropriate to bill a higher level of E/M service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed.

C. Physical Presence: In order for a service performed by a resident to be considered billable, the Teaching Physician must have provided direct supervision.

D. Documentation: The teaching physician must personally document:

i. That he/she/they performed the service or was physically present during the key or critical portions of the service when performed by the resident/fellow, and

ii. The teaching physician was directly involved in the management of the patient.

iii. Any additional documentation that is needed to support the level of service billed.

Documentation by the resident of the presence and participation of the teaching physician is not sufficient to establish the presence and participation of the teaching physician. The teaching physician must provide an appropriate attestation.

Any format or method used by the teaching physician for documenting the encounter is acceptable as long as the supportive information pertaining to the level of service can be understood from a review of the medical record. It is acceptable, for example, to write "negative" or place a check mark in the designated column for an element with normal findings if a template is designed in this manner. Comments on abnormal, unexpected findings and pertinent information must be recorded.

Following are three common scenarios for teaching physicians providing E/M services:

Scenario 1: The teaching physician personally performs all the required elements of an E/M service without a resident. In this scenario, the resident may or may not have performed the E.M service independently.

- In the absence of a note by a resident, the teaching physician would document an E/M service in a non-teaching setting.
- Where a resident/fellow has written notes, the teaching physician's note may reference the resident's/fellow's note. The teaching physician must document that he/she/they *performed the critical or key portion(s) of the service* and was *directly involved in the management of the patient*.

Scenario 2: The resident performs the elements required for an E/M service in the presence of, or jointly with, the teaching physician and the resident documents the service. There must be documentation that the teaching physician was *present during the performance of the critical or key portion(s)* of the service and that the teaching physician was *directly involved in the management of the patient. The teaching physician's note should reference the resident's note***.**

Scenario 3: The resident performs some or all of the required elements of the service in the absence of the teaching physician and documents his/her service. The teaching physician independently performs the critical or key portion(s) of the service with or without the resident present and, as appropriate, discusses the case with the resident. There must be documentation that the teaching physician personally *saw the patient, personally performed critical or key portions of the service, and participated in the management of the patient*. The teaching physician's note should reference the resident's note.

EXCEPTION FOR E/M SERVICES FURNISHED IN CERTAIN PRIMARY CARE CENTERS

Under the Medicare primary care exception, teaching physicians can bill certain services that residents provide independently without teaching physicians present, but the teaching physicians must review the care. When time-based office or outpatient E/M visit levels is selected, only the time spent performing qualifying activities, including the teaching physician presence with the residents qualifies. Additionally, the teaching physician cannot use time to select visit level and may only use MDM to select the E/M visit level.

For residency training sites outside an MSA, the teaching physician can bill some communication technology-based services and inter-professional consult services with the GE modifier. These services include:

- CPT codes 99421–99423 (codes for online digital evaluation and management) and 99452 (code for interprofessional referral service).

- HCPCS codes G2010 (code for the remote evaluation of patient video/images) and G2012 (code for virtual check-in).

Teaching physicians providing E/M services within a GME program granted a primary care exception may bill Medicare for certain office visit codes (99202, 99203, 99211, 99212, and 99213) where the teaching physicians may submit claims for services furnished by residents without the presence of a teaching physician. Teaching physicians cannot bill for office or outpatient E/M level 4–5 visits. HCPCS codes that may be billed are G0402, G0438, G0439.

For Medi-Cal patients, the primary care exception does not apply. Under California Code of Regulations, Title 22, Section 51503(j), the teaching physician must provide direct patient care pursuant to the guidelines set forth in Scenario 2, above. No professional fees are payable for services provided independently by resident in a teaching setting.

Residency programs most likely qualifying for this Medicare exception include family practice, general internal medicine, geriatric medicine, pediatrics, and obstetrics/gynecology.

Certain psychiatric GME programs may qualify as a primary care exception in special situations (like when the program provides chronically mentally ill patients comprehensive care). The range of services residents learn about and deliver at primary care centers includes comprehensive medical and psychiatric care.

For this exception to apply, a center must attest in writing that all the following conditions are met for a particular residency program. The center must maintain records demonstrating that they qualify for the exception.

a) Services are furnished in a center located in the outpatient department of a hospital or another ambulatory care entity in which the time spent by the residents in patient care activities is included in determining direct GME payments to a teaching hospital by the hospital's fiscal intermediary.

b) The teaching physician in whose name the payment is sought must not supervise more than four residents at any given time and must be immediately available when providing this supervision. The staff physician must:

   i. Have no other responsibilities (including the supervision of other personnel) during the time the residents are seeing patients under the Primary Care Exception (for example: seeing patients independent of the resident).

ii. Assume primary medical responsibility for those patients cared for by the resident/fellow.

iii. Ensure that the services furnished are reasonable and necessary.

iv. Review with each resident during or immediately after each visit, the patient's medical history, the resident's/fellow's finding on physical examination, diagnosis, and record of tests and therapies, and treatment plan, and

v. Document the extent of participation in the review and direction of the services furnished to each patient and any additional information necessary to support the level of care billed.

vi. If a patient comes to the center and requires a more comprehensive visit service (level 4 or 5) that is unexpected and unscheduled by the center, the teaching physician may see the patient, but must revert to the physical presence rule. The teaching physician may continue to bill for other level 1, 2, and 3 E/M services furnished by up to 4 residents under his/her direct supervision under the exception during the same clinic session.

c) Residents must have completed six months of a GME approved residency program.

d) The patients seen must be an identifiable group of individuals who consider the center to be the continuing source of their health care and in which services are furnished by residents under the medical direction of teaching physicians. The residents must generally follow the same group of patients throughout the course of their residency program.

e) The range of services furnished by residents includes:

i. Acute care for undifferentiated problems or chronic care for ongoing conditions.

ii. Coordination of care furnished by other physicians and providers,

iii. Comprehensive care not limited by organ system or diagnosis.

Documentation: The teaching physician must still write a personal note that indicates:

1. A review of the resident's history, exam, and plan of care as well as any labs/tests/records, etc., and that
2. The review occurred with the resident while the patient was in the clinic or immediately after the resident saw the patient. If the review does not occur within these parameters, the service is not billable.

12. Use of Medical Students

A medical student is never considered to be an intern or a resident. Medicare does not pay for any service furnished by students.

Any contribution of a medical student in the performance of a service billable by a teaching physician must be:

1. Performed in the physical presence of a teaching physician, or physical presence of a resident, in a service meeting the requirement for teaching physician billing.

2. Teaching physician or resident must verify all student medical record documentation, including history, physical exam, and medical decision making (MDM).

3. Teaching physician or resident must personally perform (or re-perform) the physical exam and medical decision-making. They can however verify student documentation in the medical record rather than re-documenting it.

When a resident uses a medical student in the performance of an E/M service, the teaching physician guidelines must be met.

Under these circumstances, a teaching physician must review and confirm key items of the E/M visit if the teaching physician intends to rely on the medical student note to establish any part of the service for which the teaching physician wishes to bill.

13. Use of Moonlighting Resident/Fellows

When a service furnished by a resident who qualifies to be treated as a moonlighting service, the service may be billed as a physician service in the name of the resident under the Medicare fee schedule. However, unless a resident satisfies the moonlighting requirements, no claim may be submitted for the resident's services under the Medicare fee schedule.

A medical and surgical resident service that are not related to their approved GME program and performed **outside the facility** where they have their GME program (also known as moonlighting) is a covered physician service when they meet the **first 2** bulleted criteria below.

A medical and surgical resident service that are not related to their approved GME program and performed **in an outpatient department or hospital emergency room** of the hospital where they have their GME program is a covered physician services when they meet **all 3** bulleted criteria below:

- Physician services need a physician to personally help diagnose or treat.
- The resident is fully licensed to practice medicine, osteopathy, dentistry, or podiatry by the state where they perform the services, and services are not performed as part of the approved GME program.
- The licensed resident services can be separately identified from those services required as part of the approved GME program.

Inpatient services of a resident in a hospital participating in the resident's approved GME program are not covered as moonlighting physician services and may not be separately billed.

Services of a resident in a hospital participating in the resident's approved GME program that are not related to the GME program in which the resident participates can be covered as moonlighting physician services (payable under the Medicare physician fee schedule) in an **outpatient or emergency department** if all the following are met:

1. The services are identifiable physician services.
2. The resident is fully licensed in the state.
3. The services performed can be separately identified from those services that are required as part of the approved GME program.

These requirements must be reflected in a written contract between the resident and the hospital, which is subject to review by the Medicare carrier.

Services furnished by a resident in **non-hospital settings or hospitals other than those participating in the resident's approved GME program** are covered as physician services and billable in the resident's name under the physician fee schedule if the following requirements are met:

1. The resident is fully licensed to practice medicine, osteopathy, dentistry, or podiatry in the State in which the service is performed.

2. The time spent in patient care activities in the non-hospital setting is not included in a teaching hospital's full-time equivalency resident count for the purposes of direct GME payments.

No bill may be submitted for teaching physician services associated with moonlighting residents.

STANDARDS AND ENFORCEMENT

Each department is responsible for ensuring that it is in compliance with this policy prior to submitting claims for services provided by residents and fellows. Questions regarding this policy should be forwarded to the Compliance Office.

Any questions about the interpretation or application of the Teaching Physician Billing Policy should be directed to the Compliance Office. Reports of instances of possible noncompliance may be made confidentially to the Compliance a

REFERENCES

- CMS Manual, Medicare Claims Processing Manual, Pub 100-04, Chapter 12, Section 100, Teaching Physician Services
- CMS Guidelines for Teaching Physicians, Interns & Residents, MLN006347 November 2024 https://www.cms.gov/files/document/guidelines-teaching-physicians-interns-residents.pdf
- Association of American Medical Colleges, Medicare's Teaching Physician Documentation Instructions
- Code of Federal Regulations, 42 CFR 415.172(b), 42 CFR 415.170, 42 CFR 415.174
- California Code of Regulations, 22 CCR 51503(j), Physician Services

Attachment 1

Acceptable Documentation Templates for
Compliance with Provider Practice Plan Teaching Physician Billing Policy

This document provides examples of acceptable medical record documentation templates for teaching physician documentation requirements when resident and/or fellow medical record documentation is also used to support billable services.

E&M: The teaching physician (TP) must personally document (dictated or hand-written) *presence and participation* in all services billed. The TP should also document any additional information necessary to support the level of care billed.

Scenario 1:
Admitting Note: "I performed a history and physical examination of the patient and discussed his management with the resident. I reviewed the resident's note and agree with the documented findings and plan of care."

Follow-up Visit: "I saw and evaluated the patient. I agree with the findings and plan of care as documented in the resident's note. OR "I saw and examined the patient. I agree with the resident's note except …….., so I will ……."

Scenario 2:
Initial or Follow-up Visit: "I was present with resident during the history and exam. I discussed the case with the resident and agree with the findings and plan as documented in the resident's note."

Follow-up Visit: "I saw the patient with the resident and agree with the resident's findings and plan."

Scenario 3:
Initial Visit: "I saw and evaluated the patient. I reviewed the resident's note and agree, except that……"

Initial or Follow-up Visit: "I saw and evaluated the patient. Discussed with resident and agree with resident's findings and plans as written."

Follow-up Visit: "See resident's note for details. I saw and evaluated the patient and agree with the resident's findings and plans as written."

Follow-up Visit: "I saw and evaluated the patient. Agree with resident's note except for….."

Unacceptable Documentation: The following documentation is not acceptable because it does not make it possible to determine whether the teaching physician was present, evaluated the patient and/or had any involvement with the plan of care.

- "Agree with above," followed by legible countersignature or identity
- "Rounded, Reviewed, Agree," followed by legible countersignature or identity
- "Discussed with resident. Agree," followed by legible countersignature or identity.
- "Seen and agree," followed by legible countersignature or identity.
- "Patient seen and evaluated," followed by legible countersignature or identity
- A legible countersignature or identity alone.

Documentation of Services Provided Under the Exception Rule: The TP must personally document (dictated or handwritten) his/her review of and direction of the services provided by the resident either during or immediately after the patient's visit.

"I discussed the care of this patient with the resident providing the service, during or immediately after the patient's visit, and was directly responsible for the patient's management. I have assured that the services provided are appropriate, and I was immediately available to the patient should the need have arisen."

Major Procedures (5 minute or greater duration) - Single: The resident can dictate the TP's presence on his/her behalf when the teaching physician is present for the entire procedure. If the resident dictates the report, the report must indicate the TP's presence during the key portion of the single procedure (non-overlapping and non-concurrent procedures) in the form of an attestation in the documentation, or via a simple declarative statement in the body of the report.

"Dr. XYZ was present to observe Dr. Resident perform this procedure.

OR

"Dr. XYZ (or I) was present for the entire procedure."

Major Procedures (5 minute or greater duration) - Concurrent: The TP must document his/her presence for the critical or key portion, define the critical or key portion, and state his/her immediate availability (or the immediate availability of another TP) for the remainder of the procedure. The note or other supporting documentation should clearly delineate which TP was immediately available.

"I was present for the key portion of the procedure,_____ (define key portion), and was immediately available for the remainder of the procedure."

OR

"I was present for the key portion of the procedure,_____ (define key portion), and another TP was immediately available for the remainder of the procedure. Back-up TP was _____."

Minor Procedures (lasting less than 5 minutes): The TP must attest to being present for the entire procedure. This can be a generic attestation that is signed by the TP.

TP must document: "I was present for the entire procedure."
The resident can document the TP's presence.

Endoscopies: The TP must attest to being present for the entire viewing portion of the procedure (including scope insertion and withdrawal). This can be a generic attestation that is signed by the TP.

TP must document: "I was present for the entire viewing portion of the procedure (including scope insertion and withdrawal) and agree with interpretation."

Radiology and Other Diagnostic Testing: The TP must attest to viewing the film/test and reviewing and agreeing with or editing the interpretation/results. This can be a generic attestation that is signed by the TP.

TP must document: "I attest to having personally viewed the images/tests and approve the above interpretation."

Maternity: The TP must document his/her presence for the critical or key portion, define the critical or key portion, and state his/her active involvement in the patient's care, and not just presence and availability at the time of delivery.

"I was present for the key portion of the delivery,_____ (define key portion), and discussed the continuing care of this patient with the resident and remained directly active in the patient's delivery of the newborn."

Interventional Radiology and Similar High Risk Procedures - Single Cases: The resident, nurse, or TP can document the TP's present for the critical or key portion in the case of single (non-overlapping and non-concurrent procedures).

"Dr. XYZ (or I) was present for the key portion of the procedure, _____ (define key portion) and was immediately available for the remainder of the procedure.

OR

"Dr. XYZ (or I) was present for the entire procedure."

Interventional Radiology and High-Risk Procedures - Concurrent Cases: The TP must document his/her presence for the critical or key portion, define the critical or key portion, and state his/her immediate availability (or the immediate availability of another TP) for the remainder of the procedure.

> "I was present for the key portion of the procedure, _____ (define key portion) and was immediately available for the remainder of the procedure."
>
> OR
>
> "I was present for the key portion of the procedure, _____ (define key portion), and another TP was immediately available for the remainder of the procedure. Back-up TP was _____."

Time-Based Codes (therapy, critical care, etc.): The TP must document the amount of time spent and a brief description of the service provided. (TP cannot count time spent teaching the resident.)

> Example: "I spent X minutes (brief description of service provided)."

Anesthesia Time-Based Services (unreduced service). The TP must document his/her presence during the critical or key portion of each case. In anesthesia, induction and emergence are critical or key portions of the service. (If the anesthesiologist supervises CRNAs in addition to one resident, then the special rules for medical direction provided by anesthesiologists will apply rather than the teaching physician rules.)

ALAMEDA HEALTH SYSTEM	Policy	
	MEDICATIONS HAZARDOUS DRUGS PREPARATION AND HANDLING	**29907 1**
	LEVEL ☐ System ☐ Site	EFFECTIVE DATE: Not Approved Yet Next Review Date: 5/2028

POLICY

Personnel preparing hazardous drugs shall take all necessary precautions, as outlined within this policy, to protect individuals and the environment from hazardous medication(s) contamination. When working with any hazardous drug in a healthcare setting, our healthcare workers shall follow the approaches described within USP 800 & current, published NIOSH table(s) while also adhering to the facility's Assessment of Risk (AOR), Departments' Standard Operating Procedures, along with any recommendations included in the manufacturer's Safety Data Sheet (SDS) or the drug package inserts (DPIs).

PURPOSE

The purpose of this policy is to promote safe work practices for all employees who prepare, handle, and administer hazardous medications. These guidelines should be implemented wherever hazardous drugs are received, stored, prepared, administered and/or disposed.

SCOPE

The scope of this policy shall encompass and apply to any employee within the health system who has the potential to perform tasks with NIOSH defined hazardous medications, which may pose a significant risk of exposure or contamination.

Hazardous drugs (HD) include those outlined in the most recent NIOSH publication.

DEFINITIONS

- AOR = Assessment of Risk
- ASTM = American Society for Testing and Materials
- BSC = Biological Safety Cabinet
- BUD = Beyond Use Date
- CDC = Centers for Disease Control and Prevention
- C-PEC = Containment Primary Engineering Control
- CSP = Compounded Sterile Preparation
- CSTD = Closed System Transfer Device
- Compounding/Manipulation = Includes altering of the dosage forms via crushing, splitting, opening capsules, dissolving, mixing, pouring, combining and/or preparation of a solution, suspension or ointment/cream that is identified as a Hazardous Drug (HD). A procedure referred to as COMPOUNDING through the document.
- DDCD = Deactivation, Decontamination, Cleaning, and Disinfection
- Deactivation = renders a compound inert or inactive. Deactivation agents are Environmental Protection Agency (EPA) registered/approved oxidizers that include peroxide formulations, quaternary ammonias, and sodium hypochlorite (bleach) products.
- Decontamination = removal by inactivating, neutralizing or physically removing HD residue by transferring it to absorbent wipe(s) for disposal. Agents include alcohol, water, peroxide formulations or sodium hypochlorite products.

- Disinfection = a chemical process that uses specific products for the minimum disinfection dwell time to destroy microorganisms and shall be used for areas that are intended to be sterile (PECs/C-PECs)
- DPI = Drug Package Insert
- EPA = Environmental Protection Agency
- IV = Intravenous
- HD = Hazardous Drug and/or Hazardous Medication
- NIOSH = National Institute for Occupation Safety and Health
- OSHA = Occupational Safety and Health Administration
- PPE = Personal Protective Equipment
- Ready To Use (RTU) = a dosage form or product that may be dispensed with minimal, if any effort or preparation, prepackaged
- SDS = Safety Data Sheet
- TABLE 1 HDs = drugs that are classified by the National Toxicology Program (NTP) as "known to be a human carcinogen" and/or are classified by the International Agency for Research on Cancer (IARC) as Group 1 "carcinogenic to humans" or Group2A "probably carcinogenic to humans"
- TABLE 2 HDs= drugs that are NOT classified by NTP as "known to be a human carcinogen"; are NOT classified by IARC as Group 1 "carcinogenic to humans" or Group 2A "probably carcinogenic to humans". Some of these drugs may present an occupational hazard to workers who are actively trying to conceive, are pregnant or may become pregnant, and those that are breastfeeding.
- USP 800 = United States Pharmacopeia General Chapter 800: Hazardous Drugs – Handling in Healthcare Settings
- Workforce = refers to employees, practitioners, volunteers, trainees, and other persons whose performance of work for the included facilities or entities shall conduct practices according to and within the scope of this policy

A. **PROCEDURES**

1. GENERAL RESPONSIBILITIES

a. **Organization**

1. Alameda Health System (AHS) practice sites will maintain a list of HDs consistent with USP 800 standards.
2. The list and AORs will be reviewed and revised annually, as deemed appropriate and necessary by the designated person(s).

b. **Departments**

1. Those departments and areas that handle HDs shall:
    i. Identify the HDs handled within each area

ii. Identify workforce that may work with these HDs

2. Comply with the facility Environment of Care (EOC) which should include: (refer to – *Hazardous Materials, Waste Management, and Waste Disposal Plan Policy* and *Pharmaceutical Waste Policy)*:
3. Develop a plan for HD specific emergency responses, including exposure and spill management.
4. Ensure spill kits are available wherever HDs are routinely handled.

c. **Pharmacy Departments**

1. Licensed Pharmacy spaces only: Pharmacist-in-Charge (PIC) or designated person(s) at each licensed pharmacy shall maintain a site-specific list of antineoplastic drugs, hazardous drugs, and Table 1 NIOSH drugs consistent with the California Board of Pharmacy Regulations.
2. Verify the appropriate HD warning labels distributed indicate special handling precautions.
3. Validate compounding and manipulation of HDs are performed by authorized, trained employees and are utilizing risk mitigation strategies, whenever possible.
4. Pharmacy employees shall follow procedures for hazardous drug preparation, compounding and labeling according to the facilities master drug formula.
5. Pharmacy employees shall review and acknowledge this policy upon initial hire and at minimum annually.

d. **Personnel**

1. Personnel preparing and/or handling oral or parenteral hazardous drug agents shall follow current NIOSH recommendations for donning personal protective equipment (PPE) and utilizing engineering controls for working with hazardous drugs within healthcare settings recommendation (See Table 1).
2. Individuals shall wash hands before donning ASTM D6978 rated gloves for handling HDs and after such gloves are removed.
3. Use of a separate counting tray or pill cutter for HDs shall be utilized to prevent cross contamination of non-hazardous medications with residue from HDs.
4. Decontaminate and deactivate tray/cutter, surfaces, and utensils used. Clean after each use, for oral or topical hazardous drugs
5. Each facility shall maintain a list of HD medications handled at their site(s). This list and AOR shall be reviewed annually and revised when deemed necessary to encompass appropriate changes for compliance to CDC, NIOSH, etc.
6. Personnel/workforce may perform immediate use compounding or manipulation of HDs only if they are Table 2 – non-antineoplastic medications in a medication preparation area, following the PPE requirement(s) delineated in Table 1 of this policy.
7. Personnel must clean the medication preparation areas appropriately.

e. **Training and competency**

1. All personnel who handle HDs must be trained based on their job functions (e.g., in the receipt, storage, compounding, repackaging, dispensing, administering, and disposing of HDs).
2. Personnel competency must be assessed at hire and re-assessed at least every 12 months.
3. The training may include the following depending on the job function:
    1. Overview of entity's list of HDs and their risks
    2. Review of the entity's SOPs related to handling of HDs
    3. Proper use of PPE
    4. Proper use of equipment and devices (e.g., engineering controls, CSTD)
    5. Response to known or suspected HD exposure
    6. Spill management
    7. Proper disposal of HDs and trace-contaminated materials
4. Ensure employees are provided information regarding the Employee Health Services Surveillance Program

f. **Personal Protective Equipment (PPE)**
1. Appropriate PPE will be utilized by individuals who prepare, handle, manipulate, administer, and manage spill waste to mitigate the risk of exposure to HDs.
2. PPE requirements are based on assessment of risk mitigation strategies and risk of exposure related to the activity being performed with the HD and may include chemotherapy rated gloves; impermeable gowns and/or protective gowns, goggles, face shield/guards, respirators, procedural masks, hair covers, full head covers, and shoe covers.

2. **RECEIPT OF HAZARDOUS MEDICATIONS**
a. Appropriate signage should be displayed for areas where handling of HD's will occur
b. Receipt and unpacking of hazardous medications must be clearly separated and performed in an area that can be used to minimize cross contamination and provide containment strategies

3. **STORAGE OF HAZARDOUS MEDICATIONS**
a. Appropriate signage should be displayed in the area that contains HDs.
b. HDs must be stored in a manner that reduces risk of exposure.
c. HDs must be stored to prevents spillage or breakage if the container were to fall inadvertently.

4. **PREPARATION – COMPOUNDING & MANIPULATION**
a. **STERILE & NON-STERILE**
1. Refer to USP 800 for specific details on Sterile Compounding Hazardous Medication as it relates to:
    i. Use of appropriate PPE mitigation strategies
    ii. Engineering controls
    iii. Use of Closed System Transfer Devises
    iv. Deactivating, decontaminating, cleaning and disinfecting (DDCD)

2. Table 2 - NON-antineoplastic hazardous drugs
    i. Properly trained pharmacists or pharmacy technicians shall reconstitute and/or dilute all parenteral Table 2, NON-antineoplastic hazardous drugs intended for administration in an ISO 5 PEC using aseptic technique.
    ii. Appropriate PPE gown and garb shall be worn to perform compounding of a compounded sterile preparation as required per facility SOP. The minimum requirement for compounding of CSPs should be utilized.

iii. For any non-sterile compounded preparation, staff may wear a disposable, single-use, back closure gown when compounding NON-antineoplastic hazardous agents in a non-sterile dosage form (i.e. oral solution, topical, etc.)

3. Table 1 - Antineoplastic hazardous drugs

i. Properly trained pharmacists or pharmacy technicians shall reconstitute and/or dilute all parenteral Table 1, antineoplastic hazardous drugs intended for administration in a negative pressure ISO 5 C-PEC which is contained within an ISO Class 7 buffer room,

ii. Personnel shall don additional PPE when compounding Table 1 antineoplastics to include an additional hair cover, pair of shoe covers, impermeable gown, and pair of ASTM D6978 chemo rate gloves.

b. TABLETS/CAPSULES

c. Manipulation of hazardous tablets (uncoated and coated) and capsules, such as cutting, crushing, or opening, should be done by trained personnel in a hazardous medication designated preparation area **(**See Table 2 for definition and examples of manipulations).

d. For drugs which are hazardous and the dosage form needs to be altered (i.e. crushing, breaking, splitting, or otherwise), the manipulation will require the individual preparing or administering the drug to wear double chemotherapy rated gloves and a protective gown.

e. Additional protective equipment (biological safety cabinet (BSC), face and eye shield, respiratory protection) may be required if altering the dosage form of these drugs poses a risk of splash or aerosolization of HD residue.

5. **TRANSPORT**

2. Table 2 - NON-antineoplastic hazardous drugs

a. All NON-antineoplastic hazardous medications (intravenous and oral) will be transported in a closed re-sealable bag labeled with the following: “CAUTION: HAZARDOUS DRUG,” or similar language.

b. Discharge medications shall be exempt from this requirement as they are protected with multiple bags and containers. Discharge prescriptions are packaged for final dispensing to patient and should contain appropriate auxiliary labeling and counseling/fact sheets provided for handling.

3. Table 1 - Antineoplastic hazardous drugs

a. All antineoplastic hazardous intravenous medications will be first placed in an enclosed re-sealable bag labeled with “CAUTION: CHEMOTHERAPY – Handle and Dispose of Properly”, or similar language.

b. All antineoplastic intravenous medications will be transported from one unit to another in a container that minimizes risk of breakage, leakage, or permeation.

H. ADMINISTRATION

1. Appropriate PPE will be used during the administration process.
2. PPE requirements for administration of HDs are detailed in Table 1 below, according to NIOSH Table toxicity, route of administration, activity.
3. Administration precautions include:

a. Each unit shall provide the necessary PPE for staff.
b. Hazardous medication identification may be found in the Electronic Health record. Hazardous medication identification is also located on the patient-specific medication label, if applicable.
c. Use appropriate PPE when opening transport container(s).
d. Inspect medication containers for leakage prior to opening and throughout the administration process.
    i. If administering Hazardous Medication IVs, never remove the spike and tubing from the IV bag.
    ii. Manipulation of Hazardous Drug dosage forms: dedicated or exclusive equipment must be used for all Hazardous medications that must be manipulated.
e. If contaminated equipment needs to be cleaned, follow steps necessary for decontamination and deactivation.
f. PPE must be properly disposed of after use, per AHS Pharmaceutical Waste Policy.

I. CLEANING

1. Table 1 antineoplastic HDs handling and compounding areas:
    a. Work surfaces and equipment where table 1 HDs are manipulated have high potential for direct contact must be deactivated and decontaminated with either a one step RTU agent or deactivated with a sodium hypochlorite product
2. Cleaning shall occur with one additional wipe and pass to complete mechanical removal of residue with a germicidal agent and by observing the appropriate dwell time.
3. Table 2 non-antineoplastic HDs handling and compounding areas:
4. Work surfaces and equipment used with table 2 HDs may follow standard cleaning precautions
5. Personnel performing cleaning shall follow the manufacturer guidelines for used, application, and dwell time for appropriate DDCD functions.

J. SPILL CONTROL & MANAGEMENT

1. All personnel who may be required to clean up a spill of HDs must receive proper training in spill management and the use of proper PPE.
2. Spills must be contained and cleaned immediately.
3. Signs must be available for restricting access to the spill area. Spill kits containing all of the materials needed to clean HD spills must be readily available in all areas where HDs are routinely handled.
4. If HDs are being prepared or administered in a non-routine healthcare area, a spill kit must be available.
5. All spill materials must be disposed of as hazardous waste.

6. The circumstances and management of spills must be reported as a safety event to the AHS Safety Alert system.
7. Personnel who are potentially exposed during the spill or spill clean-up or who have direct skin or eye contact with HDs require immediate evaluation.
8. If the containment and cleaning of spill exceeds the capacity of the spill kit in the area, contact central supply for more spill kits.

K. MEDICAL SURVEILLANCE

1. Refer to Employee Health SOP

L. QUALITY CONTROL AND ASSURANCE

1. Sampling of surfaces will occur on a routine basis per each facility standard operating procedure for quality control and assurance.
2. A quality control and mitigation plan shall be provided for any HD residue detected in sampled areas. The mitigation plan may include assessment of storage and additional DDCD activities.

M. DISPOSAL OF HAZARDOUS WASTE

1. HDs in Table 1 are classified as chemotherapeutic hazardous waste under the federal Resources Conservation and Recovery Act (RCRA).
2. Arsenic trioxide, is identified to be a P-Listed RCRA hazardous waste and must be disposed of separately to other chemotherapy waste in an appropriately labeled RCRA container.
3. Trace items shall be placed in a rigid, leak-proof, puncture resistant container labeled "Chemotherapy Waste or Trace Chemo Waste".
   a. Trace waste is commonly referred to items that contain a volume that cannot be poured or scraped. It pertains to any products or items that are used in the preparation and/or administration of table 1 antineoplastic HDs
4. Bulk hazardous waste should be disposed of in a rigid, leak proof, and puncture resistant material with a well-fitting lid. The container should be different than that used for disposal of trace chemotherapy waste.
   a. Bulk hazardous chemotherapy waste applies to containers that may contain unused/partially used vials, ampules, syringes, bags, or bottles and volume that can be poured or scraped.

REFERENCES

1. NIOSH List of Antineoplastic and Other Hazardous Drugs in Healthcare Settings, 2024

2. ASHP (American Society of Health-System Pharmacists) [2018]. ASHP guidelines on handling hazardous drugs. Am J Health-Syst Pharm Volume 75, issue 24: 1996-2031.

3. ONS (Oncology Nursing Society) [2011]. Safe handling of hazardous drugs. 2nd Ed. M. Polovich, ed. Pittsburgh, PA: Oncology Nursing Society.
4. Polovich M, Giesker KE [2011]. Occupational hazardous drug exposure among non- oncology nurses. Medsurg Nurs *20*(2):79–85,97.

5. USP 800: https://www.usp.org/compounding/general-chapter-hazardous-drugs-handling-healthcare

APPROVALS

		System	Alameda	AHS/Highland/John George/San Leandro
Pharmacy Department	**Date:**	3/2025		
Pharmacy and Therapeutics (P&T)	**Date:**	3/2025		
Clinical Practice Council (CPC)	**Date:**			
Medical Executive Committee	**Date:**			
Board of Trustees	**Date:**			

Table 1 (1)

Personal protective equipment# and engineering controls for working with hazardous drugs in healthcare settings*

Formulation	Activity	Double Chemo-Therapy Gloves	Protective gown	Eye/Face protection	Respiratory protection	Ventilated engineering control
Topical Drug	Compounding	YES	YES	YES, if not done in a control device	YES, if not done in a control device	YES†, BSC OR CACI
	Administration	YES	YES	YES; if liquid that could splash‡	YES, if inhalation potential‡	N/A
Oral liquid drug	Compounding	YES	YES	YES, if not done in a control device	YES, if not done in a control device	YES†
	Administration	YES	YES	YES, if splash risk	YES, if splash risk	N/A
Intravenous solution	Compounding	YES	YES	YES, if not done in a control device	YES, if not done in a control device	YES, BSC or CACI; recommend use of CSTD
	Administration of prepared solution§ (IV, Intrathecal, Intracerebral, Intravitreal)	YES	YES	YES; if liquid that could splash‡	YES, if inhalation potential‡	N/A; recommend use of CSTD
Subcutaneous, intramuscular injection	Preparation (withdrawing from vial or ampoule)	YES	YES	YES, IF NOT DONE IN A CONTROL DEVICE	YES, IF NOT DONE IN A CONTROL DEVICE	YES BSC OR CACI
	Administration from prepared syringe	YES	YES	YES; if liquid that could splash‡	YES, if inhalation potential‡	N/A
Solution for irrigation	Compounding	YES	YES	yes, if not done in a control device	yes, if not done in a control device	YES BSC or CACI; use of CSTD recommended
	Administration (bladder, HIPEC, limb perfusion, etc.)	YES	YES	YES	YES	N/A
Intact tablet or capsule	Administration from unit-dose package	NO (single glove should be used)	NO	NO	NO	N/A
Tablets or cap-sules	Cutting, crushing or otherwise	YES	YES	YES	YES	YES†

	manipulating tablets or capsules			,if not done in a control device	,if not done in a control device	
Drug Contaminated Waste	Disposal and cleaning	YES	YES	YES; if liquid that could splash‡	YES, if inhalation potential‡	N/A
Drugs and metabolites in bodily fluids	Disposal and cleaning	YES	YES	YES; if liquid that could splash‡	YES, if inhalation potential‡	N/A
Spills	Cleaning	YES	YES	YES	YES	N/A

The table provides general guidance for some of the possible scenarios that may be encountered in healthcare settings, but cannot cover all possible situations. For more detailed information on safe handling practices, see the reference list [NIOSH 2004; ASHP 2006; USP 2008, and ONS 2011]. BSC = Class II biological safety cabinet; CACI = compounding aseptic containment isolator; CSTD = closed system drug transfer device; HIPEC = hyperthermic intraperitoneal chemotherapy.

For nonsterile preparations, an engineering control such as a fume hood or Class I BSC is sufficient. It is recommended that these activities be carried out in a control device, but it is recognized that under some circumstances, it is not possible. If the activity is performed in an engineering control that is used for sterile intravenous preparations, a thorough cleaning is required following the activity.

Required if patient may resist (infant, unruly patient, veterinary patient) or if administered by feeding tube.

Intravenous tubing already attached and primed.

* For more detailed information on safe-handling practices, see the reference list [NIOSH 2004; ASHP 2006; ONS 2011; USP 2016; OSHA 2016].

Appropriate PPE must be worn when handling HDs including during: • Receipt • Storage • Transport • Compounding (sterile and nonsterile) • Administration • Deactivation/decontamination, cleaning, and disinfecting • Spill control • Waste disposal

Table 2- Definition of types of exposure

Routes of unintentional entry of HDs into the body include dermal and mucosal absorption, inhalation, injection, and inges-tion (e.g., contaminated foodstuffs, spills, or mouth contact with contaminated hands). Containers of HDs have been shown to be contaminated upon receipt. Both clinical and nonclinical personnel may be exposed to HDs when they handle HDs or touch contaminated surfaces. *See below for* potential routes of exposure based on activity.

Activity	Potential Opportunity of Exposure
Receipt	• Contacting HD residues present on drug containers, individual dosage units, outer containers, work surfaces, or floors
Dispensing	• Counting or repackaging tablets and capsules
Compounding and other manipulations	• Crushing or splitting tablets or opening capsules • Pouring oral or topical liquids from one container to another • Weighing or mixing components • Constituting or reconstituting powdered or lyophilized HDs • Withdrawing or diluting injectable HDs from parenteral containers • Expelling air or HDs from syringes • Contacting HD residue present on PPE or other garments • Deactivating, decontaminating, cleaning, and disinfecting areas contaminated with or suspected to be contaminated with HDs • Maintenance activities for potentially contaminated equipment and devices
Administration	• Generating aerosols during administration of HDs by various routes (e.g., injection, irrigation, oral, inhalation, or topical application) • Performing certain specialized procedures (e.g., intraoperative intraperitoneal injection or bladder instillation) • Priming an IV administration set
Patient-care activities	• Handling body fluids (e.g., urine, feces, sweat, or vomit) or body-fluid-contaminated clothing, dressings, linens, and other materials
Spills	• Spill generation, management, and disposal
Transport	• Moving HDs within a healthcare setting
Waste	• Collection and disposal of hazardous waste and trace contaminated waste

	Protocol	
	USE OF ECHOCARDIOGRAPHY CONTRAST IMAGING AGENTS	**4**
	Level ☐ System ☐ Site – HGH Cardiac NIL, SLH Cardiac NIL, ALH Cardiac NIL	**Effective Date:** 3/2025 **Last Review Date:** 2/2019
	Document Owner: Cardiac NIL Department Manager	

USE OF ECHOCARDIOGRAPHY CONTRAST IMAGING AGENTS

Purpose

This protocol guides Registered Diagnostic Cardiac Sonographers (RDCS), Registered Cardiac Sonographers (RCS) and Registered Nurses (RN) in safely and effectively administering ultrasound enhancing contrast (UEC) during echocardiography procedures. The protocol ensures enhanced image quality, improved diagnostic accuracy, and patient safety.

Image enhancing contrast agents are needed for the following reasons:

1. To opacify the left ventricular chamber and to improve the delineation of the left ventricular endocardial border:
    - When there is inability to visualize at least two (2) myocardial segments of the left ventricle.
    - When an LV aneurysm or pseudoaneurysm is suspected
    - When apical hypertrophic cardiomyopathy is suspected.
    - When a noncompaction cardiomyopathy is suspected.
    - To assess LV/RV systolic functions.
    - To rule out LV/RV and LA/RA thrombus.
2. To enhance Doppler signals when evaluating intra-cardiac pressures.

Scope

This policy applies to all Registered Diagnostic Cardiac Sonographers, (RDCS) Registered Cardiac Sonographers, (RCS) Registered Nurses, (RN) imaging departments, and associated processes and systems involved in the administration of ultrasound enhancing contrast during echocardiography procedures.

Imaging Enhancing Agent Procurement and Processing

The UEC, Perflutren Lipid Microsphere (Definity®), will be stocked by the pharmacy in the appropriate refrigerated pxyis. A nurse/sonographer will obtain the contrast agent from refrigerated storage and proceed to activate it by using a product specific shaker, per manufacturer recommendations, prior to patient administration.

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IMAGING

1. Begin imaging immediately after contrast administration, using harmonic imaging to enhance visualization.
2. Capture standard echocardiographic views, including:
    - Apical four-chamber, two-chamber, and three-chamber views.
    - Parasternal long- and short-axis views.
    - Additional views as requested by the interpreting cardiologist.
3. Assess image quality and administer additional boluses as needed.

Safety Profile:

Most frequently reported adverse effects are headache, back/renal pain, flushing, nausea, chest pain, dizziness and IV site complications. The contrast agent is undetectable after 10 minutes. Most reactions occur within 30 minutes of administration.

Serious Cardiopulmonary reactions, including fatalities, have occurred uncommonly during, or following Perflutren containing microsphere administration. Most serious reactions occur within 30 minutes of administration. Always have resuscitation equipment and trained personnel readily available. From reviews of the literature, serious allergic and anaphylactoid reactions were seen in 1/10 000 percent of subjects.

Precautions:

There are no data about safety of contrast agents in pregnancy. Given lack of data in this patient subset, use in pregnancy only if clearly needed. Patients with sickle cell disease may be at higher risk of painful crisis and Definity should be administered with caution.

Contraindications:

Definity is contraindicated in patients with known or suspected hypersensitivity to Perflutren lipid microsphere or its components, such as polyethylene glycol (PEG).

For any adverse reaction:

- Inpatients: Notify the primary team immediately.
- Outpatients: Inform the cardiologist physically present in the clinic.

Sonographer Responsibility

1. The Registered Cardiac Sonographer will determine the need for a contrast agent based on the above listed criteria.
2. The sonographer will:
   - Notify the RN or independently administer the Definity contrast if they have completed the appropriate training and demonstrated proficiency in administration.
   - Place protocol-driven order for Definity and document administration.
   - Perform imaging following contrast administration.

Nurse Responsibility

- RNs will:
  - Establish IV access as necessary.
  - Discontinue the IV access.
- Place protocol-driven order for Definity and document administration and IV placement.
- Administer the Definity® contrast when requested by the sonographer if the sonographer has not been trained to administer the agent.

DOSAGE AND ADMINISTRATION

Contrast Preparation

1. Activate Definity® using the manufacturer's specific shaking device for 45 seconds.
2. If not used within five minutes, re-suspend by hand agitation for 10 seconds.

Injection Administered by Sonographer or RN)

1. Dilute 1.5mg of Definity® in 8.5ml of 0.9% saline.
2. Administer 2ml of the prepared solution slowly (1ml/10secs)
3. If necessary, administer a second dose after the first bolus clears.
4. When complete with solution, flush 3-5ml of saline to clear the line.

	Protocol	
	USE OF ECHOCARDIOGRAPHY CONTRAST IMAGING AGENTS	**4**
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	Document Owner: Cardiac NIL Department Manager	

Procedure for Nursing Personnel

1. Upon determining the need for use of an image enhancing contrast agent by the Cardiac Sonographer, the RN will assess the existing IV, if any, for proper function and to ensure they are not using an IV line that is dedicated to medication drips. If a new IV site is needed one will be started at this time, using a 18–20-gauge angiocath.

2. Identify any known allergies and evaluate for any contraindications to the test.

3. Explain the procedure to the patient and possible side effects.

4. Once the IV has been started, the trained nurse or sonographer will:
    a. Activate the contrast agent per manufacturer's recommendations for 45 seconds. If the contrast agent sits for more than five minutes after activation, re-suspend with 10 seconds of hand agitation.
    b. Using a 10 ml flush syringe and vented spike, waste 1.5ml of saline flush. Insert the vented spike into the contrast vial and aspirate all the material (approx. 1.5ml). Hand agitate the syringe to ensure uniform mixing of the contrast and saline.
    c. Inject 1-3 ml of the contrast slowly over 10-30 seconds (injection rate approximately 10 seconds/ml. Subsequent injections of 0.25 - 2 ml may be given as needed. Dosing amounts are determined by the Cardiac Sonographer based on image effect. Max dosage of 10 ml. A slow flush using 0.9% sodium chloride may be necessary to improve image quality.
    d. Once adequate images have been obtained, the IV may be discontinued on outpatients by the Registered nurse.

5. Resuscitation equipment and trained personnel are always readily available.

6. In the event of adverse effects, the Cardiac Sonographer and/or RN will first call the cardiologist for instructions or initiate emergency response call as appropriate.

Procedure for Sonographers

1. Select the LVO (Left Ventricular Opacification) preset on the imaging system. Be sure the mechanical index is reduced, and the focal zone is at the mitral annulus.

2. Begin recording as soon as the right ventricle becomes opacified.

3. Obtain the four-chamber, two-chamber, (RV contrast should be totally out of the picture) and the apical long axis views, as necessary (labeled).

4. Obtain the parasternal long and short axis views, as necessary (labeled).

5. Obtain tricuspid regurgitation jets and aortic, mitral velocities, as necessary.

6. End exam and send all images to the Syngo reading station for physician interpretation.

Key Controls for Optimization:

1. MI (power)

If there isn't enough definition, go up on the power. If there is too much swirling and an adequate amount of contrast has been administrated, go down on the power because you are destructing the bubbles. For patients with a very low EF, going to a lower frequency will help to reduce swirling. If you need to be in a lower frequency but you think the image looks too grainy, increase the compression to soften the image. Often times increasing the MI in the parasternal views help to bring out the inferolateral wall in the far field (you also may need more contrast at this point).

2. Frequency.

Identify the best frequency setting where you see the best endocardial definition.

3. DDP

Adjust accordingly to make your image smoother or crisper.

4. Focus

Focus should typically be placed at the mitral annulus level; however, you may find your images look better on some patients when it's at the mid or apical level. It's ok to move the focus to wherever the picture looks best. If there is an apical thrombus, or anything to focus on in the apex, you should bring your focus to that level.

5. Compression

Adjust accordingly (up or down on a case-by-case basis) for optimal visualization.

6. Overall 2D gain, TGCs ("Auto" should be off)

You should strive for homogenous filling of the LV chamber, from base to apex. You should not over gain or under gained. Your gain should be set to where you clearly see endocardial definition and you see uptake of contrast in the myocardium. Use TGCs, overall gain accordingly.

7. **Color Maps** (sonographer Discretion)

Required Documentation:

Nurses / sonographers will document that they administered the contrast agent, along with name of the contrast/date/time/amount given in the patient's EMR for inpatients and for outpatients a written progress note will be sent to medical records and placed in the patient's chart. A final Echocardiogram report will be added to the patient EMR within 24 hours of the exam for inpatients and by the end of the next business day for all outpatients and will document the use of the contrast agent given.

TRAINING AND CERTIFICATION

- Sonographers must complete specific training in:
  - Safe administration of Definity® contrast.
  - Imaging techniques post-contrast administration.
- Competency will be evaluated annually, and records maintained by the department.

References

1. **American Society of Echocardiography (ASE) Guidelines**
   The ASE has issued guidelines on the use of contrast in echocardiography, which endorse sonographer-administered contrast in facilities where protocols are established, provided sonographers are trained. The **2018 ASE guidelines** emphasize that sonographers can safely administer ultrasound contrast agents like Definity under physician oversight, facilitating effective patient throughput and enhanced imaging quality in echocardiography labs.
   - **Reference**: Porter TR, Mulvagh SL, Abdelmoneim SS, et al. "Guidelines for the Cardiac Sonographer in the Performance of Contrast Echocardiography: Recommendations of the American Society of Echocardiography." *Journal of the American Society of Echocardiography*. 2018;31(3):241-257.

	Protocol	
ALAMEDA HEALTH SYSTEM	**USE OF ECHOCARDIOGRAPHY CONTRAST IMAGING AGENTS**	**4**
	Level ☐ System ☐ Site – HGH Cardiac NIL, SLH Cardiac NIL, ALH Cardiac NIL	**Effective Date:** 3/2025 **Last Review Date:** 2/2019
	Document Owner: Cardiac NIL Department Manager	

2. **Clinical Protocols for Sonographer Contrast Administration**
   A study in *Echocardiography: A Journal of Cardiovascular Ultrasound and Allied Techniques* explored the impact of sonographers administering ultrasound contrast. It found that trained sonographers could safely and efficiently administer contrast agents, improving workflow and diagnostic quality without increased adverse events. The protocol emphasized training and direct availability of a supervising physician to ensure patient safety.

   - **Reference**: Main ML, Ryan AC, Davis TE, et al. "Contrast Echocardiography: Clinical Practice and Implementation in the Echocardiography Laboratory."

   - *Echocardiography*. 2019;36(4):627-635.

3. ASE Consensus Statement on the Clinical Applications of Ultrasonic Contrast Agents in Echocardiography. JASE Nov 2008
4. Information for Healthcare Professionals: Micro-bubble Contrast Agents. http://www.fda.gov/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsa ndProviders/ucm125574.htm

APPROVAL(S):

Approving Committee / Executive	Date of Approval
Department Leader	
Clinical Practice Council	
Pharmacy & Therapeutic	
Medical Director, Non-Invasive Lab	
Specialty AOC	

	Protocol	
	Level ☐ System ☐ Site	**Effective Date:** **Last Review Date:**
	Document Owner:	

PATIENTS OWN MEDICATIONS: STORAGE, SECURITY, HANDLING, AND ADMINISTRATION

Site	Alameda Health System	***Previous Revision Dates***	
Effective Date	5/1/2025	***Date Revised***	3/2025
Document Owner	MGR SYS MED SAFETY-CLIN PHARM	***Next Scheduled Review***	5/2028

POLICY

The purposes of this policy are (a) to assure the secure storage and return of the patient's own medication, or any substance or mixture of substances intended to be used for medicinal purposes (*e.g.*, herbal and dietary supplements, medical cannabis/marijuana), brought into the hospital by patients or an external source; and (b) to provide safe and effective administration of medications, or any substance or mixture of substances intended to be used for medicinal purposes, brought into the hospital by patients or an external source.

SCOPE

This policy applies to AHS and to all employees (as well as potential employees), medical staff members, volunteers, contractors, residents, visitors, and patients (regardless of service or category of patient). This policy also applies to all facilities and property under the managing authority of Alameda Health System.

DEFINITIONS

Alameda Health System Employee - means any employee, medical staff, contracted staff, volunteer, trainer and any other person whose conduct, in the course of work for AHS or under AHS' direct control, regardless of whether or not they are paid by AHS.

Alameda Health System Property - include, but are not limited to, Alameda Hospital, Creedon Advanced Wound Care, Eastmont Wellness Center, Fairmont Rehabilitation and Wellness Center, Hayward Wellness, Highland Hospital, John George Psychiatric Hospital, Newark Wellness Center, Park Bridge Rehabilitation and Wellness Center, San Leandro Hospital, South Shore Rehabilitation and Wellness Center.

Hospital Admission - include, but are not limited to, emergency department visits, ICU admissions, inpatient hospital admissions, outpatient hospital admission, any secondary care- based activity that requires a hospital bed (*e.g.*, planned admission, day cases, births, associated deliveries, etc.), and any other admission at any of the facilities of Alameda Health System.

Marijuana - includes both (a) "medical marijuana," which is marijuana used for medical purposes under California's Compassionate Use Act (CUA), and (b) "recreational marijuana" under the Adult Use of Medical Marijuana Act (AUMA). Marijuana is considered a Controlled Substance Schedule I under the Federal DEA Controlled Substance Act. Does not include Medical Marijuana use for eligible patient approved under SB311.

Medication - includes prescription medicines, over-the-counter (OTC) medicines, and complementary and alternative medicines. ("Complementary and Alternative Medicines" include, but are not limited to, medical products containing herbs, vitamins, minerals, and nutritional supplements, homeopathic medicines, and traditional medicines). For purposes of this policy, the term "medication" *does* not include *medical and recreational marijuana*.

Patient's own medications (POMs) - for purposes of this policy, POMs includes the medication(s) a patient brings into the hospital at admission, or that is brought in from an external source at a later point during their stay in the hospital.

PROCEDURE

Patient's Own Medication (POMs)

1. Handling of POMs Brought Into Alameda Health System
    a. **POMs** brought into the hospital upon admission, or brought in from an external source at a later point, should be returned home whenever possible. If that is not possible, the admitting nurse must, in the presence of the patient, family, or another licensed staff member if the patient or family cannot observe, do the following:
        i. The admitting nurse must place the medication in a security (tamper evident) bag and seal the bag;
        ii. The admitting nurse must properly document, on the bag (in ink) in the space provided, the following information:
            1. Patient Name
            2. Medical Record Number (MRN) or admission number
            3. Date received
        iii. The patient identification sticker must be placed on the bag and receipt for the patient information;
        iv. The information above (section (a)(i)(2)) must be included on the receipt tab; and
        v. The admitting nurse must inform the patient that upon discharge he or she will have 60 days to reclaim their medication(s) or they may be destroyed per pharmacy policies.
    b. **Illegal Drugs, Unlawful Controlled Substances (*e.g., Marijuana except for Medicinal Marijuana use under SB311*), and Drug Paraphernalia** brought into the hospital upon admission (or that is brought in from an external source at a later point) should be handled in accordance with this policy and AHS policies; "Controlled Substance Management Policy" and "Marijuana: Recreational and Medical Use".

2. **Transportation and Storage of POMs**
    a. **Transportation of POM**
        i. A licensed staff member shall be responsible for ensuring delivery of the sealed bag to the pharmacy. Please note that if any of the medications are controlled substances approved for medical use, delivery must be made by the admitting nurse.
        ii. The admitting nurse's (or licensed staff's) and receiving pharmacist's initial must be written on the bag (in ink) once the POMs are delivered
    b. **Storage of POM**
        i. POMs that have not been sent home must be stored in a secure area, in accordance with the storage requirements for the medication(s). *E.g., When patients bring in refrigerated medications, nurses must seal it in a separate envelope and label as needing refrigeration. This will alert the pharmacy to the necessary storage conditions*
        ii. **Site Protocols and Procedures** - The location where POMs are stored will depend on site protocols and procedures based on local storage facilities and resources.

3. **Use of Patient's Own Medications**
    a. **General** - Medications brought by or with the patient to the hospital shall not be administered to the patient when the same medications can be supplied by the hospital with the exception of expensive non-formulary items, or medications that require restricted ordering (REMS, etc.) where timely ordering could be difficult.
    b. **Medication Administration Policy** - The use (administration) of POMs must be in accordance with the procedures set forth by Alameda Health System's "*Medication Administration*" policy.
    c. **Safety Measures** - If POMs are to be used (administered) during the patient's stay in the hospital, the following steps shall be taken to ensure safety when administering POMs:
        i. A specific order from the patient's physician must be written before such a medication may be administered.
            1. The Physician's specific order must indicate 'Patient Own Medication(s)' and must include the Patient's name, MRN, medication name, dose, route and frequency.
        ii. The pharmacist must (1) visually inspect the contents for integrity and (2) identify, and verify the medication through tablet identification.
            1. If a POM needs to be initiated outside of pharmacy hours, a physician may perform the medication verification as described above using an AHS approved drug information resource. The physician will document this verification in the drug order as a note to pharmacy. Nursing may override the drug label scan upon administration for initial dosing, however, nursing must bring the POM to pharmacy when the pharmacy re-opens for re-verification and AHS labeling.
            2. Medications that cannot be identified or those that are not FDA approved in the United States will not be used and shall be returned to the patient's family or destroyed (or in limited circumstances stored in

the pharmacy until the patient is discharged).

3. In the event that the medication brought in by the patient is not in unit dose form, the medication will be labeled according to state law and must include the patient's full name, date, name and strength of medication with instructions of when and how to use or take and must indicate approval by pharmacist. Information concerning the medication must be available in an internet drug information resource

d. **Documentation** - Medications administered from the patient's own medication supply must be documented in the patient's medical record by a licensed staff member.

e. **"POMs" Restrictions**:

i. **General** - It is the policy of AHS that *Medication* that is not in its original prescription container will not be used as patient own medication due to difficulty verifying the medication expiration date. This may include, but is not limited to blister or bubble pack, pill boxes, etc.

ii. **Complementary/Alternative Medicines** - The use (administration) of *Complementary/Alternative Medicines* is strictly prohibited by Alameda Health System.

1. **Limited exception**

a. Vitamins and supplements on the approved hospital formulary are exempt and may be prescribed for the patient by the provider.

b. If a patient insists on taking their home complementary/alternative Medicines that is not recommended or accepted by the physician, the treating provider will discuss with the patient that continued use of the complementary/alternative product is at their own risk and document this discussion in the patients chart. *Patients shall be monitored for any adverse events and interactions with other medicines as per standard care when prescribing and administering conventional medicine.*

4. **POMs Reconciliation on Discharge**

a. **Reconciliation on Discharge** - It is the nursing unit's responsibility to request the patient's medication be returned from the pharmacy to the nursing unit at the time of discharge.

b. **Medical Review** - it is important that all POMs are reviewed prior to discharge by the pharmacist or by the nurse to ensure that patients receive the correct medication(s) and are in accordance with the discharge plan.

c. **Delivery** - The pharmacy may deliver the medication to the patient unit or the nurse may pick up the medication bag from the Pharmacy. If the Pharmacy is closed, the medications can be retrieved the next day when the Pharmacy is open.

d. **Signature** - the nursing unit is responsible for obtaining the signature of the patient (or patient representative) indicating receipt of medications.

e. **Disposal of POMs** - Upon discharge, the pharmacy can offer to dispose of the medication for the patient or family. Patients who have medications stored in the

pharmacy have up to 60 days of discharge to reclaim them or they may be destroyed per pharmacy policies.

Patients in Possession of Illegal Drugs, Unlawful Controlled Substances, Opened Syringes, Needles and Drug Paraphernalia:

1. **General** - It is the policy of Alameda Health System to prohibit the use of illegal drugs (including *Controlled Substances that are unlawful under Federal law*), and the possession, concealment, transportation, or distribution of illegal drugs, drug paraphernalia, and other unauthorized items on Alameda Health System premises.

2. **Known or suspected possession or use of Illegal Drugs by Patient** –
    a. **Reporting** - If an AHS employee has a reasonable suspicion that a patient is using or is in possession of an illegal drug or in violation of this policy, the employee should report this to their immediate supervisor.
    b. **Counseling** - A licensed staff must advise the patient that Alameda Health System does not permit or tolerate the use or possession of illegal drugs on hospital premises. The patient should be invited to promptly remove or surrender, voluntarily, any illegal drugs in their possession for destruction. Specifically to Marijuana, if a patient presents to any AHS facilities with Marijuana, the patient will be informed that our facility is a Marijuana free facility.

3. **Refusal to Surrender Illegal Drugs** - Alameda Health System has no authority to remove or retain any substance without the patient's express consent. If a patient refuses to surrender a suspected illegal drug, local law enforcement shall be called for retrieval and destruction. Specifically to Marijuana, patients will be instructed to remove the Marijuana and if the patient or a family member/friend is unable to remove the marijuana, AHS will dispose in pharmaceutical waste bin (see Pharmaceutical Waste Policy and AHS System Waste Chart).

4. **Destruction of Illegal Drugs, Controlled Substances, or Drug Paraphernalia**
    a. Suspected illegal drugs or controlled substances surrendered to the AHS employee must be destroyed. Refer to AHS policies; Controlled Substances Management Policy, section Waste and Destruction of Controlled Substances.
    b. Opened Syringes, needles and illegal drug paraphernalia are not to be sent to the Pharmacy as "patient's own medications." These are to be disposed of in the appropriate sharps/drug container when they are collected from the patient.
    c. Under no circumstances may an illegal drug be handed back to a patient or the patient's representative, as the person doing so could be guilty of unlawful supply of a Controlled Substance

REFERENCES

TJC MM .03.01.05 EP 1, EP 2

APPROVALS

		System	Alameda Hospital
Pharmacy Leadership	**Date:**	**3/2025**	
Risk Management Department	**Date:**		
Legal Department	**Date:**		
System Pharmacy and Therapeutics	**Date:**	**3/2025**	
Clinical Practice Council	**Date:**	**4/2025**	
Medical Executive Committee	**Date:**	**4/2025**	
Board of Trustees	**Date:**	**5/2025**	

ALAMEDA HEALTH SYSTEM

MEDICATION THERAPEUTIC INTERCHANGE POLICY

Effective Date	No Date Set	***Date Revised***	
Document Owner	PRIYA PATEL (MGR SYS MED SAFETY-CLIN PHARM)	***Next Scheduled Review***	5/2028No Review Date
Executive Responsible	DIRECTOR, PHARMACY		

Printed copies are for reference only. Please refer to electronic copy for the latest version.

PURPOSE

To promote cost effective, rational drug therapy by controlling the number of similar medications within a given therapeutic class that will be available on the formulary.

POLICY

A therapeutically equivalent drug may be interchanged by a pharmacist following the development of objective interchange guidelines by the medical and pharmacy staff through the Pharmacy and Therapeutic Committee and the Medical Executive Committee.

PROCEDURE

1. The Pharmacy and Therapeutics Committee will identify potential therapeutic classes of medications which may provide an opportunity for therapeutic interchange.
2. Upon identification, experts in the area of the therapeutic classification will be charged with selecting an appropriate therapeutic class representative drug.
3. In making this selection, the following factors shall be considered:
    a. Mechanism of action, adverse effect profile, dosing schedule, monitoring parameters, potential drug interactions, and cost.
4. Following the agent selection, objective interchange guidelines will be established and will be reviewed with other members of the medical staff.
5. The therapeutic interchange guidelines will be reviewed and approved by the Pharmacy and Therapeutics Committee and the Medical Executive Committee.
6. Notwithstanding orders disallowing substitution, medications approved for therapeutic interchange are authorized to be interchangeable by the pharmacist.
7. Prescribers may disallow therapeutic interchanges with an order specifying “Do Not Substitute” or use of similar wording in meaning and submit a nonformulary use form with justification.
8. Any therapeutic interchanges authorized by the policy will be documented by the pharmacist through an electronic note.

APPROVALS

		System	Alameda	AHS/Highland/John George/San Leandro
Department	**Date:**	~~8/2021~~ 3/2025		
System Pharmacy and Therapeutics (P&T)	**Date:**	~~8/2021~~ 3/2025		
Clinical Practice Council (CPC)	**Date:**	~~11/2021~~		
Medical Executive Committee (MEC)	**Date:**	~~11/17/2021~~		
Board of Trustees (BOT)	**Date:**	~~01/13/2022~~		

AHS SYSTEM FORMULARY THERAPEUTIC INTERCHANGE

GRAYED OUT MEDICATIONS CONSIDERED FORMULARY

ACE-INHIBITORS (ACE-I)									
benazepril (Lotensin) *	**fosinopril (Monopril) ***	**moexipril (Univasc) ***	**perindopril (Aceon) ***	**quinapril (Accupril) ***	**ramipril (Altace) ***	**trandolapril (Mavik) ***	**enalapril (Vasotec)**	**captopril (Capoten)**	**lisinopril (Prinivil/Zestril)**
5 mg daily	5 mg daily	3.75 mg daily	2 mg daily	5 mg daily	1.25 mg daily	0.5 mg daily	5 mg daily or 2.5mg BID	N/A	**5 mg daily**
10 mg daily	10 mg daily	7.5 mg daily	4 mg daily	10 mg daily	2.5 mg daily	1 mg daily	10 mg daily or 5mg BID	25mg BID or TID	**10 mg daily**
20 mg daily	20 mg daily	15 mg daily	8 mg daily	20 mg daily	5 mg daily	2 mg daily	20 mg daily or 10mg	BID 50 mg BID	**20 mg daily**
40 mg daily	40 mg daily	30 mg daily	16 mg daily	40 mg daily	10 mg daily	4 mg daily	40mg qday or 20mg BID	100 mg BID	**40 mg daily**
40 mg BID	40 mg BID	N/A	N/A	N/A	20 mg daily	N/A	N/A	200 mg BID	**N/A**

**** All non-formulary ACE-inihibitors will be converted over to Lisinopril****
**** Captopril formulary for cardiac patients***
**** Enalapril IV formulary and oral when converted from IV Enalapril ****

ANGIOTENSIN RECEPTOR BLOCKER (ARB)						
candesartan (Atacand)	**irbesartan (Avapro)**	**olmesartan (Benicar)**	**valsartan (Diovan)**	**telmisartan (Micardis)**	**eprosartan (Teveten)**	**losartan (Cozaar)**
4 mg daily	75 mg daily	10 mg daily	40 mg daily or 20 mg BID (hypertension)	20 mg daily	400 mg daily	**25 mg daily**
8 mg daily	150 mg daily	20 mg daily	80 mg daily (hypertension) or 40mg BID (heart failure)	40 mg daily	600 mg daily	**50 mg daily**
16 mg daily	300 mg daily	40 mg daily	160 mg daily (hypertension) or 80mg BID (heart failure)	80 mg daily	800 mg daily	**100 mg daily**
32 mg daily	300 mg daily	40 mg daily	320 mg daily (hypertension) or 160 mg BID (heart failure)	80 mg daily	800 mg daily	**N/A**

ALPHA-1 ADRENERGIC BLOCKER

Terazosin (Hytrin)	**Doxazosin (Cardura)**
1 mg QHS	**1 mg QHS**
2 mg QHS	**2 mg QHS**
5 mg QHS	**4 mg QHS**
10 mg QHS	**8 mg QHS**
20 mg QHS	**8 mg QHS**

HMG-CoA REDUCTASE INHIBITOR (STATINS)

fluvastatin (Lescol)	**pitavastatin (Livalo)**	**lovastatin (Mevacor)**	**rosuvastatin (Crestor)**	**simvastatin (Zocor)**	**pravastatin (Pravachol) ***	**atorvastatin (Lipitor)**
20 mg QHS	N/A	10 mg QHS	N/A	5 mg QHS	10 mg QHS	**N/A**
40 mg QHS	1mg	20 mg QHS		10 mg QHS	20 mg QHS	
80 mg QHS	2mg	40 mg QHS	5 mg QHS	20 mg QHS	40 mg QHS	**10 mg QHS**
N/A	4mg	80 mg QHS	10 mg QHS	40 mg QHS	80 mg QHS	**20 mg QHS**
	N/A	N/A	20 mg QHS	80 mg QHS	N/A	**40 mg QHS**
			40 mg QHS	N/A		**80 mg QHS**

- ***On AHS formulary with restrictions: used for those with HIV or have DDI***

PROTON PUMP INHIBITOR

Esomeprazole (nexium)	Lansoprazole (Prevacid)	Rabeprazole (Aciphex)	Omeprazole (Prilosec)*	**Pantoprazole (Protonix)**
10 mg daily	15 mg daily	N/A	10 mg daily	**20 mg daily**
20 mg daily	30 mg daily	20 mg daily	20 mg daily	**40 mg daily**
40 mg daily	N/A	N/A	20 mg BID	**40 mg daily**
40 mg BID	30mg BID	N/A	40 mg BID	**40 mg BID**

**** Omeprazole formulary along with Pantoprazole. All other PPI's (except for Omeprazole) will be converted to Pantoprazole.***

HISTAMINE H-2 BLOCKERS

	Cimetidine (Tagamet)	Nizantidine (Axid)	Ranitidine (Zantac)	**Famotidine (Pepcid) ***
Duodenal Ulcer, Maintenance	400 mg QHS	150 mg QHS	150 mg QHS	**20 mg QHS**
	400 mg QHS	300 mg QHS	300 mg QHS	**40 mg QHS**
		150 mg BID	150 mg BID	**20 mg BID**
	400 mg BID	300 mg QHS	300 mg QHS	**40 mg QHS**
		150 mg BID	150 mg BID	**20mg BID**

Duodenal Ulcer, Active	800 mg BID	150 mg BID	150 mg BID	**40 mg QHS or 20 mg BID**
Gastric Ulcer, Active	800 mg BID	150 mg BID	150 mg BID	
GERD	800 mg BID	150 mg BID	150 mg BID	**20 mg BID**
Erosive Esophagitis	800 mg BID	150 mg BID	150 mg BID	**20 mg BID**
		150 mg BID	150 mg BID	**40 mg BID**
	800 mg BID	150 mg BID	150 mg BID	**20 mg BID**
		150 mg BID	150 mg QID	**40 mg BID**

NASAL CORTICOSTEROIDS			
Beclomethasone (Beconase/Vancenase) 1 spray in each nostril BID – QID		**Fluticasone (Flonase) 2 sprays in each nostril once daily**	**Mometasone (Nasonex) 2 sprays in each nostril once daily**
Beclomethasone AQ (Beconase AQ) 1-2 sprays in each nostril BID			
Flunisolide (Nasarel) 2 sprays in each nostril BID			
Triamcinolone (Nasacort, Nasacort AQ) 2 sprays in each nostril daily			
Budesonide (Rhinocort) 2 sprays in each nostril BID			
Budesonide AQ (Rhinocort AQ) 2 sprays in each nostril BID			
Ciclesonide (Zetonna) 1 spray in each nostril once daily			
Ciclesonide (Omnaris) 2 sprays in each nostril once daily			
Fluticasone Furoate (Veramyst) 2 sprays in each nostril once daily			
Beclomethasone (Qnasl) 2 sprays in each nostril once daily			
ANTIHISTAMINES			
Fexofenadine (Allegra)	Cetirizine (Zyrtec)	**Loratadine (Claritin)**	
30mg PO q12h	5mg PO Daily	**5mg PO Daily**	
60mg PO q12h or 180mg PO daily	10mg PO Daily	**10mg PO Daily**	

INHALED CORTICOSTEROIDS								
Budesonide DPI (Pulmicort Flexhaler)	**Ciclesonide HFA (Alvesco)**	**Fluticasone HFA (Flovent HFA)**	**Fluticasone propionate DPI (Flovent Diskus)**	**Fluticasone propionate DPI (ArmonAir RespiClick)**	**Fluticasone furoate DPI (Arnuity Ellipta)**		**Beclomethasone (QVAR)**	**Mometasone (Asmanex Twisthaler)**
90 mcg 1-3 inhalations BID OR 180 mcg 1 inhalation BID	80 mcg 1 puff BID	44 mcg 1-3 puffs BID OR 110 mcg 1 puff BID	50 mcg 1-3 inhalations BID OR 100 mcg 1 inhalation BID	55 mcg 1 inhalation BID	100 mcg 1 inhalation QD		40mcg 1 inh BID 80mcg 1 inh BID 120mcg 1 inh BID	110 mcg 1 inh QD OR 220 mcg 1 inh QD
180 mcg 2-3 inhalations BID	160 mcg 1 puff BID	110 mcg 2 puffs BID OR 220 mcg 1 puff BID	100 mcg 2 inhalations BID OR 250 mcg 1 inhalation BID	113 mcg 1 inhalation BID	N/A		160mcg 1 inh BID 240mcg 1 inh BID	220 mcg 1 inh BID
180 mcg 4 inhalations BID	160 mcg 2 puffs BID	220 mcg 2-4 puffs BID	250 mcg 2-4 inhalations BID	232 mcg 1 inhalation BID	200 mcg 1 inhalation QD		320mcg 1 inh BID	220 mcg 2 inh BID (total 440mcg per dose)

COMBINATION INHALED CORTICOSTEROIDS & LONG ACTING BETA AGONISTS				
Budesonide/formoterol HFA (Symbicort) *	**Fluticasone furoate/vilanterol DPI (Breo Ellipta)**	**Fluticasone propionate/salmeterol DPI (Airduo Respiclick)**	**Fluticasone propionate/salmeterol DPI (Advair Diskus)**	**Mometasone/formoterol HFA (Dulera)**
80/4.5 mcg 2 inhalations BID	100/25 mcg 1 inhalation QD	55/14 mcg 1 inhalation BID	100/50 mcg 1 inhalation BID	N/A
160/4.5 mcg 1 inhalation BID	N/A	113/14 mcg 1 inhalation BID	250/50 mcg 1 inhalation BID	100/5 mcg 2 inhalations BID
160/4.5 mcg 2 inhalations BID	200/25 mcg 1 inhalation QD	232/14 mcg 1 inhalation BID	500/50 mcg 1 inhalation BID	200/5 mcg 2 inhalations BID

- *Symbicort restricted to those who need to use inhalers with intubation or trach tubes*

OPHTHALMIC CARBONIC ANHYDROUS INHIBITORS	
BRINZOLAMIDE 1%	DORZOLAMIDE 2%
1 drop into affected eye(s) TID	1 drop into affected eye(s) TID

OPHTHALMIC ALPHA-2 AGONISTS	
BRIMONIDINE 0.1% AND 0.15%	BRIMONIDINE 0.2%
1 drop into affected eye(s) TID	1 drop into affected eye(s) TID

PHOSPHATE BINDERS	
SEVELAMER HCL	SEVELAMER CARBONATE
400 mg	400 mg

ALAMEDA HEALTH SYSTEM

Title: Pharmaceutical Company Representatives Policy

Campus	AHS System	***Effective Date:***	7/2019
Document Owner	Director of Pharmacy Services Medication Safety Officer	***Date Revised:***	2/2022, 3/2025
		Next Scheduled Review:	5/2028
Executive Responsible	Chief Medical Officer, Chief Administrative Officer, Chief Nurse Executive		

Policy:

Access to Alameda Health System campuses by pharmaceutical sales representatives is a privilege and may not compromise educational or patient care activities. Pharmaceutical sales representatives will be allowed in the hospital only by prior appointment with specific providers or pharmacists.

A pharmaceutical sales representative refers to anyone acting on behalf of a pharmaceutical manufacturer or its business partners for the purpose of promoting the use of items including drugs, medical supplies, nutritional supplements and any other items managed under the formulary process.

Under no circumstances are pharmaceutical representatives permitted to provide gifts, food or financial support to AHS events. AHS campuses include all parking lots, corridors, cafeteria, gift shop or other public areas on AHS property.

This policy does not apply to those providers whose private offices are located in the hospital, or in any area that may be owned, leased or rented by AHS.

Procedure:

A. Specifically prohibited are:
    1. Unscheduled “drop in” visits.
    2. Presence at any patient-oriented conferences (eg: tumor board, morbidity and mortality conference, P&T, etc.)
    3. Presence in patient care areas including, but not limited to, inpatient units, operating room suites, Emergency Department, outpatient departments such as Imaging and Pathology, nursing stations, and off-site ambulatory care areas/clinics/offices that are managed by AHS that is not accompanied by an AHS employee.
        i. Those representatives that will be meeting with an AHS employee in any patient care area must follow the Vendor Policy requirements. It will be

the responsibility of the AHS employee meeting with the representative to communicate the need for adherence to the Vendor Policy.

4. Providing any gifts or food to any hospital staff, medical staff or house staff on any AHS campus or at any AHS sponsored off-campus event. Medical staff may not receive any donations from pharmaceutical companies
5. Taking any direct payment from pharmaceutical company to speakers for any educational session at AHS.

B. Action to Pharmaceutical Sales Representative for Non-Adherence:
    1. Violation of these rules may result in one or more of the following actions:
        i. Verbal or written warning
        ii. Communication of actions to industry corporate and district offices
        iii. Denied representations in the hospital for up to 6 months (as determined by the Pharmacy & Therapeutics Committee).
        iv. Re-consideration of the company as an eligible supplier to the hospital.
C. Acceptable/Allowable Hospital Visitation
    1. In-services for the use of a specific product that has been approved for the formulary by appointment only.
    2. Visits to private offices of providers that are located on the hospital premises or in the outpatient medical building.
    3. Providers must initiate the request for the pharmaceutical representative meeting for a specific reason and notify the Chair of Pharmacy &Therapeutics Committee. The Chair of Pharmacy &Therapeutics Committee and pharmacy lead will review all requests and will notify the providers if approved and if appointment with representative may be made.
D. Appointment Check-In:
    1. They must check in with Security at each site.
    2. They must log the location and name of the provider, nurse or other allied health professional or department director with whom they have an appointment.
    3. They must obtain a printed pass which will include date range of applicability, reason for visit, parameters for topics discussed, and an end date.
E. Educational:
    1. Lectures must remain independent of pharmaceutical company influences.
    2. Journal clubs and other educational meetings sponsored by pharmaceutical companies and facilitated or sponsored by the hospital must remain independent of pharmaceutical company influence.
    3. Speakers must disclose any financial ties with any pharmaceutical company whose product they mention.
    4. All members of Pharmacy &Therapeutics Committee and any medical staff member who proposes a formulary addition or change must disclose financial ties to pharmaceutical companies and conflicts of interest.
F. Guideline/Policy Clarification
    1. Requests for clarification of these guidelines should be directed to the Pharmacy and Therapeutics Chair, Director of Pharmacy, or Pharmacy Manager or Supervisor.

2. Appeals of Pharmacy & Therapeutics Committee decisions relevant to these guidelines should be directed to the Medical Executive Committee.
3. Provider who seek discussion of the ethics of these or related aspects of Provider industry interactions are encouraged to contact the Chair of their Service Committee.

Approvals

		System	HH/SLH/JG/FM	Alameda Hospital
System Pharmacy & Therapeutics	**Date:**	**3/2025**		
Clinical Practice Council	**Date:**	**4/2025**		
Medical Executive Committee (AH & Core)	**Date:**	**4/2025**		
Board of Trustees	**Date:**	**5/2025**		

ALAMEDA HEALTH SYSTEM

SYSTEM MEDICATION SAMPLES

Site	Alameda Health System	***Previous Revision Dates***	
Effective Date	3/2022	***Date Revised***	3/2025
Document Owner	MGR SYS MED SAFETY-CLIN PHARM	***Next Scheduled Review***	5/2028

Printed copies are for reference only. Please refer to electronic copy for the latest version.

PURPOSE

To provide strict control and quality of all medications used in the hospital and clinics**.**

POLICY

Drug samples for use is not allowed for either patients in the hospital or outpatient clinics at any AHS sites unless specific sample medications for use is reviewed and approved by P&T.

PROCEDURE

1. All departments and employees of AHS who are offered drug samples by the drug manufacturer sales representatives will not accept such offers unless approved by P&T.
2. Sales representatives will be instructed not to leave any samples at the facility.
3. Emergency Department will not use drug samples for starter doses for outpatient unless approved by P&T.

REFERENCES

TJC Medication Management Standards

	System	HH/SLH/JG/FM	Alameda Hospital
Pharmacy Department	Date: 3/2025		
System P&T	Date: 3/2025		
CPC	Date: 4/2025		
Medical Executive Committee (AH & Core)	Date: 4/2025		
BOT	Date: 5/2025		

ALAMEDA HEALTH SYSTEM

MEDICATIONS: INPATIENT MEDICATION DISPENSING POLICY

Site	Alameda Health System	***Previous Revision Dates***	
Effective Date	3/2025	***Date Revised***	3/2025
Document Owner	MGR SYS MED SAFETY-CLIN PHARM	***Next Scheduled Review***	5/2028

Printed copies are for reference only. Please refer to electronic copy for the latest version.

PURPOSE

To ensure that compounding, packaging, distributing and dispensing of medications, include record keeping is in compliance with applicable laws and regulations, licensure and professional standards of pharmacy practice.

POLICY STATEMENT

All medications shall be compounded, packaged, distributed, and dispensed, including record keeping, shall be consistent with federal and state laws, rules, and regulations as well as all applicable law or regulation governing professional licensure and operation of pharmacies and professional standards of pharmacy practice.

PROCEDURE

A. **Individuals Authorized to Prepare, Dispense, Transfer Medications, and Make Labeling Changes**

1. Medication preparation and dispensing is restricted to a licensed pharmacist or to a designee under the direct supervision of a pharmacist.
2. Medication preparation and dispensing by non-pharmacists is authorized in the following circumstances:
    a. A licensed independent practitioner (LIP) (or authorized prescriber in accordance with state regulatory requirements) controls the ordering, dispensing, and administration of the medication, such as in the operating room, endoscopy suite, emergency room, and labor and delivery.
    b. *Emergent situations when time does not permit a pharmacist's prospective review of medication orders, urgent situations when patient harm could result from delay in administration of a medication, or when a patient experiences a sudden change in clinical status*

B. **A licensed pharmacist must supervise and monitor all medication preparation by non-pharmacist personnel.**

C. Only a pharmacist, or authorized pharmacy personnel under the direct supervision of a pharmacist, may fill and label containers from which medications are to be distributed or dispensed, make labeling changes, or transfer medications to different containers.

D. Supportive personnel must comply with facility and pharmacy policies and procedures.

E. The supervising pharmacist must be fully aware of all medication preparation and dispensing activities.

F. Methods of Dispensing of Medications:

1. Automated Dispensing Machines
2. Dispensing Patient Specific Medications
3. Floor Stock
4. Medication Boxes

G. Amounts to Dispense

1. The amount dispensed may not exceed the amount prescribed.
2. The amount dispensed is sufficient to meet patient needs and to minimize the potential for diversion.

H. Dispensing in Ready-To-Administer Forms

1. Medications are dispensed in the most ready-to-administer forms commercially available and to the extent practical in unit doses that have been packaged by the pharmacy or licensed repackager whenever possible.

I. Labeling

1. Medication labeling meets the specifications of the hospital's labeling policy.

J. Verifying Order Filling Accuracy
A pharmacist performs a final check after the order has been filled or refilled. This check verifies that the order was prepared, filled and labeled accurately. The pharmacist verifies the following:

1. Patient's name
2. Medication name
3. Medication dosage form
4. Medication dose
5. Medication route
6. Medication is in date
7. Preparation and compounding procedure is correct

K. Time Frames for Formulary Medication Dispensing

1. Medications are dispensed within the time frames defined to meet patient needs.
2. Stat medications are dispensed within 15 minutes of receiving the order.
3. Now medications are dispensed within 30 minutes of receiving the order.
4. Routine medications are dispensed as soon as possible after receiving the order, but no longer than 2 hours.

L. Delivery of Medications to Patient Care Areas

1. The pharmacy ensures that medications are delivered to patient care areas and are available for administration at the scheduled times.
2. If the pharmacy is unable to provide a medication prior to the scheduled administration time, the pharmacy will inform the nurse responsible for the area and/or the nurse responsible for the patient.
3. Pharmacy personnel verify that the medications are delivered to the appropriate unit and that the medications are stored in the appropriate secure area.
4. When delivering medications to a patient specific cassette/drawer, pharmacy personnel reconcile the patient's name or other identifier information on the medication bag with information on the patient cassette/drawer.

M. Medications may be delivered via a pneumatic tube system

1. If a staff member is unavailable to deliver the medication on the next delivery run and there is only one pharmacist on duty.
2. Medications that are past due, needed stat, near due time or due as needed (prn) may be tubed up. All other prepared medications will be delivered to the patient's medication cassette or a secure pocket located in the automated dispensing unit
3. Patient's nurse must be notified before medications can be tubed to ensure security measures are in place to assure medications are only accessible to authorized personnel.
4. Not all medications are suitable for delivery using a pneumatic tube system (i.e., Do not shake, do not agitate, chemotherapy medications, insulin, etc). See Do Not Tube list available on the intranet under Pharmacy.

N. Medication Storage Containers in Patient Care Areas

1. Patient specific medications are securely stored in individual containers in the patient care area (e.g., cubicles/drawers) or in an automated dispensing cabinet
2. Patient specific medication storage containers are labeled with patient identifier information that is in compliance with HIPAA (i.e., Patient name may not be used on medication carts that are in public view).

O. Labels are typed, imprinted, or hand-written neatly.

P. Evaluation

1. Any variances from the dispensing procedures described in this policy are reported using the hospital's AHS Safety Alert

REFERENCES

The Joint Commission Medication Management Standard MM.05.01.11

APPROVALS

Departmental	**Date: 3/2025**
System Pharmacy & Therapeutics	**Date: 3/2025**

CPC	**Date: 4/2025**
Medical Executive Committee	**Date: 4/2025**
Board of Trustees	**Date: 5/2025**

ALAMEDA HEALTH SYSTEM

Critical Result Communication - Nursing

Effective Date	5/2025	***Date Revised***	4/2025
Document Owner	DUSTY GILLELAND (VP, PATIENT CARE SERVICES)	***Next Scheduled Review***	5/2028
Executive Responsible	Chief Nursing Executive (interim)		

PURPOSE:

To describe the standard work for nursing to communicate critical results to the responsible provider.

POLICY STATEMENT

1. Nursing shall
   - Communicate the critical result to the responsible provider within 30 minutes of being notified following the *Emergency Issues* mode of communication outlined in the Communications Guidelines for Patient Care policy, and
   - Document the communication in the designated area of the medical record.

DEFINITIONS

Critical result - an abnormal result of potentially life-threatening consequences and for which immediate action is needed because the patient is in imminent danger. Critical results include those generated in the Clinical Laboratory, Pathology, Imaging or other diagnostic services.

Read Back – a verbal repeat of the information communicated. For critical results, it is intended to assure a common understanding of the critical information communicated.

PROCEDURE – Nursing shall

1. Upon notification of a critical result and to the person notifying them, nursing shall
   a. "Read back" the critical result
   b. Give their full identification information (first name, last name, licensure)
2. Nursing shall communicate the critical result to the appropriate provider
   a. Inpatient Units in Acute Care Facilities
   b. Emergency Department
   c. Family Birthing Center (Highland Only)
   d. John George Psychiatric Hospital
3. Critical result notification shall be documented in the electronic medical record
   a. Emergency Department – "Provider Notification" section **(see Appendix A)**
   b. Inpatient Department (Acute/JGP)– "Basic Assessment" section in Flowsheets **(see Appendix A)**
   c. Family Birthing Center – "Physical Assessment" section in Flowsheets **(see Appendix A)**

RELATED DOCUMENTS

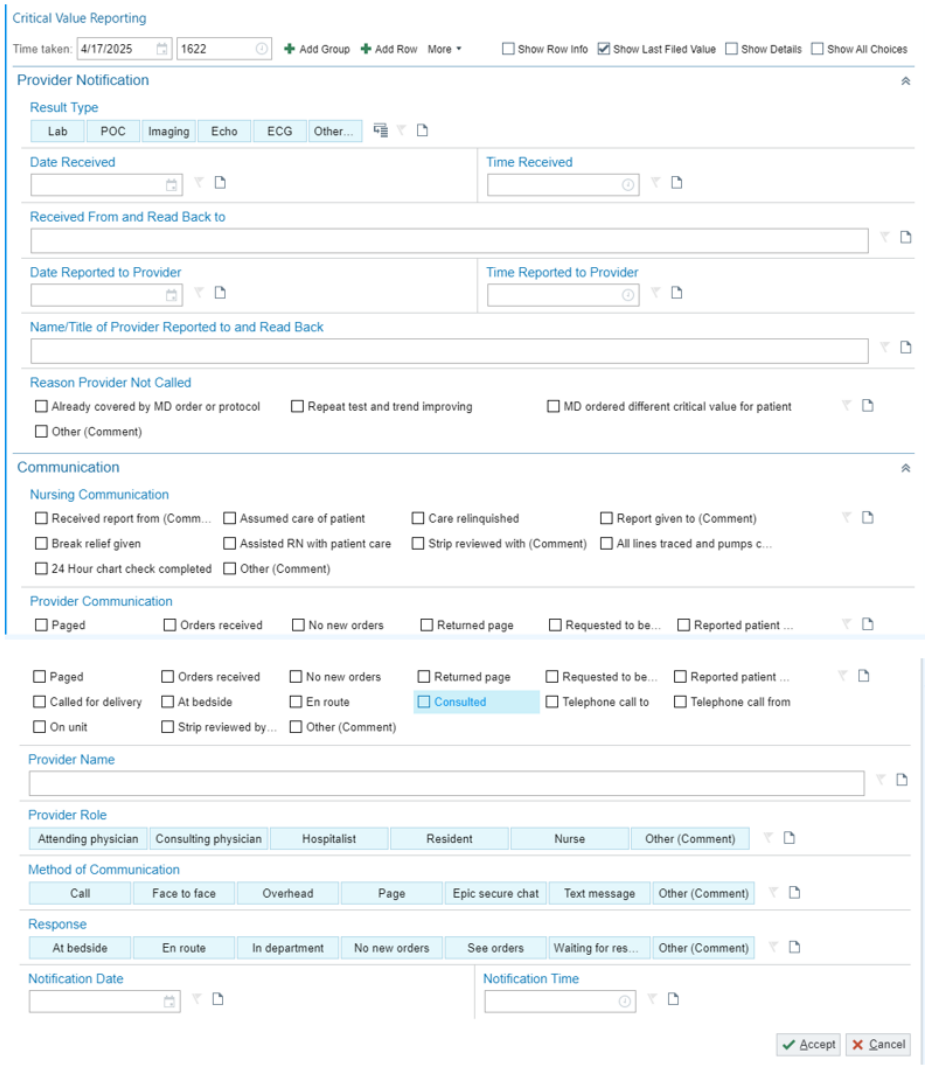
AHS Clinical Laboratory General Policy & Procedure "550 – Critical results and communication of critical results", current version.
AHS Communication Guidelines For Patient Care Policy, current version.

REFERENCES

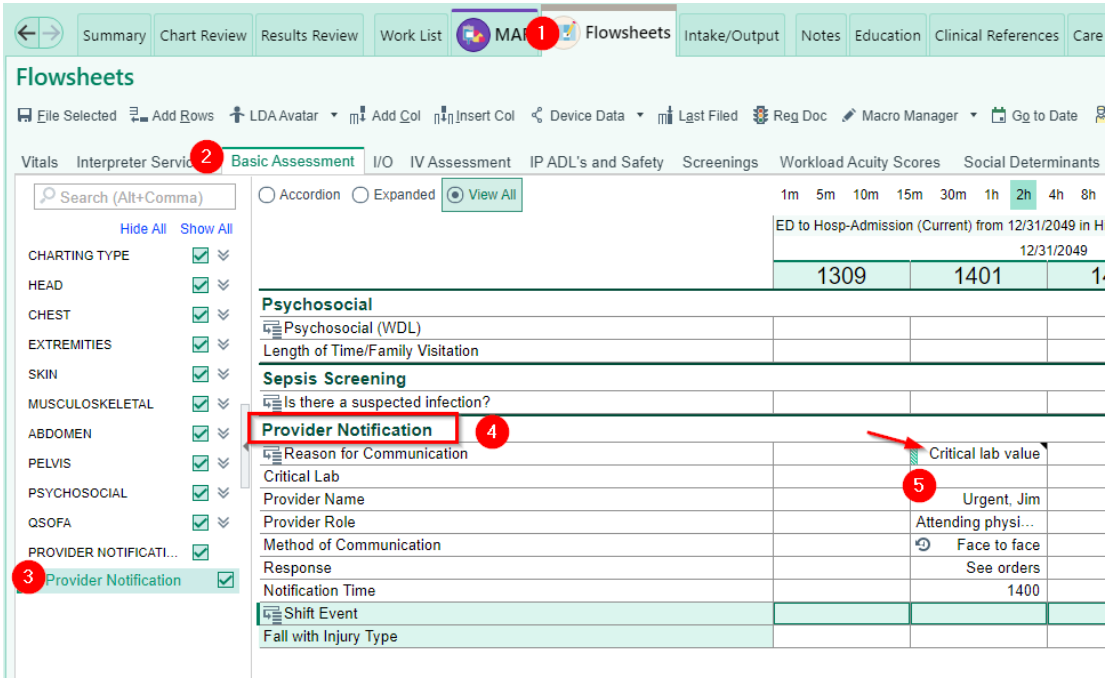
NPSG.02.03.01 "Get important test results to the right staff person on time." National Patient Safety Goal 2021, The Joint Commission.

APPENDIX A

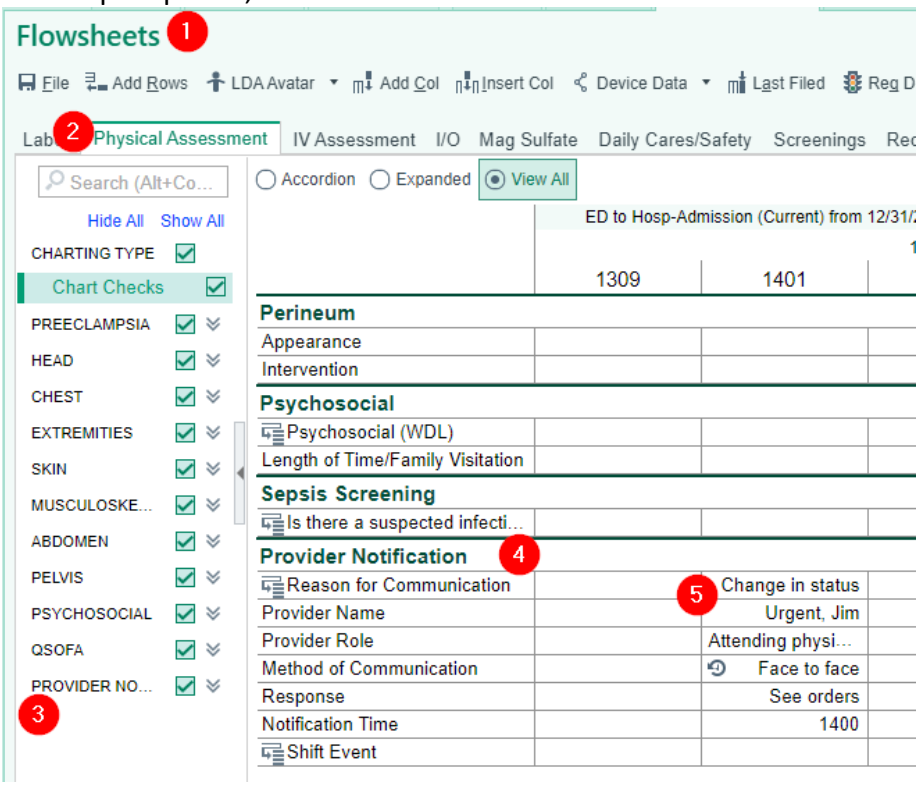
a. Emergency Department – "Provider Notification" section pictured as of Epic pictured as of April 17, 2025.



b. Inpatient Department (Acute/JGP)– “Basic Assessment” section in Flowsheets pictured as of Epic April 17, 2025.



c. Family Birthing Center – “Physical Assessment” section in Flowsheets pictured as of Epic April 17, 2025



ALAMEDA HEALTH SYSTEM

STANDARDS OF NURSING PRACTICE

Department	Nursing	***Effective Date***	12/2011
Campus	All	***Date Revised***	11/2011, 9/2019
Category	Clinical	***Next Scheduled Review***	5/2028
Document Owner	VP Patient Services	***Executive Responsible***	Chief Administrative Officer/Chief Nurse Executive

Printed copies are for reference only. Please refer to electronic copy for the latest version.

PURPOSE

The purpose of this document is to outline the Standards of Nursing Practice for the Nursing Division at Alameda Health System (AHS).

BACKGROUND

Our philosophy of nursing practice is based on the Patient Centered Care Model, the ANA Nursing Code of Ethics and Interpretive Statements and the California Registered Nurse Scope of Practice. We also endeavor to practice the art and science of nursing in a manner that represents the nursing profession in the most positive light, ensures patient safety and optimal care quality.

As nurses at AHS, we use our skills and knowledge to extend the hospital's mission to every patient and family we serve regardless of their ability to pay.

We use ANA standards of care, standards of professional performance, and evidence-based decision making to guide us in our delivery of care. To enhance patient outcomes, we make a commitment to nursing practice councils, continuous quality improvement activities, and nursing research.

We believe evidence-based decision making is enhanced by nurses' taking responsibility for their professional practice. We support professional development through nurse practice councils, succession planning, ongoing education and skills enhancement, which are conducive to independent and proactive critical decision making.

We provide educational opportunities to encourage staff development and to ensure, initiate, drive, and sustain safe, high quality care. We encourage utilization and participation in systematic investigation and nursing research to support evidence-based practice, impact or change existing practices, and to develop and contribute to generalizable knowledge.

We work collaboratively with other healthcare team members, serving as care coordinators and team leaders. We provide interventions specific to the patients we serve. We endeavor to support the Pillars of Success and put forth deliberate effort to enhance overall services and be positive stewards of the health care resources provided to us.

We view every person as a special and unique individual and we value and respect their diversity. We recognize that illness is complex and this complexity requires a collaborative approach, with all departments maintaining a seamless continuum of care. We hold ourselves accountable for respecting the privacy, personal dignity, and cultural beliefs of each patient.

We recognize the contribution that each patient and their family make to their own care experience. We endeavor to consistently show our patients respect, kindness, understanding, and courtesy, as well as deliver individualized, and personal care.

As we interact daily valuing one another — we promote satisfaction on an individual, interpersonal, and social level for all. This fosters trusting relationships, making Alameda Health System a provider of choice for the community and an employer of choice for nurses and other health care providers.

APPROVAL

		System	Alameda	AHS/Highland/John George/San Leandro
Department	**Date:**	**N/A**	**9/2019**	**9/2019**
Pharmacy and Therapeutics (P&T)	**Date:**	**N/A**	**N/A**	**N/A**
Clinical Practice Council (CPC)	**Date:**	**9/2019, 4/2025**	**N/A**	**N/A**
Medical Executive Committee	**Date:**	**4/2025**	**10/2019**	**10/2019**
Board of Trustees	**Date:**	**11/2019, 5/2025**	**N/A**	**N/A**

D4. Recommendation from the Quality Professional Services Committee to approve the AHS Medical Staff Policies and Procedures listed below:

ALAMEDA HEALTH SYSTEM

April 23, 2025

TO: Quality Professional Services Committee

FROM: Berenice Perez, M.D., Alameda Health System Chief of Staff
Catherine Pyun, D.O., Alameda Hospital Chief of Staff

SUBJECT: **Agenda Item:** A3

Meeting Date: April 23, 2025

Item Description: Medical Staff Policies and Procedures

COMMITTEE ACTION: **Recommend Approval of Medical Staff Policies and Procedures**

Background:
The Alameda Health System (AHS) and Alameda Hospital (AH) Medical Staff align policies and procedures to provide continuity across the two Medical Staffs.

The Medical Staff policies provide alignment of credentialing and privileging processes by offering a systematic approach to assessment across our facilities.

Analysis:
The Alameda Health System (AHS) and Alameda Hospital (AH) Medical Staff policies align with the Bylaws and are key to the operational functions and compliance with regulatory requirements.

Board Action Requested: Approval

AHS and AH Medical Staff:

- Medical Staff Access to Medical Staff Records
- Medical Staff Credentialing and Privileging of Providers
- Medical Staff Ongoing Monitoring and Evaluation of Actions Related to Providers

Alameda Health System

ACCESS TO MEDICAL STAFF RECORDS

Department	Medical Staff	***Effective Date***	9/18/24
Campus	AHS, AH	***Date Revised***	4/2025
Unit	All	***Next Scheduled Review***	4/2028
Manual	Medical Staff	***Author***	Vice President, Physician Services
Replaces the following Policies:		***Responsible Person***	Chief of Staff

Printed copies are for reference only. Please refer to electronic copy for the latest version.

Purpose: To define the process for Access to Medical Staff Records of the Alameda Health System (AHS) and/or Alameda Hospital (AH) Medical Staffs (individually and collectively, "Medical Staff").

Policy: This policy applies to all records maintained on behalf of the Medical Staff that are protected from discovery by California Evidence Code Section 1157 and the information contained therein. The foregoing include but are not limited to credentialing files, privilege documents, peer review documents and the records and minutes of all Medical Staff Committees, (individually and collectively referred to herein as "Information" or Medical Staff records") The AHS and AH Medical Staff have an agreement for sharing of primary source information and specified peer review information including focused professional practice evaluations (FPPE), ongoing professional practice evaluations (OPPE) and quality assurance activities; and immunization/heath records for common practitioners.

If additional entities with peer review bodies whose records are protected by California Evidence Code 1157 become affiliated with AHS, agreements for sharing Information may be established with the Medical Staff. The purpose of sharing such Information between AHS and AH is to facilitate effective credentialing and medical staff peer review by the medical staffs.

Procedure: The Medical Staff recognizes that it is vital to maintain the confidentiality of Medical Staff records for reasons of both law and policy. Medical Staff members participate and contribute to credentialing, peer review, and quality assurance activities in reliance upon the preservation of confidentiality. The members of the Medical Staff understand and agree that the confidentiality of these activities, and all of Medical Staff records, is to be preserved and that these communications, information and records will be disclosed only in the furtherance of those credentialing, peer review, and quality assurance activities. Not to limit the foregoing, this requirement of confidentiality extends to the records and minutes of all Medical Staff Committees, to the records of all Medical Staff credentialing, peer review, and quality assurance activities and to the credentials and peer review files concerning individual practitioners, including the discussions and deliberations

which take place within the confines or under the aegis of Medical Staff Committees and the names of the members of such Medical Staff committees.

Location of Records and Security Precautions

All Medical Staff records will be maintained in Medical Staff Services under the custody of the Vice President Physician Services or appropriate designee. Medical Staff Services Offices will be locked except during those times that the Vice President Physician Services or appropriate designee or an authorized representative is present and able to monitor access in accordance with this policy. Files for current Medical Staff members will be stored via AHS's secure, electronic database. Files are archived periodically within the database. Historical files prior to the electronic database have been scanned and saved on the network, stored and archived in paper format, or archived and kept in secure storage. Medical Staff records will only be released from the Medical Staff Services office in accordance with this policy.

Access by Persons Within the Organization or Medical Staff

1. **Means of Access**
   All requests for Medical Staff records by persons affiliated with AHS or AH ("Organization") and Medical Staff shall be presented to the Vice President Physician Services or appropriate designee, who will keep a record of requests made and granted. Those requests which require notice to, or approval by, other officials shall be forwarded to those persons by the Vice President Physician Services or appropriate designee. A person permitted access under this section shall be given a reasonable opportunity to inspect the records in question and to make notes regarding them, but will not be allowed to remove them from any Medical Staff Services Offices or to make copies of them. Copying shall only be allowed upon the express written permission of the Chief of Staff or their designated representative and subject to applicable provisions in the Medical Staff Bylaws and Rules. No removal is permitted except if such removal is legally required, such as in response to a criminal search warrant, in which event the Medical Staff shall request the opportunity to retain a copy before removal and the return of the original to the Medical Staff when permitted.

2. **Access by Persons Performing Official Organization or Medical Staff Functions**
   Medical Staff Officers, Chairs of Medical Staff Departments or Division Chiefs, Medical Staff Committee members, members of the Board of Trustees, consultants retained by any of the foregoing, the Vice President Physician Services or appropriate designee, Chief Executive Officer or authorized representatives, and any other persons assisting in credentialing, peer review, focused professional practice evaluations (FPPE), ongoing professional practice evaluations (OPPE) and quality assurance activities will have access to Medical Staff records, other than their own, to the extent necessary to perform those functions. More particularly:

   a. **Medical Staff Officers**: Medical Staff Officers shall have access to all Medical Staff records to the extent necessary to their official functions.

b. **Department Chairs or Division Chiefs**: Department Chairs and Division Chiefs shall have access to all Medical Staff records pertaining to the activities of their Department or Divisions. Department Chairs and Division Chiefs shall also have access to the credentials, peer review, focused professional practice evaluations (FPPE), ongoing professional practice evaluations (OPPE) and quality assurance activities files of practitioners whose qualifications or performance are reviewed as part of their official functions.

c. **Medical Staff Committee Members**: Medical Staff Committee members shall have access the records of Committees on which they serve and to the credentials, peer review, focused professional practice evaluations (FPPE), ongoing professional practice evaluations (OPPE) and quality assurance activities of practitioners whose qualifications or performance the Committee is reviewing as part of its official function. Notwithstanding the foregoing, a committee member shall not have access to records of a meeting if that member was excused from the meeting due to a conflict of interest, the member was not permitted to attend what was an executive session or other cause.

d. **Consultants**: Consultants (who may or may not be members of the Medical Staff) reviewing a practitioner's credentials or performance as part of a credentialing, peer review, or quality assurance activity may be allowed access to the credentials and peer review files of the practitioner being reviewed, and to any other pertinent Medical Staff Committee records in the discretion of a person who enjoys access to those materials pursuant to the above paragraph.

e. **Chief Executive Officer/Designated Representative:** The Board of Trustees and Chief Executive Officer as its designated representative shall have access to the Medical Staff records to the extent necessary to perform their official functions.

<u>General Access By Practitioners to Their Own Medical Staff Records</u>

1. **Credential and Peer Review Files**
   A practitioner shall be granted access to their individual credential file, subject to the following provisions:

   a. timely notice of such shall be made by the member to the chief of staff or the chief of staff's designee;

   b. the member may review, and receive a copy of, only those documents provided by or addressed personally to the member.

2. **Medical Staff Hearings**
   If a Medical Staff hearing has been offered and requested, access to Medical Staff records shall be as provided in the Medical Staff Bylaws and applicable laws regarding medical staff hearings.

Access by Persons, Organizations or Medical Staffs Outside of this Organization

1. **Credentialing or Peer Review by Other Medical Staffs and Other Peer Review Bodies**

   a. The Chief of Staff (COS) or designee may approve the release information contained in a credentials and peer review file, or other information which is the subject of this Policy, in response to a request from another hospital's medical staff or a peer review body whose information is protected from discovery by California Evidence Code Section 1157. That request must include information that the practitioner is a member of the requesting hospital's medical staff, exercises privileges at the requesting hospital, or is an applicant for medical staff membership or privileges at that hospital, and must include a release for such records signed by the concerned practitioner. No information should be released until a copy of a signed authorization, and release from liability, has been received. This often takes the form of the physician's signature on an application for medical staff membership. Disclosure shall generally be limited to the specific information requested and may not include all information requested as opposed to what may routinely be released by the Medical Staff.

   b. If a practitioner has been the subject of disciplinary action by the Medical Staff that is required to be reported to the Medical Board of California (MBOC) or other licensing agency, or has recently challenged an Executive Committee recommendation or action which, if upheld, will require a report to the MBOC or other licensing agency, or there are other matters that the COS or designee agree should be disclosed or are required to California Business and Professions Code 809.08 to be disclosed, special care must be taken. All responses to inquiries regarding that practitioner shall be reviewed and approved by the COS or their designee, and legal counsel may be consulted. A special release may be required from the practitioner and a sharing agreement required from the requesting entity before releasing information.

   c. No "off-the-record" responses on behalf or as a representative of the Medical Staff that contain Medical Staff Information shall be provided. Any proposed written response on behalf or as a representative of the Medical Staff that includes Medical Staff Information regarding a practitioner shall be provided to the Vice President Physician Services or appropriate designee for review to assure accuracy, with a copy of the final written response in the Medical Staff's files.

2. **Request by Hospital Surveyors and Health Plans**
   Hospital surveyors and Health Plans may be entitled to inspect records covered by this Policy on this organization's premises in the presence of a representative of this organization and/or Medical Staff. provided that no originals or copies may be removed from the premises.

3. **Subpoenas**
   All subpoenas of Medical Staff records shall be referred to the Vice President of Physician Services and the Chief of Staff or designee, who will consult with legal counsel regarding the appropriate response.

4. **Requests from Medical Board of California (MBOC), Board of Osteopathic Medicine (BOE), Board of Dental Examiners (BDE) and Other Professional Licensing Agencies**
   Current law allows the Medical Board of California, the Board of Osteopathic Examiners, and the Board of Dental Examiners to review certain materials pertaining to Medical Staff hearings concerning corrective action recommendations or decisions. Given the current requirements of law, copies of the following records of a Medical Staff disciplinary hearings shall be made available to the Medical Board of California, the Board of Osteopathic Examiners, or the Board of Dental Examiners upon the specific request of such Board:

   a. The Notice of Charges presented to the practitioner before the beginning of a Medical Staff hearing.

   b. Any document, medical record, or other exhibit received in evidence at that meeting.

   c. Any written opinion, findings or conclusions of the Medical Staff Hearing Committee in the disciplinary hearing which were made available to the concerned practitioner.

   The COS (or designee) must review and approve the disclosure before it is made. Any requests for documents other than those listed above shall be disclosed only in accordance with "Other Requests", below.

5. **Other Requests**
   All other requests by persons or organizations outside the organization for information contained in the Medical Staff records shall be forwarded to the Chief of Staff. The release of such information shall require the concurrence of the Medical Staff Executive Committee or its designated representative. The Executive Committee may enact disclosure policies applying to requests from specific entities. When such disclosure policies are enacted, they shall be appended to this policy.

Approvals

		AHS	AH
Medical Executive Committee	**Date:**	**4/16/25**	**4/18/25**
Quality Professional Services Committee	**Date:**	**4/23/25**	

Alameda Health System

MEDICAL STAFF CREDENTIALING AND PRIVILEGING OF PROVIDERS

Department	Medical Staff	***Effective Date***	5/2011
Campus	AHS, AH	***Date Revised***	5/2011, 6/2014, 6/2017, 6/2019, 2/2020, 1/2022, 4/2022; 4/2023; 5/2023; 10/2023; 11/2023; 2/2024; 3/2024; 3/2025; 4/2025
Unit	Medical Staff	***Next Scheduled Review***	4/2028
Manual	Medical Staff	***Author***	Manager, Medical Staff Services
Replaces the following Policies:		***Responsible Person***	Chief of Staff

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Purpose

As an extension of the Alameda Health System (AHS) and Alameda Hospital (AH) Medical Staff Bylaws this policy will establish the mechanism for gathering relevant data, which involves the collection, verification and assessment of applicant information that will serve as the basis for decisions regarding credentialing and privileging of licensed independent practitioners and Advanced Practice Providers (APP) who provide patient care services within the Alameda Health System.

Policy Statement

It is the policy of the AHS/AH Medical Staff to ensure that licensed practitioners and APPs meet minimum credentialing, privileging and performance standards for membership and/or privileges/practice prerogatives as outlined in the Medical Staff Bylaws. The credentialing process is performed jointly where applicable, however, membership appointments and granting of privileges are independently recommended to the Governing Body by the respective Medical Staff.

All applications for appointment and/or reappointment to the Medical Staff/Advanced Practice Provider, and requests for clinical privileges, will be evaluated based on critical parameters: current licensure; education and relevant training; and experience, ability, and current competence to perform the requested privilege(s). Any applications that meet the application criteria during the verification process shall be categorized in accordance with policy.

Credentialing is required for all physicians (medical or osteopathic), dentists, podiatrists, or clinical psychologists as well as those advanced practice providers approved by the Board of Trustees, which include acupuncturists, audiologists, optometrists, nurse practitioners, certified registered nurse anesthetists, certified nurse midwives and physician assistants.

Nondiscriminatory Statement and Audit Process

The AHS and AH Medical Staff credentialing, and privileging process acts in compliance with all federal and state and local laws and regulations governing discrimination involving patients, employees, vendors, visitors and other individuals and entities associated or involved with AHS. This policy reaffirms the commitment of the AHS Medical Staff and AH Medical Staff to maintaining a discrimination-free credentialing and privileging process.

The AHS and AH Medical Staff will not engage in discrimination or harassment of any person employed or seeking employment or medical staff credentialing or patient care within AHS on the basis of race, color, natural origin, age, disability, religion, sexual orientation, gender identity, gender expression, physical or mental disabilities, medical condition, pregnancy, HIV status, ancestry, marital status, citizenship, or status as a covered veteran or the type of procedure patients in which the practitioner specializes. The Medical Staff does not retaliate against a person for pursuing their right under this policy and/or for the purpose of investigatory proceedings. Non-discriminatory information is available in alternative forms of communication to meet the needs of persons with sensory impairments.

The AHS and AH Medical Staff will not discriminate against a licensed provider solely on the basis of a civil judgment, criminal conviction, or another professional disciplinary action in another state if the judgment, conviction, or professional disciplinary action is solely based on the application of another state's law that interferes with a person's right to receive care that would be lawful if provided in California

On an annual basis, each member of the AHS and AH Credentials Committee will sign a confidentiality statement that will also include an affirmative statement that all decisions are made in a non-discriminatory manner.

The Medical Staff Services Department will monitor through periodic audits of credentials files and practitioner complaints about possible discrimination, by performing audits of decisions recommended by the Credentials Committee. The findings will be reported to the Credentials Committee and the Medical Executive Committee on an annual basis to protect against discrimination and to maintain a nondiscriminatory credentialing process.

Procedure

All applications for appointment, reappointment, and requests for clinical privileges are processed as described below. The initial application process requires completion of a pre-application step prior to the initial application being issued. Telemedicine credentialing by proxy will be processed in accordance with policy.

Applicants will provide an attestation that all information submitted for credentialing and privileging is accurate and agree to report immediately any change in status of the information maintained in the Credentials files.

If any submitted items differ from information received through the verification process, the applicant will be required to resolve discrepancies. This may require further consultation between the applicant and the Department Chair or Division Chief.

Applications for membership and clinical privileges will be processed and verified as indicated herein.

Pre-Application

A pre-application will be released via email to potential applicants requesting staff membership and/or clinical privileges. The pre-application will be used to determine if the applicant meets the basic qualification for medical staff membership/advanced practice provider status as delineated in the Medical Staff Bylaws, Rules, and Policies.

Individuals requesting to be credentialed and privileged will be provided instructions outlining the basic requirements to apply for membership and/or privileges along with a link to an electronic pre-application. Once the preapplication is submitted a cursory review of the applicants' qualifications will be performed including review of the following:

1. Professional license(s); including all states and other jurisdictions
2. Medical Board of California License Verification System (LVS) – Health Facility/Peer Review Reporting Form (805 report)
3. Drug Enforcement Administration (DEA) registration, if applicable
4. National Provider Identifier Registry (NPI)
5. National Practitioner Data Bank (NPDB)self-query
6. Office of Inspector General (OIG) exclusion database
7. System for Award Management (SAM) exclusion list
8. Department of Health Care Services (DHCS) Medi-Cal Providers Suspended and Ineligible Provider list
9. California Secretary of State Business look-up
10. Centers for Medicare and Medicaid Services (CMS) Opt Out List
11. Internet search query

The applicant will be notified if they do not meet criteria and the initial application will not be released. Such action shall not give rise to hearing and appeal rights pursuant to the Medical Staff Bylaws, nor require reporting to the National Practitioner Data Bank and/or licensing body. If a potential applicant believes that they meet the criteria, that individual must submit evidence to substantiate such, in writing, to the Medical Staff within thirty (30) days after notice that criteria was not met.

If the applicant meets criteria, instructions and a link to the portal to access the initial application packet and privilege forms approved by the Medical Executive Committee will be sent. The communication will outline the time frame and basic requirements for processing the request.

Initial Application for Appointment

For a practitioner who meets criteria to become credentialed and privileged, they must submit a complete application along with copies of other documents as applicable including, but not limited to, the following:

1. California Medical License (copy required)
2. Out of State License, if applicable

3. DEA registration, if applicable
4. Other relevant certificates or permits (i.e., PALS, BLS/ACLS, Fluoroscopy, etc.)
5. Diploma, Education and Training Certificates
6. Curriculum vitae (CV) / Resume
7. Educational Commission for Foreign Medical Graduates (ECFMG) certificate, if applicable
8. Board Certification or Advanced Practice Provider National Certification
9. NPI Number
10. Evidence of current malpractice coverage of $1 million per occurrence/$3 million aggregate
11. Malpractice Insurance Declaration of Coverage for the past 10 years (recent graduates must provide malpractice during their residency)
12. Copy of government issued photo identification (i.e., driver's license)
13. Privilege Request, if applying for privileges, which shall include any relevant documentation to support the qualifying criteria
14. Procedure or clinical case log activity for the last two years
15. Application fee
16. Immunization/Vaccines in accordance with policy
17. Gaps in education, practice and work history of 90 days or more will require written documentation

The following forms must be completed and signed:

1. Background Investigation Acknowledgement Form
2. Information Release/Acknowledgment
3. AHS/AH Medical Staff Sharing Agreement
4. Confidentiality and Security Agreement
5. Medical Staff Quality and Assessment and Peer Review Agreement
6. Information Services (IS) Epic Training Data Collection Form
7. Electronic Signature authorization
8. Photography and Videotaping Attestation
9. Medicare and Tricare Acknowledgement
10. Professional Code of Conduct Agreement
11. Attestation Questionnaire: including applicant attesting to perform privileges as requested, lack of present illegal drug use, history of loss of license and/or felony convictions, and history of loss of limitation of privileges or disciplinary activity.
12. Relevant APP agreements and standardized procedures as applicable.

The applicant's identity must be verified via presentation of an original government-issued identification document prior to appointment/granting of privileges.

<u>Reappointments</u>

Reappointment to the Medical Staff and requesting of clinical privileges shall occur within a period not to exceed 24 months. The practitioner shall be required to submit a complete application along with copies of documents as applicable including, but not limited to, the following:

1. Board Certification or Advanced Practice Providers Certification

2. Evidence of current malpractice coverage of $1 million per occurrence/$3 million aggregate
3. Malpractice Insurance Declaration of Coverage for the past 2 years (recent graduates must provide malpractice during their residency)
4. Privilege Request, if applying for privileges, which shall include any relevant documentation to support the qualifying criteria
5. Reappointment application fee

The following forms must be completed and signed.

1. Background Investigation Acknowledgement
2. Information release/acknowledgment
3. Sharing agreement
4. Confidentiality and Security Agreement
5. Medical Staff Quality and Assessment and Peer Review Agreement
6. Professional Code of Conduct Agreement
7. Attestation Questionnaire: including applicant attesting to perform privileges as requested, lack of present illegal drug use, history of loss of license and/or felony convictions, and history of loss of limitation of privileges or disciplinary activity.
8. Relevant APP agreements and standardized procedures as applicable.

Reappointment Applications will be sent via the Practitioner Portal to provider approximately four (4) months prior to their appointment expiration date and are expected to be completed on-line and submitted within 60 days.

Medical Staff Services sends reappointment applications as outlined in the Medical Staff Bylaws. Communication templates are outlined in Attachment A..

If the provider fails to submit a completed application by the date as stated on the written notice, a final reminder will be made to the provider, which includes an attempt to reach the provider via phone call. Failure to do so shall be deemed as a voluntarily resignation of membership and/or privileges. The procedural rights set forth in the Medical Staff Bylaws shall not apply to voluntary resignation.

<u>Verification and Processing</u>

When the application for appointment or reappointment is submitted, a review for completeness is performed by Medical Staff Services. If additional information is required, or if questions are left blank, the applicant is contacted and informed that processing will not begin until the application is entirely complete. The applicant is responsible for providing the information to satisfy the process, including resolution of any discrepancies. Failure to submit the requested information within thirty (30) days shall be considered a withdrawal of the application. Such withdrawal shall not give rise to hearing and appeal rights pursuant to the Bylaws. In accordance with the Bylaws, the Medical Staff will not take action on an application that is not “complete”.

All information gathered on the application will be verified by the primary source (when applicable). Primary source may include oral verification which requires a dated, signed note in

the credentialing file stating who at the primary source verified the item, and the date and time of verification.

The following queries, along with the applicable source/location, will be conducted:

1. California Professional License/Professional Licenses from Other States
   Current California State professional licensure must be obtained by direct confirmation from the appropriate licensing board. Other State Medical and Professional Boards for active professional licenses.

2. DEA Certification
   All providers must have a valid DEA certificate, with a California address, with the exception of Pathologists. For Advanced Practice Providers, DEA requirements are based on scope of service. Providers who are required to have a DEA, must have an unexpired DEA, without limited schedules or an out of state address, otherwise privileges shall be suspended until evidence of a valid DEA is provided to Medical Staff Services.

3. Fluoroscopy or Radiography Certification
   A copy of the permit/certification is required for all radiologists and non-radiologists who will be using fluoroscopy equipment in the operating rooms or other procedure areas. Radiography Certificate is not acceptable as a Fluoroscopy Certificate.

   Medical Staff Services shall provide a monthly report to Radiology and Perioperative Services of all providers with a valid Fluoroscopy certificate.

4. Hospital Affiliations and/or Work History
   Written verification of ten (10) years of clinical work history from hospitals or other health care organization affiliations is required for initial appointment and the prior two (2) years for reappointment. Verifications of clinical privileges in good standing at the hospital designated by the practitioner as the primary admitting facility should be confirmed in writing or orally and include the date of appointment, scope of privileges, restrictions, and recommendations. A request of the practitioners' quality and performance profile/data may be accepted in lieu of a "good standing letter" for initial appointments and reappointments.

   If verification of an affiliation is not obtained after three attempts with the applicant's assistance, including a phone call to the facility, a file note will be created. If verification cannot be obtained due to extraordinary circumstances this needs to be documented in the file for the Department Chair/designee to review. The file may then move through the evaluation process without verification.

5. Graduation from Medical/Professional School and Completion of Residencies and Fellowships
   Verification of medical/professional school graduation and completion of residency and fellowship training may be obtained from the institution(s) where the training was completed, and/or an agency that is deemed a primary source verification, such as the American Medical Association (AMA) Physician Masterfile or American Osteopathic Association (AOA)

Physician Database, National Student Clearing House (NSCH) (upon confirmation the organization uses NSCH as their 3rd party) or Federation of State Medical Boards (FSMB) for closed residency programs or state licensing agency, if the state verifies.

Foreign Medical Graduates from schools of medicine other than those in the United States and Canada must present evidence of certification by the Education Commission for Foreign Medical Graduates (ECFMG) or successful completion of a fifth pathway, or successful passing of the Foreign Medical Graduate Examination in the Medical Sciences (FMGEMS). Verification of foreign graduation will be conducted.

6. Board Certification
   Board Certification is verified by the provider's listing in published ABMS compendium, through querying the ABMS on-line database (CertiFACTS), or primary source verification directly from the certification board. Board certification is verified at time of initial appointment, at time of reappointment, and at expiration.

   In order to be considered for privileges all Advanced Practice Registered Nurses and Physician Assistants are required to have national certification when applying for credentialing and privileging. Maintenance of certification is required by any of the following bodies:
   - American Academy of Nurse Practitioners (AANP)
   - American Nurses Association – American Nurses Credentialing Center (ANCC)
   - Pediatrics Nursing Certification Board (PNBC)
   - National Certification Corporation (NCC) for Nurse Practitioner certification
   - American Association of Critical-Care Nurses (AACN)
   - American Midwifery Certification Board (AMCB)
   - National Board of Certification & Recertification for Nurse Anesthetist (NBCRNA)
   - National Commission on Certification of Physician Assistants (NCCPA)

7. Current, Adequate Malpractice Insurance
   Professional Liability Insurance coverage and the amount of coverage must be confirmed directly with the carrier.

8. Professional Liability Claims History
   Verification of ten (10) years of claims history for new appointments and the previous two (2) years for reappointments must be obtained from the current and/or previous carriers. If after three (3) attempts with the applicants' assistance, including a phone call to the facility, the insurance carrier does not respond NPDB will be used as primary source verification. The NPDB query may be used as evidence of settlement and judgment history.

9. Background Checks
   Background checks will be conducted on all applicants at the time of initial appointment and reappointment in accordance with state and federal laws. Applicants must consent to this process by signing and submitting the Notice Regarding Background Check Investigation. Failure to complete this form shall result in the application being deemed incomplete.

Signature on the Notice Regarding Background Investigation acknowledges and authorizes Medical Staff Services to search the following databases:

- Social Security Number (SSN) Trace and Death Index
- Maiden & Alias Name Search
- Criminal Records Search – Federal, State and County Levels
- National Wants and Warrants
- National Sex Offender Registry
- General Services Administration (GSA)
- U.S. Government Terrorist List/Office of Foreign Assets Control (OFAC)

10. National Practitioner Data Bank (NPDB)
    The NPDB must be queried for all new appointments, reappointments and at the time of the request for additional privileges. Each query to the NPDB is facility specific therefore there will be one (1) NPDB query for AHS and one (1) query for AH if the provider is applying at both facilities. All providers will be enrolled in the NPDB Continuous Query and will be reviewed at initial appointment, reappointment, temporary privileges, and request for additional privileges.

11. Medicare/Medicaid Sanctions
    Sanction verifications for Medicare and Medicaid will be obtained via Sanctions Exclusions Report published by the Office of Inspector General (OIG) and Excluded Parties List System (EPLS) for all new appointments and reappointments.

12. Centers for Medicare & Medicaid Services (CMS) Opt Out
    CMS will be queried for all new appointments and reappointments to confirm whether a provider has opted out of participating in the Medicare program.

13. Professional References
    Three (3) professional references for providers with the same credentials are required for new applicants and two (2) for reappointments. For reappointments, the Department Chair or an AHS Division Chief may serve as the peer reference. These references must be from individuals familiar with a provider's work, either via direct clinical observations or through a close working relationship within the prior two years. For an Advanced Practice Provider (APP) one of the references should be from a physician within the same department that has direct observation of care provided.

14. Continuing Medical Education
    A statement documenting Continuing Medical Education must be included with the application for appointment or reappointment or a signed statement indicating that the practitioner has met or exceeded continuing medical education requirements for licensure. Courses must reflect appropriate training for the specialty and privileges requested and meet any state mandated CME requirements.

15. Provider Enrollment
    For applicants who are assigning billing, collected information will be distributed to health plans as required for purposes of billing and enrollment. Providers may be required to

complete various payor-specific forms. Provider Enrollment has access to the information in the Medical Staff Services database for the purpose of providing accurate credentialing information to health plans and for the publishing of provider directories.

16. Ongoing Professional Practice Evaluation (OPPE)
    Ongoing Professional Practice Evaluation (OPPE) is the continuous evaluation of practitioner's performance. Information contained in OPPE reports are factored into the decision to maintain existing clinical privilege(s), to revise, or to revoke an existing clinical privilege prior to or at the time of reappointment.

17. Additional Information
    Departments and Clinical Services may also require additional documentation or standards. Privilege criteria is defined in the specialty-specific privilege request forms.
    Other information as deemed necessary may also be collected and considered at the request of the Medical Executive Committee or designee.

18. Timeliness of Information
    The established processing time is estimated at 60-90 days following receipt of completed application. Applications for Behavioral Health providers will be assessed for completion and verification of qualifications within 60 days of receipt of an application. Such applicants will be notified within seven (7) business days of receipt and confirmation of whether the application is complete. The signed attestation must be no more than 180 days old at the time of Credentials Committee review. All other signed documents and primary source verifications must be no more than 120 days old at the time of Credentials Committee review.

Requests for Modification of Privileges
Providers may request a modification of additional privileges at any time. These requests are handled as follows:

1. The provider must complete the request for a modification of privileges request and privilege form along with any supporting documentation regarding training or experience, as required.

2. The following primary source verification will be conducted:
   - CA Medical or Professional License(s)
   - LVS 805 Report
   - NPDB

3. FPPE/Proctoring shall be considered by the Department Chair at the time of a request for additional privileges.

4. The privileges request and supportive documentation is sent to the appropriate Department Chair/designee for review and recommendation to the Credentials Committee with final review and recommendation for approval by the Medical Executive Committee (MEC) to the Governing Board).

Appointment/Privilege Approval Notifications

Providers will be issued a Board approval notification letter outlining the approved membership and privileges within ten (10) business days of the Quality Professional Services Committee (QPSC)/Board determination.

Application Fees

Providers are required to submit an application fee for membership and/or privileges. An application is incomplete if payment has not occurred. Application fees are non-refundable once the submitted application has been received and processing has started. Reappointment fees are applied in full, regardless of the reappointment term.

1. Medical Staff Fees:
    a. AHS/AH application fee for Temporary Privileges ONLY of $100.00.
    b. AHS application fee of $300.00 and reappointment fee of $500.00.
    c. AH application fee of $300.00 and reapplication fee of $500.00.

2. Advanced Practice Provider (APP) e.g., PA, NP, etc. Fees:
    a. AHS application fee of $150.00 and a reappointment fee of $150.00.
    b. AH application fee of $200.00 and a reappointment fee of $200.00.

3. Providers who apply for membership or privileges at more than one Medical Staff within Alameda Health System the provider will receive a 50% discount of their initial application and/or reappointment fees at the second facility.

AHS and AH Category Assessments

The number(s) of patient care activities for the associated status categories are defined in the AHS/AH Medical Staff Bylaws. During the reappointment process, each applicant's OPPE report and clinical care activity reports will be reviewed to determine accurate category assignment. If an applicant no longer qualifies to continue in the current category, the Credentialing Coordinator will notify the applicant and the applicant will be given the opportunity to clarify inaccuracies. This will be considered by the Department Chair, Credentials Committee, and Medical Executive Committee as appropriate.

Voluntary Resignation

Providers who wish to resign their Medical Staff membership and/or privileges shall complete a Voluntary Resignation form (Attachment B).

Medical Staff Services will process the voluntary resignation and complete the necessary steps for deactivation of Alameda Health System computer access. The provider will attest that their charting and medical records for any care provided will be completed on or before their voluntary resignation (H&Ps, procedure notes, orders, discharge summaries). In addition, they will acknowledge that their AHS network logon and all application access will be automatically deactivated on the indicated date of their voluntary resignation. Any changes to the voluntary resignation date or a desire to rescind this resignation MUST be communicated verbally and in writing to the Medial Staff Office and the Department Chair. Failure to communicate any changes in dates will result in the resignation being effective as of the date on the Voluntary Resignation Form and all systems access will cease as outlined in the deactivation process.

PROVIDER RIGHTS TO AMEND APPLICATION AND REVIEW CREDENTIALS FILE

Providers have the right to correct erroneous information obtained throughout the credentialing process. If any submitted items differ substantially from documentation disclosed through the verification process, the provider will be notified, asked to resolve this discrepancy, and expected to do so within thirty (30) days of the request. All identified and/or requested amendments will be included in the provider's file for consideration.

Providers are allowed access to their own credentials files as outlined in the respective Medical Staff policy.

Providers have a right to be informed of the status of their application.

RELATED DOCUMENTS

Alameda Health System and Alameda Hospital Medical Staff Bylaws, Rules & Regulations, Privilege Forms, Policies and Procedures

Approvals:

		AHS	AH
Credentials Committee	**Date:**	**4/10/25**	
Medical Executive Committee	**Date:**	**4/16/25**	**4/18/25**
QPSC/Board of Trustees	**Date:**	**4/23/25**	

Medical Staff Credentialing and Privileging of Practitioners
Attachment A

The email templates below will be used at the point where the Credentials Coordinators stop any additional work on collecting an application for reappointment.

The provider will receive two courtesy reminder emails with language in the second reminder as follows:

Subject Line: **Action Needed** Application for Reappointment AHS / AH

Reappointment Failure to Submit Application Reminder: *Used for the second notice that a reappointment application was not submitted.*

Dear (insert provider's name),

This is a second reminder to notify that your application for reappointment to the <Alameda Health System/Alameda Hospital> Medical Staff has not been received. It has been 20 days since the initial notification to apply for reappointment was sent. Your application for reappointment is due within 35 days from the date of initial notification. Should your application not be submitted, it will be considered a voluntary resignation of medical staff membership and privileges at <Alameda Health System/Alameda Hospital>.

Following voluntary resignation, you will be required to reapply for membership and privileges via initial application for appointment. If you have any questions, please contact the Medical Staff Services Department at <Alameda Health System/Alameda Hospital>.

Sincerely,

Medical Staff Services
AHS Phone: 510-437-6535
SLH Phone: 510-297-5404
AH Phone: 510-814-4035
Email: medicalstaff@alamedahealthsystem.org

If the provider fails to submit a completed application in the timeframe outlined on the written notice, a final reminder will be made to the provider by telephone requesting communication with Medical Staff Services within 24 hours. Failure to do so shall be deemed to have voluntarily resigned their Medical Staff membership. The procedural rights set forth in the Medical Staff Bylaws shall not apply to a voluntary resignation under this section.

The following two email templates would be the standard work when sending email communication to address applications for reappointment which have not been submitted after three (3) automated efforts. If an application for reappointment has been started and is in progress, the applicant will be sent The Partial Action on Application for Reappointment notification.

Subject Line: **Final Notice** Application for Reappointment AHS / AH
Cc: Department Chair, Division Chief (if applicable), Credentials Committee Chair(s), MSS Director, Manager

Regular Failure to Submit Email: *Used for the final notice that an application was not submitted, and patient care is ending.*

Dear (insert provider's name),

Medical Staff Services has not received your application for reappointment to the Medical Staff of Alameda Health System and/or Alameda Hospital.

The invitation to the online application portal was sent on month/date/year, and the application remains at 0% complete. The following reminders were sent to your email(s) on file, on the below dates:

- First reminder – month/date/year
- Second reminder - month/date/year
- Third reminder – month/date/year

As of today's date, you have exceeded the 35-day application for reappointment period, as outlined in the invitation to apply for reappointment. Per the Medical Staff Bylaws, failure to submit a completed application for reappointment with all supporting or requested documentation shall result in automatic termination of your Medical Staff Membership and/or Privileges.

In effect, this results in termination of membership and/or privileges as a voluntary resignation from the Alameda Health System Medical Staff.

As of month/date/year, your Medical Staff Membership and/or Privileges at Alameda Health System will expire, with no patient care permitted.

Please contact your Department Chair, regarding the above.

Partial Action on Application for Reappointment: *Used only if the Department Chair wants them to stay on staff or they are close to having the application completed.*

Subject Line: **Final Notice Requiring Action** Application for Reappointment AHS / AH
Cc: Department Chair, Division Chief if applicable, Credentials Committee Chair(s), MSS Director, Manager

Dear (insert provider's name)

Medical Staff Services has not received your application for reappointment to the Medical Staff of Alameda Health System and/or Alameda Hospital.

The invitation to the online application portal was sent on month/date/year, and the application remains at 14% complete. The following reminders were sent to your email(s) on file, on the below dates:

- First reminder – month/date/year
- Second reminder - month/date/year
- Third reminder – month/date/year

As of today's date, you have exceeded the 35-day application for reappointment period, as outlined in the invitation to apply for reappointment. Per the Medical Staff Bylaws, failure to

submit a completed application for reappointment with all supporting or requested documentation shall result in automatic termination of your Medical Staff Membership and/or Privileges.

In effect, this results in termination of membership and/or privileges as a voluntary resignation from the Alameda Health System Medical Staff.

Please consider this our final attempt to collect your application for reappointment for processing, which if not received by COB month/date/year, will result in expiration of Medical Staff Membership and/or Privileges.

As of month/date/year, your Medical Staff Membership and/or Privileges at Alameda Health System will expire, with no patient care permitted.

Please contact your Department Chair, regarding the above.

Medical Staff Credentialing and Privileging of Practitioners
Attachment B
Medical Staff Voluntary Resignation Form

I am formally submitting my voluntary resignation from the Medical Staff(s) listed below.
□ *Alameda Health System □ Alameda Hospital

Requested Voluntary Resignation Date (must be a date after this form is submitted to the Medical Staff Office): Date:_____

I attest that my charting and medical records and any care I provided will be completed on or before my voluntary resignation as above (H&Ps, procedure notes, orders, discharge summaries)

I acknowledge and agree that I continue to be bound by the Medical Staff Bylaws until my voluntary resignation date, including but not limited to assuring that I maintain professional liability coverage through that date.

I acknowledge that my AHS network logon and all application access will be automatically deactivated on the date of my voluntary resignation documented above.

Any request to change my voluntary resignation date or a desire to rescind this resignation **MUST** be communicated verbally and in writing to the Medial Staff Office and your Department Chair prior to the date specified above for my voluntary resignation and you must request a date after the requested change is submitted in writing to the Medical Staff Office.

Failure to communicate any changes in dates will result in the resignation being effective as of the date above and all systems access will cease as outlined on this form.

Reason(s) *(please select all that apply):*

□ Layoff / Reduction in Workforce
□ Resignation / Termination of Employment
□ No longer with contracted group
□ No longer utilize AHS Facilities
□ Moved out of state
□ Retired from practice
□ Other _____

_____	_____	_____
Practitioner's Printed Name	Department / Specialty	Medical Group Name *(if applicable)*
_____	_____	
Practitioners Signature	Date	

Please submit your completed form via email or fax: **medicalstaff@alamedahealthsystem.org** Fax: (510) 379-7440

You will receive a letter that confirms your voluntary resignation of membership and/or privileges after the resignation has been accepted by the Board. For any questions, please contact Medical Staff Services at Alameda Health System (510) 437-4292 or Alameda Hospital (510) 813-4035.

**Highland Hospital, San Leandro Hospital, John George Psychiatric Hospital, Fairmont Hospital, Wellness Clinics*

Alameda Health System

MEDICAL STAFF ONGOING MONITORING AND EVALUATION OF ACTIONS RELATED TO PROVIDERS

Department	AHS Medical Staff	***Effective Date***	3/2022
Campus	AHS, AH	***Date Revised***	8/2023; 3/2025; 4/23/25
Unit	All	***Next Scheduled Review***	4/2028
Manual	Medical Staff	***Author***	Manager, Medical Staff Services
Replaces the following Policies:		***Responsible Person***	Chief of Staff

Printed copies are for reference only. Please refer to electronic copy for the latest version.

Purpose

This policy describes the ongoing monitoring process the Alameda Health System (AHS) and Alameda Hospital (AH) Medical Staffs follow in response to alerts related to a member or privileged provider of the Medical Staff or Advanced Practice Providers, by establishing a systematic process for reviewing and evaluating such events.

Policy Statement

To ensure the quality and safety of care, the Alameda Health System Medical Staff office conducts ongoing monitoring and review of any sanctions, complaints and adverse events between credentialing cycles for Medical Staff members or privileged providers.

The ongoing review process is designed to ensure allegations and reports are reviewed timely, objectively and that actions taken are considered and instituted where appropriate to comply with the Medical Staff Bylaws and to maintain safety of care delivered to patients. Any data or information as part of the medical staff oversight and review process, are protected by California Evidence Code section 1157. Pertinent information identified in the review process shall be factored into decisions regarding what actions will be taken.

Procedure

Ongoing monitoring of provider sanctions, complaints and adverse events between credentialing cycles will be monitored via the following mechanisms:

1. Basic Responsibilities of Medical Staff
   Providers are required to notify the Medical Staff in writing within seven (7) days of any of the events listed in the Medical Staff Bylaws Section captioned “Basic Responsibilities of Medical Staff. The foregoing includes, but is not limited to, events related to their licensure, certification, registration, loss of membership, restriction or denial of privileges, employment, inability to provide care for more than 30 days, liability insurance, participation in federally funded health care organizations, professional liability suits, mental/physical health, felony or misdemeanor.

2. Licensing Boards
    a. California Medical Board: Medical Staff receives and reviews the Board's proactive disclosure notifications of actions via periodic, automated emails from the Medical Board of California subscription (MBC-ACTIONS@SUBSCRIBE.DCALISTS.CA.GOV)
    b. California Osteopathic Medical Board: Medical Staff receives and reviews the Board's proactive disclosure notifications of actions via periodic, automated emails from the Medical Board of California subscription (OMBC-GENERAL@SUBSCRIBE.DCALISTS.CA.GOV)
    c. Dental Board of California: The Dental Board of California publishes monthly information "Hot Sheets" regarding board enforcement actions. The monthly report is retrieved and cross-referenced to identify affiliated providers. (https://www.dbc.ca.gov/consumers/hotsheets.shtml).
    d. California Physician Assistant Board: The Physician Assistant Board publishes monthly information regarding administrative disciplinary actions. The monthly report is retrieved and cross-referenced to identify affiliated providers. (https://pab.ca.gov/consumers/disciplinaryactions.shtml)
    e. California Board of Psychology: Medical Staff receives and reviews the Board's proactive disclosure notifications of actions via periodic, automated emails from the Board of Psychology (LISTSERV@SUBSCRIBE.DCALISTS.CA.GOV)

3. National Practitioner Databank (NPDB)
    All providers are enrolled in the NPDB Continuous Query. Enrolled practitioners are continuously monitored, and an alert is emailed when a new report is received or an existing report is revised, corrected, or voided. The credentialing database interfaces with the NPDB to automatically receive NPDB reports.

4. Federal and State Exclusions
    Monthly provider rosters are uploaded to Verify Comply (vendor platform solution for comprehensive exclusion screening services) to screen for exclusions in all US States and Federal databases. Databases include the following:
    a. U.S. HHS OIG List of Excluded Individuals and Entities (LEIE)
    b. U.S. GSA System for Award Management (SAM)
    c. Suspended/Excluded Providers for All States
    d. U.S. Dept of the Treasury Office of Foreign Assets Control (OFAC)
    e. CMS Opt Out NPI Only

Quality of Care complaints/concerns will be facilitated in accordance with the Medical Staff Peer Review policy.

Behavior concerns/complaints will be facilitated in accordance with Medical Staff Professionalism and Conduct policy.

If the action triggers an automatic action, such as an automatic termination, suspension or restriction of membership and/or privileges under the Medical Staff Bylaws, the automatic action shall be immediately imposed in accordance with the Bylaws.

Actions will be evaluated as follows:

1. Reports will be sent to the Department Chair/Division Chief (if applicable) along with any supporting information.
2. The Division Chief (if applicable)/Department Chair (if no Division Chief) will review what is reported and assess if further information is required from the provider. If further information is required, the provider will be sent a letter that requires additional information. The response will be reviewed by the Department Chair/Division Chief (if applicable). Upon completing a review of what is reported and any response, the Department Chair/Division Chief (if applicable) will complete an Action Assessment Form (Attachment A to document their review of the report and recommend the next steps.)
3. If the Chief/Chair is uncertain how to address a situation, the Chief/Chair may refer information to Credentials and/or Medical Executive Committee for further review and recommendation.
4. Documentation related to the report will be maintained in the provider's credentialing file.
5. Actions will be logged and reported to the Credentials Committee.

Reporting Requirements:

In accordance with the California Business and Professions Code §805, a report must be filed for physicians and podiatrists within 15 days after one of the following actions occurs:

1. Denial or rejection of privileges or membership for a medical disciplinary cause or reason;
2. Revokation of privileges or membership for a medical disciplinary cause or reason;
3. Restrictions imposed, or voluntarily accepted, on privileges or membership for a total of 30 days or more within any 12 month period for medical disciplinary reasons;
4. If a resignation, leave of absence, withdrawal or abandonment of application or for renewal of privileges occurs after receiving notice of a pending investigation initiated for a medical disciplinary cause or reason;
5. Summary suspension of staff privileges or membership is imposed for a period in excess of 14 days.

In accordance with the California Business and Professions Code §805.01, a report of a final decision or recommendation to terminate, revoke, summarily suspend or restrict privileges or membership must be filed for physicians, physician assistants and podiatrists within 15 days if the reason for the investigation was one of the following:

1. Incompetence, or gross or repeated deviation from the standard of care involving death or serious bodily injury to one or more patients, to the extent or in such a manner as to be dangerous or injurious to any person or to the public. This paragraph shall not be construed to affect or require the imposition of immediate suspension pursuant to Section 809.5.
2. The use of, or prescribing for or administering to himself or herself, any controlled substance; or the use of any dangerous drug, as defined in Section 4022, or of alcoholic beverages, to the extent or in such a manner as to be dangerous or injurious to the licentiate, any other person, or the public, or to the extent that such use impairs the ability of the licentiate to practice safely.
3. Repeated acts of clearly excessive prescribing, furnishing, or administering of controlled substances or repeated acts of prescribing, dispensing, or furnishing of controlled substances without a good faith effort prior examination of the patient and medical reason therefor.

However, in no event shall a physician and surgeon prescribing, furnishing, or administering controlled substances for intractable pain, consistent with lawful prescribing, be reported for excessive prescribing and prompt review of the applicability of these provisions shall be made in any complaint that may implicate these provisions.

4. Sexual misconduct with one or more patients during a course of treatment or an examination

In accordance with the California Business and Professions Code §805.08, a report must be filed with 15 days of receiving a written allegation of sexual abuse or sexual misconduct by a provider.

In accordance with the National Practitioner Databank, a report must be submitted for physicians and dentists within 30 days of one of the following occurrences:

1. Professional review actions - based on reasons related to professional competence or conduct - adversely affecting clinical privileges for a period longer than 30 days.
2. Voluntary surrender or restriction of clinical privileges while under, or to avoid, an investigation

Approvals

		AHS Core	AH
Credentials Committee	**Date:**	**4/10/25**	
Medical Executive Committee	**Date:**	**4/16/25**	**4/18/25**
QPSC	**Date:**	**4/23/25**	

Attachment A

Alameda Health System Medical Staff Action/Allegation/Accusation Assessment Form

Date: _____

Provider Name: _____

Report of action/allegation/accusation made by or received from: _____
Reported on: _____

Brief summary of report: _____

Division Chief (if applicable)/Department Chair Recommendation:

As Chair of the Provider's Department or Division Chief, I have reviewed the reported action/allegation/accusation and recommend the following:

☐ No action at this time.
☐ Track/Trend and/or monitor for final outcome.
☐ Request additional information from the provider.
☐ Refer to QRC/Peer Review.
☐ Initiate FPPE.
☐ Refer to Well-Being Committee
☐ Limit/restrict privileges and/or membership (refer to MEC)
☐ Refer to the Credentials Committee and/or Medical Executive Committee for further review/recommendation.
☐ Other

Explanation/details supporting the above recommendation(s):

_____
_____
_____
_____

_____	_____	_____
Name	Signature	Date

This is a quality improvement/peer review document of the hospital. It includes privileged and confidential information which is protected from disclosure pursuant to California Evidence Code, Section 1157 and other provisions of state and federal law.

E. Contracts

Contract Approvals
May 2025

1. **Amendment with Virtual Radiologic Professionals of California, P.A. to renew terms of our remote imaging services agreement. The term of this amendment is July 1, 2025 through July 1, 2026 auto-renewing each year after unless prior written notice is provided no less than 120 days prior to the end of the initial term. The estimated impact of this amendment is $3,197,097.**
   Elizabeth Mahler, Chief Medical Officer

2. **Amendment with East Bay Foundation for Graduate Medical Education to renew our surgical residency program. The term of this amendment is July 1, 2025 through June 30, 2026. The estimated impact of this amendment is $4,325,956.**
   Elizbeth Mahler, Chief Medical Officer

Contract Approvals
May 2025

3. **New agreement with Strata Decision Technology, LLC for provision of financial and budgeting software services. The term of this agreement is June 1, 2025 through May 31, 2030. The estimated impact of this agreement is $2,491,181.**

   Kimberly Miranda, Chief Financial Officer

Recommendation: Motion to Recommend Approval for the above contracts to the Board of Trustees

Contractor/Vendor Name:	Virtual Radiologic Professionals of California, P.A., ("vRad"), a California professional corporation formerly doing business as Nighthawk Radiology Services, LLC.

Description:	vRad is the incumbent provider of remote diagnostic radiology interpretation services ("Teleradiology Services", or "Services") at Wilma Chan Highland Hospital ("WCHGH"), Alameda Hospital ("AH") and San Leandro Hospital ("SLH"). Services include vRad's provision of qualified radiologists to remotely interpret the following imaging procedures: 1) Plain Film ("X-Ray"), 2) Computerized Tomography ("CT"), 3) Magnetic Resonance Imaging ("MRI"), and 4) Ultrasound ("US"). AHS relies on vRad to provide 24/7 supplemental support to the desired level of in-house staffing enabling optimal service delivery at an affordable price point.
	
	vRad was founded in 2001, and currently employs over 500 board certified and eligible radiologists providing services at over 2,100 health care systems and facilities across the U.S. vRad has demonstrated an impressive commitment and ability to ensure the reliable delivery of high-quality services to its clients featuring an average "read accuracy" of 99.7% and average turn-around times of < 12 minutes for trauma studies, and < 9 minutes for stroke studies.
	
	In light of vRad's reputation as a leading provider of services, Alameda Health System ("AHS") leadership initially engaged vRad to provide Services at HGH in 2007. 3 years after the affiliation of our 2 community hospitals in 2014 (AH and SLH, or "Community Hospitals" collectively), AHS leadership performed a thorough evaluation of the ongoing and future Services needs system-wide including reviewing the performance, capabilities and market alignment of the then-incumbent ("Prior Incumbent") contracted Services provider for the Community Hospitals. At the conclusion of the evaluation process, AHS leadership determined that vRad was best positioned to provide the reliable, high-quality, and affordable Services required by our patients going forward. Upon determination that vRad was the preferred provider of system-wide Services, AHS leadership ended the relationship with the Prior Incumbent and amended the terms of our agreement with vRad ("Current Agreement") in 2017 to expand their provision of Services from HGH to include SLH and AH. This expansion and consolidation of Services provision was and remains an important element underpinning the success of the larger radiology systemization project that culminated and continues with the delivery of on-site imaging services during regular hours by Alameda Health System ("AHP")-employed radiologists at all AHS facilities.
	
	vRad provides the following services under the Current Agreement:
	
	• Remote coverage provided 24/7/365 days a year from 7am to 7am
	• Provision allowing day-time backup coverage to assist on-site radiologists address emergency utilization spikes
	• A panel of 81 board certified or eligible radiologists available to meet all anticipated AHS remote Services needs
	• Stringent quality assurance program, including:
	  ○ Random audits of reads and reports to AHS with all findings
	  ○ Peer review provided by both vRad and AHS
	  ○ AHS access to Ongoing Professional Practice Evaluation ("OPPE")

<table>
<tr><td></td><td>data as needed
○ Monthly reports sent to AHS to monitor quality metrics

In light of the reliable and critical nature of the services provided, AHS leadership is requesting Board approval to enter a renewal amendment (“Renewal”) with vRad on the following terms:

• Increase the minimum monthly payment (“Monthly Minimum”) that serves as the baseline monthly compensation if per read fees fall below this amount.
○ While the Monthly Minimum rate increase is material (29% increase over current rate), practically speaking the anticipated impact is negligible given that AHS per read volumes and associated fees significantly exceed the value of the Monthly Minimum.
• Revise fee schedule for image interpretation services.
○ 10% average increase over current fee schedule.
• Introduce a monthly Management Fee.
○ Reflects vRad administrative overhead costs associated with delivery of services to AHS.
○ Increases total annual cost of services by $62,400.</td></tr>
<tr><td>Contract Type and Term:</td><td>Amendment
July 1, 2025 through July 1, 2026, auto-renewing each year after unless prior written notice is provided no less than 120 days prior to end of initial term.</td></tr>
<tr><td>Termination Clause:</td><td>180-day without cause termination clause after 1-year term.</td></tr>
<tr><td>Total Spend with Vendor:</td><td><table><tr><th>Description</th><th>Board Approval</th><th>Total</th></tr><tr><td>Amendment Renewal 07/01/2025– 06/30/2026</td><td>Approval Requested</td><td>$3,197,097</td></tr></table></td></tr>
<tr><td>Estimated Cost Savings:</td><td>Based on current utilization levels, AHS estimates actual compensation paid will increase by $421,437 over the 1-year Renewal term. Compensation paid to vRad under the Current Agreement will be offset by collections assigned to AHS by vRad (professional fees) which are valued at $1,469,524 annually. The addition of a new employed AHS diagnostic radiologist is anticipated to redirect up to 8% of the current vRad workflow in-house further reducing actual cost of the proposed Renewal.</td></tr>
<tr><td>Fiscal Implications:</td><td>This Renewal Amendment is contemplated under the FY26 budget.</td></tr>
<tr><td>Reasons for Recommendation:</td><td>vRad is the recognized leader in provision of Teleradiology Services nation-wide and has a proven record of providing reliable, affordable and high-quality Services at AHS.</td></tr>
</table>

<table>
<tr><td>Impacted Facilities:</td><td>
<table>
<tr><th>AHS</th><th>JGPH</th><th>Highland</th><th>Fairmont</th><th>San Leandro</th><th>Alameda</th><th>Clinic(s)</th></tr>
<tr><td></td><td></td><td>X</td><td></td><td>X</td><td>X</td><td></td></tr>
</table>
</td></tr>
<tr><td>Coordination with Medical Staff:</td><td>The Chief Medical Officer in conjunction with the Chair of Radiology have both reviewed and support entering the Renewal Agreement on the proposed terms.</td></tr>
<tr><td>Administrative Review:</td><td>Primary: Chair Radiology
Secondary: Chief Medical Officer</td></tr>
<tr><td>Prior BOT Review/Action:</td><td>In April 2023, the Board approved a 2-year renewal with vRad.</td></tr>
<tr><td>Executive Sponsor:</td><td>Chief Medical Officer</td></tr>
</table>

Contractor/ Vendor Name:	East Bay Foundation for Graduate Medical Education ("EBFGME")
Description:	EBFGME is a non-profit corporation that administers the East Bay Residency Program for surgical residents under the UCSF School of Medicine. The residents from EBFGME have been participating in clinical rotations at Alameda Health System's ("AHS") Wilma Chan Highland Hospital ("WCHGH") since 1989, as well as at Kaiser Permanente (various locations within the East Bay), San Francisco VA Medical Center and Children's Hospital. All participating hospitals make a financial commitment to EBFGME for the purpose of sharing certain costs and expenses proportionally to hospital participation, including resident salaries and benefits (salary portion) as well as expenses incurred by EBFGME in the administration of resident salaries, benefits and recruitment activities (administration portion). Hospital financial commitment is calculated based on the number and experience of the residents assigned to the hospital for the salary portion and the percentage of students assigned to the hospital for the administration portion. The EBFGME program will place a total of 55 residents across all participating hospitals during FY 26 comprising 40 continuing residents and 15 new residents. Of the 55 surgical residents in the program for the upcoming year, 28 have been assigned to the Accreditation Council of Graduate Medical Education ("ACGME") accredited Surgical Department Residency Training Program at WCHGH accounting for 52% of the residents in the EBFGME program. The residents range from those in their first through fifth years of residency ("Program Years I through V, often abbreviated PGY I, II, etc.") and will provide the following services: • Inpatient and Outpatient Duty Hours (where "Duty Hours" include all clinical and academic activities related to the residency requirements) • Administrative Duties related to patient care • On-Call Duty Hours Supervision of the residents and oversight of the Surgical Department Residency Training Program is performed by the UCSF East Bay Faculty Surgeons, under the UCSF Professional Services Agreements for Trauma, Surgery and Neurosurgery. All terms of the proposed Renewal Amendment with EBFGME remain unchanged over the prior term. Specifically, AHS' proposed total financial obligation has increased by 3.7% over current rates due to the following changes: 1) 3.9% overall increase in residents' salaries due to EBFGME's Board of Directors approval of a cost-of-living increase. 2) 4.1% average increase in benefits allocation. 3) 5.6% increase in the cost of the share of the administrative budget for which AHS is responsible. • AHS administrative budget allocation increase reflects the following: 1. 25% increase in personnel tax and benefits cost 2. 37% increase in payroll fees

<table>
<tr><td></td><td>3. 167% increase in general liability and property insurance fees</td></tr>
<tr><td>Contract Type and Term:</td><td>Renewal Amendment
Term: 07/01/2025 – 06/30/2026 (12 months)</td></tr>
<tr><td>Termination Clause:</td><td>Without Cause Termination: This contract automatically renews for an additional one-year period if either party fails to give the other party written notice to terminate prior to November 1, 2025.</td></tr>
<tr><td>Total Spend with Vendor:</td><td>
<table>
<tr><th>Description</th><th>Board Approval</th><th>Total</th></tr>
<tr><td>Amendment (07/01/2025 – 06/30/2026)</td><td>Approval Requested</td><td>$4,325,956</td></tr>
</table>
</td></tr>
<tr><td>Estimated Cost Savings:</td><td>There is no cost savings associated with this renewal amendment.</td></tr>
<tr><td>Fiscal Implications:</td><td>If the maximum requested expenditure of $4,325,956 were incurred, AHS would experience a negative variance of $1,031,328. Critically, this unlikely scenario assumes none of our assigned residents completes any of the usual rotations at other (non-AHS) facilities during the term of the proposed renewal. However, it is usual for our residents to do rotations at non-AHS institutions during a portion of their assigned year with AHS (to optimize their educational experience) resulting in lower costs incurred by AHS which only pays for resident time spent at AHS. Taking this into account and accounting for the past run-rate for these services, we are projecting actual expenditures over the course of the proposed amendment to be $3,306,776 with a correspondingly smaller budget variance in the amount of $12,149. We are requesting Board approval of the maximum expenditure amount of $4,325,956 due to the fact that we do not know our residents' rotational schedules at the time this proposed renewal will be signed. A reconciliation process ensures that we only pay for services rendered at AHS facilities during the agreement term.</td></tr>
<tr><td>Reasons for Recommendation:</td><td>EBFGME has a proven track-record of providing high quality and reliable resident physicians that enhance AHS' ability to provide vital services to the community while simultaneously furthering our teaching mission.</td></tr>
<tr><td>Impacted Facilities:</td><td>
<table>
<tr><th>AHS</th><th>JGPH</th><th>WCHGH</th><th>Fairmont</th><th>San Leandro</th><th>Alameda</th><th>Clinic(s)</th></tr>
<tr><td></td><td></td><td>X</td><td></td><td>X</td><td>X</td><td></td></tr>
</table>
</td></tr>
<tr><td>Coordination with Medical Staff:</td><td>The proposed renewal amendment was reviewed by AHS' Chief Medical Officer and discussed with the Chair of Surgery at WCHGH.</td></tr>
<tr><td>Administrative Review:</td><td>Primary: Director, Graduate Medical Education
Secondary: Designated Institutional Officer</td></tr>
</table>

Prior BOT Review/Action:	In May 2024, the Board approved an amendment for a 12-month extension.
Executive Sponsor:	Chief Medical Officer

Contractor/ Vendor Name:	Strata Decision Technology, LLC (Strata)
Description:	Strata is a software developer whose cloud-based financial planning and decision support software, data, and service solutions are well-received in the healthcare industry having been adopted by local peer institutions, including Stanford & Packard Children's Hospital, John Muir Health, and Kaiser Permanente. Strata is based in Chicago and has software implemented in over 2,300 organizations. KLAS Research publishes reports that recognize software and service companies that excel in helping healthcare professionals improve patient care. Strata has been #1 in the KLAS report for 19 years. Healthcare organizations are challenged with understanding complex financial data that is fragmented and not consistently and readily accessible to both those compiling the information and those end-users tasked with making informed financial decisions. StrataJazz, a financial planning application developed by Strata, is a software tool that will help Alameda Health System's (AHS') leadership ("Leadership") plan, analyze, and perform in the areas of financial planning, decision support, efficient and accountable performance management, and data intelligence to identify trends and opportunities. Leadership proposes to shift from its current Strata product, EPSi and implement StrataJazz software to enhance and expand upon the capabilities of the legacy system ("EPSi"). Under terms of the proposed arrangement, StrataJazz will provide 200 AHS system users with access to operating, budgeting and management reporting, long range financial planning and rolling forecasting for 50 users, cost accounting access for 50 users, and unifying AHS data with Sg2 Grouper. The cost of implementation and subscription for 5-years is as follows:

	Year 1	Year 2	Year 3	Year 4	Year 5
StrataJazz implementation Fee	$768,000	0	0	0	0
Discount	($153,600)	0	0	0	0
Sub-Total	$614,400	0	0	0	0
StrataJazz Subscription Fees	$736,459	$758,552	$781,310	$804,749	$828,892
Discount	($382,959)	($394,448)	($406,281)	($418,469)	($431,024)
Sub-Total	$353,500	$364,104	$375,029	$386,280	$397,868
Total	$967,900	$364,104	$375,029	$386,280	$397,868

5-Year TOTAL $2,491,181

Moving from EPSi to StrataJazz will provide financial management tools that are more robust and easier to use. StrataJazz has better functionality and improved reporting capabilities. StrataJazz is cloud-based while EPSi is not. This translates into StrataJazz requiring no hardware or database installation, fewer IT resources and business owner software intervention and maintenance. AHS Leadership recommends approval of the approval of the StrataJazz subscription agreement on the terms outlined above and below.

Board of Trustees Contract Summary May 2025

<table>
<tr><td>Contract Type and Term:</td><td>Software Use Agreement
Contract Term: June 1, 2025, through May 31, 2030</td></tr>
<tr><td>Termination Clause:</td><td>With cause termination upon notice to breaching party. Breaching party has 45 days to cure after which agreement will terminate.

AHS may terminate without cause within the first 6 months of the agreement. Neither party may terminate without cause after the initial 6 months of the agreement term.</td></tr>
<tr><td>Total Spend with Vendor:</td><td>
<table>
<tr><th>Description</th><th>Board Approval</th><th>Total</th></tr>
<tr><td>Implementation Fee</td><td></td><td>$614,400.00</td></tr>
<tr><td>Subscription Fees 6/1/2025 5/31/2030</td><td></td><td>$1,876,781.00</td></tr>
<tr><td>Total Estimated Spend:</td><td>Approval Requested</td><td>$2,491,181.00</td></tr>
</table>
</td></tr>
<tr><td>Estimated Cost Savings:</td><td>AHS will receive $2,186,781 in discounts off the subscription and implementation costs.</td></tr>
<tr><td>Fiscal Implications:</td><td>This agreement has been included in the budget for FY26. Migration to StrataJazz will provide among other benefits a more robust and fully-supported cost accounting system recommended by the State of California to satisfy the requirement for additional supplemental funding Enhanced Payment Program (EPP) for public healthcare systems. Acquisition of StrataJazz (and its enhanced cost-reporting application) will enable AHS to apply for up to $5 million annually in additional EPP funding.</td></tr>
<tr><td>Reasons for Recommendation:</td><td>AHS Leadership has previous experience with Strata as the current developer of the EPSi software used in financial analytics. Strata is ending software support for EPSi as they sunset this legacy system and transition to StrataJazz. The additional capabilities of StrataJazz over the current tool will save time in processing and save money in uncovering trends and spending opportunities.</td></tr>
<tr><td>Impacted Facilities:</td><td>
<table>
<tr><th>JGPH</th><th>Highland</th><th>Fairmont</th><th>San Leandro</th><th>Alameda</th><th>Clinic(s)</th></tr>
<tr><td>X</td><td>X</td><td>X</td><td>X</td><td>X</td><td>X</td></tr>
</table>
</td></tr>
<tr><td>Coordination with Medical Staff:</td><td>N/A</td></tr>
<tr><td>Administrative Review:</td><td>Primary: Chief Financial Officer
Secondary: Director, Financial Planning and Analysis</td></tr>
<tr><td>Prior BOT Review/Action:</td><td>N/A</td></tr>
</table>

Executive Sponsor:	Chief Financial Officer

MONTHLY REPORT
LIFETIME VENDOR SPEND - MAY 2025

Vendor Name	Revised Contract Term	Proposed Contract Spend	Total Lifetime Vendor Spend (including proposed contract)	Proposed Contract Description	Status
East Bay Pulmonary Medical Group	6/1/2025-5/31/2026	$286,239.80	$ 2,066,389.38	This Third Amendment extends the PSA by one year for sub-acute services, increases compensation, and increases administrative hours.	Executed
CompSpec Inc	05/01/2023-04/30/2027	$600,000	$ 1,949,275.72	Retroactive to cover course of dealing and extends SOW for 2 additional years. Contractor will continue to provide uncompensated care reimbursement recovery services. Screens patients for eligibility for Medi-Cal, Workers Comp, Third Party Liability, Victims of Crime or any other source of reimbursement for medical care.	Executed

ALAMEDA HEALTH SYSTEM

BOT Previously Approved Contracts - FY25 (July 1, 2024 - June 30, 2025)

#	Vendor	Amount Requiring BOT Approval	Start Date	Ending Date	BOT approved Date	Agenda Summary	Expectation	Executive Sponsor
1	Cardea Health	$2,075,025	8/1/2024	7/31/2025	FC - 7-3-24 BOT Approved 7-10-24	Medically supported shelter for AHS-discharged homeless patients.		Chief Operating Officer
2	D'ville Construction, Inc.	$2,210,979	8/1/2024	7/31/2026	FC - 7-3-24 BOT Approved 7-10-24	Construction services for SPD expansion at SLH.		Chief Administrative Officer, Community Hospitals
3	Mesa Energy Systems, Inc. dba EMCOR Services	$2,811,758	7/15/2024	7/14/2026	FC - 7-3-24 BOT Approved 7-10-24	Chillers replacement at SLH.		Chief Operating Officer
4	Onward Health Inc.	$7,052,370	8/1/2024	7/31/2028	FC - 7-3-24 BOT Approved 7-10-24	Non-medical patient transport services.		Chief Operating Officer
5	Royal Ambulance, Inc.	$23,408,147	8/1/2024	7/31/2028	FC - 7-3-24 BOT Approved 7-10-24	Medical transport services.		Chief Operating Officer
6	Mint Medical, LLC dba Mint Medical Services	$4,242,697	10/1/2024	9/30/2027	FC - 9-4-24 BOT Approved 9-18-24	Vascular ultrasound services.		Chief Medical Officer
7	Vascular Surgery Group Inc.	$1,783,527	10/1/2024	9/30/2027	FC - 9-4-24 BOT Approved 9-18-24	Vascular surgery call coverage services at SLH and AH.		Chief Medical Officer
8	The Regents of the University of California on behal of the University of California, San Francisco, School of Medicine, Department of Obstetrics, Gynecology, and Reproductive Sciences	$2,071,685	10/1/2024	9/30/2026	FC - 9-4-24 BOT Approved 9-18-24	Maternal-fetal medicine coverage services at HGH.		Chief Medical Officer
9	Optum360 Solutions, LLC	$2,100,000	10/1/2024	9/30/2027	FC - 9-4-24 BOT Approved 9-18-24	Utilization management transactional services.		Chief Medical Officer
10	Lescure Company, Inc.	$2,066,300	10/1/2024	9/30/2025	FC - 9-4-24 BOT Approved 9-18-24	Construction services for above-ground fuel storage tanks at SLH.		Chief Operating Officer
11	Compass Group USA, Inc. by and through its subsidiary Morrison Management Specialists, Inc.	$23,227,049	10/1/2024	9/30/2027	FC - 9-4-24 BOT Approved 9-18-24	Food and nutrition management services.		Chief Operating Officer
12	Inter-Con Security Systems, Inc.	$40,872,148	10/1/2024	9/30/2027	FC - 9-4-24 BOT Approved 9-18-24	Security services.		Chief Operating Officer

13	Medline Industries, Inc.	$50,000,000	10/20/2024	10/20/2026	FC - 10-2-24 BOT Approved 10/9/24	Surgical supplies.		Chief Operating Officer
14	Agiliti Health, Inc.	$18,341,250	12/1/2024	11/30/2029	FC - 11-6-24 BOT Approved 11-13-24	Imaging equipment maintenance and repair services		Chief Information Officer
15	EverWatt Lights, LLC	$1,591,053	12/1/2024	6/30/2025	FC - 11-6-24 BOT Approved 11-13-24	Installation of energy efficiency upgrades at HGH		Chief Operating Officer
16	Diablo Infectious Disease Consultative Medical Group, Inc.	$2,414,031	1/1/2025	12/31/2027	FC - 11-6-24 BOT Approved 11-13-24	Infectious disease professional services		Chief Medical Officer
17	Traditions Behavioral Health	$10,605,018	1/1/2025	12/31/2027	FC - 11-6-24 BOT Approved 11-13-24	Behavioral health professional services		Chief Medical Officer
18	Agiliti Healthcare, Inc.	$1,554,222	5/1/2024	12/31/2025	FC - 1-8-25 BOT Approved 1-15-25	Extension of biomedical maintenance and repair report services		Chief Technology Officer
19	Agiliti Healthcare, Inc.	$13,987,994	2/1/2025	1/31/1930	FC - 1-8-25 BOT Approved 1-15-25	Renewal of biomedical maintenance and repair report services		Chief Technology Officer
20	Inter-Con Security Systems, Inc.	$1,600,000	10/1/2024	9/30/2027	FC - 1-8-25 BOT Approved 1-15-25	Funding increase for provision of unplanned additional security services.		Chief Operating Officer
21	Inter-Con Security Systems, Inc.	$2,000,000	2/1/2025	9/30/2027	FC - 1-8-25 BOT Approved 1-15-25	Provision of patient watch services in San Leandro Hospital		Chief Operating Officer
22	Lescure Company, Inc.	$1,429,300	2/1/2025	4/30/2026	FC - 1-8-25 BOT Approved 1-15-25	Provision of temporary HVAC services at Alameda Hospital.		Chief Operating Officer
23	Lescure Company, Inc.	$80,993	2/1/2025	4/30/2026	FC - 1-8-25 BOT Approved 1-15-25	Provision of Phase 1 repair and upgrade services for legacy HVAC system at Alameda Hospital.		Chief Operating Officer
24	EverWatt Lights, LLC	$3,915,013	3/1/2025	3/31/2026	FC - 2-5-25 BOT Approved 2-12-25	Installation of energy efficiency upgrades at SLH.		Chief Operating Officer
25	Hayward Sisters Hospial dba St. Rose Hospital and Saint Rose Medical Building, Inc.	$49,420,328	11/1/2024	10/31/2029	FC - 2-5-25 BOT Approved 2-12-25	Management services agreement.		Chief Executive Officer
26	Metropolis California, LLC	$2,258,508	11/1/2024	12/31/2025	FC - 3-5-25 BOT Approved 3-12-25	Parking services agreement		Chief Operating Officer
	Total Amount for FY 24 year to date	$273,119,395						

TO: Board of Trustees

FROM: Ahmad Azizi, General Counsel

SUBJECT: **Agenda Item:** F1

Meeting Date: May 14, 2025

Item Description: AHS Board of Trustees Bylaws

BOARD ACTION: Recommend approval of the revised Bylaws to the Board of Supervisors

Background:

The Alameda Health System Board of Trustees Bylaws were last updated by the Board of Supervisors in October of 2020. An ad hoc committee of the Board of Trustees recommended changes to the Bylaws in 2023. These changes are reflected in the attached redline document. The Board of Supervisors must approve any changes made to these Bylaws before they can be enacted.

Analysis:

The revisions to the Bylaws aim to reflect best governance practices, clarify and update language, enhance operational flexibility, and align with recent organizational changes and legal requirements.

Summary of Key Changes:

Board Composition and Membership (Article 2):

- Updated language to reflect current practices.
- Added language to protect Trustees consistent with AHS's Directors and Officers Insurance Policy.

Board Committees (Article 4):

- Updated committee titles.

Meetings of the Board (Article 5):

- Updated the Officer titles as indicated, changes are carried through the entire document:
  - President changed to Chair
  - Vice President changed to Vice Chair

Medical Staff (Article 7):

- Updated various language to match the current, Board of Trustees-approved, Medical Staff Bylaws, and for consistency with updated titles therein.
- Added references to Medical Staff Policies and Procedures where appropriate, for clarity.

Medical Director (Article 8):

- Updated “Medical Director” to “Chief Medical Officer,” consistent with current practice.

Miscellaneous Revisions:

- Made various stylistic, formatting, and grammar updates throughout for clarity and consistency.
- Removed or updated outdated references and terminology.

Recommendation:

Staff recommends the Board of Trustees move approval of the Bylaws as presented and recommend approval to the Board of Supervisors. If the Board of Trustees approves the changes presented, the next step is to send the changes to the Board of Supervisors for its approval.

Prior Board Action:

AHS Bylaws call for the Board to review and propose changes to the AHS Bylaws every two years.

Board Action Requested:

Approve the Bylaws as presented, and request staff to forward it to the Board of Supervisors for approval.

Fiscal Impact: n/a.

Budgeted/Authorized: n/a

Estimated Cost Savings: n/a

Strategic Plan Pillar: n/a

ALAMEDA HEALTH SYSTEM
BOARD OF TRUSTEES
BYLAWS

The following Bylaws have been adopted and issued by the Alameda County Board of Supervisors on behalf of Alameda Health System ("AHS") a public entity created by the Board of Supervisors pursuant to Section 101850 of the California Health and Safety Code for the purpose of managing, administering and controlling the group of Alameda County-owned public hospitals and ambulatory care clinics. The AHS shall be governed by a Board of Trustees ("Board of Trustees") as set forth in these Bylaws.

ARTICLE 1.

Mission and Purpose

Section 1. Mission

AHS is committed to maintaining and improving the health of all Alameda County residents, regardless of ability to pay.

AHS will strive to provide comprehensive, high quality medical treatment, health promotion and health maintenance through an integrated system of hospitals, clinics, and health services staffed by individuals who are responsive to the diverse cultural needs of our community.

AHS, as a training institution, is committed to maintaining an environment that is supportive of a wide range of educational programs and activities. Education, including continuing education, of medical students, residents, nursing and other staff, along with clinical research, are all essential components of our environment.

AHS has adopted the following mission and vision statements:

> Our Mission – Caring, Healing, Teaching, Serving All
>
> Our Vision – Alameda Health System will be recognized as a world-class patient and family centered system of care that promotes wellness, eliminates disparities and optimizes the health of our diverse communities.

Section 2. Purpose

The purpose of the Alameda Health System is to manage, administer and control the group of county-owned hospitals and ambulatory care clinics, in a manner that assures accessible, cost effective, quality medical care.

In pursuit of its mission and purpose AHS shall, except as jointly determined from time to time with the County:

A. Maintain facilities to serve the primary, secondary and tertiary medical care and health services of patients.

B. Establish and promote cost-effective health care delivery including timely adaptations to meet evolving Medicare, Medi-Cal and other regulations mandating data accumulation and cost control.

C. Provide medical and other health services at no cost or reduced cost to the medically indigent and other special populations.

D. Improve the standards of health care in the community by participating in the Alameda County health care network in conjunction with the county criminal justice system, public health, primary care, mental health and substance abuse programs.

E. Provide health education to its patients and the general public regarding wellness and prevention.

F. Instruct patients, their families and caretakers regarding the management of their illness or injury as may be justified by the facilities, personnel, funds or other resources that are available.

G. Engage in scientific medical research to the extent such research, in the opinion of the Board of Trustees, is consistent with the mission and purpose of AHS.

H. Attract and retain a diverse staff of qualified, well trained and competent health care practitioners and support personnel who will provide care in a culturally competent manner.

I. Develop and maintain responsible and effective labor policies.

J. Practice sound organization methods and efficient financial and personnel management.

K. Participate in, so far as circumstances and available resources may warrant, any activity designed and carried on to promote the general health of the community.

L. Guard against any activity in or on behalf of AHS having, or tending to have, an undesirable effect upon the Medical Center or the services it renders.

M. Establish by resolution mechanisms by which auxiliary or voluntary organizations associated with AHS are formed.

ARTICLE 2.

Governing Body

Section 1. Qualifications

A. General Qualifications

The Board of Trustees should, to the extent feasible, reflect both the expertise necessary to maximize the quality and scope of care of AHS in a fiscally responsible manner and the diverse interests that the AHS serves. Desirable skills include, but are not limited to, business management, public health, health care administration, personnel management and labor relations, medical services, managed care, consensus building, finance, fund raising, and cultural sensitivity.

B. Specific Qualifications

Qualifications that are desirable in Trustees include the following:

(1) A familiarity with the health care delivery systems;

(2) A working knowledge of the existing health care funding sources;

(3) An understanding of the multitude of issues relating to participating in managed care programs;

(4) Experience with employee organizations;

(5) A strong business management, legal, finance and/or program management background;

(6) Experience with managing hospital services;

(7) Experience with, or understanding of, the delivery of health care services by non-profit entities;

(8) An interest in or experience with the health care needs of the AHS's patient populations;

(9) Experience in advocating for safety net institutions including, but not limited to, the pursuit of public funding for the delivery of health care services;

(10) Reside in Alameda County (except that this need not be considered desirable when selecting the Medical Staff representative);

(11) A familiarity with public sector collective bargaining, including interest-based bargaining;

(12) A willingness to work collaboratively and maintain positive relationships with AHS partners, including the County of Alameda; and

(13) A willingness to hold the Administration, including the Chief Executive Officer and other members of the Executive Leadership Team, accountable for AHS's financial and operational performance.

C. Disqualified Persons

(1) Persons who are providers of medical care, or are employed by a provider of medical care, who are or, in the view of the Board of Supervisors, may be in competition with AHS.

(2) With the exception of the representative of the Medical Staff and the Chief Executive Officer, persons employed by or who are contractors/vendors of AHS or who are employed by a contractor/vendor of AHS.

Except where prohibited by law, any disqualification may be waived by majority vote of the Board of Supervisors.

Section 2. Composition: Term of Office

The governing body of AHS shall be known as the AHS Board of Trustees. The Board of Trustees shall consist of nine (9) members.

A. Eight (8) of whom shall be appointed by majority vote of the Board of Supervisors. The Board of Trustees may make recommendations to the Board of Supervisors for appointments to the AHS Board. Notwithstanding any recommendations received from the AHS Board of Trustees, at least one (1) of the eight (8) shall be appointed by majority vote of the Board of Supervisors without input from the Board of Trustees or the Medical Staff.

B. One (1) of the nine (9) Trustees shall be a representative of the Medical Staff, provided the nominee is appointed by a majority vote of the Board of Supervisors.

C. The Board of Supervisors shall exercise its power of appointment to ensure that each member of the Board of Supervisors shall make at least one appointment to the Board of Trustees.

D. A Term of Office shall conform to the following:

(1) A full term as a Trustee shall be for a period of three years from the date of the initial Annual Meeting;

(2) The Board of Supervisors may appoint a number of Trustees to partial Terms of Office calculated from the date of the initial annual Meeting. A partial Term of Office shall not be considered a complete term for purposes of applying paragraph 2.D, below;

(3) A Term of Office that is permitted to expire shall create a vacancy absent a determination of the Board of Supervisors to the contrary.

E. Trustees may serve more than one term if re-appointed by the Board of Supervisors. No Trustee shall serve greater than three consecutive terms.

Section 3. Vacancies; Removal

A. Attendance

A trustee shall automatically be removed from office, and said office shall become vacant, if within a one year period of time he or she either fails to attend any combination of three (3) consecutive, properly noticed regular and/or special meetings of the Board of Trustees or regularly scheduled meetings of a committee or committees on which the Trustee serves, or fifty (50%) of all Board of Trustees and/or regularly scheduled meetings of a committee or committees on which the Trustee serves during any twelve month period without having secured, either in advance of or promptly after the missed meeting, authority from the majority of the Board of Trustees or from the Chair to miss the meeting ("excused absence").

An excused absence from a meeting or an absence due to illness shall not operate to interrupt the tracking of consecutive unexcused absences as that tracking is described in the immediately preceding paragraph. An excused absence or absence due to illness shall reduce the number of total meetings used to determine compliance with the 50% overall attendance requirement.

A vacancy under this section shall occur without official action of the Board of Trustees or the Board of Supervisors. The Board of Trustees shall advise in writing the Board of Supervisors of the removal of a Trustee under this section and shall include the facts in support of

removal. The removal shall stand unless the Board of Supervisors determines that there is not credible evidence in support thereof. The Board of Trustees may recommend individuals to fill the vacancy or vacancies.

B. Removal

A Trustee may be removed by the Board of Supervisors during his or her term with or without cause, on its own initiative or following consideration for removal submitted by the Board of Trustees, but only upon the affirmative vote for removal of at least four (4) members of the Board of Supervisors.

C. Vacancies

Vacancies so created or vacancies created by other means, such as resignation or death, shall be filled by appointment by majority vote of the Board of Supervisors. An individual who is appointed to fill a vacancy mid-term shall have the balance of that term constitute his or her first full term.

Section 4. Compensation and Reimbursement

AHS will provide a stipend to Trustees for attendance at board and committee meetings as follows: The Chair of the Board of Trustees will receive a stipend of $800 per month and all other Trustees will receive a stipend of $600 per month. ~~The Trustees by a resolution adopted by a majority vote of the members of the board, may authorize the payment of not to exceed two hundred dollars ($200) per regular or special board or committee meeting, not to exceed four meetings a month as compensation to each member of the Board of Trustees.~~ The Trustees are not otherwise precluded from receiving compensation in connection with individual pursuits. Any reasonable modification of the compensation plan, within the limits set forth above, may be made upon a resolution adopted by a majority of the members of the Board of Trustees, at a regularly scheduled meeting of the Board.

Trustees shall be reimbursed for actual and reasonable expenses incurred in the performance of official business of AHS assigned by the Board of Trustees. Actual and reasonable expenses in the form of airfare/hotel accommodations shall be reimbursed as established by policy of the Board of Trustees.

Section 5. Conflict of Interest

A. Conflict of Interest Code

The Board of Trustees shall adopt and, from time to time may amend the Conflict of Interest Code of AHS as required by applicable law. The Conflict of Interest Code shall identify all persons required to file an annual Statement of Economic Interests. The Board of Supervisors, as the code reviewing body pursuant to Government Code Section 82011, shall approve the adoption and subsequent amendments to the Conflict of Interest Code.

B. Code of Conduct and Ethics

Trustees and officers of AHS shall conduct their activities in conformity with the applicable laws and regulations related to impartiality in the conduct of its business. A Trustee shall not vote or participate in the discussion and consideration of matters directly affecting their~~his/her~~ financial interest;

The Board of Trustees shall develop and adopt an Alameda Health System Code of Ethics.

Section 6. Confidentiality: Public Statements

The Board of Trustees, and each of its members, shall maintain the confidentiality of any and all information that has been discussed in closed session or is normally discussed in closed session.

No Trustee shall make a public statement on behalf of the Board of Trustees, or in a manner that appears to be on behalf of the Board of Trustees, unless a majority of the Board of Trustees has given prior authorization for the public statement.

Section 7. Powers and Duties of the Board of Trustees

The Board of Trustees has responsibility to manage, administer and control AHS, including but not limited to all matters pertaining to quality of care. The Board of Trustees shall exercise this responsibility in conformity with applicable laws, regulations and accreditation requirements. To accomplish this, the Board of Trustees is obligated pursuant to these Bylaws and to formal agreement(s) with the County of Alameda, and amendments thereto, to the following general duties and responsibilities:

A. Budget

(1) Determine that the fiscal year shall be from July 1 through June 30.

(2) Adopt a balanced budget by June 30 for the following fiscal year.

(3) Strive to maintain a balanced budget, making adjustments to offset unanticipated expenditures or unrealized revenues as needed.

(4) Surplus revenues shall be retained by AHS to be expended in a manner consistent with its mission. Revenue shortfalls shall be the sole responsibility of AHS.

(5) Adopt an operating and capital expenditure budget. This budget shall delineate the scope of services to be offered, costs of programs and justification for capital expenditures.

(6) Adopt a policy concerning how adjustments to the operating or capital expenditure budgets may be made. This policy may reflect participation of appropriate members of the administration and Medical Staff.

(7) Analyze periodic financial reports in addition to the budget.

B. Contracts: Finance

(1) Delegate to the Chief Executive Officer or his or her designee the authority to execute contracts of up to the contract value limit determined by the Board of Trustees. A single contractor shall not be awarded, within a fiscal year, contract(s) exceeding the contract value limit without approval by the Board of Trustees.

(2) Authorize the Chief Executive Officer, on a contract by contract basis, to execute other contracts for services approved in the AHS approved budget.

(3) Adopt a written request for proposal process.

(4) Pursue interest-bearing loans from the County or other sources as needed.

(5) Recommend financing arrangements and/or disposition of County assets to the Board of Supervisors.

(6) Accounting policies and procedures shall conform to generally accepted accounting principles.

(7) An audit of AHS's financial operations shall be conducted by a firm of independent certified public accounts at least annually, and the audited financial statement of AHS shall be reviewed by the Chief Executive Officer and the Board of Trustees at least annually. Such financial statements shall be available to Tthe Joint Commission ~~on~~

("TJC~~JCAHO~~") at the time of AHS's accreditation survey and shall be forwarded to the County of Alameda within 30 days.

C. Personnel

(1) Establish qualifications and appoint the Chief Executive Officer who shall serve at the pleasure of the Board of Trustees.

(2) Develop written personnel policies and establish a procedure for notifying employees of changes in such personnel policies.

(3) Strongly consider adopting an interest-based bargaining approach in labor negotiations.

D. Services

(1) Plan for the growth, development and evaluation of the operation of AHS through a Strategic Plan. The function shall include, but is not necessarily limited to, modifications of services and/or facilities, and development of new services, in compliance with applicable law.

(2) Establish a formal means of liaison with the Medical Staff.

(3) Negotiate and execute written agreement(s) with the County of Alameda for necessary services and other performance deemed mutually beneficial to both parties. Such agreement(s) are to comply with the provisions of Section 101850 and provide that such Alameda County departments providing services are to do so in conformity with applicable standards, regulations and requirements promulgated by the California Department of Health Services, the Joint Commission on Accreditation of Healthcare Organizations or by federal or state regulatory agencies.

(4) Adopt policies and procedures to promote care, treatment and rehabilitation that are appropriate to the patient's needs, planned and provided in an interdisciplinary, collaborative manner by qualified individuals, and is delivered in a manner that respects privacy and other patient rights.

(5) Establish by resolution mechanisms by which patient and community input and recommendations can be made to the Board of Trustees regarding the services and operations of AHS.

(6) Seek and attempt to secure appropriate outside resources for the benefit of AHS where deemed appropriate by the Board of Trustees.

(7) Require the implementation of mandated quality assurance activities. The Board of Trustees has the final decision-making authority with respect to all matters pertaining to credentialing, privileges and peer review.

(8) Require that a complete and accurate medical record is prepared and maintained for each patient.

(9) Require that the state Department of Health Services be notified in writing whenever a change of administration occurs.

(10) Require that all appropriate steps be taken to comply with applicable federal, state and local laws and regulations.

(11) Require the staff of departments and services and others as appropriate to review and revise all department and service policies and procedures when warranted and ensure that the Medical Staff participates, as appropriate. The period between reviews shall be as determined by the Board of Trustees.

(12) Mandate that if any AHS-affiliated auxiliary or voluntary organization is proposed, the implementation of any such proposal shall require Board of Trustees approval.

(13) Direct that adequate support personnel be available to assist the Medical Staff with organizational functions, including Medical Staff membership and clinical privileges (credentialing), physician performance evaluation (peer review), and collection and analysis of clinical data (performance improvement, utilization review, and risk management).

E. Accountability and Reporting; Compliance with Laws

(1) The Board of Trustees is accountable to the Board of Supervisors as provided in Section 101850 and shall report to, and make accountings to, the Board of Supervisors as set forth in written agreements executed by and between the Board of Trustees and the County of Alameda.

(2) In carrying out its mission and performing its functions, duties and responsibilities the Board of Trustees shall comply with the applicable laws and regulations.

(3) The Board of Trustees shall require compliance with all audits and inspections required by governmental entities and accreditation organizations.

(4) The Board of Trustees has the power to enter into agreement(s) with other hospitals, health facilities or providers provided that such agreement(s) do not affect the ownership of facilities owned by the County of Alameda.

(5) The Board of Supervisors, and not the Board of Trustees, shall have the authority, as permitted by law, to effectuate a sale, lease, disposition, exchange, pledge or other encumbrance or disposition of any asset, real or personal, owned by the County of Alameda which has not been otherwise transferred pursuant to separate formal agreement between AHS and the County.

(6) The Board of Trustees shall conduct an annual self-evaluation of its performance of the duties specified in Article 2, Section 7, of these bylaws. The scope and results of such annual report shall be reduced to writing and provided to the Board of Supervisors on a not less than annual basis and shall include a section detailing the key accomplishments of the Chief Executive Officer for the review period.

Section 8. AHS Obligation to Defend Trustees

AHS will carry a Directors and Officers insurance policy sufficient to allow AHS to fulfill any obligation to defend and indemnify a Trustee against claims that arise out of an act or omission taken within the scope of Trustee's duties. The precise circumstances under which AHS will defend and indemnify a Trustee will be governed by AHS' obligations under the California Government Code.

ARTICLE 3.

Meetings

Section 1. Frequency

The Board of Trustees shall conduct regular, noticed meetings to be held on a monthly or near-monthly basis. The first regular meeting of the calendar year shall be the Annual Meeting at which the officers of the Board will be selected and installed.

At least three meetings per year shall be joint meetings with the Alameda County Board of Supervisors. Written notice of the date, time and place of regular meetings shall be given to each Trustee no less than 5 days prior to the regular meeting. Notice shall be transmitted either by regular U.S. mail or by facsimile.

In the event that a regular meeting is rescheduled for a lack of a quorum or other cause, seven (7) days' notice of the rescheduled date shall be provided.

Standing Committees meet as frequently as is necessary to fulfill the committee's duties, but not less than quarterly. Ad hoc committees formulated by the Board of Trustees shall meet as frequently as is necessary to fulfill the assigned mission.

Section 2. Hearing Procedure

The meetings of the Board of Trustees shall be conducted in a manner consistent with applicable laws. All meetings shall be open to the public except as otherwise determined by the Board of Trustees as permitted by law. No Trustee may vote on or participate in any manner that materially affects his or her personal financial interest within the meaning of the Political Reform Act

Section 3. Special Meetings; Emergency Meetings

Special meetings may be called at any time for a specific, announced purpose by the Board of Trustees Chair, or on request of any three (3) Trustees. Emergency meetings may be called pursuant to applicable law. Special meetings and emergency meetings must be noticed as required by law.

Section 4. Quorum

For regular and special and emergency meetings of the Board of Trustees, a quorum shall be a majority of the duly appointed members.

For Committees, a quorum shall be a majority of the duly appointed members of that committee, and shall include at least one Trustee.

Section 5. Official Action

Actions of the Board of Trustees shall be by a majority of members who are present at the meeting provided there is a quorum except in those circumstances where a super- majority is required by these Bylaws.

Section 6. Minutes

A record of proceedings of all meetings of the Board of Trustees and of committees of the Board of Trustees shall be kept on file.

Section 7. Agenda

Each meeting shall have an agenda, structured and posted as required by law.

ARTICLE 4.

Committees

Section 1. Standing Committees

The Board of Trustees shall have the following standing committees: Executive Committee; Finance Committee; ~~Joint Strategic Planning Committee; Medical Credentialing & Policy Committee;~~ Quality of Care Committee; Human Resources Committee, Mission Integration Committee, and Audit & Compliance Committee. The duties of each standing committee shall be as provided in the Policies and Procedures for Standing Committees as adopted and amended by the Board of Trustees, provided nothing set forth in such Policies and Procedures for Standing Committees shall conflict with these bylaws. The Executive Committee is authorized to act on emergency items when a quorum of the Board of Trustees cannot be gathered in sufficient time. Any actions taken by the Executive Committee will be ratified at the next Board of Trustees meeting.

The Joint Strategic Planning Committee shall be comprised of two (2) members of the Board of Trustees and two (2) members of the Board of Supervisors.

Section 2. Ad Hoc Committees

Ad hoc committees, as well as their function and duration, may be established from time to time by the Board of Trustees. Appointment of members and chairpersons shall be as determined by the Board of Trustees, or its designee.

ARTICLE 5.

Alameda Health System Board of Trustees Officers

Section 1. List of Officers

A. Chair
B. Vice-Chair
C. Secretary/Treasurer
D. Other officers deemed necessary by the Board of Trustees.

Section 2. Appointment; Terms of Office

A. Officers are elected by the Board of Trustees at the annual meeting from among its own members.

B. Officers are elected for the period of one (1) year and shall serve until a

successor has been duly elected.

C. A Trustee shall not simultaneously hold more than one AHS office.

Section 3. Duties of the Officers

A. The Chair shall:

(1) Preside at all meetings of the Board of Trustees;

(2) Be an ex-officio, non-voting member of all committees;

(3) Execute contracts, correspondence, conveyances, and other written instruments as properly authorized by the Board of Trustees;

B. The Vice-Chair shall:

(1) In the absence of the Chair assume the duties of the Chair

(2) Perform such reasonable duties as may be required by the members of the Board of Trustees or by the Chair of the Board of Trustees.

C. The Secretary/Treasurer shall:

(1) Keep, or cause to be kept, accurate and complete minutes of all meetings, call meetings on order of the Chair, attend to all correspondence of the Board, and perform such other duties as ordinarily pertain to ~~his/her~~their office.

(2) Perform all duties related to finance as assigned by the Board of Trustees.

Section 4. Vacancies and Removal of Officers

A. A vacancy in any office shall be filled by nomination and election by the Board of Trustees as soon as is reasonably possible.

B. Officers may be removed by a majority vote of Board of Trustees, at a scheduled meeting where a quorum is present.

ARTICLE 6.

Chief Executive Officer

Section 1. Selection; Authority to Act

A. The Board of Trustees shall select and employ a competent and experienced Chief Executive Officer who shall be its direct representative in the management of AHS.

B. The Chief Executive Officer shall serve at the pleasure of the Board of Trustees.

C. The Chief Executive Officer shall be given necessary authority to operate AHS in all its activities and departments and shall be held responsible for the administration of AHS, subject only to the policies adopted or orders issued by the Board of Trustees or by any of the committees to which the Board of Trustees has delegated authority for such action.

D. Subject to the control of the Board of Trustees, the Chief Executive Officer shall act as the duly authorized representative of the Board of Trustees in all matters in which the Board of Trustees has not formally designated some other person to so act.

Section 2. Powers and Duties

The Board of Trustees must adopt a statement of duties and responsibilities for the Chief Executive Officer.

Section 3. Performance Monitoring

The Board of Trustees shall conduct a formal evaluation of the Chief Executive Officer's operational and financial performance every six months. The Chief Executive Officer shall not be present during the discussions of ~~his/her~~their performance except that the Chief Executive Officer shall be given the opportunity to address the Board of Trustees as part of the evaluation process.

ARTICLE 7.

Medical Staff

Section 1. Organization and Appointments

A. The Board of Trustees shall ensure that the physicians and other persons granted clinical privileges at~~in~~ AHS are organized into one or more integrated Medical Staffs under each set of Medical Staff Bylaws approved by the Board of Trustees;

B. The Board of Trustees shall consider recommendations of each of the Medical Staffs concerning: 1) appointments, re-appointments, and other changes in Medical Staff status; 2) the granting of clinical privileges; 3) disciplinary actions; 4) all matters relating to professional competency; and 5) such other specific matters as may be referred to it by any of the Medical Staffs. If the Board of Trustees refers a matter to any of the Medical Staffs for further consideration, the Board of Trustees shall make a decision on the matter after receiving the new Medical Staff recommendation.

C. The Board of Trustees shall appoint to each Medical Staff, in numbers not exceeding AHS's needs, physicians and others who meet the qualifications for membership as set forth in the Bylaws of each Medical Staff. The Board of Trustees has the final decision-making authority with respect to all appointments, re-appointments, clinical privileges and disciplinary actions with respect to each of the Medical Staffs.

D. Appointments shall require each member of each Medical Staff to have appropriate authority and responsibility for the care of ~~his/her~~their patients, subject to such limitations as are contained in these Bylaws and in the Bylaws, Rules and Regulations for each of the Medical Staffs, and subject further to any limitations attached to ~~his/her~~their appointment.

E. All applications for membership to any of the Medical Staffs shall be in writing, shall be signed by the applicant, and shall be submitted on a form prescribed by the Board of Trustees. Each application shall contain the detailed information necessary to complete the credentialing process as required by law. This information shall be verified by the credentials evaluation function performed by each of the Medical Staffs as set forth in its Bylaws or other policy.

F. E. ~~All initial appointments shall be provisional for a period of six months.~~

G. F. Recommendations of a Medical Executive Committee to the Board of Trustees regarding an application for appointment or re-appointment, or the granting or restriction of clinical privileges or taking of disciplinary action may be appealed as set forth in the Bylaws of each Medical Staff.

H. G. The Board of Trustees shall, at least once each year, review and identify, based on occupation, profession, or AHS need, the categories of ~~Allied Health Professionals~~Advanced Practice Providers (APPs) eligible to apply for practice prerogatives in AHS. In the event that an APP does not have licensure or certification in an APP category identified as eligible to apply for practice prerogatives at AHS, the APP may ask the Board of Trustees to add that category to those eligible to apply for practice prerogatives at AHS. The Board of Trustees shall consider such request either before or at the time of its annual review of the categories of APPs eligible to apply for practice prerogatives at AHS.

Section 2. Evaluation of Medical Care

~~A.~~ The Board of Trustees shall exercise its responsibility for the overall quality of patient care provided in AHS. The Board of Trustees shall, in the exercise of its overall responsibility, oversee the operations of each of the Medical Staffs to ensure that appropriate professional care is rendered to AHS's patients, and may unilaterally take appropriate action to assure a high quality of medical care and orderly operations of AHS.

~~B. Each of the Medical Staff Bylaws shall require the Medical Staff to, in coordination with the management of AHS, develop a written Performance Improvement Plan. These Plans shall address recommendations for improvement in delivery of services, efficiency, outcomes, performance and quality assessment and other matters relating to the overall medical operations of AHS. Progress with respect to the Plans shall be reported to the Chief Executive Officer on an ongoing basis. The Board of Trustees shall review and approve the Plans on an annual basis.~~

~~Each of the Medical Staff Bylaws shall also require that the Medical Staff report other AHS-wide performance improvement activities to the Board of Trustees on no less than a quarterly basis.~~

~~C.~~ B. Each of the Medical Staff Bylaws shall require the Medical Executive Committee to be responsible for the evaluation of professionals who have clinical privileges in AHS, as outlined in the respective Bylaws of the Medical Staffs.

Section 3. Medical Staff

A. There shall be Bylaws, Rules and Regulations, and Policies and Procedures for each Medical Staff that set forth its organization and government.

B. None of the Medical Staffs nor the Board of Trustees shall unilaterally amend the Bylaws, ~~or~~ the Rules and Regulations, or the Policies and Procedures of a~~each~~ Medical Staff. All amendments or changes proposed by any Medical Staff shall be submitted to the Board of Trustees for approval, whose approval shall not be unreasonably withheld.

C. The Board of Trustees shall review the Bylaws, Rules and Regulations, and Policies and Procedures of each Medical Staff as necessary.

D. The Bylaws, Rules and Regulations, and Policies and Procedures of each Medical Staff shall provide that each Medical Staff is responsible to the Board of Trustees for the quality of all medical care to patients and for the ethical and professional practices of its members.

E. Such Bylaws, Rules and Regulations, and Policies and Procedures shall require that patient care services be provided only by a member of the Medical Staff for the respective licensed facility or under supervision or direct order of a member of that facility's Medical Staff, and within the scope of privileges granted by the Board of Trustees.

Section 4. Board of Trustees Role in Corrective Action and Medical Staff Appeals

A. Summary Suspensions: When no person authorized by the applicable Medical Executive Committee is available to summarily suspend or restrict clinical privileges, the Board of Trustees, or its designee, may immediately suspend a member's clinical privileges if a failure to summarily suspend those privileges is likely to result in an imminent danger to the health of any individual, provided the Board of Trustees or such designee has, before the suspension, made reasonable attempts to contact the relevant Medical

Executive Committee. A suspension by the Board of Trustees which has not been ratified by the relevant Medical Executive Committee within two working days, excluding weekends and holidays, after the suspension shall terminate automatically.

B. Appeal of Medical Staff Recommendations: Following are the Board of Trustees procedures for the appeal hearing (Appellate Review)~~, by the relevant Medical Executive Committee or an affected existing or applicant Medical Staff member (Member),~~ of a decision by a Medical Staff Judicial Review Committee, promulgated pursuant to the applicable Medical Staff Bylaws ~~Article VIII~~.

(1) Time For Appellate Review

Within thirty (30) days after receipt of the decision of the Judicial Review Committee, either the Member, the Medical Executive Committee, or the Board of Trustees, if applicable, may request ~~an~~ Appellate Review. A written request for Appellate Review shall be delivered to the Chair, the Chief Executive Officer, and to either the Member, the Medical Executive Committee, or the Board of Trustees, as applicable. If such a request for Appellate Review is not received within such period, that Judicial Review Committee decision shall thereupon become final.

(2) Grounds For Appellate Review

The grounds for Appellate Review shall be: (a) substantial ~~failure of the Medical Executive Committee, Judicial Review Committee, or Board of Trustees to comply with the procedures required by the Medical Staff Bylaws or the Board of Trustees Bylaws~~ noncompliance with the standards or procedures required by the applicable Medical Staff Bylaws, or applicable law, which has created demonstrable prejudice; (b) the decision was arbitrary or capricious; ~~(c) the evidence introduced in the Judicial Review Committee hearing did not support the Judicial Review Committee's findings~~; ~~(~~c) the Judicial Review Committee's findings did not support the Judicial Review Committee's decision; (d) the Judicial Review Committee's failure to sustain an action or recommendation of the Medical Executive Committee that, based on the evidence, was reasonable and warranted; or (e) the decision was inconsistent with applicable law.

(3) Appeal Board

The appeal shall be to an Appeal Board. The Board of Trustees may

sit as the Appeal Board, or it may appoint an Appeal Board which shall be composed of not less than three (3) members of the Board of Trustees. In the event the Board of Trustees delegates the Appellate Review to an Appeal Board other than the full Board of Trustees, there is no further right to Appellate Review before the full Board of Trustees. Knowledge of the matter involved shall not preclude any person from serving as a member of the Appeal Board, so long as that person did not take part in a prior hearing on the same action or recommendation being challenged ~~matter~~. The Appeal Board may select an attorney to assist it in the Appellate Review, but that attorney shall not be entitled to vote with respect to the appeal.

(4) Time, Place And Notice

If an Appellate Review is to be conducted, the Appeal Board shall, within 30 days after receipt of a request for Appellate Review, schedule the Appellate Review date and cause the Member, the Medical Executive Committee, and the Board of Trustees, if applicable, to be given notice of the time, place and date of the Appellate Review. The date of Appellate Review shall not be less than 30 or more than 60 days from the date of such notice; provided, however, that when a request for Appellate Review concerns a Member who is under suspension which is then in effect, the Appellate Review shall be held as soon as the arrangements may reasonably be made, not to exceed 30 days from the date of the notice. The time for Appellate Review may be extended by the Appeal Board for good cause.

(5) Appellate Review Procedure

The Appellate Review shall be in the nature of an appellate hearing based upon the record of the Judicial Review Committee hearing, provided that the Appeal Board may accept additional oral or written evidence, subject to a foundational showing that such evidence could not have been made available to the Judicial Review Committee in the exercise of reasonable diligence and subject to the same rights of cross-examination or confrontation provided at the Judicial Review hearing; or the Appeal Board may remand the matter to the Judicial Review Committee for the taking of further evidence and for further decision. Each party shall have the right to be represented by legal counsel in connection with the Appellate Review, to present a written statement in support of ~~his/her~~their/its position on appeal and to personally appear and make oral argument.

The Appeal Board may thereupon conduct, at a time convenient to itself, deliberations outside the presence of the appellant and respondent and their representatives. The Appeal Board, if other than the full Board of Trustees, shall present to the Board of Trustees its written recommendations as to whether the Board of Trustees should affirm, modify, or reverse the Judicial Review Committee decision, or remand the matter to the Judicial Review Committee for further review and decision.

(6) Decision

a. Except as otherwise provided herein, within 60 days after the conclusion of the Appellate Review, the Board of Trustees shall render a decision in writing, including a statement of the basis for the decision, and shall forward copies thereof to the Member, the Medical Executive Committee, and the Board of Trustees, if applicable.

b. The decision of the Board of Trustees may affirm, modify, or reverse the decision of the Judicial Review Committee or remand the matter to the Judicial Review Committee for reconsideration. If the matter is remanded to the Judicial Review Committee for further review and recommendation, the Judicial Review Committee shall promptly conduct its review and make its recommendations to the Board of Trustees. This further review and the time required to report back shall not exceed 30 days in duration except as the parties may otherwise agree or for good cause as jointly determined by the Board of Trustees and the Judicial Review Committee.

c. The decision of the Board of Trustees shall be final. Any recommendation affirmed by the Board of Trustees shall become effective immediately.

(7) Neither a Member, the Medical Executive Committee, nor the Board of Trustees, if applicable, shall be entitled to more than one Judicial Review hearing and one Appellate Review related to a particular Judicial Review Committee decision.

Section 5. Additional Duties and Responsibilities

In addition to those duties and responsibilities of each Medical Staff and its membership as set forth in the respective Bylaws, Rules and Regulations of each Medical Staff and as

set forth elsewhere in these Bylaws, the Board shall:

A. Ensure that each of the Medical Staff Bylaws require the respective Medical Staffs to receive, question, and act upon performance improvement reports of the clinical activities of Medical Staff members and of other practitioners actively engaged in providing clinical services in or under the auspices of AHS;

B. Ensure that each of the Medical Staff Bylaws require the respective Medical Staff to cooperate with and assist the Hospital Administration as needed in the preparations for accreditation reviews or other audits or inspections required by law.

Section 6. Termination and Procedural Rights

Membership on each of the Medical Staffs and specific clinical privileges are subject to denial, suspension, termination, or curtailment. In such event, procedural rights shall be provided as described in the Bylaws, Rules and Regulations of the relevant Medical Staff and the Board of Trustees Bylaws. The Board of Trustees takes final action on all denials, suspensions, terminations, or curtailment of Medical Staff membership and specific clinical privileges.

ARTICLE 8.

Chief Medical Officer

~~Medical Director~~ Section 1. Employment and Duties

A. The Chief Executive Officer, after consultation with the Board of Trustees and with the Medical Executive Committee, may select a ~~Medical Director~~Chief Medical Officer who shall serve at the pleasure of the Chief Executive Officer.

B. The Chief Executive Officer shall adopt a statement of duties and responsibilities for the ~~Medical Director~~Chief Medical Officer.

Section 2. Removal

Removal of the ~~Medical Director~~Chief Medical Officer shall be by the Chief Executive Officer, according to the terms of the ~~Medical Director~~Chief Medical Officer's Contract, if any, and only after consultation with the Board of Trustees.

Section 3. Responsiveness to the Medical Staff and Board

The job description of the ~~Medical Director~~Chief Medical Officer and ~~his/her~~their periodic performance evaluation by the Chief Executive Officer shall include reasonable responsiveness to the needs and concerns of Medical Staff officers and members, clinical department chiefs and to the Board of Directors.

ARTICLE 9.

Admission of Patients

No patient shall be admitted to an AHS facility unless he or she is under the care of a member of the relevant Medical Staff with admitting privileges. Individuals with such admitting privileges may practice only within the scope of the privileges granted by the Board of Trustees. No patient shall be permitted to remain in an AHS facility unless his or her general medical condition is the responsibility of a qualified physician member of the respective Medical Staff.

ARTICLE 10.

Indemnification

Section 1. Indemnification

AHS shall indemnify, defend and hold harmless the County of Alameda, the Alameda County Board of Supervisors individually and collectively, its officers, employees and agents, against all claims, liabilities and expenses incurred as a result of any act or omission by AHS's Board of Trustees, or its officers, employees or agents.

The County of Alameda shall indemnify, defend and hold harmless AHS, its officers, employees and agents, against all claims, liabilities and expenses incurred as a result of any act or omission by the County of Alameda, or its officers, employees or agents.

ARTICLE 11.

Rules and Procedures

Agreed upon rules and detailed procedures for implementation of these Bylaws may be contained in a companion document entitled, "Bylaws Implementation Policies and Procedures," upon adoption by the Board of Supervisors.

ARTICLE 12.

Adoption of Bylaws

The Board of Supervisors shall, by majority vote, adopt the Bylaws.

ARTICLE 13.

Amendment of Bylaws

These Bylaws may be amended at any properly noticed meeting of the Board of Supervisors by a majority vote.

ARTICLE 14.

Review of Bylaws

The Bylaws will be reviewed by the Board of Trustees at least every two years, who shall forward recommendations for modifications to the Board of Supervisors where deemed necessary and appropriate by majority vote of the Board of Trustees.

APPROVED AND ADOPTED on the 3rd day of February 1998 by the Alameda County Board of Supervisors.

AMENDMENT APPROVED AND ADOPTED on the 19th day of May 1998 by the Alameda County Board of Supervisors.

AMENDMENT APPROVED AND ADOPTED this 11th day of May 1999 by the Alameda County Board of Supervisors.

AMENDMENT APPROVED AND ADOPTED this 25th day of April 2000 by the Alameda County Board of Supervisors.

AMENDMENT APPROVED AND ADOPTED this 31st day of October 2000 by the Alameda County Board of Supervisors.

AMENDMENT APPROVED AND ADOPTED this 9th day of September 2003 by the Alameda County Board of Supervisors.

AMENDMENT APPROVED AND ADOPTED this 23rd day of May 2006 by the Alameda County Board of Supervisors.

AMENDMENT APPROVED AND ADOPTED this 26th day of November 2013 by the Alameda County Board of Supervisors.

AMENDMENT APPROVED AND ADOPTED this 10th day of May 2016 by the Alameda County Board of Supervisors.

AMENDMENT APPROVED AND ADOPTED this 20th day of October 2020 by the Alameda County Board of Supervisors.

F2. Highland Labor and Delivery Update

Department of Obstetrics, Midwifery, and Gynecology (OMG)

OMG to BOT

May 14, 2025

ALAMEDA HEALTH SYSTEM

Who We are

Clinical Providers

- 17 Certified Nurse Midwives (FTE)
- 6 Advanced Practice Practitioners
- 15 OBGYN Physicians (13.6 FTE) + 3 open FTE

Learners

- Emergency Medicine Residents
- UCSF Medical Students
- Midwife Students

Sub-Specialists

- 1 Gynecologic Oncologists
- 5 Perinatologists (UCSF)
- 2 MIGS Fellowship Trained Specialists (also Generalist OBGYN)
- 1 Family Planning Fellowship Trained Specialist (also Generalist OBGYN)

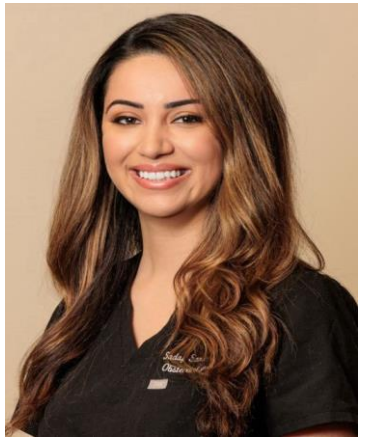
Leadership Structure

Lan Na Lee, MD
OMG Department Chair
Minimally Invasive GYN

Stephanie Ho, MD, MPH
Division Chief of Obstetrics
QRC Chair

Monica Berletti, MD
Division Chief of Gynecology
Substance Use in Pregnancy Champion

Melissa Myo, MD, MS
Director of Family Planning
Family Planning Specialist



Sadaf Samizay, MD
Scheduler
AHS Trafficking Task Force
SART clinic

Ayisha Owens BSN, MSN, PNP
OMG & Pediatrics Service Line Director

ALAMEDA HEALTH SYSTEM

Christine Delgado, RN
Director of Family Birthing Center

Advanced Practice Provider Leadership

Eva Goodfriend-Reaño, CNM, WHNP, IBCLC
Midwife Clinical Chief

Laurel Bernstein, CNM
Midwife Manager

Reena Cho, NP, MSN
Lead Advanced Practice Practitioner
Gynecologic Oncology Service NP

Jyesha Wren, CNM
Beloved Black Centering

Devorah Roisman, CNM. MSc, WHNP
Centering Pregnancy Lead

ALAMEDA HEALTH SYSTEM

Department of Obstetrics, Midwifery and Gynecology Sub Specialists

Maternal Fetal Medicine

Martha Tesfalul, MD
Lead MFM

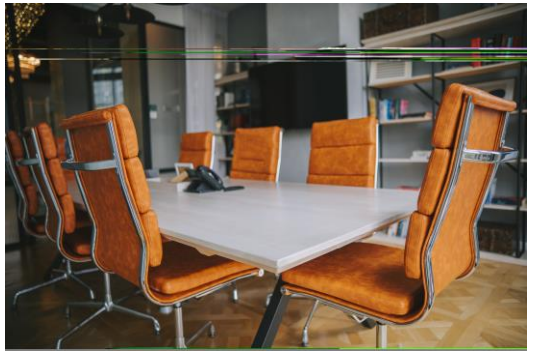
Gynecologic Oncology

Dimitry Lerner MD
Director Gynecology-Oncology

Pelvic Pain and Endometriosis

Rebecca Falik , MD
General OB/GYN
Minimally Invasive GYN

Urogynecology



UCSF
(MOU pending)

AHS OMG Organizational Service Objectives

- Reinforce acute care staffing using accepted criteria.
  - Improve patient safety and throughput
  - Address provider burnout and turnover

- Establish acceptable standard for OMG ambulatory access
  - OMG urgent care access

- Patient centered innovations
  - SART clinic – PILOT phase.
  - Centering Pregnancy – Sustain and Expand

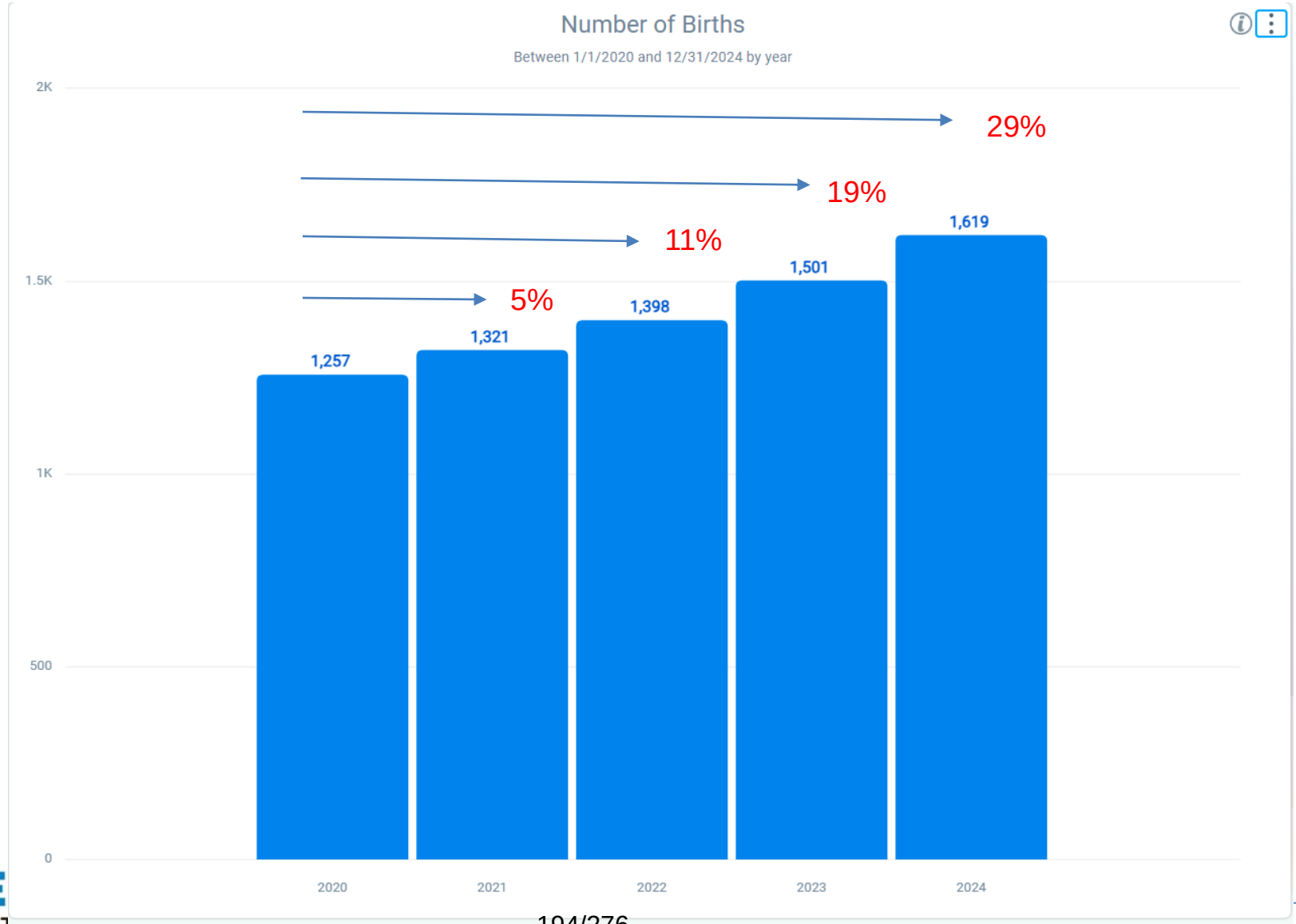
Where We Work

- Family Birthing Center (4ACT)
  - Labor and Delivery
  - Mother/Baby Unit (Postpartum)
- Hospital
  - Emergency/ inpatient consults
  - Gynecology inpatient service
    - Highland
  - Elective Surgery
    - Highland
    - San Leandro
- Ambulatory
  - 4 Wellness Centers
    - Highland Women's Clinic
    - Eastmont Women's Clinic
    - Hayward Wellness
    - Newark Wellness
  - Specialty services
    - Pelvic Pain
    - Family Planning
    - GYN Oncology

Trends in Women's Health Care at AHS

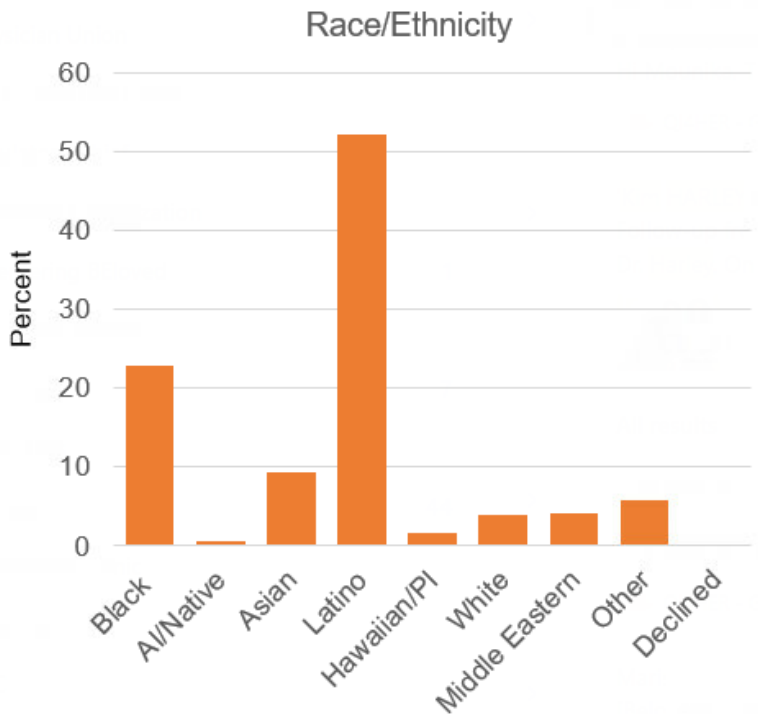
- Increasing birth volumes
- Higher acuity of care
- Critical lack of patient access to care

Birthing Volume at the Family Birth Center
Alameda Health System 2020-2024



Who we Serve

Characteristics of AHS Birthing People from AHS



Preferred language:

- 47.2% English
- 36.2% Spanish
- 4.4% Arabic
- 3.3% Mam
- 1.9% Dari
- 1.2% Pashto

40 different languages overall

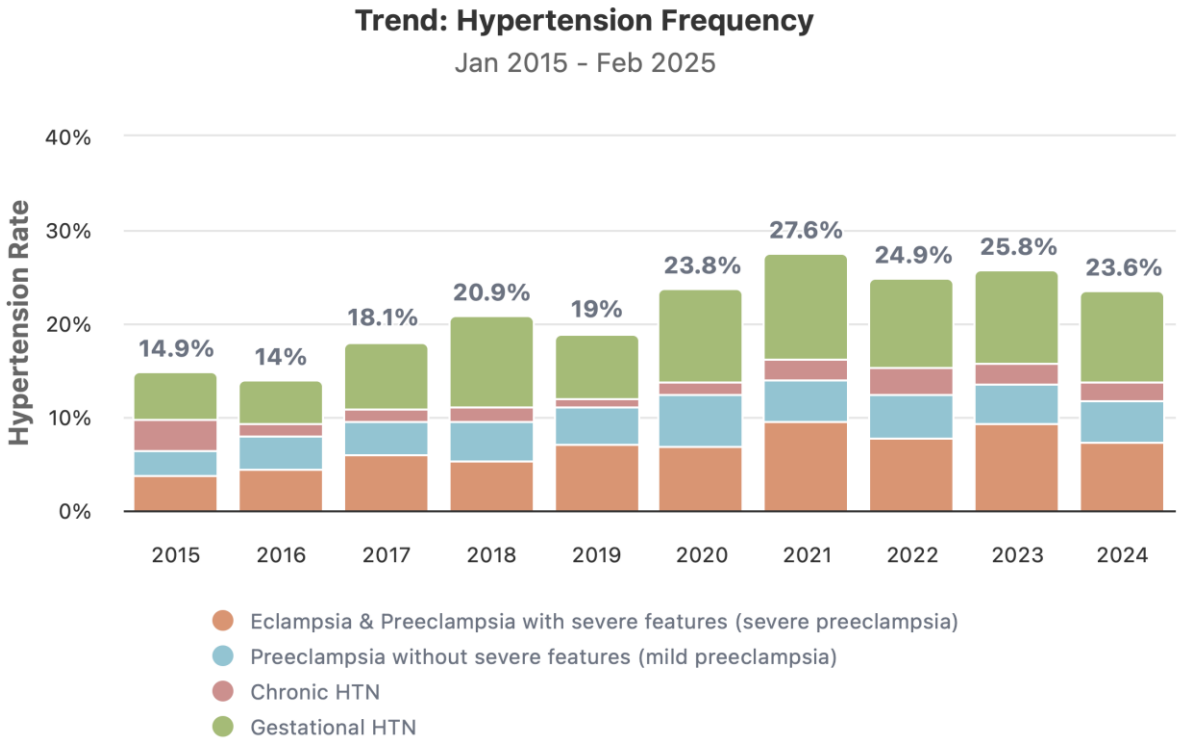
The Wallace Center for maternal, child & adolescent health

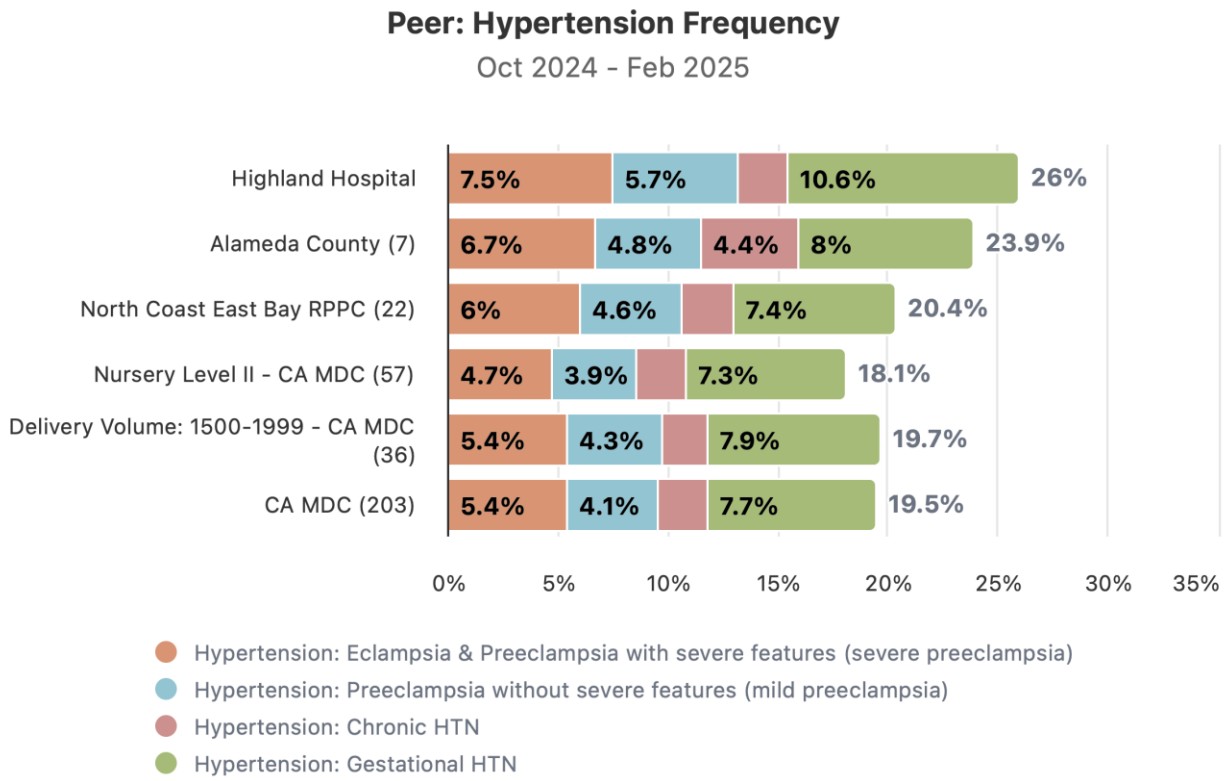
Berkeley Public Health

ALAMEDA HEALTH SYSTEM

Who We Serve

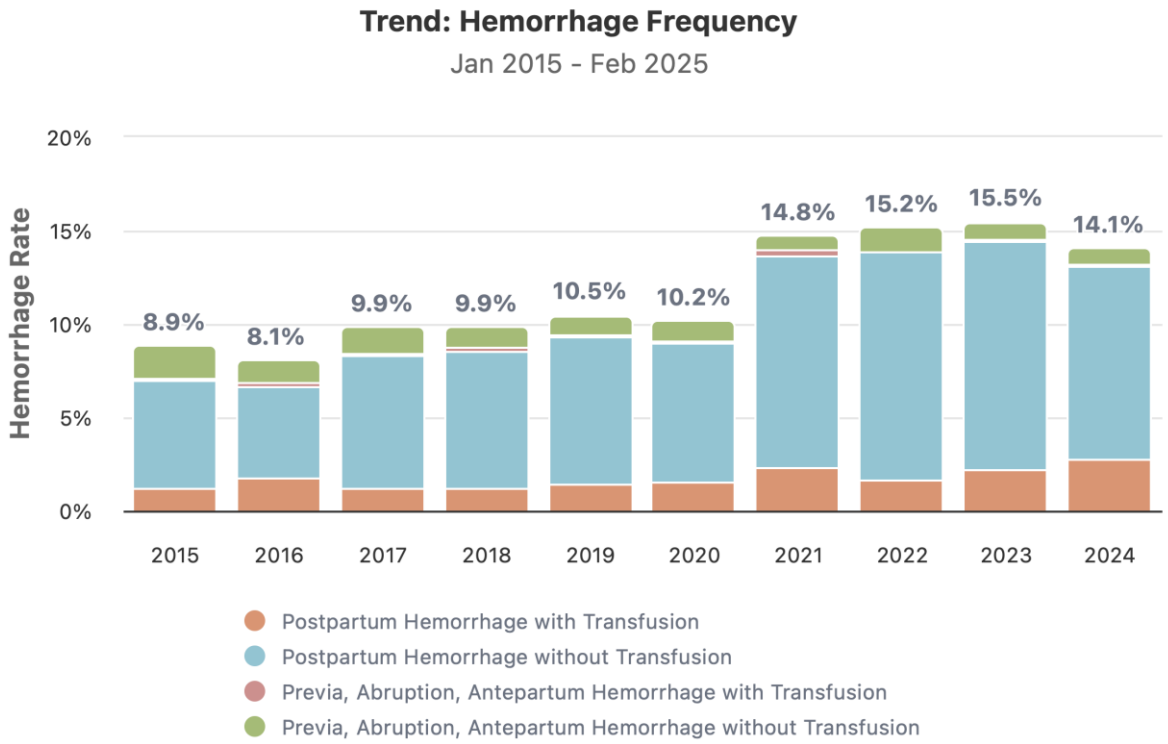
Characteristics of AHS Birthing People from AHS – Hypertension

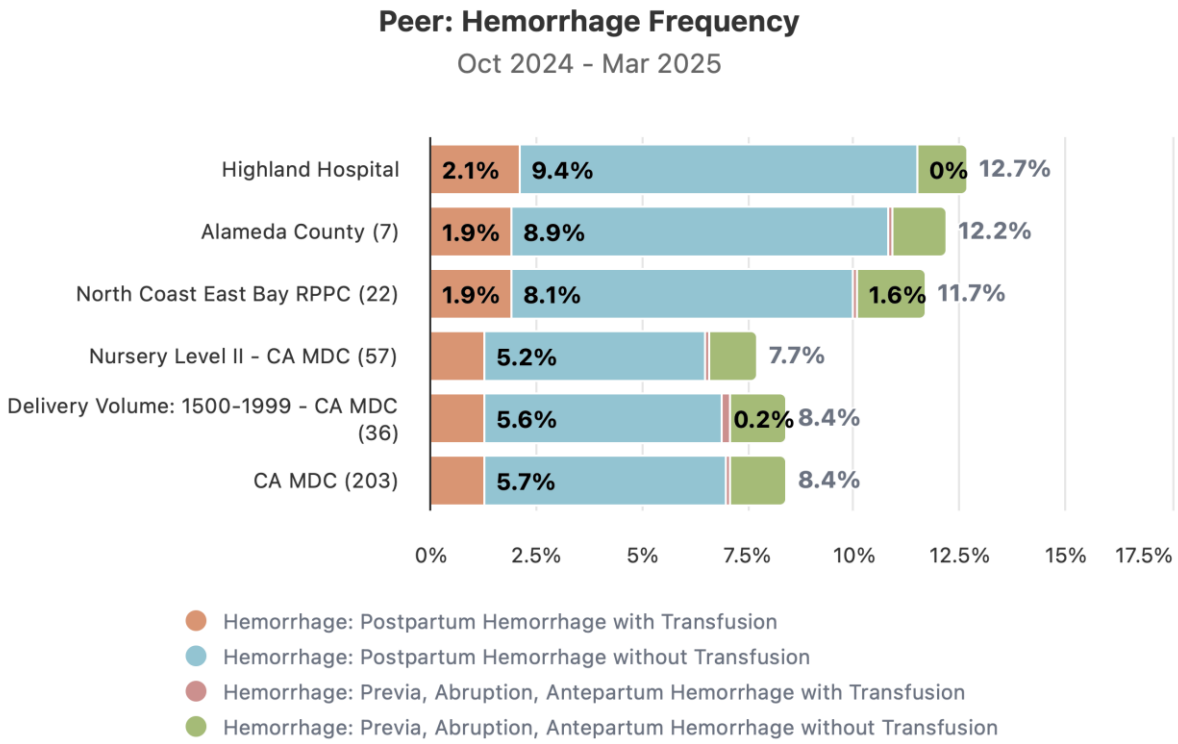




Who We Serve

Characteristics of AHS Birthing People from AHS - Hemorrhage





HCAI Maternity Honor Roll

- 223 eligible California hospitals analyzed for their quality performance

- Highland Hospital is one of 19 hospitals who:
  - Made honor roll 9 years running
  - Meet or exceed performance standards for:
    - NTSV C-Sections
    - SSI after C-Section
    - VBAC
    - Episiotomies
    - Early elective deliveries prior to 39 weeks

HCAI
Department of Health Care Access and Information

Cal Hospital Compare
Maternity Honor Roll

CMQCC Profile Report – WC HGH Hospital

Maternity Care Measures	Your Hospital 2022	Your Hospital 2023	Your Hospital 2024	RPPC Region (n=22) 2024	Peer Acuity[5] (n=55) 2024	CA MDC (n=201) 2024
Episiotomy Rate[2]	0.4% ↓	0.4% ↓	0.4% ↓	1.7%	3.3%	2.6%
VBAC Rate, TSV[2]	32.9% ↑	32.8% ↑	28.3% ↑	21.2%	15.9%	16.8%
Total Cesarean Rate[2]	24.2% ↓	26.7% ↓	26.6% ↓	29.8%	30.2%	31.6%
NTSV Cesarean Rate (PC-02 Period Specific)[1]	17.4% ↓	23.5%	21.6% ↓	23.8%	24.7%	25.1%
NTSV Cesarean Rate (Age/BMI adjusted)[1]	N/A	25.9%	21.7%	22.0%	23.2%	23.6%

TIER 1 / TIER 1+2	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Alameda Health System - Highland Hospital			TIER 1+2			TIER 1+2	TIER 1+2	TIER 1+2	TIER 1+2	TIER 1+2	TIER 1+2	TIER 1+2	TIER 1+2	TIER 1+2	TIER 1+2	TIER 1+2
Arrowhead Regional Medical Center						TIER 1	TIER 1	TIER 1+2	TIER 1+2	TIER 1+2	TIER 1+2	TIER 1+2	TIER 1+2	TIER 1	TIER 1+2	TIER 1+2
CHA Hollywood Presbyterian Medical Center														TIER 1		
Children's Specialists of San Diego														TIER 1+2	TIER 1+2	TIER 1+2
Hazel Hawkins Memorial Hospital				TIER 1	TIER 1+2	TIER 1+2	TIER 1+2			TIER 1	TIER 1	TIER 1+2	TIER 1+2	TIER 1+2	TIER 1+2	TIER 1+2
John Muir Health - Walnut Creek									TIER 1+2	TIER 1+2	TIER 1+2	TIER 1+2		TIER 1+2	TIER 1+2	TIER 1+2

Timeline of Access Crisis - Physician Burnout

March 2023
Meeting with CMO to discuss staffing crisis
Physicians decline to work overtime

→

May 2023
Physician staffing reduction

→

August 2023
Consultant Benchmarking and Assessment

2024 Clinic sessions closed per template - for rounder, PTO, hours reduction				
	clinic sessions closed	hours	FTE equivalent	% closed
Q1	54	216	0.1038461538	13.27%
Q2	92	368	0.1769230769	23.90%
Q3	127	508	0.2442307692	32.07%
Q4	127	508	0.2442307692	32.82%
Total	400	1600	0.7692307692	25.40%

~ 3600 – 4000 patient visits

ALAMEDA HEALTH SYSTEM

Timeline of Access Crisis - Physician Burnout

March 2023
Meeting with CMO to discuss staffing crisis
Physician decline to work overtime

→

May 2023
Physician staffing reduction

→

August 2023
Consultant Benchmarking and Assessment

Elective surgery ORs closed per template - for Rounder, PTO, hours reduction			
	OR blocks closed	hours	FTE equivalent
Q1	13	104	0.05
Q2	16	128	0.06153846154
Q3	44	352	0.1692307692
Q4	36	288	0.1384615385
Total	109	872	0.4192307692

~ 327 – 545 elective surgery cases

Current (since 2010) AHS OMG Physician Inpatient staffing model

On-Site Coverage - Physician Hours (Fixed Payment)												FTE			
Coverage	Hospital	Department	Time	Hours	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Core FTE	PTO coverage	Holiday coverage	Required FTE coverage
Labor & Delivery Day	HGH	Inpatient	7am-7pm	13	0.325	0.325	0.325	0.325	0.325	0.325	0.325	2.275	Y	Y	2.275
Labor & Delivery Night	HGH	Inpatient	7pm-7am	13	0.325	0.325	0.325	0.325	0.325	0.325	0.325	2.275	Y	Y	2.275
GYN Rounder (include consult, emergency surgeries, phone consults)	HGH	Inpatient	7am-5pm	10	0.250	0.250	0.250	0.250	0.250			1.250	Y	N	1.250

Total: 5.8 FTE (actual)

Indian Health Service

The Federal Health Program for American Indians and Alaska Natives

Staffing Criteria
OB/GYN Surgeon staff of 1.5 FTEs for each facility with at least 200 OB/GYN deliveries plus surgical cases, plus 1.0 FTE OB/GYN Surgeon for every 210 OB/GYN deliveries plus surgical cases above 200/ year.

Total: 7.5 FTE (minimum recommended)

Physician Staffing Restructure

Supplement the OMG physician program with nocturnist coverage.

1 2 3

The addition of nocturnist physicians will alleviate the call burden, allowing for a transition of work hours to an increased daytime clinic presence.

Common Program Features

- Coverage for L&D patients and emergencies
- Residency supervision
- Partnership and backup for the CNM program
- Coverage for the ED and L&D triage
- Coverage for GYN ED patients, including consults and procedures (scheduled and emergency)
- Collaborative model with trainees, midwives, and other practice physicians
- 12-hour shifts for either nighttime coverage or both night and weekend coverage

Option One

Full nighttime coverage requires approximately **2.2 FTE physicians**.

Option Two

Night and weekend coverage requires an additional 0.6 FTEs for an approximate total of **2.8 FTE physicians**.

PILOT Physician Swing Shift (Jan-Mar 2025)

Backup utilization prior to pilot swing shift :

Time of day	%
Nights (M-S)	47.5
Weekend Day	69

Backup utilization after start of pilot shift:

Time of day	%
Nights (M-S)	35.0
Weekend Day	N/A

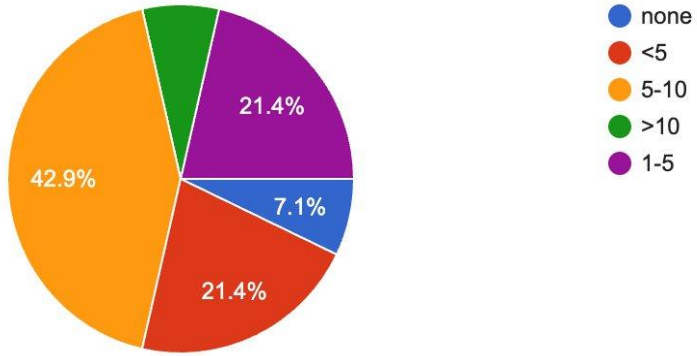
Staff and Provider Feedback:

ØEven when volume not a lot, feels like improved patient care, patients seen in a timely fashion when multiple MD things happening at once

ØCame on as swing, good number of consults including 2 patients who were very ill and required a lot of attention. This was also a situation where a very ill patient needed full attention from the L&D MD, which proves why having a swing is important because while L&D was being taken care of I was able to focus on the Gyn consults needing a lot of attention.

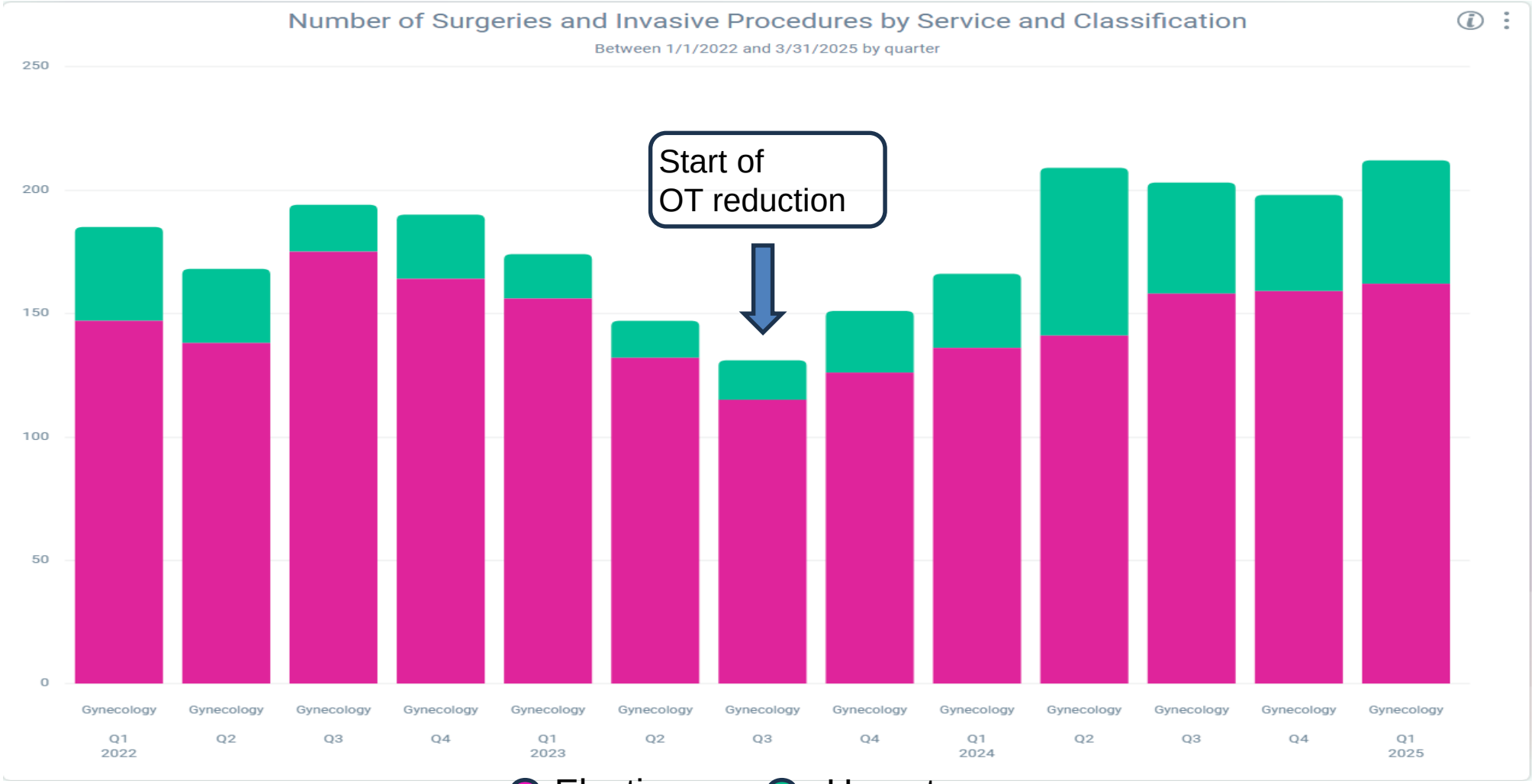
How many patient encounters did you have (i.e., closed progress notes, beta calls, NST charts)?

14 responses



GYNECOLOGY SURGERY

Gynecology and Urogynecology Volume – 2022 – 2025 (HGH, AH, SLH)



OMG Ambulatory sites

Highland WC Campus
Prenatal Care, Pregnancy Assessment
MFM
GYN
Procedural Abortion care
Abortion intake/ Medication Abortion
Cervical Dysplasia treatment
Gyn Oncology (HCP 5)
Centering Pregnancy
Level 2 ultrasound – MFM/ Radiology

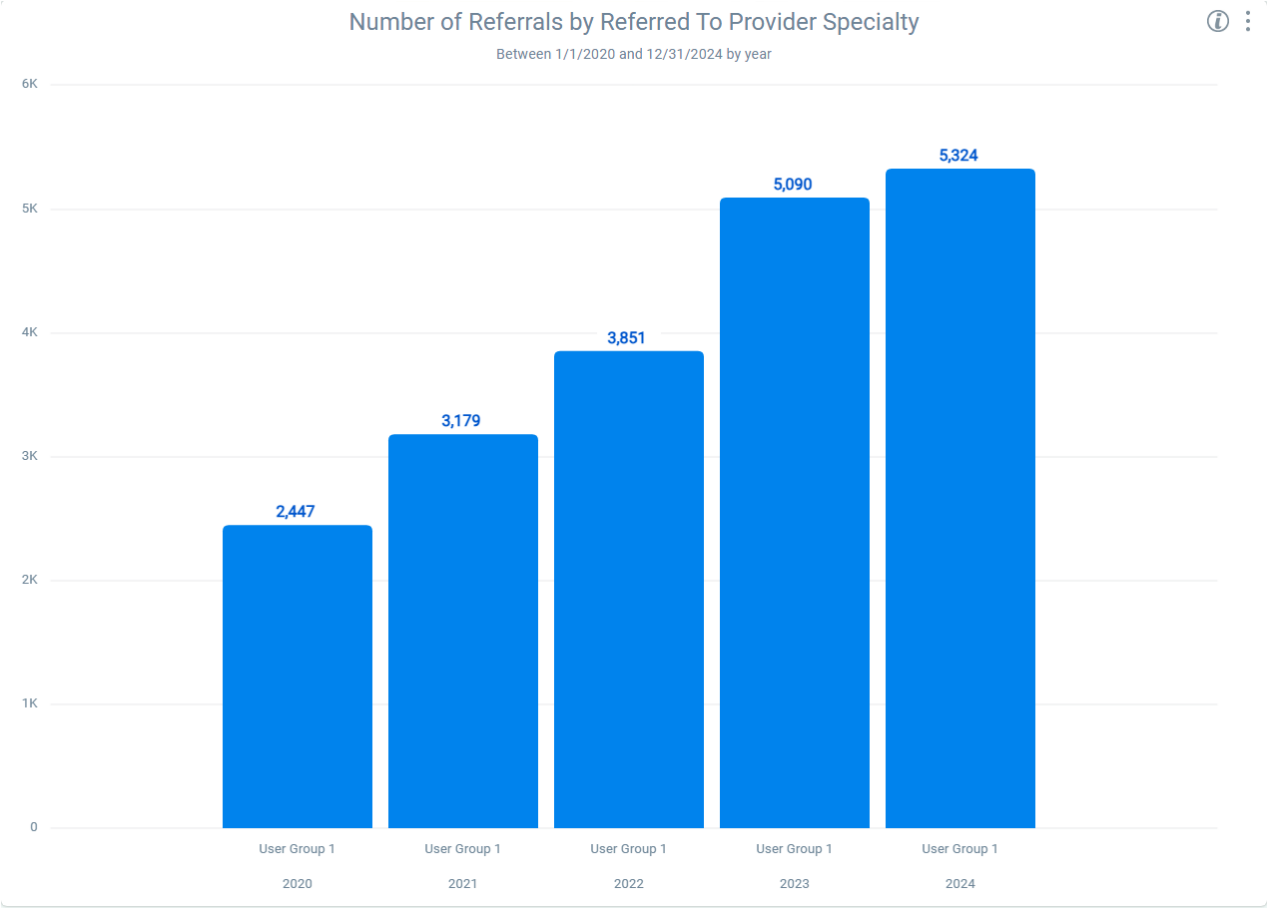
Newark WC
Prenatal Care
GYN

Eastmont WC
Prenatal Care, Pregnancy Assessment
Abortion intake/ Medication Abortion
GYN
Centering Pregnancy

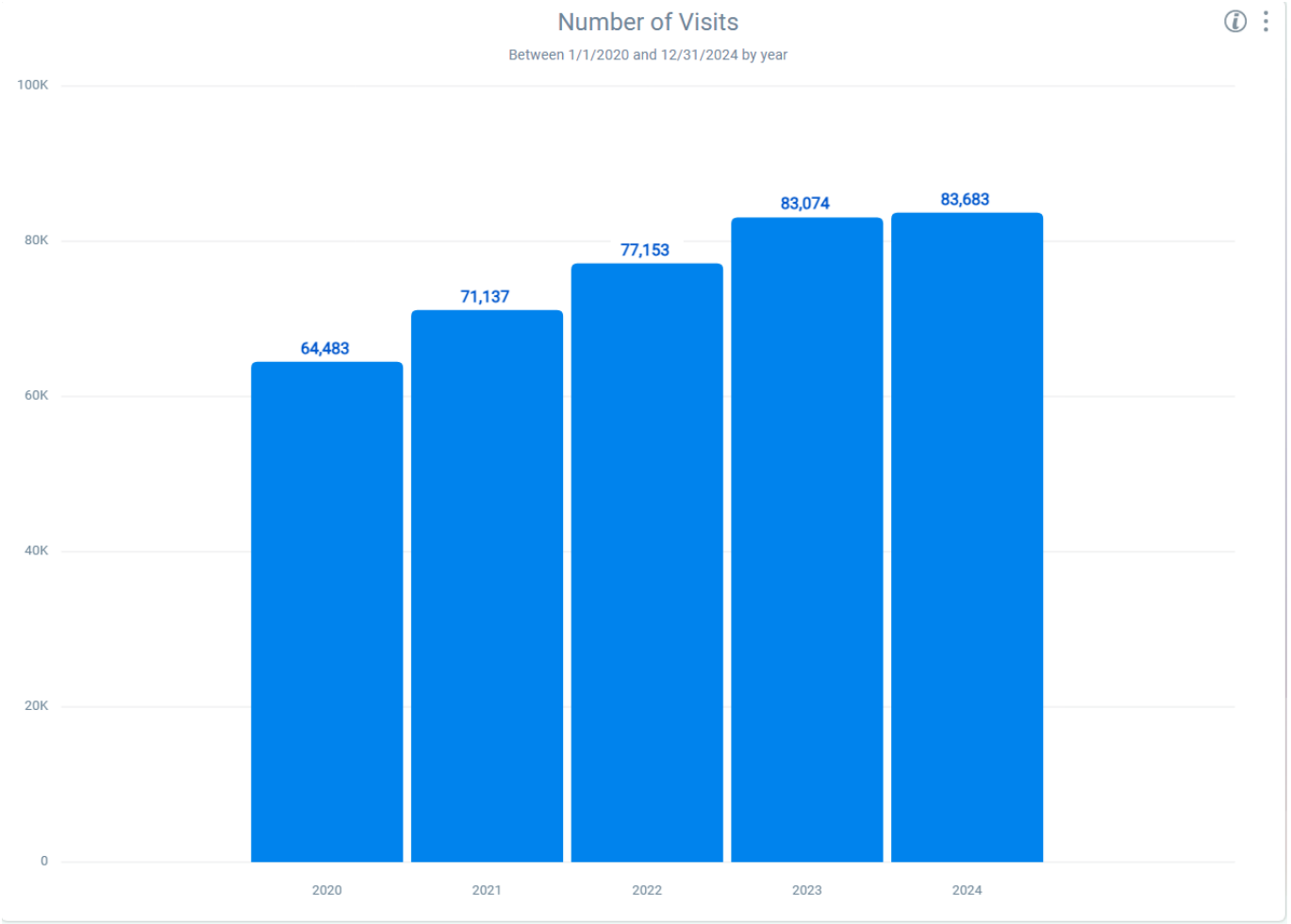
Hayward WC
Prenatal Care, Pregnancy Assessment
Medication Abortion
GYN

OMG REFERRALS/ E-consults

OMG E-consult Categories
High risk Obstetrics/ Maternal Fetal Medicine
Complex GYNECOLOGY/ GYN surgery
Cervical dysplasia
Complex Family planning
Pelvic Pain and Endometriosis
Gynecology Oncology
Infertility



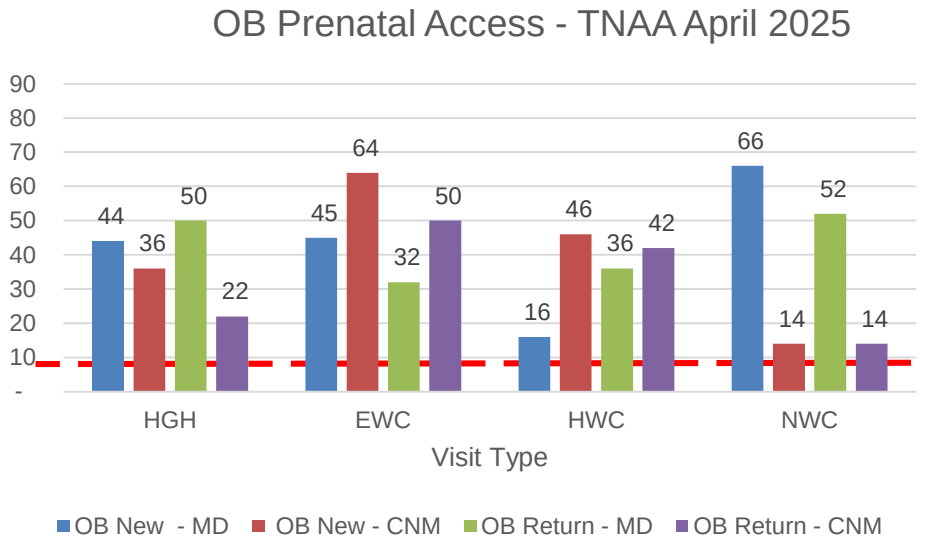
OMG Ambulatory visits
HGH, EWC, HWC, NWC

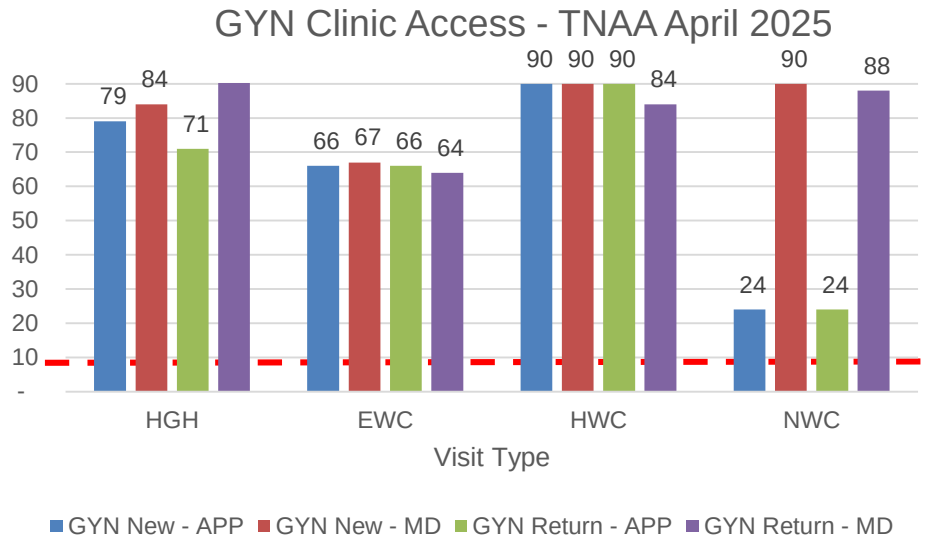


Population

Base: All Visits
Any of:
- Department: NWC WOMENS SVCS CLINIC
- Department: HWC WOMENS SVCS CLINIC
- Department: EWC WOMENS SVCS CLINIC
- Department: HGH WOMENS SVCS CLINIC

OMG Outpatient Access - TNAA





*Third Next Available Appointment (TNAA) - measure of patient access

ECG Industry Standard – -----

OMG Measures

- **OMG directly leads and indirectly supports 12+ QIP measures worth $18M with more metrics becoming *priority measures***
- This works gets harder and harder as targets reset each year

QIP PY7 Dashboard - October 2024

Anticipated Dollars Expected to Receive (Green) *Approximately*	Dollars At Highest Risk (Red) *Approximately*
$49,350,000	$10,650,000

Priority metrics at target (out of 20)	Non-priority metrics at target (need 20)
12.9	25.5

Internal Monitoring | Target Met | Target Not Met

Category	Metric	AAH PFP	Accountable Executive	Target	Dollar Value	25th - 90th Percentile	BaseLine Submitted	Number Needed For Target*	2024-12	2025-01	2025-02	2025-03
Primary Care - Preventative Care	Chlamydia Screening *		Porshia Mack	69.07 %	$1,500,000.00	49.65 % - 69.07 %	76.28 %		76.20 %	76.46 %	77.04 %	76.55 %
	Cervical Cancer Screening *	x	Porshia Mack	49.64 %	$1,500,000.00	49.64 % - 67.46 %	44.17 %	1,284	44.19 %	44.20 %	44.32 %	44.11 %
Maternal & Perinatal Health	Exclusive Human Milk Feeding (PC-05)		Ro Lofton	70.17 %	$1,500,000.00	44.41 % - 74.96 %	69.64 %	9	69.64 %	69.44 %	69.42 %	
	PC-02: Cesarean Birth *		Beth Mahler	22.17 %	$1,500,000.00	25.00 % - 22.00 %	22.20 %		22.20 %	21.60 %	20.67 %	
	Prenatal Immunization Status		Porshia Mack	35.60 %	$1,500,000.00	13.37 % - 35.60 %	43.29 %		43.23 %	43.57 %	44.25 %	44.54 %
	Timeliness of Prenatal Care *		Porshia Mack	85.87 %	$1,500,000.00	79.81 % - 91.85 %	85.20 %		85.20 %	84.70 %	85.13 %	85.95 %
	Postpartum Care *		Porshia Mack	86.62 %	$1,500,000.00	75.67 % - 86.62 %	87.33 %		87.47 %	88.17 %	88.35 %	90.17 %
	Prenatal Depression Screening: % of Depression Screening		Porshia Mack	41.38 %	$750,000.00	0.24 % - 41.38 %	74.32 %		74.32 %	76.00 %	76.34 %	76.97 %
	Prenatal Depression Screening: % of Follow-up on Positive Screen		Porshia Mack	66.67 %	$750,000.00	41.9 % - 66.67 %	70.11 %		70.11 %	68.13 %	67.02 %	66.67 %
	Postpartum Depression Screening: % of Depression Screening		Porshia Mack	29.84 %	$750,000.00	0.08 % - 29.84 %	66.03 %		66.03 %	67.17 %	67.74 %	67.94 %
	Postpartum Depression Screening: % of Follow-up on Positive Screen		Porshia Mack	75.74 %	$750,000.00	51.3 % - 84.44 %	74.77 %		74.77 %	75.24 %	76.85 %	76.19 %

Cervical Cancer Screening

% of women 21-64 years who were screened for cervical cancer (cervical cytology in the last 3 years OR HPV co-testing in the last 5 years for 30+)

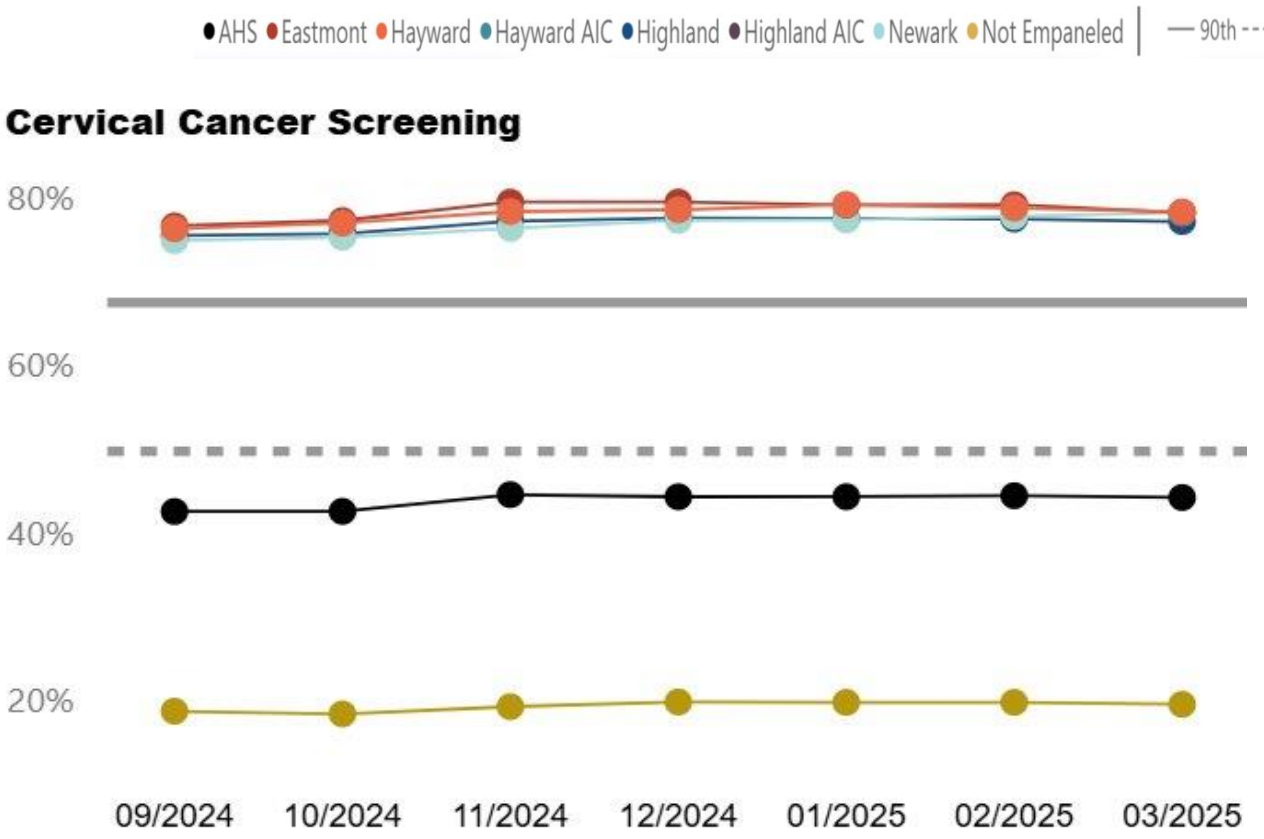
Required reporting – priority metric

Metric	Target	Dollar Value	25th - 90th Percentile	BaseLine Submitted	Number Needed For Target*	2024-12	2025-01	2025-02	2025-03
Cervical Cancer Screening *	49.64 %	$1,500,000.00	49.64 % - 67.46 %	44.17 %	1,284	44.32 %	44.20 %	44.32 %	44.11 %

Key Strategies:

- Exploring HPV Primary Testing (including self-swab HPV) to expand opportunities
- Exploring MA standard work to decrease potential barriers (patient readiness, supplies)

CCS: When Patients Are In Our Care, Screenings Get Done



Key Highlights:

- If patients are empaneled (seen at AHS), performance is above 90th percentile
- Population of patients assigned not seen (unempaneled) is large (~58% of denominator)

Timeliness of Prenatal Care

% of deliveries that received prenatal care visit within the 1st trimester or within 42 days of assignment with Alameda Health System

Required reporting – priority metric

Metric	Target	Dollar Value	25th - 90th Percentile	BaseLine Submitted	Number Needed For Target*	2024-12	2025-01	2025-02	2025-03
Timeliness of Prenatal Care *	85.87 %	$1,500,000.00	79.81 % - 91.85 %	85.20 %		85.20 %	84.70 %	85.13 %	85.95 %

Key Strategies:

- Focusing on processes within PAC (Pregnancy Assessment Clinic)
  - Expanding # of clinics
  - POC Ultrasound training for CNM's
- Exploring potential of ED e-consults to lower barriers for pregnant patients who have initial touchpoint in ED

Ambulatory Space Constraints

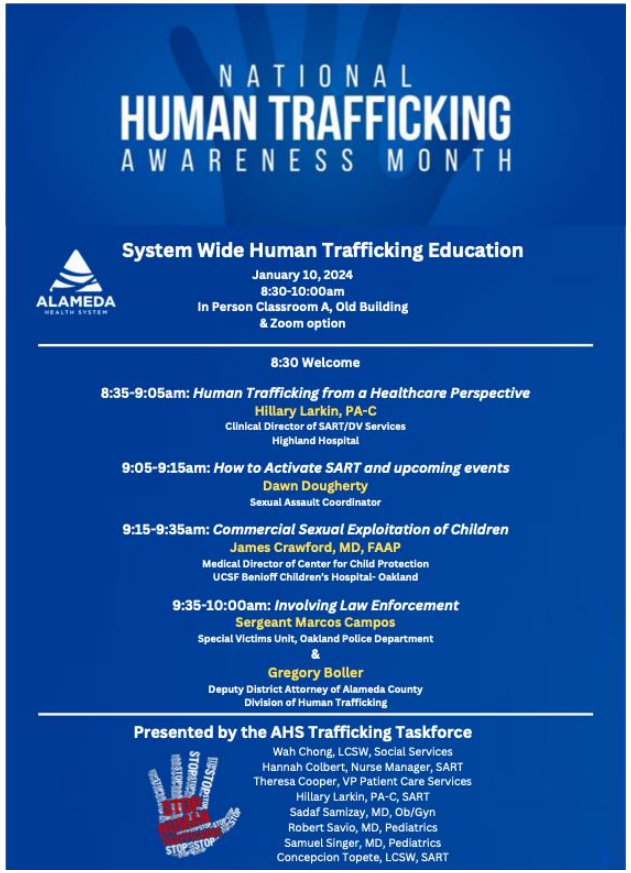
WEEK 1	Room	MA	MONDAY AM	MONDAY PM	TUESDAY AM	TUESDAY PM	WEDNESDAY AM	WEDNESDAY PM	THURSDAY AM	THURSDAY PM	FRIDAY AM	FRIDAY PM
1	Procedure 1, 2 +/- 16		Lee	Brown Lechner	Procedure	Altshuler	Samizay	Samizay	Pierce	Procedure	Procedure	Lee
2	Room 6,7		SAN APP	SAN APP	SAN APP	SAN APP	Heimer-Smith	Cho	Cho	SAN APP	Goodfriend-Reano	Goodfriend-Reano
3	Roome 14, 15		Lomeli	Lomeli	Heimer-Smith	Heimer-Smith	Lomeli	PAC	Heimer-Smith	Heimer-Smith	Berletti	Berletti
4	Room 17, 18		Roisman	Roisman	Nevin	Brown Lechner	Schwarting	Schwarting	Schwarting	Schwarting	Lance	Lance
5	Ultrasound 1, 2		MFM	MFM	Provider	Provider	Ho	Ho	Tukenmez	Tukenmez	MFM	MFM
6	Room 8,10		Samizay	Samizay PAC	PAC	PAC	CNM	CNM	Lomeli	Lomeli	Goodfriend-Reano	Goodfriend-Reano
7	Room 5 (shared with AIC), Room 11								Goodfriend-Reano			
AIC	Room 1,2, 3, 4											
WEEK 2	Room	MA	MONDAY AM	MONDAY PM	TUESDAY AM	TUESDAY PM	WEDNESDAY AM	WEDNESDAY PM	THURSDAY AM	THURSDAY PM	FRIDAY AM	FRIDAY PM
1	Procedure 1, 2 +/- 16				Procedure	Altshuler	Samizay	Samizay	Pierce			Lee
2	Room 6,7		PAC	PAC	SAN APP	SAN APP	SAN APP	Cho	Cho			Heimer-Smith
3	Roome 14, 15		Lomeli	Lomeli	Heimer-Smith	Heimer-Smith	Heimer-Smith	Ho	Heimer-Smith	Heimer-Smith	Berletti	Berletti
4	Room 17, 18		Roisman	Roisman	Nevin	Brown Lechner	Schwarting	Schwarting	Schwarting	Schwarting	Lance	Lance
5	Ultrasound 1, 2		MFM	MFM	Pierce		Ho	PAC	Tukenmez	Tukenmez	MFM	MFM
6	Room 8,10		Samizay	Samizay PAC	PAC	PAC	CNM	CNM	Lomeli	Lomeli	Goodfriend-Reano	Goodfriend-Reano
7	Room 5 (shared with AIC), Room 11							Wilson	Goodfriend-Reano			
WEEK 3	Room	MA	MONDAY AM	MONDAY PM	TUESDAY AM	TUESDAY PM	WEDNESDAY AM	WEDNESDAY PM	THURSDAY AM	THURSDAY PM	FRIDAY AM	FRIDAY PM
1	Procedure 1, 2 +/- 16		Lee	Provider	PAC	PAC	Samizay	Samizay	Pierce	Procedure	Procedure	Lee
2	Room 6,7		PAC	PAC	Heimer-Smith	Heimer-Smith	Heimer-Smith	Cho	Cho			N APP
3	Roome 14, 15		Samizay		Nevin	Brown Lechner	Lomeli	Pierce	Heimer-Smith	Heimer-Smith	Berletti	Berletti
4	Room 17, 18		3rd Monday of the Month clinic canceled	CNM	Pierce	Altshuler	Schwarting	Schwarting	Schwarting	Schwarting	Lance	Lance
5	Ultrasound 1, 2		MFM	MFM	Provider SAN	Provider SAN	Ho	PAC	Tukenmez	Tukenmez	MFM	MFM
6	Room 8,10		Lomeli	Lomeli	Provider SAN	Provider SAN	CNM	CNM	Lobeli	Lomeli	Goodfriend-Reano	Goodfriend-Reano
7	Room 5 (shared with AIC), Room 11							Wilson	Goodfriend-Reano			

Consultant's report on Ambulatory Space

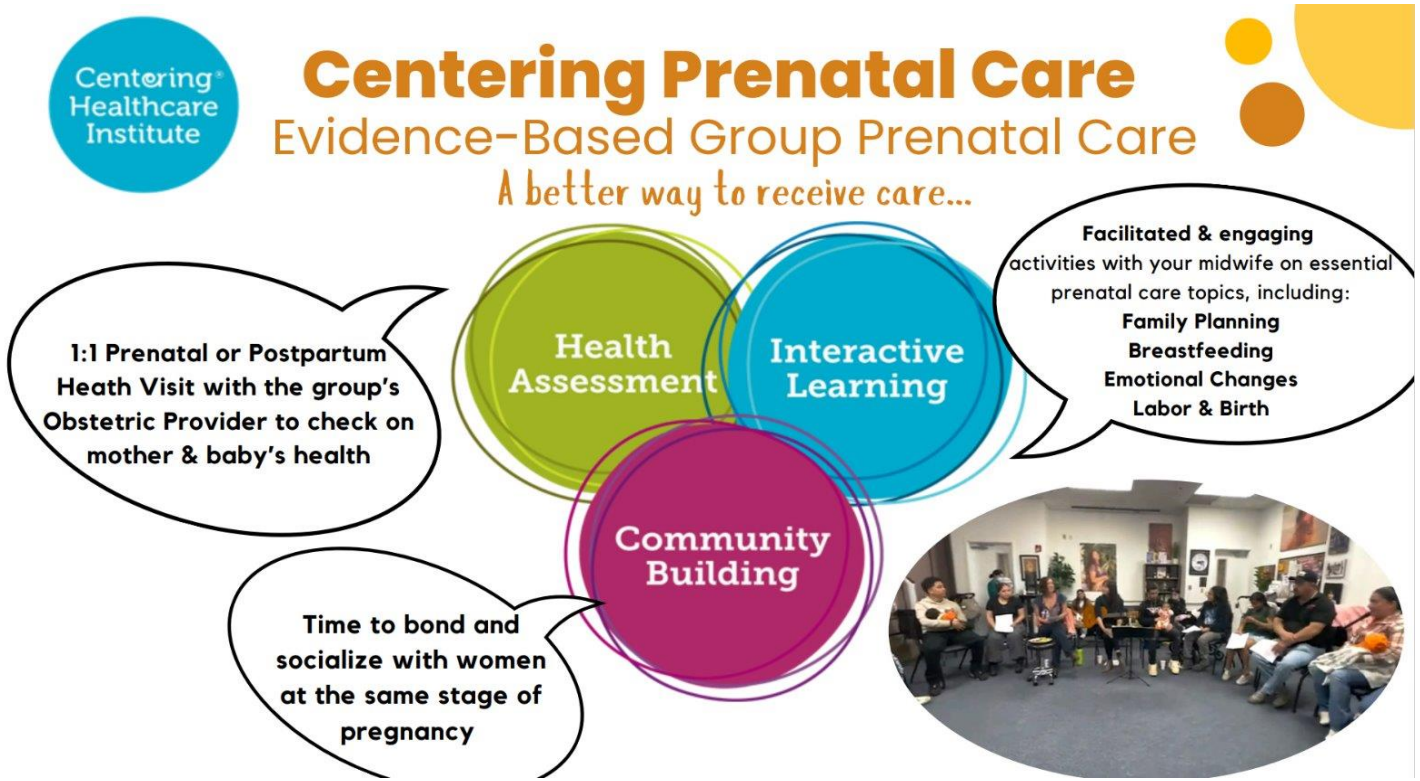
ECG MANAGEMENT CONSULTANTS
A Siemens Healthineers Company

PATIENT CENTERED CARE

- SAART follow-up clinic PILOT
- Dr Samizay – SAFE (Sexual Assault Forensic Examiner) certified
- Mandated Reporting for OMG, Pediatrics providers



Prenatal Care: Centering Pregnancy



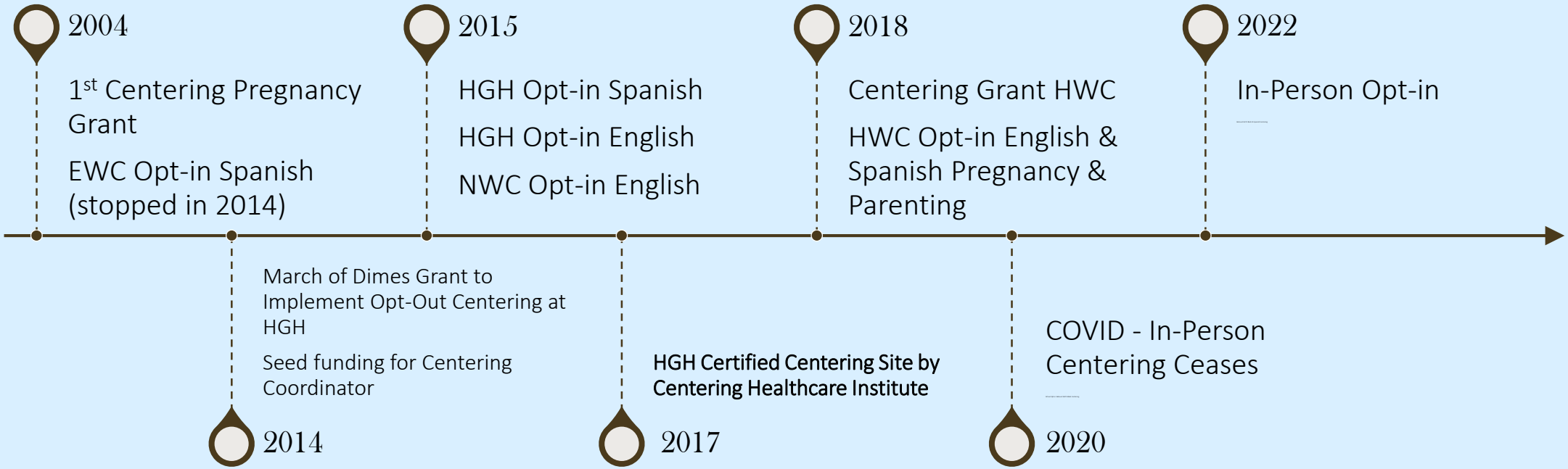
ALAMEDA HEALTH SYSTEM

Centering at Alameda Health System

Centering Healthcare Institute

AHS is the first ever Centering Certified System by the Centering Healthcare Institute & a leader in Centering care Innovation

History of Centering at AHS



National and Local Rates

Preterm Birth Rate
United States: 9.8%
California: 8.6%
Alameda County: 8.1%
Highland, all deliveries: 8.3%
Highland, Centering: 5.1%

Low Birth Weight Rate
United States: 8.0%
California: 6.7%
Alameda County: 6.9
Highland, all deliveries: 6.0%
Highland, Centering: 4.7%

Pre-COVID data

Thank you!

H1. Chief Financial Officer Report, February Financial Report

ALAMEDA HEALTH SYSTEM

March 2025 Financial Report
Finance Committee: May 7, 2025

March 2025 Financial Report
YTD Finance Dashboard

March-2025

	Metric	FY2025 Goal YTD	Actual YTD	YTD	Trend Lines
Volume					
	Total Adjusted Discharges	23,420	22,520		
	Total Adjusted Patient Days	251,479	262,321		
Revenue Cycle					
	Collection Ratio	19.3%	19.5%		
	Cash as % of Net Revenue	100.0%	103.0%		
	Gross Days in Patient Receivables	65.0	62.0		
Labor					
	Productivity %	100.0%	101.9%		
	Registry as % of Total FTEs	3.8%	4.4%		
	Total FTEs	4,919	5,142		
	FTE per Adjusted Discharge	0.21	0.23		
	*Labor Cost/FTE w/o GASB	$217,745	$223,022		
Profitability					
	Total Cost per Adjusted Discharge	$46,550	$52,475		
	Total Cost per Adjusted Patient Days	$4,335	$4,505		
	Net Income	$4,822	$14,659		
	EBIDA Margin	3.0%	4.0%		
	NNB (Net Negative Balance)	<$100M	-$71,042		
	Net Position	>$0	-$65,962		
Capital					
	Capital Spent	$26,004	$13,533		
	% of Capital Spent		52.0%		

*Labor costs excludes contracted physicians; Includes Registry travel & housing costs

ALAMEDA HEALTH SYSTEM

March 2025 Financial Report
Volume Highlights – Part 1

	Mar-25	Budget	Variance	% Var	YTD Actual	YTD Budget	Variance	% Var	PY YTD Actual	Variance	% Var
Total Adjusted Patient Days	30,174	28,567	1,607	5.6%	262,321	251,479	10,842	4.3%	250,420	11,901	4.8%
Total Adjusted Discharges	2,494	2,653	(158)	-6.0%	22,520	23,420	(900)	-3.8%	22,905	(385)	-1.7%
GENERAL ACUTE											
Patient Days	6,876	6,697	179	2.7%	58,168	61,138	(2,970)	-4.9%	60,563	(2,395)	-4.0%
Discharges	1,249	1,370	(121)	-8.8%	11,032	12,333	(1,301)	-10.5%	11,924	(892)	-7.5%
Average Daily Census	221.8	216.0	5.8	2.7%	211.5	222.3	(10.8)	-4.9%	220.2	(8.7)	-4.0%
Average Length of Stay	5.5	4.9	(0.6)	-12.6%	5.3	5.0	(0.3)	-6.4%	5.1	0.2	3.8%
Adjusted Patient Days	12,546	11,675	871	7.5%	106,593	103,313	3,280	3.2%	103,428	3,165	3.1%
Adjusted Discharges	2,279	2,388	(109)	-4.6%	20,216	20,840	(624)	-3.0%	20,364	(148)	-0.7%
CMI	1.580	1.630	(0.050)	-3.1%	1.640	1.600	0.040	2.5%	1.570	0.070	4.5%
Emergency Visits	9,261	9,139	122	1.3%	82,175	77,790	4,385	5.6%	77,548	4,627	6.0%
Left Without Being Seen (LW	7.6%	7.8%	0.1%	1.9%	6.8%	7.7%	0.9%	12.7%	7.3%	0.5%	7.4%
Trauma Cases	270	260	10	3.8%	2,747	2,626	121	4.6%	2,553	194	7.6%
Observation Equivalent Days	642	259	383	147.9%	5,742	2,477	3,265	131.8%	1,512	4,230	279.8%
Surgeries	652	825	(173)	-21.0%	6,184	7,001	(817)	-11.7%	6,816	(632)	-9.3%
IP Surgeries	258	344	(86)	-25.0%	2,404	3,174	(770)	-24.3%	3,015	(611)	-20.3%
OP Surgeries	394	481	(87)	-18.1%	3,780	3,827	(47)	-1.2%	3,801	(21)	-0.6%
Deliveries	134	133	1	0.8%	1,206	1,116	90	8.1%	1,161	45	3.9%
PSYCH											
Patient Days	2,057	2,055	2	0.1%	17,603	18,199	(596)	-3.3%	17,998	(395)	-2.2%
Discharges	184	226	(42)	-18.6%	1,859	2,000	(141)	-7.1%	2,001	(142)	-7.1%
Average Daily Census	66.4	66.3	0.1	0.1%	64.0	66.2	(2.2)	-3.3%	65.4	(1.4)	-2.2%
Average Length of Stay	11.2	9.1	(2.1)	-22.9%	9.5	9.1	(0.4)	-4.1%	9.0	0.5	5.3%
Adjusted Patient Days	2,461	2,420	41	1.7%	21,078	21,591	(513)	-2.4%	21,283	(205)	-1.0%
Adjusted Discharges	220	266	(46)	-17.3%	2,226	2,373	(147)	-6.2%	2,366	(140)	-5.9%
PES Equivalent Days	717	717	-	0.0%	6,045	6,385	(340)	-5.3%	5,958	87	1.5%
REHAB											
Patient Days	713	731	(18)	-2.5%	6,308	6,460	(152)	-2.4%	5,915	393	6.6%
Discharges	49	53	(4)	-7.5%	464	465	(1)	-0.2%	431	33	7.7%
Average Daily Census	23.0	23.6	(0.6)	-2.5%	22.9	23.5	(0.6)	-2.4%	21.5	1.4	6.7%
Average Length of Stay	14.6	13.8	(0.8)	-5.5%	13.6	13.9	0.3	2.1%	13.7	(0.1)	-0.8%
Adjusted Patient Days	713	731	(18)	-2.5%	6,308	6,460	(152)	-2.4%	5,915	393	6.6%
Adjusted Discharges	49	53	(4)	-7.5%	464	465	(1)	-0.2%	431	33	7.7%

March 2025 Financial Report
Medicare GMLOS Benchmark – Trend of Excess Days

Acute Care Hospitals: HGH, SLH, AH (excludes any rehab)

- LOS Variance Days | March: There were 2,613 excess days which is a 2.96% month over month Increase and is a 4.07% Decrease year over year. This reflects the total # of actual days in a bed in excess of the allowed # of days compared to the Medicare acuity model benchmark.

- Medicare GMLOS Benchmark: Compares the total AHS patient population against the Federal regulatory guidelines (Medicare), regardless if the patient is a non-Medicare State (APR) payer or a Medicare Federal (MSDRG) payer.

March 2025 Financial Report
Volume Highlights – Part 2

	Mar-25	Budget	Variance	% Var	YTD Actual	YTD Budget	Variance	% Var	PY YTD Actual	Variance	% Var
SNF with Sub-Acute											
Patient Days	8,524	8,546	(22)	-0.3%	75,340	75,533	(193)	-0.3%	75,023	317	0.4%
Discharges	20	26	(6)	-23.1%	163	228	(65)	-28.5%	224	(61)	-27.2%
Average Daily Census	275.0	275.7	(0.7)	-0.3%	275.0	275.7	(0.7)	-0.3%	272.8	2.2	0.8%
Average Length of Stay	426.2	331.4	(94.8)	-28.6%	462.2	331.4	(130.8)	-39.5%	334.9	127.3	38.0%
Bed Holds	87	96	(9)	-9.4%	791	841	(50)	-5.9%	787	4	0.5%
CLINIC VISITS	34,962	36,408	(1,446)	-4.0%	308,507	292,888	15,619	5.3%	288,856	19,651	6.8%
Clinic Visits	29,294	29,806	(512)	-1.7%	258,174	241,378	16,796	7.0%	237,476	20,698	8.7%
Telehealth Visits	5,668	6,602	(934)	-14.1%	50,333	51,510	(1,177)	-2.3%	51,380	(1,047)	-2.0%
FQHC Visits	29,263	31,128	(1,865)	-6.0%	258,550	249,218	9,332	3.7%	245,928	12,622	5.1%
Clinic Visits	24,495	25,580	(1,085)	-4.2%	216,187	205,591	10,596	5.2%	202,506	13,681	6.8%
Telehealth Visits	4,768	5,548	(780)	-14.1%	42,363	43,627	(1,264)	-2.9%	43,422	(1,059)	-2.4%
Non-FQHC Visits	5,699	5,280	419	7.9%	49,957	43,670	6,287	14.4%	42,928	7,029	16.4%
Clinic Visits	4,799	4,226	573	13.6%	41,987	35,787	6,200	17.3%	34,970	7,017	20.1%
Telehealth Visits	900	1,054	(154)	-14.6%	7,970	7,883	87	1.1%	7,958	12	0.2%
Physician wRVU	136,760	130,687	6,073	4.6%	1,300,434	1,081,040	219,394	20.3%	1,024,240	276,194	27.0%
PAYOR MIX											
Insurance %	6.8%	7.2%	-0.4%	-5.4%	7.0%	7.3%	-0.3%	-4.4%	7.1%	-0.1%	-2.0%
Medi-Cal %	7.9%	13.0%	-5.2%	-39.5%	9.0%	13.1%	-4.1%	-31.6%	19.4%	-10.4%	-53.6%
Medi-Cal MC %	52.6%	45.5%	7.1%	15.6%	51.5%	45.5%	6.0%	13.2%	40.1%	11.4%	28.3%
Medicare %	21.5%	20.1%	1.4%	6.9%	21.1%	20.1%	1.0%	4.9%	20.5%	0.5%	2.6%
Medicare MC %	6.2%	6.9%	-0.6%	-9.2%	7.2%	7.0%	0.3%	3.6%	6.8%	0.4%	6.2%
Other Govt %	1.6%	3.9%	-2.4%	-60.7%	1.7%	3.8%	-2.2%	-56.5%	3.2%	-1.5%	-48.0%
Self-Pay %	3.4%	3.4%	0.1%	1.5%	2.7%	3.3%	-0.6%	-19.1%	2.9%	-0.3%	-8.9%
Total Payor Mix %	100%	100%	0.0%	0.0%	100%	100%	0.0%	0.0%	100%	0.0%	0.0%

March 2025 Financial Report
Financial Summary and YTD Highlights

- Favorable YTD revenue variance of $104.2M.
  - Higher volumes for outpatient and professional fees resulting in higher net patient revenue ($43.3M). Collections higher than plan.
  - Distinct Part Nursing Facility Pass-Through CY23, new supplemental program ($19.1M).
  - EPP FY25 accrual increased based on CMS pre-print notification ($6.9M).
  - QIP FY25 accrual increased based on CMS pre-print notification ($17.4M).
  - FEMA revenue based on paid claims ($5.8M).

- Unfavorable YTD expense variance of $91.5M.
  - Labor costs unfavorable ($63.3M) - FTE utilization higher than planned (223 FTE, $31.3M), higher wage rates ($15.7M), and higher benefit/retirement ($16.3M).
  - Materials and Supply cost unfavorable ($8.1M) – pharmaceuticals ($5.8M) and supplies ($2.3M).
  - General and Administrative cost unfavorable ($14.8M) – St. Rose Hospital contribution for IGT funding ($12.2M) and prior year settlements ($2.1M).

	March 2025				Year-To-Date				FY 2024	
	Actual	Budget	Variance	% Var	Actual	Budget	Variance	% Var	YTD	% Var
Operating revenue	$ 138,548	$ 124,234	$ 14,314	11.5%	$ 1,199,858	$ 1,095,672	$ 104,186	9.5%	$ 1,065,697	12.6%
Operating expense	148,772	123,233	(25,539)	(20.7)%	1,181,731	1,090,205	(91,526)	(8.4)%	1,077,011	(9.7)%
Operating income (loss)	**(10,224)**	**1,001**	**(11,225)**	**(1121.4)%**	**18,127**	**5,467**	**12,660**	**231.6%**	**(11,314)**	**260.2%**
Other non-operating activity	(450)	(97)	(353)	(363.9)%	(3,468)	(645)	3,007	466.2%	(964)	344.9%
Net Income (loss)	**$ (10,674)**	**$ 904**	**$ (11,578)**	**(1280.8)%**	**$ 14,659**	**$ 4,822**	**$ 15,667**	**324.9%**	**$ (12,278)**	**266.9%**
EBIDA adjustments	2,514	2,111	403		33,003	28,472	4,531		30,434	
EBIDA	**$ (8,160)**	**$ 3,015**	**$ (11,175)**		**$ 47,662**	**$ 33,294**	**$ 20,198**		**$ 18,156**	
Operating Margin	(7.4)%	0.8%	(8.2)%		1.5%	0.5%	1.0%		(1.1)%	
EBIDA Margin	(5.9)%	2.4%	(8.3)%		4.0%	3.0%	1.0%		1.7%	

March 2025 Financial Report
Net Patient Services Revenue Highlights

- Gross patient service revenue is favorable driven by overall higher volumes for inpatient, outpatient and professional services.
  - General acute inpatient days above budget; Length of Stay (LOS) exceeding budget and PY.
    - Discharges below budget
    - CMI below budget by 0.7% and consistent with PY.
    - Trauma 3.8% above budget. Inpatient surgery 25.0% below budget.
  - Observation exceeded budget at HGH, SLH, and AH.
  - ED visits 1.3% above budget. Outpatient surgery unfavorable 18.1%.
  - SNF census and discharges below budget; however, paid days exceed budget with bed holds.
- NPSR Collection ratio ahead of budget driven from ZBA analysis.
  - YTD, additional collections on fully reserved accounts ($8.2M) improved collection ratio (0.3%).

	March 2025				Year-To-Date				FY 2024	
	Actual	Budget	Variance	% Var	Actual	Budget	Variance	% Var	YTD	% Var
Inpatient service revenue	$ 221,780	$ 220,095	$ 1,685	0.8%	$ 1,927,199	$ 1,979,363	$ (52,164)	(2.6)%	$ 1,880,931	2.5%
Outpatient service revenue	146,518	131,361	15,157	11.5%	1,284,162	1,105,314	178,848	16.2%	1,072,353	19.8%
Professional service revenue	41,791	40,251	1,540	3.8%	386,056	319,232	66,824	20.9%	313,822	23.0%
Gross patient service revenue	410,088	391,707	18,381	4.7%	3,597,417	3,403,909	193,508	5.7%	3,267,106	10.1%
Deductions from revenue	(330,530)	(316,189)	(14,341)	(4.5)%	(2,896,905)	(2,746,682)	(150,222)	(5.5)%	(2,644,320)	9.6%
Net patient service revenue	**79,559**	**75,518**	**4,041**	**5.4%**	**700,512**	**657,226**	**43,286**	**6.6%**	**622,786**	**(12.5)%**
Collection % - NPSR	19.4%	19.3%	0.1%		19.5%	19.3%	0.2%		19.1%	
Capitation and HPAC	4,629	4,136	492	11.9%	41,537	37,227	4,310	11.6%	37,028	12.2%
Other government programs	48,083	40,060	8,023	20.0%	411,459	360,540	50,919	14.1%	363,390	13.2%
Other operating revenue	6,277	4,520	1,757	38.9%	46,349	40,678	5,671	13.9%	42,493	9.1%
Total operating revenue	**$ 138,547**	**$ 124,234**	**$ 14,313**	**11.5%**	**$ 1,199,857**	**$ 1,095,671**	**$ 104,185**	**9.5%**	**$ 1,065,697**	**12.0%**

March 2025 Financial Report
Governmental and Other Revenue Highlights

- Other government programs favorable from higher QIP CY2025 ($5.8M) and EPP CY2025 ($2.3M). YTD, significant favorable variances are from SNF DP-NF CY2023 ($19.1M), QIP CY2023/CY2025 ($18.9M), EPP CY2023/CY2025 ($9.8M), FEMA ($5.8M), offset by Prop 56 recoupment 1/01/22 through 10/14/24 ($1.9M), SNF Supplemental FY2020 recoupment ($1.3M), and Measure A Q1-Q2 ($1.3M). So far, AHS has received FEMA COVID recovery totaling $6.9M.
- Other operating revenue favorable from higher grant revenue ($1.4M), primarily from FY2024 MAA invoicing ($1.0M), and timing differences in other operating revenue ($0.4M). YTD, higher retail pharmacy receipts ($5.3M), grant revenue ($3.5M) offset by timing differences in other operating revenue ($1.2M) and recording of payor settlements into NPSR ($1.9M).

	March 2025				Year-To-Date				FY 2024	
	Actual	Budget	Variance	% Var	Actual	Budget	Variance	% Var	YTD	% Var
Net patient service revenue	79,559	75,518	4,041	5.4%	700,512	657,226	43,286	6.6%	622,786	(12.5)%
Capitation and HPAC	4,629	4,136	492	11.9%	41,537	37,227	4,310	11.6%	37,028	12.2%
Medi-Cal Waiver	9,011	9,289	(278)	(3.0)%	84,062	83,602	460	0.6%	73,339	14.6%
Measure A and parcel tax	12,785	12,785	(0)	(0.0)%	115,325	115,068	257	0.2%	121,507	(5.1)%
Supplemental Programs	26,287	17,986	8,301	46.2%	206,241	161,870	44,371	27.4%	168,544	22.4%
Covid-19	-	-	-	0.0%	5,830	-	5,830	100.0%	-	100.0%
Other government programs	**48,083**	**40,060**	**8,023**	**20.0%**	**411,459**	**360,540**	**50,919**	**14.1%**	**363,390**	**13.2%**
Grant Revenue	2,335	986	1,348	136.7%	12,378	8,877	3,500	39.4%	11,890	4.1%
Other Operating Revenue	3,942	3,533	409	11.6%	33,971	31,801	2,170	6.8%	30,603	11.0%
Other operating revenue	**6,277**	**4,520**	**1,757**	**38.9%**	**46,349**	**40,678**	**5,671**	**13.9%**	**42,493**	**9.1%**
Total operating revenue	**$ 138,547**	**$ 124,234**	**$ 14,313**	**11.5%**	**$ 1,199,857**	**$ 1,095,671**	**$ 104,185**	**9.5%**	**$ 1,065,697**	**12.6%**

March 2025 Financial Report
Expense Highlights excluding Labor

- Physician contract services unfavorable with variances under $0.1M by specialty. YTD, unfavorable with the largest variances in Psychiatry, OMFS, Rehab, General Surgery, and Hospitalist.
- Purchased services unfavorable from interpretive services ($0.2M), software licenses ($0.1M), and remaining variance across many cost centers ($0.2M). YTD, unfavorable from emergency food/shelter ($1.0M), software licenses ($0.9M), security ($0.9M), clinical services ($0.6M), laundry ($0.4M), refuge services ($0.4M), interpretive services ($0.3M) offset by favorable management consultants ($0.6M), billing/collection fees ($0.5M), and outside medical services ($0.5M).
- Material and supplies favorable from non-medical supplies ($0.7M) offset by medical supplies ($0.6M). YTD, unfavorable from retail pharmaceuticals ($2.6M), other pharmaceuticals ($3.2M), surgical/medical supplies ($1.7M), and non-medical supplies ($0.6M). The Las Vegas Data Center invoices were reclassed reducing non-medical supplies by ($0.3M). The retail pharmacy has a positive margin.

	March 2025				Year-To-Date				FY 2024	
	Actual	Budget	Variance	% Var	Actual	Budget	Variance	% Var	YTD	% Var
Labor costs	$ 102,271	$ 90,581	$ (11,690)	(12.9)%	$ 860,084	$ 796,747	$ (63,337)	(7.9)%	$ 780,693	(10.2)%
Physician contract services	3,711	3,358	(353)	(10.5)%	32,035	30,224	(1,811)	(6.0)%	35,938	10.9%
Purchased services	8,777	8,292	(485)	(5.8)%	77,720	74,849	(2,871)	(3.8)%	78,401	0.9%
Materials and supplies	12,903	13,033	130	1.0%	115,085	107,002	(8,083)	(7.6)%	103,223	(11.5)%
Facilities	3,986	3,402	(584)	(17.2)%	29,109	30,575	1,466	4.8%	28,648	(1.6)%
Depreciation and amortization	2,220	2,001	(219)	(10.9)%	29,819	27,712	(2,107)	(7.6)%	29,354	(1.6)%
General and administrative	14,904	2,566	(12,338)	(480.8)%	37,879	23,096	(14,783)	(64.0)%	20,754	(82.5)%
Total operating expense	**$ 148,772**	**$ 123,233**	**$ (25,539)**	**(20.7)%**	**$ 1,181,731**	**$ 1,090,205**	**$ (91,526)**	**(8.4)%**	**$ 1,077,011**	**(9.7)%**

March 2025 Financial Report
Expense Highlights excluding Labor (part 2)

- Facilities unfavorable from building/equipment repairs ($0.3M) and the IT Data Center lease reclass from Materials and Supplies ($0.3M). YTD, favorable due to timing of facility/equipment repairs ($1.5M), rental equipment ($0.3M) offset by IT Las Vegas Data Center ($0.3M). Utilities approximate budget for the month and YTD.
- Depreciation and amortization unfavorable from lease/software amortization ($0.2M). YTD, unfavorable from timing of lease/software amortization ($2.1M) and building/equipment depreciation at budget.
- General and administrative unfavorable from insurance ($0.1M) and contribution to St. Rose Hospital for IGT funding ($12.2M). YTD, unfavorable from settlements ($2.1M), insurance ($1.5M), St. Rose Hospital contribution ($12.2M) offset by lower legal fees ($0.4M) and dues/subscriptions ($0.2M) and remaining variance ($0.4M) is spread across many cost centers.

	March 2025				Year-To-Date				FY 2024	
	Actual	Budget	Variance	% Var	Actual	Budget	Variance	% Var	YTD	% Var
Labor costs	$ 102,271	$ 90,581	$ (11,690)	(12.9)%	$ 860,084	$ 796,747	$ (63,337)	(7.9)%	$ 780,693	(10.2)%
Physician contract services	3,711	3,358	(353)	(10.5)%	32,035	30,224	(1,811)	(6.0)%	35,938	10.9%
Purchased services	8,777	8,292	(485)	(5.8)%	77,720	74,849	(2,871)	(3.8)%	78,401	0.9%
Materials and supplies	12,903	13,033	130	1.0%	115,085	107,002	(8,083)	(7.6)%	103,223	(11.5)%
Facilities	3,986	3,402	(584)	(17.2)%	29,109	30,575	1,466	4.8%	28,648	(1.6)%
Depreciation and amortization	2,220	2,001	(219)	(10.9)%	29,819	27,712	(2,107)	(7.6)%	29,354	(1.6)%
General and administrative	14,904	2,566	(12,338)	(480.8)%	37,879	23,096	(14,783)	(64.0)%	20,754	(82.5)%
Total operating expense	**$ 148,772**	**$ 123,233**	**$ (25,539)**	**(20.7)%**	**$ 1,181,731**	**$ 1,090,205**	**$ (91,526)**	**(8.4)%**	**$ 1,077,011**	**(9.7)%**

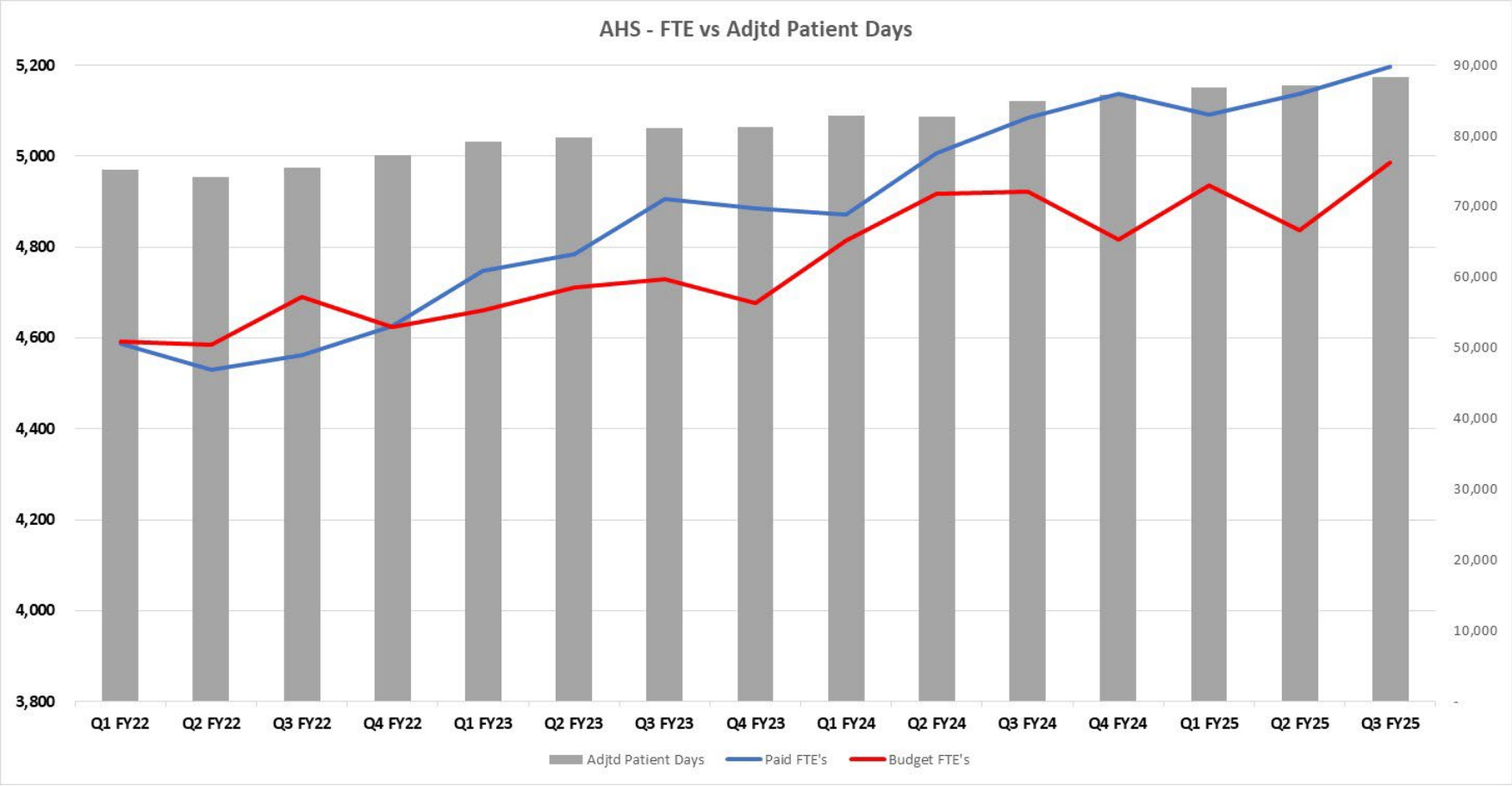
March 2025 Financial Report
Expense Highlights – Labor and Benefits

- Salary and registry costs were unfavorable to budget by $8.7Mand 12.9% driven by higher FTE volume (342 FTEs/$4.7M) and higher rates ($3.9M).
- YTD, salary and registry costs were unfavorable to budget by $47.0M and 7.8% driven by higher FTE volume (223 FTEs/$27.3M) and higher rates ($19.7M).
  - Budget was understated approximately $7.4M for the year due to higher than budget raises provided to staff and underestimating PTO and holiday pay.
  - YTD registry is 49 FTE over budget. Demand for registry continues; however, overall rates have decreased from pandemic levels.
  - YTD physician FTEs are unfavorable by 15 FTE as the result of recruiting. Paternity benefit under the SEIU MOU ($1.6M) was paid this month.
- Employee Benefits unfavorable from FICA ($0.8M/month, $5.2M YTD), self-funded health ($1.3M/month, $5.6M/YTD) offset by other benefit plans ($0.4M/month, $1.5M YTD).
- Retirement unfavorable from ACERA ($1.1M) and other AHS plans ($0.3M). YTD, ACERA ($4.0M), AHS plan ($2.5M) and AHMG ($0.5M) exceed budget.

	March 2025				Year-To-Date				FY 2024	
	Actual	Budget	Variance	% Var	Actual	Budget	Variance	% Var	YTD	% Var
Salaries and wages (staff)	$ 60,049	$ 53,963	$ (6,086)	(11.3)%	$ 516,046	$ 481,419	$ (34,627)	(7.2)%	$ 466,767	(10.6)%
Salaries and wages (physicians)	12,047	9,660	(2,387)	(24.7)%	94,152	84,759	(9,393)	(11.1)%	79,724	(18.1)%
Registry	4,193	3,978	(215)	(5.4)%	39,141	36,136	(3,005)	(8.3)%	48,501	19.3%
Employee benefits (taxes, insurance)	17,261	15,641	(1,620)	(10.4)%	139,889	130,576	(9,313)	(7.1)%	120,897	(15.7)%
Retirement	8,721	7,339	(1,382)	(18.8)%	70,856	63,857	(6,999)	(11.0)%	64,804	(9.3)%
Total labor costs	**$ 102,271**	**$ 90,581**	**$ (11,690)**	**(12.9)%**	**$ 860,084**	**$ 796,747**	**$ (63,337)**	**(7.9)%**	**$ 780,693**	**(10.2)%**
Compensation ratio	73.8%	72.9%	-0.9%		72.0%	72.7%	0.7%		73.3%	
Paid FTEs	5,215	4,873	(342)	(7.0)%	5,142	4,919	(223)	(4.5)%	4,993	(3.0)%

March 2025 Financial Report
Labor Expense – FTE Trending

- FTE trend includes Registry and compares staffing to adjusted patient days (Gross Patient Revenue divided by Inpatient Revenue equals Outpatient Factor, then multiplied by Total Patient Days).
  - Patient volume, measured by adjusted patient days, has returned and exceeding pre-pandemic level (84,000/FY19 average).
  - FTE growth has outpaced volumes. (FY19 FTE approximately 4,400)



March 2025 Financial Report
Physician Expenses Variance

Budget Variances by Physician Specialty
(in thousands)

	Current Month - Mar 2025			Year to Date		
Specialty	**Salaries**	**Contract**	**Total**	**Salaries**	**Contract**	**Total**
Radiology	(316)	5	(311)	(1,976)	(263)	(2,239)
Hospitalist	(303)	(19)	(322)	(1,018)	(409)	(1,427)
ED	(390)	0	(390)	(1,175)	(80)	(1,255)
Orthopedic	(183)	46	(137)	(1,023)	333	(689)
Cardiology	(138)	10	(127)	(746)	70	(676)
Rehab	(44)	(35)	(78)	(121)	(399)	(520)
General Surgery	0	(66)	(66)	0	(486)	(486)
Psychiatry	5	35	40	8	(490)	(482)
OB/GYN	(76)	31	(45)	(344)	(46)	(391)
Hospice	(94)	0	(94)	(369)	0	(369)
Wellness Centers	46	6	52	(240)	(128)	(368)
Pediatrics	(105)	(1)	(106)	(342)	(13)	(355)
Nephrology	(43)	11	(32)	(308)	(28)	(336)
Pulmonology	(113)	19	(95)	(431)	113	(318)
OMFS	208	(56)	152	189	(496)	(308)
Medical Oncology	0	0	0	0	(281)	(281)
Neurosurgery	0	(31)	(31)	0	(232)	(232)
General Dentistry	(217)	0	(217)	(231)	1	(230)
Podiatry	(22)	0	(22)	(166)	0	(166)
Pathology	(62)	0	(62)	(150)	0	(150)
Anesthesia	(99)	0	(99)	0	(119)	(119)
Ophthalmology	(68)	43	(26)	(192)	305	113
Gastroenterology	(50)	0	(50)	(115)	0	(115)
Other	(323)	(350)	(672)	(644)	839	194
	$ (2,387)	**$ (353)**	**$ (2,740)**	**$ (9,393)**	**$ (1,811)**	**$ (11,205)**

**Variances less than ($100k) in "Other"*

March 2025 Financial Report
Balance Sheet Key Metrics

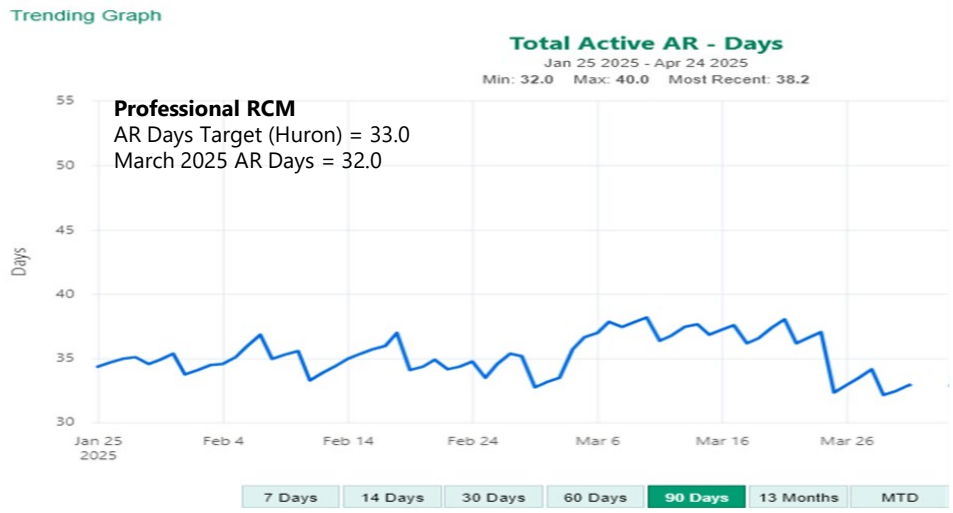
- Days in Cash are 2.6 and higher than year-end; typically, run below 5.0 days.
- Gross AR Days decreased 0.8 days and Net AR Days increased 0.3 days. See next slide for additional detail.
- Days in Accounts Payable decreased due to timing of check run. The target is 30 days. The % of AP over 60 days decreased 1.8% as the team works through the OnBase issues.
- Net Position is negative $66.0M and improved $14.6M from June 30, 2024 reflecting YTD Net Income.
- Net Negative Balance is a payable of $71.0M. NNB consists of the liquidity facility (loan) of $97.9M offset by the restricted cash of $26.9M; and is expected to be below the June 30, 2025 credit ceiling of $100.0M at the end of the fiscal year.

	Mar-25	Feb-25	FY 2024
Days in cash	2.6	3.0	1.3
Gross days in patient receivable	62.0	62.8	69.0
Net days in patient receivable	36.2	35.9	41.1
Due from/(to) third-party payors	$ 372,793	$ 218,146	$ 145,333
Due from/(to) County	$ (114,084)	$ 16,434	$ 24,800
Days in accounts payable	36.3	41.5	39.3
% of AP over 60 days	4.8%	6.6%	10.6%
Net position - fund balance/(deficit)	$ (65,962)	$ (55,288)	$ (80,622)
Net negative balance - receivable/(payable)	$ (71,042)	$ (30,849)	$ 21,227

March 2025 Financial Report
AR Trending

Hospital Revenue Cycle Key Indicators

- HB AR Days decreased by 1.0 days compared to prior month. February AR Days 66.9, March AR Days 65.9
- March collections were $62.9M. Higher than average of the prior twelve months at $60.4M.
- Candidate for Billing (CFB) was increased by 2.8 days. February CFB was 6.9 and March CFB ended at 9.7 days.



Professional Revenue Cycle Key Indicators

- PB AR Days decreased by 0.8 days compared to prior month. February AR Days 32.8 days, March AR Days 32.0 days.
- March collections were $12.6M. Higher than average of the prior twelve months at $10.8M.
- Enterprise CDI launched to address provider clinical documentation along with charge automation and usage of Epic tools. Pilot project in progress with Obstetrics & Gynecology and Neurology. Project completed in Orthopedics and Otolaryngologists (ENT).

March 2025 Financial Report
Patient Collections

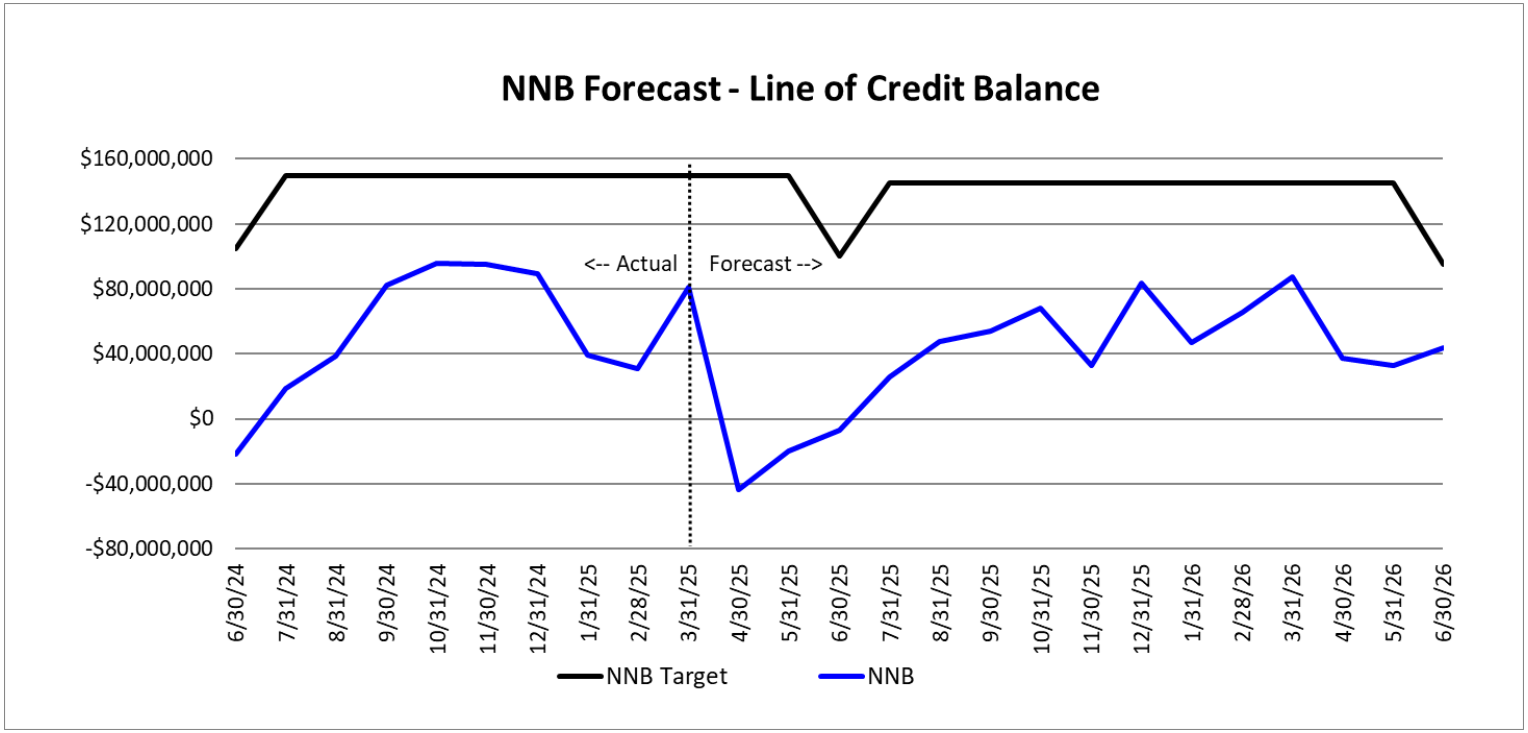
- FY25 Patient collections approximately 21.0% higher than the same period in FY24.
- JGP FY25 current contract with the County is $49.2M; payments through January is $34.8M. As a reminder, AHS is accruing revenue at $72.1M consistent with the FY23 contract. AHS is seeking an amendment to increase funding and avoid an audit adjustment.
- JGP FY24 amended agreement is $61.2M and has been paid in full. Working on 2nd amendment with County to submit remaining invoices for services.

PATIENT COLLECTIONS
(in thousands)

	Behavioral Health	Epic	Total FY 2025	FY 2024	FY 2023	FY 2022	FY 2021
Jul	4,941	67,753	72,694	79,592	74,260	59,732	41,373
Aug	4,628	75,140	79,768	69,313	58,590	57,374	53,893
Sep	2,493	67,248	69,741	63,322	76,063	61,968	64,484
Oct	-	76,783	76,783	63,122	59,796	49,923	51,514
Nov	5,073	73,674	78,747	57,781	56,939	52,057	49,499
Dec	12,050	82,581	94,631	63,867	67,018	68,121	53,274
Jan	9,227	79,787	89,014	68,757	71,452	62,292	34,443
Feb	5,194	63,317	68,511	75,852	57,886	52,269	49,157
Mar	16,378	75,473	91,851	54,720	65,320	62,888	58,922
Apr	-	-	-	61,895	55,307	56,235	55,646
May	-	-	-	102,015	63,795	69,591	44,005
Jun	-	-	-	71,208	70,027	53,187	43,889
Total	**59,984**	**661,756**	**721,740**	**831,444**	**776,453**	**705,637**	**600,099**
	% change between fiscal years		21.0%	7.1%	10.0%	17.6%	

March 2025 Financial Report
Line of Credit (NNB) Forecast through 6/30/25

- NNB (at 6/30/25) improved over prior month by $15.0M and the NNB is projected to end as a receivable of $6.8M this fiscal year.
  - Patient receipts higher than anticipated ($11.4M).
  - GME FY2024 Final Recon increased based on notification ($3.6M).
  - SRH $15.0M line of credit is forecasted to be exhausted in May 2025. Repayment of $12.0M is expected in June after IGT funding is received. Net impact on NNB is $3.0M.
- NNB (at 6/30/26) increased due to the elimination of AB85 Realignment funds ($50.0M).



March 2025 Financial Report
Material Items Impacting NNB Forecast

- EPP and QIP payment timing moved from May 2025 to April 2025.
- AB85 Realignment was eliminated for FY2026 as the result of additional funding disallowing the advancement of funds ($50.0M) in FY26 Q2.
- St. Rose Hospital LOC expended at $15M by May 31st; repayment of $12.0M expected in June 2025. As a reminder, AHS donated $12.2 in March to maximize SRH IGT funding.
- Prior year activity for the old Waiver, Medi-Cal FQHC and Physician SPA settlements are reflected in bottom table as the final settlement and timing are unknown. Amounts are excluded from the forecast.

Material Items Included in NNB Forecast
(in thousands)

	Apr-25	May-25	Jun-25	FY26 Q1	FY26 Q2	FY26 Q3	FY26 Q4
GPP (quarterly)	$ 55,866	$ -	$ -	$ 25,700	$ 25,700	$ 25,700	$ 25,700
EPP (semi-annual)	24,443	-	-	-	21,000	-	21,000
QIP	74,914	-	-	-	34,364	-	34,364
Medi-Cal Rate Range	-	-	-	-	-	42,700	-
BHCS (JGP/Alameda County) - fy25	4,100	4,100	4,100	21,200	-	-	-
BHCS (JGP/Alameda County) - fy26	-	-	-	6,084	18,251	18,251	18,251
HPAC	9,796	-	-	-	21,600	10,800	10,800
AB85 Realignment	-	-	10,125	-	(40,000)	-	-
SNF DP-NF	-	-	-	19,100	-	-	19,100
St. Rose Hospital LOC	-	(5,000)	12,000	-	-	-	-
	$ 169,119	$ (900)	$ 26,225	$ 72,084	$ 80,915	$ 97,451	$ 129,215

Prior Year Reimbursement Settlements

Waiver recoupment (fy11)	$ (4,796)	TBD
Medi-Cal FQHC recoupment (fy08 - fy13)	(40,000)	TBD
Physician SPA (fy08 - fy13)	(25,000)	TBD
	$ (69,796)	

Overall, we are exceeding our GRIT target by $18.6M, driven by the initiative #3 – Patient Status ($16.6M) and #2 – OP Non FQ Charge Capture ($6.9M) and offset by #8 - Decrease Acute Length of Stay by $4.5M

#	Project Name	FY2025 Budget YTD Q3	FY2025 Actual YTD Q3	Variance	Status
1	Recovery on Underpayment	$1,875	$1,020	($855)	
2	OP Non-FQ Charge Capture(Enterprise CDI)	$2,519	$9,460	$6,941	
3	Patient Status	$601	$17,239	$16,638	
4	Improve patient access and increase physician productivity (excluding ER and Hospitalists)	$1,056	$59	($997)	
5	Supplies Savings Initiative	$2,250	$5,482	$3,232	
6	Implement process for reimbursement on Implants	$1,125	$884	($241)	
7	Reduce Overtime %	$329	($1,251)	($1,580)	
8	Decrease Acute Length of Stay (LOS)	$1,838	($2,694)	($4,532)	
Grand Total		**$11,592**	**$30,198**	**$18,606**	

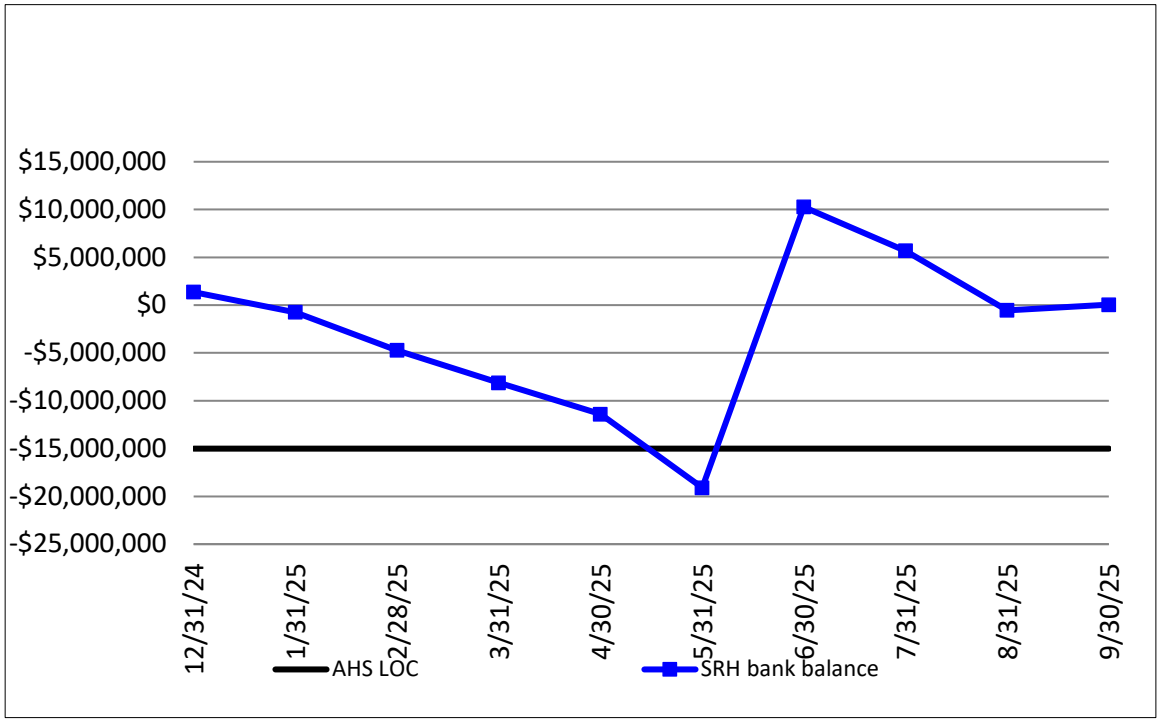
February 2025
Financial Summary & YTD Highlights

- SRH is struggling with lower volume and higher expenses
  - Discharges below PY, Maternity unit closed, progress licensing Sub-Acute Unit.
- MOB is exceeding budget:
  - Fewer repairs and maintenance cost
  - Higher AR related to two tenants delayed in rent submission by $54K ($37K was received in April)
- Foundation is exceeding budget driven by The Dee Jordan Trust ($0.3)

	February 28, 2025			Year-To-Date		
	Actual	Budget	Variance	Actual	Budget	Variance
Total Net Patient Service Revenue	**$7,497**	**$8,515**	**($1,018)**	**$41,753**	**$41,354**	**$400**
Total Other Revenue	$178	$935	($757)	$9,168	$11,635	($2,467)
TOTAL OPERATING REVENUE	**$7,675**	**$9,451**	**($1,776)**	**$50,921**	**$52,989**	**($2,068)**
Less: Operating Expenses	$10,767	$11,356	$589	$58,732	$58,481	($251)
EBITDA	**($3,092)**	**($1,906)**	**($1,187)**	**($7,810)**	**($5,492)**	**($2,319)**
Total Non-Operating Exp/(Income	$395	$394	$1	$2,249	$1,993	$256
Restr Donation - AA Geropscych)	$0	$292	($292)	$0	$1,458	($1,458)
NET INCOME/(LOSS)	**($3,487)**	**($2,008)**	**($1,479)**	**($10,059)**	**($6,027)**	**($4,033)**

February 2025
Cash Flow Projection

- SRH started drawing down from AHS LOC in January and has borrowed $10M through April 15, 2025. Interest is being accrued based on County's cost of fund rate.
- The weekly cash projection reflects cash shortfall starting May 9th until the IGT is received.
- SRF donated $1M on April 16
- AHS line of credit will be extinguished by May 23 and additional funding will be needed to cover cash flow deficit. The IGT of $30 million is expected by June 30th. Interim funding will be needed between mid-May and end of June; requiring AHS BOT's consideration and approval at the May 14th meeting.



ALAMEDA HEALTH SYSTEM

1411 East 31st Street
Oakland, CA 94602

MEMORANDUM

TO: AHS Finance Committee
FROM: Kim Miranda, CFO
DATE: May 2, 2025
SUBJECT: March 2025 Financial Report

Financial Summary

Net Income for the month was a loss of $10.7 million compared to a budget of $1.0 million, which was unfavorable to budget by $11.6 million and 1280.8%. Operating Revenue was $138.5 million and favorable to budget by $14.3 million and 11.5%. Operating Expense was $148.8 million and unfavorable to budget by $25.5 million and 20.7%. Earnings before interest, depreciation, and amortization (EBIDA) was a negative $8.2 million and the EBIDA Margin was a negative 5.9% compared to a budget EBIDA of $3.0 million and a budget EBIDA Margin of 2.4%. For the month, EBIDA was unfavorable to budget by $11.2 million.

	March 2025				Year-To-Date				FY 2024	
	Actual	Budget	Variance	% Var	Actual	Budget	Variance	% Var	YTD	% Var
Operating revenue	$ 138,548	$ 124,234	$ 14,314	11.5%	$ 1,199,858	$ 1,095,672	$ 104,186	9.5%	$ 1,065,697	12.6%
Operating expense	148,772	123,233	(25,539)	(20.7)%	1,181,731	1,090,205	(91,526)	(8.4)%	1,077,011	(9.7)%
Operating income (loss)	**(10,224)**	**1,001**	**(11,225)**	**(1121.4)%**	**18,127**	**5,467**	**12,660**	**231.6%**	**(11,314)**	**260.2%**
Other non-operating activity	(450)	(97)	(353)	(363.9)%	(3,468)	(645)	(2,823)	(437.7)%	(964)	(259.6)%
Net Income (loss)	**$ (10,674)**	**$ 904**	**$ (11,578)**	**(1280.8)%**	**$ 14,659**	**$ 4,822**	**$ 9,837**	**204.0%**	**$ (12,278)**	**219.4%**
EBIDA adjustments	2,514	2,111	403		33,003	28,472	4,531		30,434	
EBIDA	**$ (8,160)**	**$ 3,015**	**$ (11,175)**		**$ 47,662**	**$ 33,294**	**$ 14,368**		**$ 18,156**	
Operating Margin	(7.4)%	0.8%	(8.2)%		1.5%	0.5%	1.0%		(1.1)%	
EBIDA Margin	(5.9)%	2.4%	(8.3)%		4.0%	3.0%	1.0%		1.7%	

Net Income year-to-date (YTD) was $14.7 million compared to a budget of $4.8 million, which was favorable to budget by $9.8 million and 204.0%. Operating Revenue was $1.2 billion and favorable to budget by $104.2 million and 9.5%. Operating Expense was $1.2 billion and unfavorable to budget by $91.5 million and 8.4%. YTD, EBIDA was $47.7 million and the EBIDA Margin was 4.0% compared to budget EBIDA of $33.3 million and a budget EBIDA Margin of 3.0%. For the year, EBIDA is favorable to budget by $14.4 million.

Operating Revenue

Gross Patient Service Revenue (patient charges) was $410.1 million for the month and favorable to budget by $18.4 million and 4.7%. Inpatient, Outpatient and Professional Fee charges were above budget by 0.8%, 11.5% and 3.8%, respectively. For the year, Gross Patient Service Revenue was $3.6 billion and favorable $193.5 million and 5.7%. Inpatient charges fell below budget by 2.6%; and Outpatient and Professional Fee charges were above budget by 16.2% and 20.9%, respectively. In March, summary statistics for hospital services were split into three categories – general acute, psych, and rehab to better compare statistics with industry standards. Inpatient charges were favorable in the month driven by higher patient days. General acute patient days were above budget by 2.7% for the month and below budget by 4.9% for the year. Length of Stay (LOS) is 5.5 which exceeded budget for the month, YTD and prior year driven by lower discharges for all time periods. The case mix index (CMI) was below budget for the month and above YTD, although slightly higher than the prior year. CMI is an indicator of the overall complexity of inpatient illness and services being provided. Trauma cases were above budget for the month and YTD by 3.8% and 4.6%, respectively. Inpatient surgeries were below budget for the month and YTD by 25.0% and 24.3%, respectively. The favorable outpatient charge variance was driven by observation charges at Highland Hospital and San Leandro Hospital and emergency visits, which continue to exceed budget and prior year. Outpatient surgeries were below budget for the month and YTD by 18.1% and 1.2%, respectively. Pain procedures were moved from the OR and are no longer included in the case count. Clinic visits were below budget for the month by 4.0% and above YTD by 5.3%. Physician wRVU are above budget driven by ED and patient days. Overall, on an adjusted day basis, volumes were above budget from the month and YTD driven by the increase in Outpatient charges. Adjusted discharges are behind budget due to higher LOS and fewer discharges.

	March 2025				Year-To-Date				FY 2024	
	Actual	Budget	Variance	% Var	Actual	Budget	Variance	% Var	YTD	% Var
Inpatient service revenue	$ 221,780	$ 220,095	$ 1,685	0.8%	$ 1,927,199	$ 1,979,363	$ (52,164)	(2.6)%	$ 1,880,931	2.5%
Outpatient service revenue	146,518	131,361	15,157	11.5%	1,284,162	1,105,314	178,848	16.2%	1,072,353	19.8%
Professional service revenue	41,791	40,251	1,540	3.8%	386,056	319,232	66,824	20.9%	313,822	23.0%
Gross patient service revenue	410,088	391,707	18,381	4.7%	3,597,417	3,403,909	193,508	5.7%	3,267,106	10.1%
Deductions from revenue	(330,530)	(316,189)	(14,341)	(4.5)%	(2,896,905)	(2,746,682)	(150,222)	(5.5)%	(2,644,320)	9.6%
Net patient service revenue	**79,559**	**75,518**	**4,041**	**5.4%**	**700,512**	**657,226**	**43,286**	**6.6%**	**622,786**	**(12.5)%**
Collection % - NPSR	19.4%	19.3%	0.1%		19.5%	19.3%	0.2%		19.1%	
Capitation and HPAC	4,629	4,136	492	11.9%	41,537	37,227	4,310	11.6%	37,028	12.2%
Other government programs	48,083	40,060	8,023	20.0%	411,459	360,540	50,919	14.1%	363,390	13.2%
Other operating revenue	6,277	4,520	1,757	38.9%	46,349	40,678	5,671	13.9%	42,493	9.1%
Total operating revenue	**$ 138,547**	**$ 124,234**	**$ 14,313**	**11.5%**	**$ 1,199,857**	**$ 1,095,671**	**$ 104,185**	**9.5%**	**$ 1,065,697**	**12.6%**

Net Patient Revenue

Net Patient Service Revenue (NPSR) was $79.6 million for the month and favorable to budget by $4.0 million and 5.4% driven by higher volume and collection expectation. The current month collection ratio is favorable driven by improved revenue cycle performance measured based on payments on zero balance or paid accounts. Collections on fully reserve accounts (over 270 days) was consistent with the trend in March. For the year, NPSR was $700.5 million and favorable to budget by $43.3 million and 6.6%. YTD, the collection ratio was 19.5% also higher than plan. The impact on higher than trend collections on fully reserve accounts was $8.2 million and 0.3% which include Sac Law settlements which are part of the GRIT.

Other Government Program Revenue

Other Government Program Revenue for the month was $48.1 million and favorable to budget by $8.0 million and 20.0% based on the transactions below.

- EPP CY2025 funding increased from DHCS notification by $2.3 million.
- QIP CY2025 funding increased from DHCS notification by $5.8 million.
- Remaining variance, netting to a negative $0.1 million, is spread across many programs.

For the year, Other Government Program Revenue is $411.5 million and favorable to budget by $50.9 million and 14.1% based on the transactions below.

- Measure A FY2025 Q1-Q2 below budget based on receipts by $1.3 million.
- Parcel Tax revenue, from City of Alameda Health Care District, increased based on receipts by $1.5 million.
- GPP CY2023 increased from filing final report by $1.1 million.
- CalAIM Enhanced Care Management increased from higher receipts of $0.3 million.
- EPP CY2023 revenue increased from final reconciliation by $2.9 million.
- EPP CY2025 revenue increased from CMS pre-print notification by $6.9 million.
- QIP CY2023 revenue increased from final reconciliation by $1.5 million.
- QIP CY2025 revenue increased from CMS pre-print notification by $17.4 million.
- DP-NF CY2023 recognized revenue of $19.1 million.
- Rate Range CY2023 revenue decreased from final filing by $0.6 million.
- SNF Supplemental FY2020 recoupment for AHS and Alameda Hospital of $1.3 million.
- Prop 56 recoupment for January 1, 2022 through October 14, 2024 of $1.9 million.
- FEMA revenue received in FY2025 for successful filing of Covid-related expenditures is $5.8 million. Total FEMA receipts, received starting in FY2024, is $6.9 million.
- Remaining variance, netting to a negative $0.5 million, is spread across many programs.

Other Operating Revenue

Other Operating Revenue for the month was $6.3 million and favorable $1.8 million and 38.9%. Grant revenue is favorable from FY24 MAA invoicing ($1.0 million) and grant timing differences ($0.4 million). Other Operating revenue ($0.4 million) is favorable driven from by higher retail pharmacy ($0.8 million) offset by timing of payor settlements ($0.2 million), and other revenue ($0.2 million). YTD, Other Operating Revenue was $46.3 million and favorable $5.7 million and 13.9%. Higher retail pharmacy receipts ($5.3 million), grant receipts ($3.5 million) were offset by timing differences between actual and budget for payor settlements ($1.9 million) which were posted to NPSR, cafeteria sales ($0.7 million), and IT fee revenue ($0.5 million). Payer settlements included in NPSR are part of the GRIT initiative.

Operating Expense

Operating Expense was $148.8 million for the month and unfavorable to budget by $25.5 million and 20.7%. Labor costs are discussed in a subsequent section. Non-labor expense variances net to an unfavorable variance of $13.8 million as follows.

- Physician contract services were unfavorable to budget by $0.4 million and 10.5%. The largest negative variances in General Surgery and OMFS but all variances were under $0.1 million.
- Purchased services were unfavorable to budget by $0.5 million and 5.8% driven by interpretive services ($0.2 million), software licenses ($0.1 million), and remaining variance ($0.2 million) is spread across many cost centers.

	March 2025				Year-To-Date				FY 2024	
	Actual	Budget	Variance	% Var	Actual	Budget	Variance	% Var	YTD	% Var
Labor costs	$ 102,271	$ 90,581	$ (11,690)	(12.9)%	$ 860,084	$ 796,747	$ (63,337)	(7.9)%	$ 780,693	(10.2)%
Physician contract services	3,711	3,358	(353)	(10.5)%	32,035	30,224	(1,811)	(6.0)%	35,938	10.9%
Purchased services	8,777	8,292	(485)	(5.8)%	77,720	74,849	(2,871)	(3.8)%	78,401	0.9%
Materials and supplies	12,903	13,033	130	1.0%	115,085	107,002	(8,083)	(7.6)%	103,223	(11.5)%
Facilities	3,986	3,402	(584)	(17.2)%	29,109	30,575	1,466	4.8%	28,648	(1.6)%
Depreciation and amortization	2,220	2,001	(219)	(10.9)%	29,819	27,712	(2,107)	(7.6)%	29,354	(1.6)%
General and administrative	14,904	2,566	(12,338)	(480.8)%	37,879	23,096	(14,783)	(64.0)%	20,754	(82.5)%
Total operating expense	**$ 148,772**	**$ 123,233**	**$ (25,539)**	**(20.7)%**	**$ 1,181,731**	**$ 1,090,205**	**$ (91,526)**	**(8.4)%**	**$ 1,077,011**	**(9.7)%**

- Materials and supplies were favorable to budget by $0.1 million and 1.0% driven by favorable variances in non-medical supplies ($0.7 million) offset by medical supplies ($0.6 million). The non-medical supplies variance includes an invoice ($0.3 million) for the Las Vegas Data Center which was reclassed to facilities. Pharmaceuticals approximated budget for the month.
- Facilities were unfavorable to budget by $0.6 million and 17.2% driven by timing of building/equipment repairs ($0.3 million) and lease expense for Las Vegas Data Center reclassed from Materials and Supplies ($0.3 million).
- Depreciation and amortization were unfavorable to budget by $0.2 million and 10.9% driven by lease/software amortization ($0.2 million). Building and equipment depreciation approximates budget.
- General and administrative costs were unfavorable to budget by $12.3 million and 480.8% driven by insurance ($0.1 million) and a contribution to St. Rose Hospital for IGT funding ($12.2 million).

For the year, Operating Expense was $1.2 billion and unfavorable to budget by $91.5 million and 8.4%. Labor costs are discussed in a subsequent section. Non-labor expense variances net to an unfavorable variance of $28.2 million as follows.

- Physician contract services were unfavorable to budget by $1.8 million and 6.0% with the largest unfavorable variances driven by Psychiatry ($0.5 million), OMFS ($0.5 million), General Surgery ($0.5 million), Rehab ($0.4 million), Hospitalist ($0.4 million) and offset by positive variance for Ophthalmology ($0.3 million) and Orthopedic ($0.3 million).
- Purchased services were unfavorable to budget by $2.9 million and 3.8% driven by unfavorable variances in emergency food/services ($1.0 million), software licenses ($0.9 million), security ($0.9 million), clinical services ($0.6 million), laundry ($0.4 million), refuge services ($0.4 million), interpretive services ($0.3 million) offset by favorable variances in management services/consultants ($0.6 million), billing/collection fees ($0.5 million), and outside medical services ($0.5 million).
- Materials and supplies were unfavorable to budget by $8.1 million and 7.6% driven by unfavorable variances in retail pharmaceuticals ($2.6 million), pharmaceuticals ($3.2 million), medical supplies ($1.3 million), non-medical supplies ($0.6 million), and surgery supplies ($0.4 million). Retail pharmacy continues to a favorable profit margin as discussed as part of Other Operating Revenue.
- Facilities were favorable to budget by $1.5 million and 4.8% driven by positive variances for facility repairs ($1.2 million), equipment repairs ($0.3 million), equipment rentals ($0.3 million) offset by IT Las Vegas Data Cener lease reclass ($0.3 million). The favorable variance for facility repairs was in Fairmont ($0.4 million), San Leandro ($0.3 million), Alameda Hospital ($0.2 million), Highland ($0.2 million), and Eastmont ($0.1 million).

- Depreciation and amortization were unfavorable to budget by $2.1 million and 7.6%. Amortization of leases and software agreements is unfavorable ($2.1 million), which is expected to continue for the remainder of the fiscal year. Building and equipment depreciation approximates budget.
- General and administrative costs were unfavorable to budget by $14.8 million and 64.0% driven by prior period Medicare settlements ($2.1 million), higher insurance ($1.5 million), St. Rose Hospital contribution ($12.2 million) offset by lower legal fees ($0.4 million), dues/subscriptions ($0.2 million), and remaining variance ($0.4 million) is spread across many cost centers.

Labor Costs

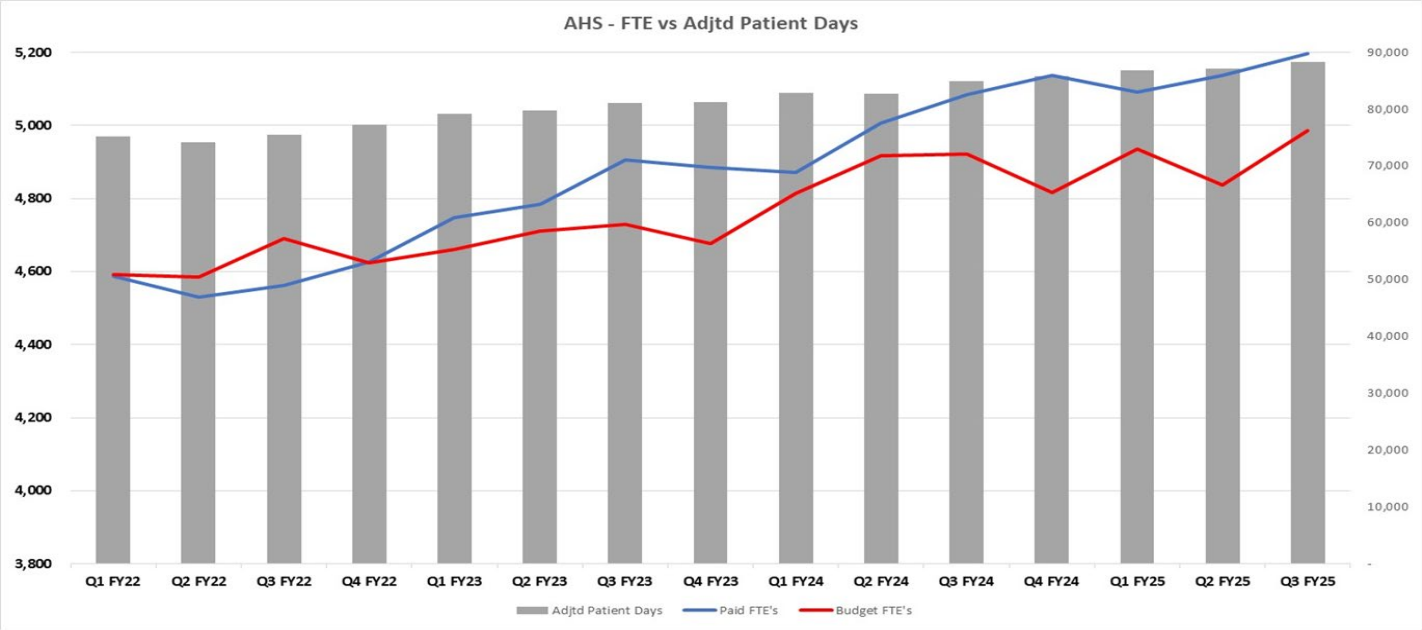
	March 2025				Year-To-Date				FY 2024	
	Actual	Budget	Variance	% Var	Actual	Budget	Variance	% Var	YTD	% Var
Salaries and wages (staff)	$ 60,049	$ 53,963	$ (6,086)	(11.3)%	$ 516,046	$ 481,419	$ (34,627)	(7.2)%	$ 466,767	(10.6)%
Salaries and wages (physicians)	12,047	9,660	(2,387)	(24.7)%	94,152	84,759	(9,393)	(11.1)%	79,724	(18.1)%
Registry	4,193	3,978	(215)	(5.4)%	39,141	36,136	(3,005)	(8.3)%	48,501	19.3%
Employee benefits (taxes, insurance)	17,261	15,641	(1,620)	(10.4)%	139,889	130,576	(9,313)	(7.1)%	120,897	(15.7)%
Retirement	8,721	7,339	(1,382)	(18.8)%	70,856	63,857	(6,999)	(11.0)%	64,804	(9.3)%
Total labor costs	**$ 102,271**	**$ 90,581**	**$ (11,690)**	**(12.9)%**	**$ 860,084**	**$ 796,747**	**$ (63,337)**	**(7.9)%**	**$ 780,693**	**(10.2)%**
Compensation ratio	73.8%	72.9%	-0.9%		72.0%	72.7%	0.7%		73.3%	
Paid FTEs	5,215	4,873	(342)	(7.0)%	5,142	4,919	(223)	(4.5)%	4,993	(3.0)%

Labor cost for the month was $102.3 million and unfavorable to budget by $11.7 million and 12.9%. YTD, labor cost was $860.1 million and unfavorable to budget by $63.3 million and 7.9%. For the month, salary and registry costs were unfavorable to budget by $8.7 million and 12.9% driven by higher FTE volume (342 FTEs/$4.7 million) and higher rates ($3.9 million). YTD, salary and registry costs were unfavorable to budget by $47.0 million and 7.8% driven by higher FTE volume (223 FTEs/$27.3 million) and higher rates ($19.7 million). The salary budget was understated approximately $7.4 million for the year due to higher than budget raises provided to staff and underestimating PTO and holiday pay. YTD registry is 49 FTE over budget. Demand for registry continues; however, overall rates have decreased from pandemic levels. YTD physician FTEs are unfavorable by 15 FTE as the result of recruiting. Physician salaries included the payout of the paternity benefit under the SEIU MOU of $1.6 million this month.

Employee benefits were unfavorable $1.6 million and 10.4% driven by self-funded health insurance ($1.3 million), FICA ($0.8 million) offset by positive variance driven by Kaiser insurance plan ($0.4 million). YTD, employee benefits were unfavorable $9.3 million and 7.1% driven by FICA ($5.2 million), self-funded health ($5.6 million) offset by positive variances for Kaiser insurance plan ($0.9 million), workers compensation ($0.2 million), and other benefits ($0.4 million).

Retirement was unfavorable $1.4 million and 18.8% from ACERA ($1.1 million) and other AHS plans ($0.3 million). YTD, retirement was unfavorable $7.0 million and 11.0% from ACERA ($4.0 million), other AHS plans ($2.5 million), and AHMG plan ($0.5 million).

FTE Trending



For the month, Paid FTE was 5,215 compared to a budget of 4,873 which was unfavorable to budget by 342 and 7.0%. YTD, Paid FTE was 5,142 compared to a budget of 4,919 which was unfavorable to budget by 223 and 4.5%. The FTE trend graph reflects paid FTE and adjusted patient days (Total Gross Revenues / Inpatient Revenues = Outpatient Factor x Patient Days) by quarter beginning in FY2022.

Overall, adjusted patient days (gray bars) have recovered to pre-COVID19 levels and exceeded budget for the month; however, growth of FTEs is outpacing the growth in adjustment patient days. As a reminder, pre-COVID19 adjusted patient days for FY2018 Q4 approximated 83,000 and AHS reported FTE of 4,400.

Balance Sheet and Financial Condition
The Balance Sheet key financial metrics are reflected in the table below.

	Mar-25	Feb-25	FY 2024
Days in cash	2.6	3.0	1.3
Gross days in patient receivable	62.0	62.8	69.0
Net days in patient receivable	36.2	35.9	41.1
Due from/(to) third-party payors	$ 372,793	$ 218,146	$ 145,333
Due from/(to) County	$ (114,084)	$ 16,434	$ 24,800
Days in accounts payable	36.3	41.5	39.3
% of AP over 60 days	4.8%	6.6%	10.6%
Net position - fund balance/(deficit)	$ (65,962)	$ (55,288)	$ (80,622)
Net negative balance - receivable/(payable)	$ (71,042)	$ (30,849)	$ 21,227

Days in Cash

Days in Cash is low as all AHS cash receipts are swept to the County Treasury. The Days in Cash can fluctuate based on timing of cash draws from the County treasury and timing of vendor payments and payroll.

Accounts Receivable (AR)

The Gross Days in AR were 62.0 days and 0.8 days lower than last month due to higher collections. Net Days in AR were 36.3 and 0.3 days higher than the previous month due to revenue per day improvement. The calculation reflects 90 days versus actual days for the quarter to standardize the calculation. Utilizing a 90-day period does lead to more fluctuations. Key update on work in progress within the Revenue Cycle are noted below:

- Settlements through arbitration using Sac Law continue to support GRIT.
- Implementation for Experian Clearinghouse was started mid-October and went live in March 2025.
- Enterprise CDI team addressing clinical documentation and EPIC tool improvement. Pilot project in progress with Obstetrics & Gynecology (GYN) and Neurology. Orthopedics and Otolaryngologists (ENT) projects were completed.

Patient collections are reflected in the table below. Behavioral Health represents the County receipts under contract for JGP services which total $60.0 million. The final payment of $11.7 million was received in March 2025 for FY2024 contract maximum of $61.2 million. AHS is working with County on an amendment to capture the remaining unpaid invoices. Payments under the FY2025 contract for July 2024 through January 2025 total $34.8 million on a maximum contract of $49.2 million. As a reminder the FY2023 contract was $72.1 million, and AHS continues to accrue at this higher level of reimbursement assuming resolution this year.

PATIENT COLLECTIONS
(in thousands)

	Behavioral Health	Epic	Total FY 2025	FY 2024	FY 2023	FY 2022	FY 2021
Jul	4,941	67,753	72,694	79,592	74,260	59,732	41,373
Aug	4,628	75,140	79,768	69,313	58,590	57,374	53,893
Sep	2,493	67,248	69,741	63,322	76,063	61,968	64,484
Oct	-	76,783	76,783	63,122	59,796	49,923	51,514
Nov	5,073	73,674	78,747	57,781	56,939	52,057	49,499
Dec	12,050	82,581	94,631	63,867	67,018	68,121	53,274
Jan	9,227	79,787	89,014	68,757	71,452	62,292	34,443
Feb	5,194	63,317	68,511	75,852	57,886	52,269	49,157
Mar	16,378	75,473	91,851	54,720	65,320	62,888	58,922
Apr	-	-	-	61,895	55,307	56,235	55,646
May	-	-	-	102,015	63,795	69,591	44,005
Jun	-	-	-	71,208	70,027	53,187	43,889
Total	**59,984**	**661,756**	**721,740**	**831,444**	**776,453**	**705,637**	**600,099**
	% change between fiscal years		21.0%	7.1%	10.0%	17.6%	

Accounts Payable

Days in Accounts Payable is 36.3 at the end of the month and decreased 5.2 days over the prior month from timing of recurring check runs versus the last day of the calendar month and resolution of ongoing implementation issues with OnBase. The Percent over 60 Days is 4.8% and is below the 5% target for the first time this fiscal year. Purchasing and Accounts Payable teams are making positive progress resolving older invoices held in work queues.

Supplemental Program Revenue Receivable/Payable

Net Reimbursement Supplemental Programs as of 3/31/2025					
Programs	**FY97-20**	**FY21-24**	**FY25**	**Net Balance**	**Comments**
Medicare Cost Report	(1,657)	(2,865)	(932)	(5,454)	Older years pending disputed SSI ratio and outlier holds for both OPPS / IPPS services from CMS.
Medi-Cal P14 Waiver	6,323	9,424	(7,150)	8,598	P14 audits are in various stages of completion. Currently DHCS has finalized up to FY18.
Current Waiver (GPP & CalAIM)	-	32,930	99,764	132,694	Global Payment Program (GPP) subsidizing remaining uninsured. GPP extended to 2026 as CalAIM.
AB85 Realignment	0	(40,822)	(34,200)	(75,022)	Realignment reserves for HPAC amendment passing through the County for physical health for Medi-Cal and Indigent populations.
Physician SPA	(6,000)	1,201	3,337	(1,461)	Reconciliation based on P14 utilization file with the State. FY14-FY16 Finalized. Catch-up ACA interim payments began during FY22.
FQHC	(7,922)	(6,768)	(3,750)	(18,441)	Negotiating settlement for a new FQ rate. The difference between the new FQ rate and FFS rate will determine the settlement for the impacted years. AHS started billing as a FQ in March 2022.
Medi-Cal Managed Care EPP	0	88,176	45,240	133,416	EPP (Enhanced Payment Program). New supplemental program for services provided to Medi-Cal Managed Care.
Medi-Cal Managed Care QIP	0	138,239	63,860	202,098	QIP (Quality Incentive Program). New supplemental program for services provided to Medi-Cal Managed Care.
Medi-Cal Managed Care Rate Range	(0)	24,213	35,125	59,337	Subsidize rates for Medi-Cal Managed Care members in Alameda County.
Medi-Cal Managed Care GME	0	3,987	1,891	5,878	CMS approved in March 2020. GME is paying concurrently with fiscal year.
Medi-Cal Managed Care DP-NF Pass-Through	-	-	-	-	New payment program assisting AHS with LTC carve-in from FFS to managed care, time-limited CY2023 through CY2025. First year disclosed and received Jan 2025, further years TBA
Medi-Cal SNF Cost Settlement	0	(679)	1,053	374	The State began their reconciliation.
AB915	(17,000)	4,888	9,040	(3,072)	AB915/Medi-Cal Hospital OP cost settlement. DHCS began reconciling older years during FY23.
All Other Supplemental Programs	0	911	2,733	3,644	Hospital Fee, NDPH & P4P programs
Subtotal	**$ (26,256)**	**$ 252,834**	**$ 216,012**	**$ 442,590**	
Old Waiver (FY11, DSH/SNCP)	(4,796)	0	0	(4,796)	FY11 DY5 & DY6 is pending reconciliation. All other years have been finalized.
Physician SPA (FY08-12)	(25,000)	0	0	(25,000)	FY13 final settled.
FQHC (FY12-18)	(40,000)	0	0	(40,000)	Negotiating settlement for Highland FQ clinics is pending for HGH K-6 clinic.
Subtotal	**$ (69,797)**	**$ -**	**$ -**	**$ (69,797)**	
Grand Total	**$ (96,053)**	**$ 252,834**	**$ 216,012**	**$ 372,793**	

The information presented in the table provides subsidiary information for Supplemental Program receivables and payables on the Balance Sheet. The net receivable balance for Supplemental Programs is $372.8 million, which was an increase of $154.7 million over last month. Key items are noted below.

- Payment received for GME FY2025 Q3 ($5.4 million).
- Payment received for Hospital Fee CY2024 Q3 ($1.8 million).
- Payment received for Medicare Cost Reports for prior years ($1.3 million).
- Payment made for Medi-Cal P14 FY2018 Final Settlement ($2.6 million).
- IGT funded for GPP CY2024 Q4 ($41.9 million).
- IGT funded for GPP CY2025 Q1 ($39.0 million).
- IGT funded for QIP CY2023 ($32.9 million).
- IGT funded for EPP CY2023 Phase 1 ($17.9 million).
- Minor cost report adjustments and monthly accruals ($28.9 million).

Estimates are necessary to record supplemental income because the ultimate amount that may be collected under the program is uncertain, and dependent on costs for services that were ultimately provided, quality metrics achieved, Medi-Cal enrollment, and our ability to identify and claim related costs. The timing of receipts and payments is critical because these cashflows affect the NNB under our Line of Credit with the County. Nearly half of AHS annual revenue comes from supplemental funding. AHS has liability under the old Medi-Cal Waiver, Physician SPA and Highland FQHC. The total estimated amount due is $69.8 million which is consistent with the prior month.

Net County Receivable and Payable

Due To/From County of Alameda

	Mar-25	Feb-25	FY 2024
Due from County of Alameda	$ 28,256	$ 29,250	$ 32,869
Capital designation receivable	-	-	7,000
Due from County of Alameda	**28,256**	**29,250**	**39,869**
Due to County of Alameda	(4,537)	(3,838)	(1,446)
County IGT funding	(131,683)	(2,858)	-
Capital cost payable	(6,120)	(6,120)	(13,623)
Due to County of Alameda	**(142,340)**	**(12,816)**	**(15,069)**
Net due from/(to) County	**$ (114,084)**	**$ 16,434**	**$ 24,800**

The net County receivable and payable due under arrangements with the County are reflected as part of the Due to and Due From accounts reported on the Balance Sheet as follows:

- The County receivable includes the HPAC contract, John George Pavilion (JGP) services agreement and grants.
- The Capital Designation receivable reflects reimbursement expected from the County ($7 million per year) to help fund the Sapphire project. An annual invoice is sent to the County after AHS transfers the

funds and contractual requirements are met at the end of the fiscal year. The FY2024 payment was received in December 2024.

- Inter-government transfers (IGT) are ongoing to draw down federal supplemental funding and then paid back to the County.
- The Capital Cost Transfer reflects a payable based on the balance remaining on open cost report settlements associated with County owned buildings ($6.1 million). AHS transfers cost reimbursement estimates to the County each year and AHS has the contractual ability to benefit from these funds to help maintain and invest in County owned facilities. In May 2024, the County accessed $1.2 million to pay for an emergency transformer on the Fairmont campus.

Net Position

The Net Position or Fund Balance of AHS as of March 31, 2024, is negative $66.0 million, which deteriorated $10.7 million over last month reflecting the net loss for the month.

Net Negative Balance

The Net Negative Balance (NNB) or Line of Credit with the County is $71.0 million on March 31, 2025 and remains compliant with the terms of the Permanent Agreement. The Working Capital Loan is reported on the Balance Sheet as a long-term liability labeled "Liquidity Facility – County of Alameda." To calculate the NNB, the Liquidity Facility ($97.9 million payable) is offset by the County Restricted Cash Fund ($26.9 million) which is included in Cash.

Contingencies

John George Pavilion (JGP)

Like FY2024, AHS is accruing revenue for FY2025 assuming payment of $72.1 million under the County contract consistent with the FY23 contract maximum based on our understanding that the change from Short Doyle cost reimbursement to fee for service payments under Cal Aim was not going to reduce funding for behavioral health services. The FY2025 interim contract maximum is only $49.2 million, which remains low. The FY24 contract amendment with the County signed on October 19, 2024 provided maximum funding for FY2024 for $61.2 million which resulted in a FY2024 audit adjustment reducing revenue $10.9 million. AHS is at risk of another audit adjustment if reimbursement from the County remains at current levels.

AHS and the County are working together to work through issues surrounding the transition to Cal Aim. The published FY2024 Alameda County inpatient rates under Cal Aim developed by the State were low because they were developed using older cost data and did not reflect current reality. Alameda County was not the only County negatively impacted by the published CalAIM rates either due to inflation or other issues. Alameda County and other Counties worked with the State and submitted a State Plan Amendment (SPA) giving the State more flexibility to calculate rates using the best available information. This SPA, number 23-0045, was approved by CMS in May 2024, with an effective date of December 12, 2023. The new rates resulting from this approved SPA were eventually posted, with FY 2024 rates increased to $4,716/day and FY 2025 rates to $4,866/day, both significantly higher versus the previous $2,642. Unfortunately, because the rates only apply for inpatient days starting December 12, 2023, that leaves about 5.5 months of days still to be reimbursed at the low rate. The County paid AHS based on the interim contracted rate of $3,092.10, which covered a portion of the shortfall starting July 1, 2023.

Also complicating matters, the County implemented new billing software, SmartCare, which has delayed billing. JGP technical services have been input into SmartCare to be billed and paid for by the State although AHS has not received any information from the County on denials or payments they have received. AHS and

the County partnered to determine appropriate billing of professional fees, which under this new system are payable separate from technical services for the first time. There is a twelve-month timely filing requirement which began impacting claims after July 1, 2024. The County has indicated it will ensure claims are paid even if the timely filing deadline means they cannot be federally matched. AHS has submitted professional claims to the County; however, no information has been provided to us on the status of these claims.

Highland Federally Qualified Healthcare Center (FQHC) Settlement
The State reached out to AHS inquiring about a new application that AHS submitted to establish the dental clinic located at Highland as a new FQHC. The State wanted to understand the new application request which started a conversation that ultimately resulted in the State allowing AHS to resume billing previous service locations on the Highland campus as FQHC. AHS began billing as an FQHC for these service locations on March 1, 2022. AHS and the State started negotiations on a retroactive settlement going back to the FY2012 filing made by AHS to establish an FQHC rate. Once the negotiations progress to a point where a new estimate can be determined, AHS will adjust the current liability on the balance sheet. AHS currently has a pending recoupment of $40.0 million. AHS is being paid at the historical Highland FQ rate for the additional service locations until the new rate is finalized.

Line of Credit (Net Negative Balance) Forecast
The Line of Credit Balance or the Net Negative Balance (NNB) held with the County is forecasted in the line graph below through June 30, 2026 for planning purposes. AHS is currently forecasting that the NNB will be compliant with the terms of the agreement with the County which limit the NNB to $100.0 million on June 30, 2025 and $95.0 million on June 30,2026. The forecast updates as actual activity is reflected in the cashflow model and assumes that additional debt will not be needed to fund AHS operations in FY2026. The projection will be updated once the Budget for FY26 is approved.

The forecasted NNB on June 30, 2025 improved $15.0 million this month from:

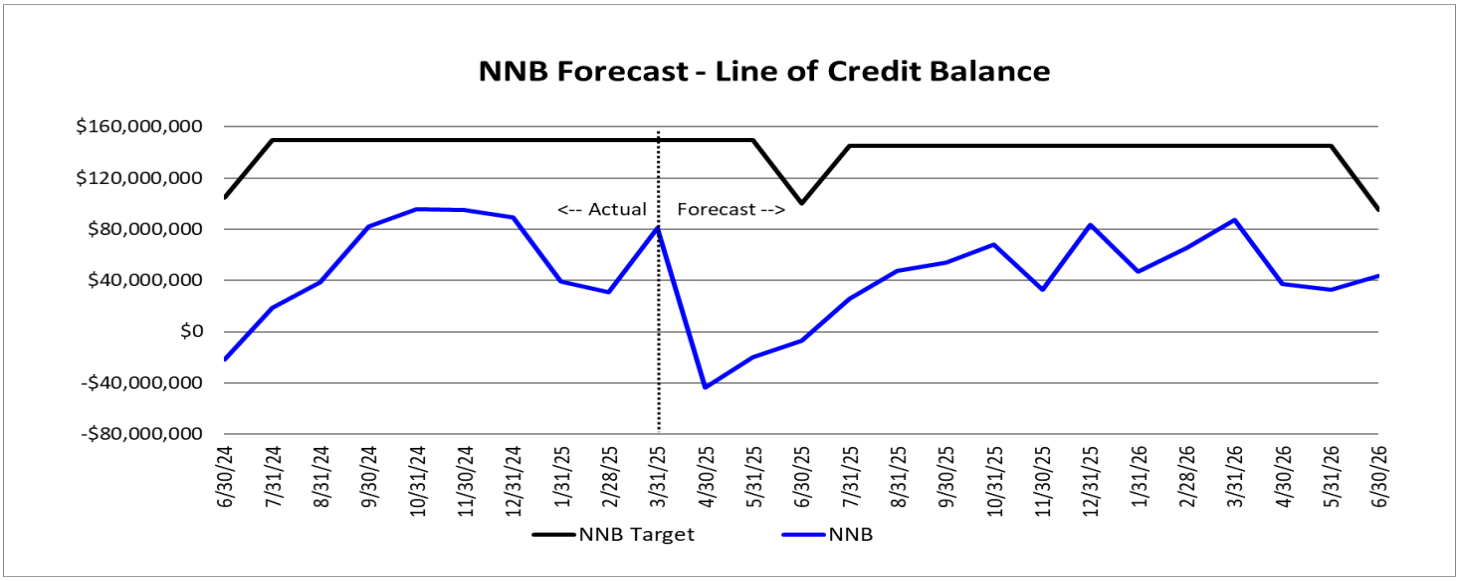
- Patient receipts higher than anticipated ($11.4 million)
- GME FY2024 Final Recon increased based on notification ($3.6 million).
- SRH Line of credit of $15.0 million was accessed and is forecasted to be exhausted by the end of May 2025. Repayment of $12.0 million is expected in June 2025 after SRH receives the IGT funding. Net impact on the NNB Forecast is $3.0 million. As a reminder, the donation of $12.2M to SRH was included in the February forecast and paid in March.

The NNB on June 30, 2026 deteriorated due to the elimination of AB85 Realignment funds ($50.0 million), based on the state's projection which includes AHS's safety net costs and revenues meant to determine if it is likely we will retain any 1991 Realignment funds under the AB85 sharing formula. Each year the traditional 1991 Realignment funding for Alameda County is calculated to determine if preliminary funding with be provided to the county, and a portion redirected to AHS, pending final reconciliation two years later. With the addition of recently approved increases to EPP and QIP for CY 2025, the state added over $100 million to estimated revenue for the year FY 2025-26, so the AB85 formula resulted in the County and AHS unable to receive preliminary funding in FY2026. AHS's results under this formula vary significantly from year to year.

Material items impacting the NNB are summarized in the table below. The top portion of the table provides expected cash flow from sizable items included in NNB forecast. Forecasted items have changed as follow.

- EPP and QIP payment timing moved from May 2025 to April 2025.

- AB85 Realignment was eliminated for FY2026 as the result of additional EPP/QIP funding disallowing the advancement of funds ($50.0M) in FY26 Q2.
- SRH operational funding is based on the $15.0M line of credit, which will be exhausted by the end of May 2025. Repayment of $12.0M is expected in June after IGT funding is received.



The bottom portion of the table below reflects prior year recoupments which are not included in the forecast (blue line). Beginning with the final open Waiver recoupment for FY2011. The timing of the settlement remains unknown. The Federal Qualified Health Center (FQHC) recoupment is a conservative settlement estimate based on the difference between reimbursement rates for services provided at Highland campus locations that were considered qualified and subsequently denied by the State. AHS is in current discussions with the State and once an agreement is reached with the State the FQHC liability will be adjusted Lastly, Physician SPA reconciliations are delayed because the State is having difficulty obtaining claim data. No additional information is available on the timing of settlements.

Material Items Included in NNB Forecast
(in thousands)

	Apr-25	May-25	Jun-25	FY26 Q1	FY26 Q2	FY26 Q3	FY26 Q4
GPP (quarterly)	$ 55,866	$ -	$ -	$ 25,700	$ 25,700	$ 25,700	$ 25,700
EPP (semi-annual)	24,443	-	-	-	21,000	-	21,000
QIP	74,914	-	-	-	34,364	-	34,364
Medi-Cal Rate Range	-	-	-	-	-	42,700	-
BHCS (JGP/Alameda County) - fy25	4,100	4,100	4,100	21,200	-	-	-
BHCS (JGP/Alameda County) - fy26	-	-	-	6,084	18,251	18,251	18,251
HPAC	9,796	-	-	-	21,600	10,800	10,800
AB85 Realignment	-	-	10,125	-	(40,000)	-	-
SNF DP-NF	-	-	-	19,100	-	-	19,100
St. Rose Hospital LOC	-	(5,000)	12,000	-	-	-	-
	$ 169,119	$ (900)	$ 26,225	$ 72,084	$ 80,915	$ 97,451	$ 129,215

Prior Year Reimbursement Settlements

Waiver recoupment (fy11)	$ (4,796)	TBD
Medi-Cal FQHC recoupment (fy08 - fy13)	(40,000)	TBD
Physician SPA (fy08 - fy13)	(25,000)	TBD
	$ (69,796)	

ALAMEDA HEALTH SYSTEM (consolidated)
Statement of Revenues and Expenses
For the Period Ended March 31, 2025
(In Thousands)

	March 2025				Year-To-Date				FY 2024		
	Actual	Budget	Variance	% Variance	Actual	Budget	Variance	% Variance	YTD	Variance	% Variance
Operating revenue											
Net patient service revenue	$ 79,559	$ 75,518	$ 4,041	5.4%	$ 700,512	$ 657,227	$ 43,285	6.6%	$ 622,786	$ 77,726	12.5%
Capitation revenue	4,629	4,136	493	11.9%	41,537	37,227	4,310	11.6%	37,028	4,509	12.2%
Other government programs	48,083	40,060	8,023	20.0%	411,460	360,540	50,920	14.1%	363,390	48,070	13.2%
Other operating revenue	6,277	4,520	1,757	38.9%	46,349	40,678	5,671	13.9%	42,493	3,856	9.1%
Total operating revenue	**138,548**	**124,234**	**14,314**	**11.5%**	**1,199,858**	**1,095,672**	**104,186**	**9.5%**	**1,065,697**	**134,161**	**12.6%**
Operating expense											
Labor costs	102,271	90,581	(11,690)	(12.9)%	860,084	796,747	(63,337)	(7.9)%	780,693	(79,391)	(10.2)%
Physician contract services	3,711	3,358	(353)	(10.5)%	32,035	30,224	(1,811)	(6.0)%	35,938	3,903	10.9%
Purchased services	8,777	8,292	(485)	(5.8)%	77,720	74,849	(2,871)	(3.8)%	78,401	681	0.9%
Materials and supplies	12,903	13,033	130	1.0%	115,085	107,002	(8,083)	(7.6)%	103,223	(11,862)	(11.5)%
Facilities	3,986	3,402	(584)	(17.2)%	29,109	30,575	1,466	4.8%	28,648	(461)	(1.6)%
Depreciation and amortization	2,220	2,001	(219)	(10.9)%	29,819	27,712	(2,107)	(7.6)%	29,354	(465)	(1.6)%
General and administrative	14,904	2,566	(12,338)	(480.8)%	37,879	23,096	(14,783)	(64.0)%	20,754	(17,125)	(82.5)%
Total operating expense	**148,772**	**123,233**	**(25,539)**	**(20.7)%**	**1,181,731**	**1,090,205**	**(91,526)**	**(8.4)%**	**1,077,011**	**(104,720)**	**(9.7)%**
Operating income (loss)	**(10,224)**	**1,001**	**(11,225)**	**(1121.4)%**	**18,127**	**5,467**	**12,660**	**231.6%**	**(11,314)**	**29,441**	**260.2%**
Non-operating activity											
Interest income (expense)	(294)	(110)	(184)	(167.3)%	(3,184)	(760)	(2,424)	(318.9)%	(1,080)	(2,104)	(194.7)%
Other nonoperating revenue	(156)	13	(169)	(1300.0)%	(284)	115	(399)	(347.0)%	116	(400)	(344.8)%
Total non-operating activity	**(450)**	**(97)**	**(353)**	**(363.9)%**	**(3,468)**	**(645)**	**3,007**	**466.2%**	**(964)**	**3,326**	**344.9%**
Net income (loss)	**$ (10,674)**	**$ 904**	**$ (11,578)**	**(1280.8)%**	**$ 14,659**	**$ 4,822**	**$ 15,667**	**324.9%**	**$ (12,278)**	**$ 32,767**	**266.9%**
EBIDA adjustments											
Interest income (expense)	294	110	184		3,184	760	2,424		1,080	2,104	
Depreciation and amortization	2,220	2,001	219		29,819	27,712	2,107		29,354	465	
Total EBIDA adjustments	2,514	2,111	403		33,003	28,472	4,531		30,434	2,569	
EBIDA	**$ (8,160)**	**$ 3,015**	**$ (11,175)**		**$ 47,662**	**$ 33,294**	**$ 20,198**		**$ 18,156**	**$ 35,336**	

ALAMEDA HEALTH SYSTEM (consolidated)
Balance Sheet
As of March 31, 2025
(In Thousands)

	Current Month	Prior Month	FYE 2024
ASSETS			
Cash & cash equivalents	$ 12,159	$ 13,421	$ 5,630
Patient account receivables, net	95,313	95,255	106,096
Due from third-party payors	529,843	371,323	313,969
Due from County of Alameda	28,256	29,250	39,869
Due from State of California	27,893	25,132	24,264
Inventories	11,928	11,996	11,987
Other current assets	22,411	18,718	17,622
TOTAL CURRENT ASSETS	**727,803**	**565,095**	**519,437**
Restricted cash equivalents	26,878	26,878	26,328
Right-to-use lease assets, net	33,475	34,098	39,085
Right-of-use subscription assets, net	2,874	3,022	869
Capital assets - nondepreciable	9,021	9,021	9,021
Capital assets - depreciable, net	127,307	127,379	136,930
TOTAL NONCURRENT ASSETS	**199,555**	**200,398**	**212,233**
DEFERRED OUTFLOWS OF RESOURCES	**167,665**	**167,665**	**167,665**
TOTAL ASSETS & DEFERRED OUTFLOWS	**$ 1,095,023**	**$ 933,158**	**$ 899,335**
LIABILITIES & NET ASSETS			
Accounts payable and accrued expenses	$ 57,859	$ 59,175	$ 85,488
Accrued compensation	38,915	38,105	56,267
Due to third-party payors	157,050	153,177	168,636
Due to County of Alameda	142,340	12,816	15,069
Other Payables	55,354	55,358	32,642
TOTAL CURRENT LIABILITIES	**451,518**	**318,631**	**358,102**
Liquidity facility - County of Alameda	97,920	57,727	5,101
Net pension obligation	425,359	425,359	426,007
Post employment benefit asset	38,374	38,374	38,374
Accrued compensated absences, net of current portion	23,293	23,293	23,293
Self-insurance liabilities, net of current portion	39,820	39,820	37,258
Lease obligations, net of current portion	31,944	32,476	36,469
Subscription obligations, net of current portion	278	287	167
Other long-term liabilities	76	76	2,783
TOTAL LONG TERM LIABILITIES	**657,064**	**617,412**	**569,452**
DEFERRED INFLOWS OF RESOURCES	**52,403**	**52,403**	**52,403**
Fund balance - capital contribution	85,451	85,451	85,451
Fund balance - prior years	(166,072)	(166,072)	(169,139)
Current year income/(loss)	14,659	25,333	3,066
FUND BALANCE	**(65,962)**	**(55,288)**	**(80,622)**
TOTAL LIABILITIES, DEFERRED INFLOWS, & FUND BALANCE	**$ 1,095,023**	**$ 933,158**	**$ 899,335**

ALAMEDA HEALTH SYSTEM (consolidated)
Statement of Cash Flows
For the Period Ended March 31, 2025
(in thousands)

	Current Month	Year-to Date	FYE 2024
CASH FLOWS FROM OPERATING ACTIVITIES			
Operating income (loss)	$ (10,224)	$ 18,127	$ 4,809
Depreciation and amortization	2,220	29,819	41,048
Net changes in operating assets and liabilities:			
Patient account receivables, net	(58)	10,783	(11,664)
Due from/to third-party payors	(154,647)	(227,460)	(72,070)
Due from/to County	130,518	138,884	(3,778)
Due from State	(2,761)	(3,629)	2,648
Inventory	68	59	(318)
Other current assets	(3,693)	(4,789)	242
Accounts payable and accrued expenses	(1,315)	(27,628)	11,238
Accrued compensation	810	(17,352)	16,540
Other current payables	(5)	22,712	2,572
Net pension liability	-	(648)	(87,151)
Other postemployment benefits obligations	-	-	4,703
Other long-term liabilities	-	2,562	8,608
Deferred outflows/inflows	-	-	72,675
Net cash provided by (used in) operating activities	**(39,087)**	**(58,560)**	**(9,898)**
CASH FLOWS FROM NONCAPITAL FINANCING ACTIVITIES			
Change in liquidity facility	40,193	92,819	38,104
Interest payments on working capital loan	356	3,306	2,655
Receipts of rental income	(156)	(284)	155
Net cash provided by (used in) noncapital financing activities	**40,393**	**95,841**	**40,914**
CASH FLOWS FROM CAPITAL AND FINANCING ACTIVITIES			
Purchase and construction of capital assets	(1,377)	(13,094)	(20,601)
Proceeds from disposals of capital assets	0	0	0
Repayment of other long-term liabilities	0	(2,707)	(3,977)
Payments of lease liabilies	(532)	(4,526)	(6,148)
Interest payments on lease liabilities	99	942	997
Payments of subscription obligations	(9)	(3,385)	(870)
Interest payments on subscription obligations	7	75	43
Capital contributions and transfers	-	-	385
Net cash provided by (used in) capital and financing activities	**(1,812)**	**(22,695)**	**(30,171)**
CASH FLOWS FROM INVESTING ACTIVITIES			
Interest and investment income	(756)	(7,507)	(5,593)
Net cash provided by (used in) investing activities	**(756)**	**(7,507)**	**(5,593)**
CHANGES IN CASH AND CASH EQUIVALENTS	**(1,262)**	**7,079**	**(4,748)**
CASH AND CASH EQUIVALENTS, beginning of period	40,299	31,958	36,706
CASH AND CASH EQUIVALENTS, end of period	**$ 39,037**	**$ 39,037**	**$ 31,958**

ALAMEDA HEALTH SYSTEMS Volume Reports

Month: March 2025

	Mar-25	Budget	Variance	% Var	YTD Actual	YTD Budget	Variance	% Var	PY YTD Actual	Variance	% Var
Total Adjusted Patient Days	30,174	28,567	1,607	5.6%	262,321	251,479	10,842	4.3%	250,420	11,901	4.8%
Total Adjusted Discharges	2,494	2,653	(158)	-6.0%	22,520	23,420	(900)	-3.8%	22,905	(385)	-1.7%
GENERAL ACUTE											
Patient Days	6,876	6,697	179	2.7%	58,168	61,138	(2,970)	-4.9%	60,563	(2,395)	-4.0%
Discharges	1,249	1,370	(121)	-8.8%	11,032	12,333	(1,301)	-10.5%	11,924	(892)	-7.5%
Average Daily Census	221.8	216.0	5.8	2.7%	211.5	222.3	(10.8)	-4.9%	220.2	(8.7)	-4.0%
Average Length of Stay	5.5	4.9	(0.6)	-12.6%	5.3	5.0	(0.3)	-6.4%	5.1	0.2	3.8%
Adjusted Patient Days	12,546	11,675	871	7.5%	106,593	103,313	3,280	3.2%	103,428	3,165	3.1%
Adjusted Discharges	2,279	2,388	(109)	-4.6%	20,216	20,840	(624)	-3.0%	20,364	(148)	-0.7%
CMI	1.580	1.630	(0.050)	-3.1%	1.640	1.600	0.040	2.5%	1.570	0.070	4.5%
Emergency Visits	9,261	9,139	122	1.3%	82,175	77,790	4,385	5.6%	77,548	4,627	6.0%
Left Without Being Seen (LW	7.6%	7.8%	0.1%	1.9%	6.8%	7.7%	0.9%	12.7%	7.3%	0.5%	7.4%
Trauma Cases	270	260	10	3.8%	2,747	2,626	121	4.6%	2,553	194	7.6%
Observation Equivalent Days	642	259	383	147.9%	5,742	2,477	3,265	131.8%	1,512	4,230	279.8%
Surgeries	652	825	(173)	-21.0%	6,184	7,001	(817)	-11.7%	6,816	(632)	-9.3%
IP Surgeries	258	344	(86)	-25.0%	2,404	3,174	(770)	-24.3%	3,015	(611)	-20.3%
OP Surgeries	394	481	(87)	-18.1%	3,780	3,827	(47)	-1.2%	3,801	(21)	-0.6%
Deliveries	134	133	1	0.8%	1,206	1,116	90	8.1%	1,161	45	3.9%
PSYCH											
Patient Days	2,057	2,055	2	0.1%	17,603	18,199	(596)	-3.3%	17,998	(395)	-2.2%
Discharges	184	226	(42)	-18.6%	1,859	2,000	(141)	-7.1%	2,001	(142)	-7.1%
Average Daily Census	66.4	66.3	0.1	0.1%	64.0	66.2	(2.2)	-3.3%	65.4	(1.4)	-2.2%
Average Length of Stay	11.2	9.1	(2.1)	-22.9%	9.5	9.1	(0.4)	-4.1%	9.0	0.5	5.3%
Adjusted Patient Days	2,461	2,420	41	1.7%	21,078	21,591	(513)	-2.4%	21,283	(205)	-1.0%
Adjusted Discharges	220	266	(46)	-17.3%	2,226	2,373	(147)	-6.2%	2,366	(140)	-5.9%
PES Equivalent Days	717	717	-	0.0%	6,045	6,385	(340)	-5.3%	5,958	87	1.5%
REHAB											
Patient Days	713	731	(18)	-2.5%	6,308	6,460	(152)	-2.4%	5,915	393	6.6%
Discharges	49	53	(4)	-7.5%	464	465	(1)	-0.2%	431	33	7.7%
Average Daily Census	23.0	23.6	(0.6)	-2.5%	22.9	23.5	(0.6)	-2.4%	21.5	1.4	6.7%
Average Length of Stay	14.6	13.8	(0.8)	-5.5%	13.6	13.9	0.3	2.1%	13.7	(0.1)	-0.8%
Adjusted Patient Days	713	731	(18)	-2.5%	6,308	6,460	(152)	-2.4%	5,915	393	6.6%
Adjusted Discharges	49	53	(4)	-7.5%	464	465	(1)	-0.2%	431	33	7.7%
SNF with Sub-Acute											
Patient Days	8,524	8,546	(22)	-0.3%	75,340	75,533	(193)	-0.3%	75,023	317	0.4%
Discharges	20	26	(6)	-23.1%	163	228	(65)	-28.5%	224	(61)	-27.2%
Average Daily Census	275.0	275.7	(0.7)	-0.3%	275.0	275.7	(0.7)	-0.3%	272.8	2.2	0.8%

ALAMEDA HEALTH SYSTEMS Volume Reports

Month: March 2025

	Mar-25	Budget	Variance	% Var	YTD Actual	YTD Budget	Variance	% Var	PY YTD Actual	Variance	% Var
Average Length of Stay	426.2	331.4	(94.8)	-28.6%	462.2	331.4	(130.8)	-39.5%	334.9	127.3	38.0%
Bed Holds	87	96	(9)	-9.4%	791	841	(50)	-5.9%	787	4	0.5%
CLINIC VISITS	34,962	36,408	(1,446)	-4.0%	308,507	292,888	15,619	5.3%	288,856	19,651	6.8%
Clinic Visits	29,294	29,806	(512)	-1.7%	258,174	241,378	16,796	7.0%	237,476	20,698	8.7%
Telehealth Visits	5,668	6,602	(934)	-14.1%	50,333	51,510	(1,177)	-2.3%	51,380	(1,047)	-2.0%
FQHC Visits	29,263	31,128	(1,865)	-6.0%	258,550	249,218	9,332	3.7%	245,928	12,622	5.1%
Clinic Visits	24,495	25,580	(1,085)	-4.2%	216,187	205,591	10,596	5.2%	202,506	13,681	6.8%
Telehealth Visits	4,768	5,548	(780)	-14.1%	42,363	43,627	(1,264)	-2.9%	43,422	(1,059)	-2.4%
Non-FQHC Visits	5,699	5,280	419	7.9%	49,957	43,670	6,287	14.4%	42,928	7,029	16.4%
Clinic Visits	4,799	4,226	573	13.6%	41,987	35,787	6,200	17.3%	34,970	7,017	20.1%
Telehealth Visits	900	1,054	(154)	-14.6%	7,970	7,883	87	1.1%	7,958	12	0.2%
Physician wRVU	136,760	130,687	6,073	4.6%	1,300,434	1,081,040	219,394	20.3%	1,024,240	276,194	27.0%
PAYOR MIX											
Insurance %	6.8%	7.2%	-0.4%	-5.4%	7.0%	7.3%	-0.3%	-4.4%	7.1%	-0.1%	-2.0%
Medi-Cal %	7.9%	13.0%	-5.2%	-39.5%	9.0%	13.1%	-4.1%	-31.6%	19.4%	-10.4%	-53.6%
Medi-Cal MC %	52.6%	45.5%	7.1%	15.6%	51.5%	45.5%	6.0%	13.2%	40.1%	11.4%	28.3%
Medicare %	21.5%	20.1%	1.4%	6.9%	21.1%	20.1%	1.0%	4.9%	20.5%	0.5%	2.6%
Medicare MC %	6.2%	6.9%	-0.6%	-9.2%	7.2%	7.0%	0.3%	3.6%	6.8%	0.4%	6.2%
Other Govt %	1.6%	3.9%	-2.4%	-60.7%	1.7%	3.8%	-2.2%	-56.5%	3.2%	-1.5%	-48.0%
Self-Pay %	3.4%	3.4%	0.1%	1.5%	2.7%	3.3%	-0.6%	-19.1%	2.9%	-0.3%	-8.9%
Total Payor Mix %	100%	100%	0.0%	0.0%	100%	100%	0.0%	0.0%	100%	0.0%	0.0%

ALAMEDA HEALTH SYSTEMS Volume Reports

Month: March

	MONTH				YEAR-TO-DATE				PRIOR YEAR-TO-DATE		
	MTD Actual	MTD Budget	Var	% Var	YTD Actual	YTD Budget	Var	% Var	YTD PY Actual	Var	% Var
Campus: HIGHLAND											
ACUTE ----------											
General Acute Days	4,544	4,186	358	8.5%	39,414	40,512	-1,098	-2.7%	40,840	-1,426	-3.5%
Total Patient Days	4,544	4,186	358	8.5%	39,414	40,512	-1,098	-2.7%	40,840	-1,426	-3.5%
General Acute Discharges	757	718	39	5.4%	6,661	6,949	-288	-4.1%	6,892	-231	-3.4%
Total Discharges	757	718	39	5.4%	6,661	6,949	-288	-4.1%	6,892	-231	-3.4%
Acute OP Factor	1.765	1.717	-0.05	-2.8%	1.749	1.659	-0.09	-5.4%	1.653	-0.096	-5.8%
Average Daily Census	146.6	135	11.5	8.5%	143.8	147.9	-4	-2.7%	148.5	-4.7	-3.1%
Average Length of Stay	6	5.8	-0.2	-3.0%	5.9	5.8	-0.1	-1.5%	5.9	0	0.1%
Adjusted Patient Days	8,022	7,189	833	11.6%	68,934	67,206	1,728	2.6%	67,496	1,438	2.1%
Adjusted Discharges	1,336	1,233	103	8.4%	11,650	11,528	122	1.1%	11,390	260	2.3%
Occupancy %	87%	80%	0%	0.0%	85%	87%	0%	0.0%	88%	0%	0.0%
Observation Equiv Days	222	164	58	35.1%	2,162	1,660	502	30.2%	503	1,659	330.1%
TOTAL FTE, HOURS, WRVU											
Total Paid FTE	1,781	1,602	-179	-11.2%	1,777	1,661	-116	-7.0%	1,708	-68	-4.0%
Total Productive FTE	1,563	1,356	-207	-15.3%	1,518	1,408	-110	-7.8%	1,476	-42	-2.9%
Total Adjusted Patient Days	8,050	7,206	844	11.7%	69,167	67,378	1,790	2.7%	67,690	1,477	2.2%
Total Adjusted Discharges	1,341	1,236	105	8.5%	11,689	11,557	132	1.1%	11,423	266	2.3%
Total Paid FTE per AOB	6.86	6.89	0.03	0.5%	7.04	6.76	-0.28	-4.2%	6.94	-0.1	-1.4%
Worked Hours Per APD	34.4	33.3	-1.1	-3.2%	34.4	32.7	-1.6	-5.0%	34.3	-0.1	-0.3%
Worked Hours Per AD	206	194	-12	-6.2%	203	191	-13	-6.6%	203	0	-0.2%
Physician wRVU	4	5	-1	-13.6%	50	78	-28	-36.2%	56	-7	-11.5%
OTHER STATS ----------											
Emergency Visits	4,661	4,663	-2	0.0%	40,945	39,125	1,820	4.7%	38,934	2,011	5.2%
Trauma Cases	270	260	10	4.0%	2,747	2,626	121	4.6%	2,553	194	7.6%
Left Without Being Seen	507	562	55	10.8%	4,148	4,714	566	13.6%	4,416	268	6.5%
Deliveries	134	133	1	1.0%	1,206	1,116	90	8.0%	1,161	45	3.9%
IP Surgeries	203	253	-50	-19.7%	1,832	2,258	-426	-18.9%	2,205	-373	-16.9%
OP Surgeries	231	234	-3	-1.4%	1,776	2,107	-331	-15.7%	1,510	266	17.6%
Total Surgeries	434	487	-53	-10.9%	3,608	4,364	-756	-17.3%	3,715	-107	-2.9%
GI Procedures	390	396	-6	-1.5%	2,981	3,402	-421	-12.4%	3,342	-361	-10.8%
Cardiac Procedures	29	200	-171	-85.5%	551	1,564	-1,013	-64.8%	485	66	13.6%
HGH Cath Lab and IR Procedures	300	2,503	-2,203	-88.0%	5,349	14,416	-9,067	-62.9%	5,093	256	5.0%
CLINIC / TELEHEALTH											
Specialty	727	452	275	60.8%	5,604	3,556	2,048	57.6%	3,484	2,120	60.8%
Behavioral Health	701	821	-120	-14.6%	6,361	7,288	-927	-12.7%	7,100	-739	-10.4%
Clinic Visits	1,428	1,273	155	12.2%	11,965	10,844	1,121	10.3%	10,584	1,381	13.0%
Telehealth Specialty	737	887	-150	-16.9%	6,486	6,520	-34	-0.5%	6,797	-311	-4.6%
Telehealth Behavioral	102	106	-4	-3.8%	822	854	-32	-3.7%	798	24	3.0%
Telehealth Visits	839	993	-154	-15.5%	7,308	7,374	-66	-0.9%	7,595	-287	-3.8%
TOTAL CLINIC VISITS	2,267	2,266	1	0.0%	19,273	18,218	1,055	5.8%	18,179	1,094	6.0%
PAYOR MIX ----------											
Insurance %	6.72%	8.17%	-1.46%	-17.80%	7.92%	8.37%	-0.44%	-5.30%	7.92%	0.00%	0.10%
Medi-Cal %	8.60%	13.82%	-5.23%	-37.80%	9.51%	14.03%	-4.52%	-32.20%	23.43%	-13.92%	-59.40%
Medi-Cal MC %	52.58%	44.69%	7.89%	17.70%	50.85%	44.44%	6.41%	14.40%	35.78%	15.06%	42.10%
Medicare %	20.53%	18.36%	2.17%	11.80%	19.52%	18.30%	1.22%	6.70%	19.02%	0.49%	2.60%
Medicare MC %	6.70%	7.18%	-0.48%	-6.70%	7.39%	7.33%	0.05%	0.70%	7.23%	0.15%	2.10%
Other Govt %	1.89%	4.39%	-2.50%	-57.00%	1.92%	4.24%	-2.32%	-54.70%	3.55%	-1.63%	-45.80%
Self-Pay %	2.99%	3.38%	-0.39%	-11.60%	2.90%	3.30%	-0.40%	-12.20%	3.06%	-0.17%	-5.50%
Total Payor Mix %	100.00%	100.00%	0.00%	0.00%	100.00%	100.00%	0.00%	0.00%	100.00%	0.00%	0.00%
CMI Highland MTD	1.624	1.725	-0.101	-5.80%	1.721	1.683	0.038	2.30%	1.657	0.063	3.80%

ALAMEDA HEALTH SYSTEMS Volume Reports

Month: March

	MONTH				YEAR-TO-DATE				PRIOR YEAR-TO-DATE		
	MTD Actual	MTD Budget	Var	% Var	YTD Actual	YTD Budget	Var	% Var	YTD PY Actual	Var	% Var
Campus: ALAMEDA											
ACUTE ----------											
General Acute Days	1,167	1,297	-130	-10.0%	9,422	10,210	-788	-7.7%	10,338	-916	-8.9%
Total Patient Days	1,167	1,297	-130	-10.0%	9,422	10,210	-788	-7.7%	10,338	-916	-8.9%
General Acute Discharges	236	295	-59	-19.9%	2,039	2,320	-281	-12.1%	2,287	-248	-10.8%
Total Discharges	236	295	-59	-19.9%	2,039	2,320	-281	-12.1%	2,287	-248	-10.8%
Acute OP Factor	1.716	1.551	-0.165	-10.6%	1.787	1.573	-0.215	-13.7%	1.67	-0.118	-7.1%
Average Daily Census	37.6	41.8	-4.2	-10.0%	34.4	37.3	-2.9	-7.7%	37.6	-3.2	-8.5%
Average Length of Stay	4.9	4.4	-0.5	-12.4%	4.6	4.4	-0.2	-5.0%	4.5	-0.1	-2.2%
Adjusted Patient Days	2,003	2,011	-9	-0.4%	16,841	16,057	784	4.9%	17,261	-420	-2.4%
Adjusted Discharges	405	457	-52	-11.4%	3,645	3,649	-5	-0.1%	3,818	-174	-4.6%
Occupancy %	57%	63%	0%	0.0%	52%	56%	0%	0.0%	57%	0%	0.0%
Observation Equiv Days	187	20	167	852.0%	1,912	169	1,743	1029.7%	252	1,660	658.4%
SNF ----------											
SNF Patient Days	5,227	5,290	-63	-1.2%	46,204	46,761	-557	-1.2%	45,979	225	0.5%
SNF Discharges	12	12	0	-2.1%	91	108	-17	-16.0%	101	-10	-9.9%
SNF OP Factor	1.0051	1.0045	-0.0006	-0.1%	1.0049	1.0037	-0.0011	-0.1%	1.0042	-0.001	-0.1%
Average Daily Census	168.6	170.7	-2	-1.2%	168.6	170.7	-2	-1.2%	167.2	1.4	0.9%
Average Length of Stay	435.6	431.5	4.1	0.9%	507.7	431.5	76.2	17.7%	455.2	52.5	11.5%
Adjusted Patient Days	5,254	5,314	-61	-1.1%	46,429	46,935	-507	-1.1%	46,171	257	0.6%
Adjusted Discharges	12	12	0	-2.1%	91	109	-17	-15.9%	101	-10	-9.8%
Occupancy %	93%	94%	0%	0.0%	93%	94%	0%	0.0%	92%	0%	0.0%
Bed Holds	41	51	-10	-19.3%	458	449	9	2.0%	442	16	3.6%
Paid FTE	238	212	-26	-12.1%	211	212	1	0.7%	184	-27	-14.9%
Worked Hours per APD	7.2	6.1	-1.1	-18.4%	6.3	6.1	-0.2	-3.4%	5.4	-0.9	-16.1%
Worked Hours per AD	3156	2640	-515	-19.5%	3193	2625	-569	-21.7%	2467	-727	-29.5%
TOTAL FTE, HOURS, WRVU											
Total Paid FTE	661	606	-55	-9.1%	625	606	-20	-3.3%	592	-34	-5.7%
Total Productive FTE	582	523	-59	-11.4%	545	519	-27	-5.1%	515	-30	-5.9%
Total Adjusted Patient Days	2,003	2,011	-9	-0.4%	16,841	16,057	784	4.9%	17,261	-420	-2.4%
Total Adjusted Discharges	405	457	-52	-11.4%	3,645	3,649	-5	-0.1%	3,818	-174	-4.6%
Total Paid FTE per AOB	10.23	9.34	-0.89	-9.5%	10.17	10.33	0.16	1.5%	9.43	-0.75	-8.0%
Worked Hours Per APD	51.5	46.1	-5.5	-11.9%	50.7	50.6	-0.1	-0.2%	46.9	-3.8	-8.1%
Worked Hours Per AD	255	203	-52	-25.7%	234	223	-12	-5.3%	212	-22	-10.5%
OTHER STATS ----------											
Emergency Visits	1,669	1,685	-16	-0.9%	14,952	14,275	677	4.7%	14,132	820	5.8%
Left Without Being Seen	71	46	-25	-35.7%	479	387	-92	-19.2%	384	-95	-19.8%
IP Surgeries	13	24	-11	-44.8%	133	210	-77	-36.7%	214	-81	-37.9%
OP Surgeries	4	0	4	0.0%	448	0	448	0.0%	1,271	-823	-64.8%
Total Surgeries	17	24	-7	-27.8%	581	210	371	176.7%	1,485	-904	-60.9%

ALAMEDA HEALTH SYSTEMS Volume Reports

Month: March

	MONTH				YEAR-TO-DATE				PRIOR YEAR-TO-DATE		
	MTD Actual	MTD Budget	Var	% Var	YTD Actual	YTD Budget	Var	% Var	YTD PY Actual	Var	% Var
Campus: ALAMEDA											
CLINIC / TELEHEALTH											
Specialty	1,344	1,222	122	10.0%	11,591	9,553	2,038	21.3%	9,599	1,992	20.8%
Clinic Visits	1,344	1,222	122	10.0%	11,591	9,553	2,038	21.3%	9,599	1,992	20.8%
Telehealth Specialty	11	18	-7	-38.9%	143	126	17	13.5%	121	22	18.2%
Telehealth Visits	11	18	-7	-38.9%	143	126	17	13.5%	121	22	18.2%
TOTAL CLINIC VISITS	1,355	1,240	115	9.3%	11,734	9,679	2,055	21.2%	9,720	2,014	20.7%
PAYOR MIX ----------											
GA Insurance %	9.71%	10.14%	-0.43%	-4.20%	9.25%	10.32%	-1.06%	-10.30%	9.29%	-0.04%	-0.40%
GA Medi-Cal %	3.29%	11.79%	-8.49%	-72.00%	4.47%	11.11%	-6.64%	-59.70%	14.89%	-10.42%	-70.00%
GA Medi-Cal MC %	36.62%	30.02%	6.60%	22.00%	38.12%	30.45%	7.67%	25.20%	29.45%	8.68%	29.50%
GA Medicare %	37.48%	33.57%	3.91%	11.60%	33.48%	33.60%	-0.12%	-0.40%	32.20%	1.28%	4.00%
GA Medicare MC %	9.09%	10.25%	-1.17%	-11.40%	11.75%	10.17%	1.57%	15.50%	9.77%	1.98%	20.20%
GA Other Govt %	1.84%	1.82%	0.02%	1.30%	1.74%	1.88%	-0.14%	-7.30%	2.51%	-0.77%	-30.80%
GA Self-Pay %	1.96%	2.41%	-0.45%	-18.50%	1.18%	2.47%	-1.28%	-52.00%	1.89%	-0.71%	-37.30%
GA Total Payor Mix %	100.00%	100.00%	0.00%	0.00%	100.00%	100.00%	0.00%	0.00%	100.00%	0.00%	0.00%
CMI Alameda MTD	1.52	1.405	0.115	8.20%	1.471	1.437	0.033	2.30%	1.392	0.079	5.70%

ALAMEDA HEALTH SYSTEMS Volume Reports

Month: March

	MONTH				YEAR-TO-DATE				PRIOR YEAR-TO-DATE			
	MTD Actual	MTD Budget	Var	% Var	YTD Actual	YTD Budget	Var	% Var	YTD PY Actual	Var	% Var	
Campus: SAN LEANDRO												
GENERAL ACUTE ----------												
General Acute Days	1,165	1,214	-49	-4.0%	9,332	10,416	-1,084	-10.4%	9,385	-53	-0.6%	
General Acute Discharges	256	357	-101	-28.3%	2,332	3,064	-732	-23.9%	2,745	-413	-15.0%	
Acute OP Factor	1.1	1.0	(0.1)	-10.2%	1.2	0.9	(0.30)	-34.7%	0.9	0.25	26.2%	
Average Daily Census	37.6	39.2	-1.6	-4.0%	34.1	38.0	-4.0	-10.4%	34.3	-0.2	0.6%	
Average Length of Stay	4.6	3.4	-1.2	-25.3%	4.0	3.4	-0.6	-15.0%	3.4	0.6	-14.6%	
Adjusted Patient Days	1,290	1,220	(70.4)	-5.8%	11,024	9,137	-1,888	-20.7%	8,783	2,241	25.5%	
Adjusted Discharges	283.56	358.77	75.2	21.0%	2,755	2,688	-67.25	-2.5%	2,569	186	7.2%	
Occupancy %	60%	62%	0%	0.0%	54%	60%	0%	0.0%	54%	0%	0.0%	
Observation Equiv Days	233	75	158	210.7%	1,668	648	1,020	157.3%	757	911	120.3%	
ACUTE REHAB ----------												the
Rehab Patient Days	713	731	-18	-2.5%	6,308	6,460	-152	-2.4%	5,915	393	6.6%	
Rehab Discharges	49	53	-4	-6.8%	464	465	-1	-0.2%	431	33	7.7%	
Rehab OP Factor	1	1	0	0.0%	1	1	0	0.0%	1	0	0.0%	
Average Daily Census	23	23.6	-0.6	-2.5%	23	23.6	-0.6	-2.4%	21.5	1.5	7.0%	
Average Length of Stay	14.6	13.9	0.6	4.7%	13.6	13.9	-0.3	-2.2%	13.7	-0.1	-0.9%	
Adjusted Patient Days	713	731	-18	-2.5%	6,308	6,460	-152	-2.4%	5,915	393	6.6%	
Adjusted Discharges	49	53	-4	-6.8%	464	465	-1	-0.2%	431	33	7.7%	
Occupancy %	82%	84%	0%	0.0%	82%	84%	0%	0.0%	77%	0%	0.0%	
Bed Holds	0	1	-1	-100.0%	0	12	-12	-100.0%	7	-7	-100.0%	
Paid FTE	70	70	0	0.1%	71	72	1	1.6%	68	-2	-3.3%	
Productive FTE	59	59	0	-0.4%	61	61	1	0.9%	57	-4	-6.6%	
Paid FTE per AOB	3.02	2.95	-0.07	-2.5%	3.07	3.05	-0.02	-0.8%	3.18	0.11	3.4%	
Worked Hours per APD	14.7	14.3	-0.4	-2.9%	15	14.8	-0.2	-1.5%	15.1	0.1	0.4%	
Worked Hours per AD	215	199	-15	-7.7%	204	206	1	0.7%	207	3	1.4%	
TOTAL FTE, HOURS, WRVU												
Total Paid FTE	495	446	-49	-11.1%	478	459	-19	-4.2%	458	-20	-4.4%	
Total Productive FTE	434	373	-62	-16.5%	410	383	-26	-6.8%	394	-15	-3.9%	
Total Adjusted Patient Days	4,065	4,000	65	1.6%	35,176	32,417	2,759	8.5%	30,357	4,819	15.9%	
Total Adjusted Discharges	660	842	-182	-21.6%	6,288	6,778	-489	-7.2%	6,302	-13	-0.2%	
Total Paid FTE per AOB	3.78	3.45	-0.32	-9.3%	3.73	3.88	0.15	3.9%	4.15	0.42	10.2%	
Worked Hours Per APD	18.9	16.5	-2.4	-14.7%	18.2	18.5	0.3	1.5%	20.4	2.2	10.7%	
Worked Hours Per AD	117	78	-38	-48.7%	102	89	-13	-15.1%	98	-4	-3.7%	
OTHER STATS ----------												
Emergency Visits	2,931	2,792	139	5.0%	26,278	24,390	1,888	7.7%	24,482	1,796	0.07	
Left Without Being Seen	127	102	-25	-19.9%	989	889	-100	-10.1%	894	-95	(0.10)	
IP Surgeries	43	68	-25	-36.4%	439	707	-268	-37.9%	596	-157	(0.26)	
OP Surgeries	158	246	-88	-35.8%	1,556	1,720	-164	-9.5%	1,020	536	0.53	
Total Surgeries	201	314	-113	-35.9%	1,995	2,427	-432	-17.8%	1,616	379	0.24	
PAYOR MIX ----------												
Insurance %	7.10%	6.25%	0.85%	13.70%	6.10%	6.23%	-0.13%	-2.10%	6.52%	-0.42%	-6.50%	
Medi-Cal %	6.96%	9.80%	-2.84%	-29.00%	7.84%	9.83%	-1.99%	-20.20%	16.85%	-9.00%	-53.40%	
Medi-Cal MC %	49.80%	44.37%	5.43%	12.20%	48.42%	43.91%	4.51%	10.30%	37.07%	11.34%	30.60%	
Medicare %	24.14%	22.93%	1.21%	5.30%	24.91%	23.41%	1.50%	6.40%	24.34%	0.57%	2.30%	
GA Self-Pay %	3.74%	3.92%	-0.18%	-4.50%	2.93%	4.05%	-1.12%	-27.60%	3.84%	-0.90%	-23.60%	
GA Total Payor Mix %	100.00%	100.00%	0.00%	0.00%	100.00%	100.00%	0.00%	0.00%	100.00%	0.00%	0.00%	
CMI San Leandro MTD	1.512	1.533	-0.021	-1.40%	1.506	1.458	0.048	3.30%	1.435	0.071	4.90%	

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	MONTH				YEAR-TO-DATE				PRIOR YEAR-TO-DATE		
	MTD Actual	MTD Budget	Var	% Var	YTD Actual	YTD Budget	Var	% Var	YTD PY Actual	Var	% Var
Campus: JOHN GEORGE											
ACUTE ----------											
Psych Days	2,057	2,055	2	0.1%	17,603	18,199	-596	-3.3%	17,998	-395	-2.2%
Total Patient Days	2,057	2,055	2	0.1%	17,603	18,199	-596	-3.3%	17,998	-395	-2.2%
Psych Discharges	184	226	-42	-18.5%	1,859	2,000	-141	-7.0%	2,001	-142	-7.1%
Total Discharges	184	226	-42	-18.5%	1,859	2,000	-141	-7.0%	2,001	-142	-7.1%
Acute OP Factor	1.197	1.178	-0.019	-1.6%	1.197	1.186	-0.011	-0.9%	1.183	-0.015	-1.3%
Average Daily Census	66.4	66.3	0.1	0.1%	64.2	66.4	-2.2	-3.3%	65.4	-1.2	-1.8%
Average Length of Stay	11.2	9.1	-2.1	-22.8%	9.5	9.1	-0.4	-4.1%	9	-0.5	-5.3%
Adjusted Patient Days	2,461	2,420	41	1.7%	21,078	21,591	-514	-2.4%	21,283	-206	-1.0%
Adjusted Discharges	220	266	-46	-17.2%	2,226	2,373	-147	-6.2%	2,366	-140	-5.9%
Occupancy %	96%	96%	0%	0.0%	93%	96%	0%	0.0%	95%	0%	0.0%
TOTAL FTE, HOURS, WRVU											
Total Paid FTE	387	358	-29	-8.2%	387	377	-10	-2.7%	381	-6	-1.6%
Total Productive FTE	339	300	-39	-12.9%	333	317	-16	-5.0%	328	-5	-1.6%
Physician wRVU	9,037	6,325	2,711	42.9%	176,149	101,201	74,948	74.1%	77,921	98,229	126.1%
OTHER STATS ----------											
PES Equivalent Days	717	717	0	0.0%	6,045	6,385	-340	-5.3%	5,958	88	1.5%
PES Visits	797	752	45	6.0%	7,074	6,739	335	5.0%	7,043	31	0.4%
PES Hours	17,207	15,143	2,064	13.6%	145,084	141,877	3,207	2.3%	142,981	2,103	1.5%
CLINIC / TELEHEALTH VISITS -											
PAYOR MIX ----------											
Insurance %	7.84%	5.68%	2.16%	38.10%	5.59%	5.75%	-0.16%	-2.80%	5.82%	-0.24%	-4.10%
Medi-Cal %	12.87%	12.66%	0.21%	1.70%	13.42%	12.82%	0.60%	4.70%	16.33%	-2.91%	-17.80%
Medi-Cal MC %	50.13%	48.52%	1.60%	3.30%	50.95%	49.02%	1.93%	3.90%	47.92%	3.03%	6.30%
Medicare %	23.67%	20.84%	2.84%	13.60%	22.10%	21.04%	1.06%	5.00%	20.93%	1.17%	5.60%
Medicare MC %	3.49%	2.62%	0.87%	33.10%	3.24%	2.65%	0.60%	22.60%	2.32%	0.92%	39.50%
Other Govt %	0.59%	2.34%	-1.75%	-74.80%	1.35%	2.38%	-1.02%	-43.00%	1.13%	0.22%	19.70%
Self-Pay %	1.41%	7.35%	-5.94%	-80.80%	3.34%	6.34%	-3.00%	-47.30%	5.54%	-2.19%	-39.60%
Total Payor Mix %	100.00%	100.00%	0.00%	0.00%	100.00%	100.00%	0.00%	0.00%	100.00%	0.00%	0.00%
CMI Behavioral Health MTD	1.382	1.236	0.146	11.8%	1.351	1.204	0.147	12.20%	1.276	0.075	5.90%

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	MONTH				YEAR-TO-DATE				PRIOR YEAR-TO-DATE		
	MTD Actual	MTD Budget	Var	% Var	YTD Actual	YTD Budget	Var	% Var	YTD PY Actual	Var	% Var
Campus: FAIRMONT											
SNF ----------											
SNF Patient Days	3,297	3,255	42	1.3%	29,136	28,772	364	0.01	29,044	92	0.3%
SNF Discharges	8	14	-6	-40.9%	72	120	-48	(0.40)	123	-51	-41.5%
SNF OP Factor	1.0699	1.0793	0.0093	0.9%	1.0722	1.0825	0.0103	0.01	1.0707	-0.0015	-0.1%
Average Daily Census	106.4	105	1.3	1.3%	106.3	105	1.3	0.01	105.6	0.7	0.7%
Average Length of Stay	412.1	240.6	171.5	71.3%	404.7	240.6	164.1	0.68	236.1	168.5	71.4%
Adjusted Patient Days	3,528	3,513	14	0.4%	31,240	31,146	94	0.00	31,098	141	0.5%
Adjusted Discharges	9	15	-6	-41.4%	77	129	-52	(0.40)	132	-55	-41.4%
Occupancy %	98%	96%	0%	0.0%	98%	96%	0%	-	97%	0%	0.0%
Bed Holds	46	45	1	2.2%	333	392	-59	(0.15)	345	-12	-3.5%
Paid FTE	279	292	14	4.7%	287	285	-3	(0.01)	282	-5	-1.8%
Worked Hours per APD	12.5	12.9	0.4	2.9%	12.4	12.4	0	0.00	12.2	-0.2	-1.5%
Worked Hours per AD	5160	3103	-2057	-66.3%	5017	2985	-2031	(0.68)	2885	-2132	-73.9%
ACUTE REHAB ----------											
Total Paid FTE	287	294	6	2.2%	296	288	-7	(0.03)	289	-6	-2.1%
Total Productive FTE	258	256	-2	-0.7%	255	249	-6	(0.02)	248	-7	-2.6%
CLINIC / TELEHEALTH											
Behavioral Health	1,991	1,720	271	15.8%	18,325	15,324	3,001	19.6%	14,717	3,608	24.5%
Rehab	14	11	3	27.3%	106	66	40	60.6%	70	36	51.4%
Clinic Visits	2,005	1,731	274	15.8%	18,431	15,390	3,041	19.8%	14,787	3,644	24.6%
Telehealth Behavioral Health	44	43	1	2.3%	519	383	136	35.5%	242	277	114.5%
Telehealth Visits	44	43	1	2.3%	519	383	136	35.5%	242	277	114.5%
TOTAL CLINIC VISITS	2,049	1,774	275	15.5%	18,950	15,773	3,177	20.1%	15,029	3,921	26.1%
PAYOR MIX ----------											
Insurance %	0.41%	0.91%	-0.49%	-54.40%	1.09%	0.88%	0.21%	23.90%	0.72%	0.37%	51.80%
Medi-Cal %	6.14%	7.45%	-1.31%	-17.60%	7.31%	7.40%	-0.10%	-1.30%	9.46%	-2.15%	-22.70%
Medi-Cal MC %	70.61%	70.45%	0.16%	0.20%	70.10%	70.42%	-0.32%	-0.50%	71.08%	-0.98%	-1.40%
Medicare %	17.97%	17.48%	0.49%	2.80%	18.55%	17.59%	0.96%	5.40%	15.30%	3.24%	21.20%
Medicare MC %	2.57%	2.30%	0.28%	12.00%	2.47%	2.31%	0.16%	7.00%	2.08%	0.39%	18.80%
Other Govt %	0.24%	1.23%	-1.00%	-80.80%	0.22%	1.22%	-1.00%	-81.70%	1.00%	-0.77%	-77.50%
Self-Pay %	2.06%	0.19%	1.87%	1003.30%	0.26%	0.17%	0.09%	51.00%	0.36%	-0.10%	-28.10%
Total Payor Mix %	100.00%	100.00%	0.00%	0.00%	100.00%	100.00%	0.00%	0.00%	100.00%	0.00%	0.00%

H2. Public Affairs and Community Engagement Report

ALAMEDA HEALTH SYSTEM

TO: Board of Trustees

FROM: Alice Kinner, Vice President, Public Affairs & Community Engagement

DATE: May 2, 2025

SUBJECT: Public Affairs and Community Engagement Report

Public Affairs and Community Engagement (PACE) provides collaborative and integrated strategic communications and meaningful engagement with stakeholders that support, promote, and amplify AHS's mission and vision while reinforcing its brand identity. PACE has four main functional areas: Government and Legislative Affairs, Community Engagement, Communications, and Media. This report provides an overview of key activities.

Government and Legislative Affairs

The primary responsibility of Government and Legislative Affairs is to develop and maintain relationships with elected officials at local, state, and federal levels, to track and analyze legislation's impact on AHS, and facilitate the participation of AHS's interested parties in legislative and policy development.

The State Assembly and Senate Health Committees have begun hearings on bills introduced this session. They have until May 2 to pass fiscal bills and May 9 to pass non-fiscal bills. Appropriations Committees have until May 23 to pass bills. Appendix A includes a preliminary list of state bills AHS is currently tracking.

Community Engagement

The community engagement team supports and participates in activities throughout the year that align with organizational priorities and strategies. Engagement efforts help develop and maintain relationships with key community-based organizations, local business groups, and elected officials, in addition to enhancing the health and well-being of the communities we serve. Outreach and engagement initiatives support AHS's mission and strategic goals.

Below is a recap of activities for April 2025 and a preview of activities for May 2025.

Date	Location	Event	Description
April 5, 2025 8:30 a.m. – 11:30 a.m.	Alameda County Community Food Bank, Oakland	AHS Volunteer Event with the CEO	Over 30 members of the AHS family joined CEO James Jackson and other organizations to volunteer at the Alameda County Community Food Bank. Volunteers packaged over 30,000 pounds of produce, equivalent to more than 25,000 meals.

April 11, 2025 10:30 a.m. – 11:30 a.m.	St. Rose Hospital, Hayward	St. Rose Hospital Community Celebration and Ribbon Cutting	Community stakeholders, AHS leaders, and elected officials attended a ribbon-cutting ceremony honoring the community partners whose collaboration ensures that St. Rose Hospital continues to serve the community.
April 18, 2025 10:30 a.m. – 3:30 p.m.	San Leandro Hospital, San Leandro	American Red Cross Community Blood Drive	In partnership with the American Red Cross, AHS hosted a successful community blood drive at San Leandro Hospital. Approximately 30 units of blood were collected to help save lives.
April 19, 2025 12:00 p.m. – 3:00 p.m.	Alameda Point Gymnasium, Alameda	Alameda Spring Shindig	AHS/Alameda Hospital joined other community organizations and businesses in this annual Earth Day celebration. AHS offered information about its programs and services, as well as interactive health and wellness activities for families.
April 26, 2025 11:00 a.m. – 2:00 p.m.	The Club at Castlewood, Pleasanton	Alameda County Women's Hall of Fame	AHS leaders attended this annual event that recognized outstanding women for their achievements and contributions to Alameda County and its residents.
April 27, 2025 8:30 a.m**.**	Harbor Bay Isle Ferry Terminal, Alameda	Alameda Hospital Foundation Spring Run	Nearly 600 people participated in the Alameda Hospital Foundation's (AHF) Spring Run that featured a 5k, 10k, and kids' fun run. Proceeds benefit the AHF, which raises and manages funds to support Alameda Hospital's programs and services.
May 8, 2025 5:30 p.m**.**	Jack London Square, Oakland	Let's Walk with CEO James Jackson	AHS family and friends are invited to join CEO James Jackson for a two-mile walk at Jack London Square and to connect with colleagues. The walk will start at 55 Harrison.
May 9, 2025 9:00 a.m. – 10:00 a.m.	Sequoyah Country Club, Oakland	Youth Alive Annual Breakfast	AHS and the AHS Foundation are partnering to sponsor and attend this annual event that supports Youth Alive, Oakland's community-based violence prevention, intervention, and healing agency.
May 15, 2025 5:30 p.m.	Yoshi's, Oakland	Building Futures Jazz it Up!	AHS leaders will attend this annual event, which supports Building Futures, an organization dedicated to providing housing and resources to those experiencing homelessness and domestic violence. Services are offered in the communities of Alameda, Oakland, and San Leandro.

May 17, 2025 10:00 a.m. – 1:00 p.m.	Community Child Care Council, Hayward	4 Cs of Alameda County Children's Fair	AHS will participate in this annual children's fair hosted by 4Cs of Alameda County. 600-700 families are expected to attend this event. Interactive activities, health education, and AHS service information will be provided.
May 17, 2025 6:00 p.m.	Henry J. Kaiser Center for the Arts, Oakland	Alameda Health System Foundation (AHSF) Soul of Spring	AHSF's Soul of Spring benefits AHS' patients and programs in a festive evening of community and entertainment. This year's event will feature Grammy Award Winner Sheila E. and honor the heroes in our community.
May 23, 2025 3:00 p.m. – 7:00 p.m.	Newark City Center, Newark	City of Newark 2025 State of the City	AHS Newark Wellness will join other community organizations at this annual celebration of culture and community. Newark Wellness staff will provide information about the services and programs offered.
May 30, 2025 11:00 a.m. – 5:00 p.m.	Alameda Hospital, Conference Room. A, Alameda	American Red Cross Community Blood Drive	In partnership with the American Red Cross, AHS/Alameda Hospital will host a community blood drive to help save lives and alleviate the blood supply shortage.

COMMUNICATIONS

The PACE Communications Team develops and implements communication strategies and plans for key organizational initiatives. Updates are provided as of May 2, 2025.

Unique Stories

In April 2025, PACE wrote 25 unique stories to spotlight AHS programs and departments. These stories were shared via the AHS intranet, the internet, CEO Chronicles and social media.

CEO Chronicles Newsletter

The CEO Chronicles is a monthly newsletter sent to nearly 6,000 internal recipients and 645 community stakeholders, including elected officials, community partners and local businesses. PACE drives the strategy, planning and content development for each newsletter.

When compared to industry standards, as published by Constant Contact Email Content Management System (CMS), the AHS newsletter typically performs at or above industry benchmarks.

The CEO Chronicles is sent to two separate distribution lists, internally and externally.

The April 2025 newsletter's open rate was 53% for internal distribution and the open rate for external distribution was also 53%. The benchmark for open rate (i.e., the percentage of newsletter emails that are opened) is 27%.

The April 2025 CEO video featured our Sexual Assault Response and Recovery Team (SARRT) for Sexual Assault Awareness Month. The Real People, Real Care Spotlight featured Intensive Care Unit Nurse Vernne Victa.

The stories included our Walk with Your Doc event, germ detectives and measles and an update on advocacy in Sacramento. The AHS index focused on Black Maternal Health, and we included two media pieces about the Chaplain and The Doctor film and about Christine Yang, interim chief information officer, being recognized as one of Modern Healthcare's Leading Women. The newsletter also included a calendar of events for upcoming AHS community engagement events and a workplace violence raffle question.

The CEO Chronicles video continues to be the most viewed for internal distribution, followed by Walk with Your Doc. The CEO video was also the top story for external distribution and the Real People, Real Care feature was number two.

Leadership Desktop Chat

PACE supports employee and physician engagement by producing Leadership Desktop Chats every Wednesday. This includes coordinating and preparing talking points, determining the run of show, booking guest speakers and special presentations, coordinating follow-up to employee questions, tracking and posting frequently asked questions, and posting Chat videos and FAQs on the intranet for those who were unable to attend.

The webinar is hosted by the Vice President of PACE. Regular panelists include our Chief Executive Officer, Chief Operating Officer, Interim Chief Human Resources Officer, Interim Chief Medical Officer, Chief Nursing Officer, Vice President of Support Services and an Information System representative. Finance attends monthly to provide updates.

Attendees hear a report from the CEO and have an opportunity to ask questions of leadership. Guest panelists are invited to provide information about key AHS initiatives.

In April 2025, staff received updates from Security, Finance, Quality and Integrated Behavioral Health. In addition, we had presentations on the FindHelp tool.

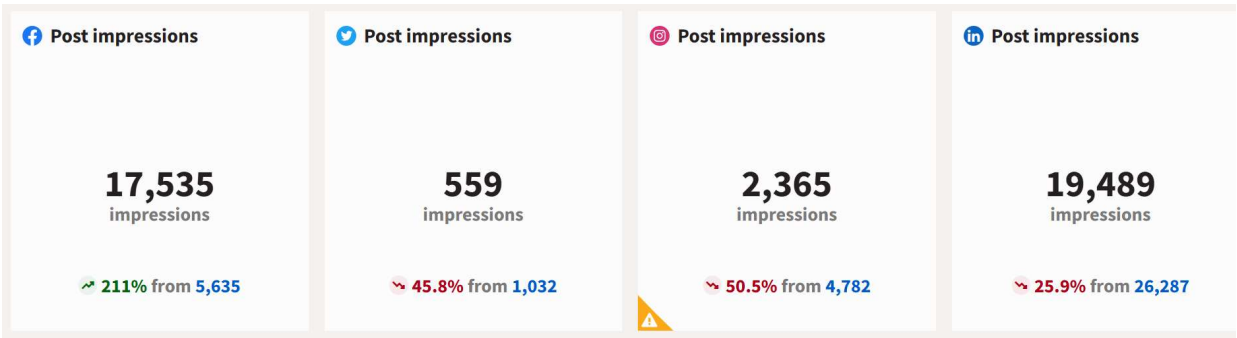
For April 2025, the Chat averaged 494 total participants every Wednesday. Total participants include panelists and attendees.

Social Media Report
Date Range of Report: April 1 to April 30, 2025

Number of Followers/Fans Compared to Previous 30 Days

Social media engagement is the measure of interactions - comments, likes, shares, posts, etc. that our audience has with the content AHS posts.

Post engagement is the number of interactions (reactions, comments, shares and more) our posts received. Post impressions is the number of times content we published during the time frame was displayed on a person's screen. Content includes statuses, photos, links, videos and more.



Top 3 Social Media Posts Based on Engagement
On All Social Media Platforms April 1 to April 26, 2025
Compared to Previous 30 Days

Facebook

Post engagement

1,767
engagements

24.8% from 1,416

Top posts

As measles cases surge nationwide, Alameda Health System's "germ detective", Dr. Ellis and her team urge swift action: vaccinate and stay

44 likes and reactions

We're honored to have affiliated with St. Rose Hospital to deliver quality care to patients in Central and South Alameda County.

27 likes and reactions

We were honored to welcome San Leandro Mayor Juan Gonzalez, representatives from County Supervisor Lena Tam's office and the

15 likes and reactions

X (formerly Twitter)

Tweets

19
tweets

17.4% from 23

Top tweets

We are honored to welcome San Leandro Mayor @JuanGonzalezSL, city reps, and County Supervisor @SupervisorLTam's office to John

19 engagements

Happy National Patient Experience Week! A heartfelt thank you to our AHS teams for their dedication and commitment to making every

5 engagements

April is Rosacea Awareness Month. Research shows skin diseases, including rosacea, often go overlooked in Black patients. Dr. Leon Clark,

4 engagements

Instagram

Post engagement

185
engagements

39.3% from 305

Top posts

April is Rosacea Awareness Month. Research shows skin diseases, including rosacea, often go overlooked in Black patients. Dr. Leon Clark,

30 engagement

Vernne Victa, an ICU nurse at AHS, shares his dedication to supporting the families of organ and tissue donor patients—and how he finds

26 engagement

We were honored to welcome San Leandro Mayor @mayorjuangonzalez representatives from County @SupervisorLTam's office and the

18 engagement

LinkedIn

Post reactions

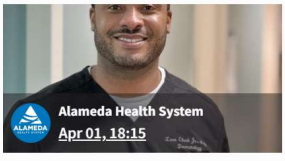
507
reactions

32.8% from 755

Top posts

This week, we joined the California Association of Public Hospitals and Health Systems and other public health care systems at the State

68 reactions



April is Rosacea Awareness Month. Research shows skin diseases, including rosacea, often go overlooked in Black patients. Dr. Leon Clark,

60 reactions

We're honored to have affiliated with St. Rose Hospital to deliver quality care to patients in Central and South Alameda County. See this

54 reactions

Explanation for Decline in Engagement:

During March, our social media content attracted a substantial amount of online trolling. This activity led to an abnormal spike in engagement metrics, thereby inflating the overall performance figures for the month. The subsequent decline in analytics reflects a return to typical engagement levels following the resolution of that incident.

When comparing this month's social media engagement to a normal month like January 2025, our engagements on posts are up by at least 5% on every Social Media Platform and up by 232% on Facebook alone due to boosting strategies.

Media and Communications

Media and Communications is responsible for press coverage, media relations, and public relations that champion Alameda Health System (AHS) and our critical role in the community. We amplify stories that inform the public, elevate the profiles of AHS leadership, publicize the heroic acts our staff perform every day, and establish AHS as the community health pillar within Alameda County.

Audience & Reach

PACE uses Critical Mention, an all-in-one platform for real-time media monitoring across Television, Radio, Social Media, and Online News. Critical Mention calculates our audience and publicity values using data from industry-leading media data providers such as LexisNexis, Nielsen and Podchaser. The performance metrics below are a measure of media mentions, audience size, and publicity value associated in the United States.

Mentions are the number of instances in which Alameda Health System, Alameda Hospital, Highland Hospital, John George Psychiatric Hospital, San Leandro Hospital, or The Wilma Chan Highland Hospital Campus were mentioned across all media. The audience estimate represents the number of people who potentially viewed the AHS mentions. The publicity value estimate represents the cost to advertise for a specific time, program, and/or platform used multiplied by the audience number.

Time Period	Mentions	Audience	Publicity Value
April 1 – April 30, 2025	365	1,312,936,348	$12,794,390

Media Highlights –April 1 – 30, 2025

AHS' new Canine Visitation Program
News stations KTVU, KRON, ABC and CBS covered the launch of AHS' new Canine Companion Program.

[Tri-City Voice: ‘Organizations like AHS are more vital than ever’]

Local leaders and health care providers gathered for a ribbon cutting at St. Rose Hospital to celebrate its affiliation with AHS. The Tri-City Voice reported, “as mounting political and financial pressures threaten the nation’s public health infrastructure, organizations like Alameda Health System are becoming more vital than ever.”

[KQED highlights documentary featuring AHS chaplain, doctor]

AHS Chaplain Betty Clark and Physician Jessica Zitter were on KQED’s *Forum* to discuss the premiere of “The Chaplain & The Doctor,” a documentary set at The Wilma Chan Highland Hospital Campus that premiered this month at The San Francisco International Film Festival.

Appendix A – AHS Activities on Key State Bills – 4/30/2025

Bill No.	Author	Title	Summary	Status	AHS Activities & Potential Impact
AB 40	Bonta	Emergency services and care	would add "reproductive health services, including abortion," to the definition of "emergency services and care" under the Health and Safety Code. Per the state's laws governing the provision of emergency services, health facilities must provide "emergency services and care" to determine if an emergency medical condition or active labor exists.	Sen. Rules Committee	AHS is monitoring this bill
AB 315	Bonta	Medi-Cal: Home and Community-Based Alternatives Waiver	would require the Department of Health Care Services to expand capacity in the Medi-Cal Home and Community-Based Alternatives (HCBA) waiver and submit a study to the Legislature on rates and rate-setting methodologies for HCBA waiver services by March 1, 2026.	Asm. Appropriations	AHS is monitoring this bill
AB 339	Ortega	Local public employee organizations: notice requirement	would require public entities, including public hospitals and health systems, to give recognized employee organizations a minimum of 120 days' written notice before issuing requests for proposals, requests for quotes, or renewing or extending existing contracts that affect job classifications represented by these organizations.	Asm. Appropriations	AHS is monitoring this bill
AB 447	González	ED patient prescriptions: dispensing unused portions upon discharge	would allow physicians or authorized prescribers to dispense an unused portion of a non-controlled medication to an emergency department (ED) patient upon discharge if all of the following conditions are met: the drug is not a controlled substance, it was previously ordered and administered to the patient during their ED visit, it was administered from single patient use multidose packaging and can be self-administered by the patient, and dispensing the remaining portion is necessary to continue the patient's treatment.	Asm. Appropriations	AHS is monitoring this bill
AB 1386	Bains	Health facilities: perinatal services	would require perinatal services to be considered a basic service at general acute care hospitals, as well as establish a process for hospitals that do not provide this service to submit a compliance plan to the California Department of Public Health (CDPH) for approval or denial. The plan must include information on the hospital's transfer agreements, financial limitations, efforts to establish perinatal care, and other requirements as determined by CDPH.	Asm. Appropriations	AHS is monitoring this bill

Bill No.	Author	Title	Summary	Status	AHS Activities & Potential Impact
AB 1460	Rogers	Prescription Drug pricing	would prohibit prescription drug manufacturers from discriminating against qualifying nonhospital 340B community clinics by imposing conditions or restrictions on their ability to purchase or receive federally discounted drugs based on the type of pharmacy they use, including contract pharmacies, to dispense the medication to eligible patients.	Asm. Floor	AHS is monitoring this bill
SB 81	Arreguín	Health facilities: information sharing	would prohibit health facilities from collaborating with, providing access to, or providing information about patients to immigration authorities.	Sen. Appropriations	AHS collaborated closely with CAPH on this bill to ensure its feasibility for implementation and alignment with current hospital practices.
SB 596	Menjivar	Health facilities: administrative penalties	would increase hospitals' nurse staffing compliance requirements by mandating that they document the use and exhaustion of their on-call nurse list before qualifying for an exemption from staffing violation penalties. The bill defines an on-call list as at least 10% of the hospital's registered nurse staff and requires that all nurses on the list maintain verified competencies specific to their assigned unit.	Sen. Appropriations	AHS is monitoring this bill
SB 632	Arreguín	Workers' compensation: hospital employees	would create a series of workers' compensation rebuttable presumptions for hospital employees for a variety of infectious and respiratory diseases, including COVID-19 and severe acute respiratory syndrome, and extend the presumptions after the employee's termination.	Sen. Appropriations	AHS is monitoring this bill