QUALITY PROFESSIONAL SERVICES COMMITTEE MEETING

Wednesday, May 28, 2025
5:00pm-7:00pm

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: HCP Conference Center, see above address

Members of the public may also participate at the following ZOOM Meeting Link:[1]
https://alamedahealthsystem.zoom.us/j/9361457125?pwd=4JnAmhDnBaLgY4GWf4PQBwp3w0Puy2.1&omn=82847186511
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COMMITTEE MEMBERS
Greg Garrett
Lilavati Indulkar, MD, Chair
Donna Linton
Nicholas Moss, MD

NON-VOTING MEMBERS
Chief of Staff – AHS Medical Staff
Chief of Staff - AH Medical Staff

[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.

NOTE: In the event that a quorum of the Board of Trustees participates on this Committee, the meeting is noticed as a Special Meeting of the Board of Trustees; however, no final Board of Trustees action can be taken.

QUALITY PROFESSIONAL SERVICES COMMITTEE 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. DISCUSSION: Clinical Highlights of the OKRs
Lilavati Indulkar, MD, Chair

B. ACTION: Consent Agenda

B1. Approval of the Minutes of the April 23, 2025 Quality Professional Services Committee Meetings

B2. Recommendation to the Board of Trustees for approval of the System Wide Policies and Standardized Procedures listed below:

- Antibiotic Desensitization Policy, Procedure and Protocol
- Oral Amoxicillin Challenge Policy and Procedure
- Medication Adverse Drug Reaction (ADR) Reporting
- Medication Heparin Continuous Infusion Policy
- MARIJUANA_RECREATIONAL AND_MEDICATION_USE Policy
- SYSTEM MEDICATIONS LOOK ALIKE SOUND ALIKE Policy
- Social Networking and other Web Based Communications Policy
- Internal Communications Policy
- AHS Bed Bug, Lice, Scabies Management Prevention Plan
- CARBAPENEM-RESISTANT ORGANISM (CRO) INFECTION PREVENTION AND CONTROL PLAN
- Blood Product Administration
- Critical Results and Critical Results Communication

- Patient Identification Policy
- HR SECTION 3.00 POLICY 3.24 Compliance Enforcement and Discipline
- Alameda Health System MRSA Policy

B3. **Recommendation to the Board of Trustees for approval of the AHS Medical Staff Policies and Procedures listed below:**

AHS and AH Medical Staff:
- Medical Staff Ongoing Professional Practice Evaluation (OPPE) Policy and Procedure
- Telemedicine Credentialing By Proxy

AHS Medical Staff:
- Medical Staff Committees
- Medical Staff Department Structure and Division Leadership

AH Medical Staff:
- Medical Staff Committees

B4. **Approval of Revised Medical Staff Application Forms and Privilege Form listed below:**

Revised Application Forms for AHS & AH:
- Provider Initial Application: Events to Report to the Chief of Staff Memo

Revised Privilege Forms for AHS:
- Pediatrics
- Pediatric Cardiology
- Pediatric Neonatology-Perinatal Medicine

Revised Privilege Forms for AHS & AH:
- Family Medicine – Multifacility
- Internal Medicine – Multifacility
- Neurology – Multifacility
- Pathology – Multifacility
- Teleneurology – Multifacility

Recommendation: Motion to Approve

END OF CONSENT AGENDA

C. **REPORT/DISCUSSION: Medical Staff Reports**

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

D. REPORT/DISCUSSION: Quality Reports

D1. Regulatory Affairs, Quality OKR Dashboard
Ana Torres, Vice President, Quality

D2. Post Acute
Richard Espinoza, Chief Administrative Officer, Post Acute

E. DISCUSSION/ACTION: FY 2026 OKR Metric Discussion
Elizabeth Mahler, MD, Interim Chief Medical Officer

F. DISCUSSION: Operating Room Efficiency
Jaimie Weber, System Director, Perioperative Services

G. INFORMATION: Planning Calendar/Issue Tracking

H. CLOSED SESSION

H1. Consideration of Confidential Medical Staff Credentialing Reports
Chief of Staff, AHS Medical Staff
Chief of Staff, AH Medical Staff

H2. Regulatory Affairs, Risk Management, Patient Safety
[Health and Safety Code 101850(ai) (1)]

(Reconvene to Open Session)

OPEN SESSION

I. REPORT: Legal Counsel's Report on Action Taken in Closed Session
Ahmad Azizi, General Counsel

ADJOURNMENT

ADDENDUMS

- Ageda Item C, Medical Staff Reports Presentation
- Agenda Item D, OKRs
- Agenda Item D Post Acute Presentation
- Agenda Item E, OKR Metric Recommendation

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
The Meeting Rooms are wheelchair accessible. Assistive listening devices are available upon request at the Clerk of the Board's Office. 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.

QUALITY PROFESSIONAL SERVICES COMMITTEE MEETING

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COMMITTEE MEMBERS
Greg Garrett
Donna Linton
Nicholas Moss, MD

NON-VOTING MEMBERS
Chief of Staff – AHS Medical Staff
Chief of Staff - AH Medical Staff

QUALITY PROFESSIONAL SERVICES COMMITTEE MEETING MINUTES

THE MEETING WAS CALLED TO ORDER AT 5:10 pm

ROLL CALL WAS TAKEN AND THE FOLLOWING TRUSTEES WERE PRESENT: Greg Garrett, Donna Linton, Nicholas Moss, MD

ABSENT: None

PUBLIC COMMENT: None

A. ACTION: Consent Agenda

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

A1. Approval of the Minutes of the March 26, 2025 Quality Professional Services Committee Meetings

NOTE: In the event that a quorum of the Board of Trustees participates on this Committee, the meeting is noticed as a Special Meeting of the Board of Trustees; however, no final Board of Trustees action can be taken.

A2. Recommendation to the Board of Trustees for approval of the System Wide Policies and Standardized Procedures 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

A3. Recommendation to the Board of Trustees for approval of 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

A4. Approval of Revised Medical Staff Application Forms and Privilege Form listed below:

Revised Application Forms for AHS & AH

- Application Instructions: Peer Reference Criteria
- Verification Template Letter/Form

Revised Privilege Form for AHS & AH

- Teleradiology - Multifacility

Trustee moved Linton and Trustee Moss seconded 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 Garrett, Linton, and Moss
NAYS: None
ABSTENTION: None

END OF CONSENT AGENDA

B. REPORT/DISCUSSION: Medical Staff Reports

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

Trustee Linton asked Trustee Moss when the EMS agency would be looking at ambulance offloading times to comply with California Assembly bill AB40. Trustee Moss said he would look into it. Trustee Linton said AHS was doing a lot of work to meet the requirements, but still falling short. It would be challenging if the special needs designation was withdrawn as a result.

Trustee Moss, referring to the slide showing that Highland and San Leandro were meeting the AB40 requirements 70% of the time, asked if that before or after the implementation of the changes. Dr. Wu said it was after. They had been working on a series of initiatives to address the need.

Trustee Garrett asked if there had been progress with the ambulance wait times initiatives. Dr. Wu said there has been progress in a lot of areas. The majority of the planned actions have been implemented. Trustee Garrett asked for regular updates on the efforts.

Trustee Garrett asked about the 52 total harms YTD at Alameda, noting that they were at mid-year and were double the improvement goal. Dr. Pyun said they had a really good wound care team who approached patients to document everything very early on whereas before, they may not have done so. It was important to document wounds that patients came in with, so they were not attributed to AHS.

C. REPORT/DISCUSSION: Quality Reports

C1. Regulatory Affairs, Quality OKR Dashboard
Ana Torres, Vice President, Quality

C2. Post Acute
Richard Espinoza, Chief Administrative Officer, Post Acute

D. DISCUSSION: Patient Family Advisory Committee and Patient Experience Update
Angela Ng, MD, Director of Care Experience

Trustee Garrett asked if the Ambient AI pilot at the clinics was going to expand into the hospital system. Dr. Mahler said ultimately it could be useful integrated with EPIC and in multiple contexts.

Trustee Garrett asked if the Rover Device was part of the work being done to reduce HAPIs (Hospital Acquired Pressure Injury). Dr. Mahler said it was part of the work and part of the nursing workflow for HAPI assessments.

Trustee Moss asked if the PFAC inputs came from AHS projects or if the PFAC members brought up their own experiences as examples for improvement. Dr. Ng said it was both. A lot of times they would bring up things that we were already working on. A lot of the conversations were about wayfinding, patient education, and communication at the bedside.

Trustee Garrett asked if they got compensated at all. Dr. Ng said AHS gave them gift cards at a rate of $25 an hour. They've surveyed what was done for this type of group around the country. There

were challenges with stipends and such because the members would be taxed. Additionally, some of the members were limited in how much they could get because they could lose certain services. They were working on developing a policy to help in this process. Trustee Garrett said the Board would be interested in seeing that policy.

Trustee Moss asked if they were able to review CMS data from other systems and if it included the whole scores or just the top box. Dr. Ng said she thought they only could see the top box.

Trustee Moss asked if the percentiles moved when they look at systems such as San Francisco General and LA County. Dr. Ng said they did. They wanted to benchmark with all facilities. AHS patients deserved the best care.

Trustee Garrett said they wanted to compare themselves to private hospitals and to better funded organizations. Our patients should receive the higher level of patient experience that those hospitals provided.

E. DISCUSSION: Quality Safety Protections
Ann Mary Olson, Senior Associate General Counsel

Trustee Moss asked if criminal action would be an exception to the protections in Evidence Code 1157. Ms. Olson said 1157 was not generally a shield in a criminal situation, though it didn't come up often. Mr. Azizi said they sometimes advise the Quality team to put communications under attorney client privilege just in case.

F. INFORMATION: Planning Calendar/Issue Tracking

Mr. Azizi said the Quality Committee of the Board would meet in Closed Session to discuss the items as set forth on the agenda.

G. <u>CLOSED SESSION</u>

G1. Consideration of Confidential Medical Staff Credentialing Reports
Chief of Staff, AHS Medical Staff
Chief of Staff, AH Medical Staff

G2. Regulatory Affairs, Risk Management, Patient Safety
[Health and Safety Code 101850(ai) (1)]

(Reconvene to Open Session)

<u>OPEN SESSION</u>

H. <u>REPORT: Legal Counsel's Report on Action Taken in Closed Session</u>
Ahmad Azizi, General Counsel

Mr. Azizi reported that the Committee met in Closed Session and considered credentialing reports for each of the medical staffs and approved credentials/privileges for fully qualified practitioners recommended by the medical staffs.

ADJOURNMENT 7:30 pm

This is to certify that the foregoing is a true and correct copy of the minutes of the Quality Professional Services Committee meeting of April 23, 2025, as approved by the Quality Professional Services Committee on May 28, 2025:

_____
Ronna Jojola Gonsalves
Clerk of the Board

APPROVED AS TO FORM:

Reviewed by: _____
Ahmad Azizi
General Counsel

B2. Policies and Standardized Procedures listed below_

Alameda Health System			CPC Executive Summary to AHS and AH Medical Executive Committee(s) – May 2025			
Policies and Procedures				Chair: Dr. Bullard		
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						
Antibiotic Desensitization Policy, Procedure and Protocol	Matt Labreche, PharmD	• Revisions to include IV Penicillin to Policy • Consent Item – Policy in PolicyTech		05/2028		• Antimicrobial Stewardship Committee Approved 3/2025 • System P&T 4/2025 • CPC 5/01/2025 • MEC 5/21/2025
Oral Amoxicillin Challenge Policy and Procedure	Matt Labreche, PharmD	• New Policy • Consent Item – Policy in PolicyTech		05/2028		• Antimicrobial Stewardship Committee Approved 3/2025 • System P&T 4/2025 • CPC 5/01/2025 • MEC 5/21/2025
Medication Adverse Drug Reaction (ADR) Reporting	Priya Patel, PharmD	• TJC Triennial Review – minor language revisions • Consent Item – Policy in PolicyTech		05/2028		• System P&T 4/2025 • CPC 5/01/2025 • MEC 5/21/2025
Medication Heparin Continuous Infusion Policy	Priya Patel, PharmD	• TJC Triennial Review – minor language revisions, add new Heparin indications in policy • Consent Item – Policy in PolicyTech		05/2028		• System P&T 4/2025 • CPC 5/01/2025 • MEC 5/21/2025
MARIJUANA_RECREATIONAL_AND_MEDICATION_USE	Priya Patel, PharmD	• TJC Triennial Review – minor language revisions made by legal • Consent Item – Policy in PolicyTech		05/2028		• System P&T 4/2025 • CPC 5/01/2025 • MEC 5/21/2025
SYSTEM MEDICATIONS LOOK ALIKE SOUND ALIKE	Priya Patel, PharmD	• TJC Triennial Review – no changes • Consent Item – Policy in PolicyTech		05/2028		• System P&T 4/2025 • CPC 5/01/2025 • MEC 5/21/2025

Alameda Health System			CPC Executive Summary to AHS and AH Medical Executive Committee(s) - May 2025			
Policies and Procedures				**Chair: Dr. Bullard**		
TOPIC or TITLE OF POLICY	**Document Owners**	**Summary of Changes**	**Last Approved Date**	**Next review date after BOT approval**	**Purpose**	**History of Review Committee**
Social Networking and other Web Based Communications Policy	Victoria Balladares Alice Kinner	• Revised • Minor changes were made to the policy to update the list of social media platforms and correct grammar.		05/2028		• CPC 5/01/2025 • MEC 5/21/2025
Internal Communications Policy	Victoria Balladares Alice Kinner	• Revised • The policy was revised to make clearer and to provide principles and guidelines.		05/2028		• CPC 5/01/2025 • MEC 5/21/2025
AHS Bed Bug, Lice, Scabies Management Prevention Plan	Dr. Deborah Ellis David Nino-Lopez	• Revised • Hair shaving was added and addressed In area 2.6 (b) re: treatment		05/2028		• CPC 5/01/2025 • MEC 5/21/2025
CARBAPENEM-RESISTANT ORGANISM (CRO) INFECTION PREVENTION AND CONTROL PLAN	Dr. Deborah Ellis David Nino-Lopez	• Revised • Addition of supporting statements on pgs. 6 and 8.		05/2028		• CPC 5/01/2025 • MEC 5/21/2025
Blood Product Administration	Dr. Harris Goodman	• Revised • updated the Blood Product Administration to reflect minor edits necessary to meet JC requirements surrounding blood pressure changes		05/2028		• CPC 5/01/2025 • MEC 5/21/2025
Critical Results and Critical Results Communication	Dr. Harris Goodman	• Revised • updated the Critical Results policy to add POCT results to meet CAP requirements and to add phosphorus		05/2028		• CPC 5/01/2025 • MEC 5/21/2025
Patient Identification Policy	Dusty Gilleland	• Revised • Inaccurate information related to identifiers for lab was edited and FBC info was updated for newborns.		05/2028		• CPC 5/01/2025 • MEC 5/21/2025

Alameda Health System			CPC Executive Summary to AHS and AH Medical Executive Committee(s) - May 2025			
Policies and Procedures				Chair: Dr. Bullard		
TOPIC or TITLE OF POLICY	**Document Owners**	**Summary of Changes**	**Last Approved Date**	**Next review date after BOT approval**	**Purpose**	**History of Review Committee**
HR SECTION 3.00 POLICY 3.24 Compliance Enforcement and Discipline	Sara McElfresh Arleen Gomez	• Sources noted in Reference section. • Moved to new template and reviewed by HR				• CPC 3/6/2025 • MEC 4/2025
Alameda Health System MRSA Policy	Dr. Deborah Ellis David Nino-Lopez	• Revised				• Infection Control Committee 4/2025 • CPC 5/01/2025 • MEC 5/21/2025

	Policy	
	ANTIBIOTIC DESENSITIZATION POLICY, PROCEDURE, & PROTOCOL	**27766 3**
	LEVEL ☐ System ☐ Site	EFFECTIVE DATE: 4/2025

Alameda Health System

ANTIBIOTIC DESENSITIZATION POLICY, PROCEDURE, & PROTOCOL

Department	AHD CRITICAL CARE UNIT CCU, AHS COO ADMINISTRATION, HGH CRITICAL CARE SUPPORT SVCS, SYS IS PHARMACY	***Effective Date***	2/2016
Campus	Highland/Fairmont/JGPH	***Date Revised***	9/2015, 1/2018, 5/2024
Unit	Pharmacy	***Next Scheduled Review***	1/2021, 4/2028
Manual	Pharmacy	***Author***	Director, Pharmacy
Replaces the following Policies:		***Responsible Person***	Chief Administrative Officer

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

Purpose

To outline physician, nursing and pharmacy responsibilities and guidelines in the proper administration of antibiotics for patients that require desensitization.

Policy

Antibiotic desensitization will be administered safely with multi-disciplinary instructions provided by this policy and procedures.

Procedure

Antibiotics included in document:

- Cefazolin
- Meropenem
- Metronidazole
- Nafcillin
- Penicillin (PO)
- Penicillin (IV)
- Trimethoprim-Sulfamethoxazole (TMP-SMX) (PO and IV)

Antibiotic Desensitization Protocol

1. Physician to determine need for the protocol and ensure patients to meet the following requirements:

a. If allergy was any of the following, recommend against desensitization (physician clinical discretion required): Steven-Johnson's Syndrome (SJS), exfoliative dermatitis, or erythroderma
b. IV line established (if therapeutic dose of antibiotic ordered as IV)

2. Physician to place order for antibiotic desensitization protocol AND
    a. Order the following as part of the antibiotic desensitization protocol
        i. Epinephrine 1:10,000 dose 0.1mg IM x1 dose prn severe reaction (hypotension, throat swelling, wheezing/respiratory distress)
        ii. Hydrocortisone 100mg IV x1 dose prn severe reaction (hypotension, throat swelling, wheezing/respiratory distress)
        iii. Diphenhydramine 50mg IV x1 dose prn severe reaction (hypotension, throat swelling, wheezing/respiratory distress)
        iv. Albuterol neb 2.5mg inh x1 dose prn severe reaction (hypotension, throat swelling, wheezing/respiratory distress)
    b. Consider discontinuing beta blockers for one dose prior to initiating protocol
3. Physician will notify the Charge Nurse of the unit of protocol activation
    a. The patient must have ICU transfer orders written to move to ICU
    b. Once the protocol is completed (with no adverse effects) the patient will need updated transfer orders to move out of ICU.

4. The Charge Nurse will notify the Nursing Supervisor

5. Nursing supervisor will arrange for a non-urgent ICU transfer of this patient to ICU (ideally within 8h time period). Patients of a more critical nature will take priority if limited ICU bed availability.
    a. Pt on PO antibiotic desensitization protocol should be on 1:1 nurse to patient ratio

6. Once the patient has an ICU bed assigned, the ICU Charge Nurse o notifies the pharmacy to start compounding the meds (pharmacy needs 1-2 hours to prepare meds), fax the this protocol order to pharmacy and notify pharmacy of new bed number to send the meds

7. Pharmacy will compound the desensitization medications according to pharmacy instructions on page 2

8. The ICU nurse will administer the desensitization medications according to nursing instructions on page 2

9. After the first therapeutic dose of antibiotic is given, the nurse will observe the patient for 30min. If no hypersensitivity reactions, the nurse will call the physicians to arrange for transfer out of the ICU (unless patient has other indications to be in the ICU)

Physician Signature:_____ Date:_____ Time:_____

Cefazolin Desensitization

1. Pharmacy will prepare the following items
    a. Physician should order 1st dose of full therapeutic cefazolin (pharmacy will call physician for order unless already ordered)
    b. Enter all the doses in EPIC (Order Panel: IV Cefazolin Desensitization Protocol) and deliver all desensitizing doses when everything is ready once the patient has an ICU bed (pharmacy will be notified by nurse)
    c. Prepare dilutions with cefazolin 1gram inj vial
    d. Compound 3 vials of the following: 1gram in 5ml sterile water (SW)
    e. After reconstitution, the original concentration of 1000mg/5mL is equivalent to stock solution #4 (200mg/mL)
        i. Keep one vial of this for dose #14
        ii. Keep one vial for doses #12 (draw 1.25mL out) and #13 (draw 2.5mL out)
        iii. Use the third vial to reconstitute stock solution #3
    f. Use 3rd vial of stock solution #4 to prepare stock solution #3:
        i. Draw 2 mL from 200mg/mL bottle and dilute in 18mL of SW to make a final concentration of 20mg/mL
    g. Use stock solution #3 to prepare stock solution #2:
        i. Draw 1 mL from 20mg/mL bottle and dilute in 9mL of SW to make a final concentration of 2mg/mL
    h. Use stock solution #2 to prepare stock solution #1:
        i. Draw 1 mL from 2mg/mL bottle and dilute in 9mL of SW to make a final concentration of 0.2mg/mL
    i. Follow the steps indicated in below table and QS each dose with NS to 5mL syringe before sending the doses up to the floor (exception: syringe #11 is 6ml total)

2. Nurse
    a. Administer each dose IVP over 5min at 15 min intervals until step 14
    b. Observe patient for hypersensitivity reactions during and after each dose administration
        i. If hypersensitivity reaction develops, stop desensitization dose administration
        ii. Call prescribing primary team for further instructions
    c. After step #14, observe the patient for 30min. If no hypersensitivity reactions, call the physician to arrange for transfer out of the ICU (unless patient has other indications to be in the ICU)

d. After step 14, observe patient for 30 minutes then patient is ready to be transferred out, the next dose of cefazolin will be on the next dosing interval (ie: 8h later)

Dose #	Concentration (mg/ml)	Volume (ml)	Dose (mg)	Cumulative Dose (mg)
1	Stock #1 0.2	0.5 (dilute to 5ml)	0.1	0.1
2	0.2	1 (dilute to 5ml)	0.2	0.3
3	Stock #2 2	0.25 (dilute to 5ml)	0.5	0.8
4	2	0.5 (dilute to 5ml)	1	1.8
5	2	1 (dilute to 5ml)	2	3.8
6	2	2 (dilute to 5ml)	4	7.8
7	2	4 (dilute to 5ml)	8	15.8
8	Stock #3 20	0.8 (dilute to 5ml)	16	31.8
9	20	1.5 (dilute to 5ml)	30	61.8
10	20	3 (dilute to 5ml)	60	121.8
11	20	6 (dilute to 6m	120	241.8
12	Stock #4 200	1.25 (dilute to 5ml)	250	491.8
13	200	2.5 (dilute to 5ml)	500	991.8
14	200	5 (dilute to 5ml)	1000	1991.8

*****Each subsequent dose should be administered 15 minutes apart. Administer all dose IV push over 5 minutes.*****

Reference: Cash JH et al. Desensitization as a tool for beta-lactam antibiotic use in methicillin sensitive Staphylococcus aureus infections. J of Pharmaceutical Tech and Drug Research. 2013 ISSN 2050-120X

Meropenem Desensitization

1. Pharmacy will prepare the following items:
   a. Physician should order 1st dose of full therapeutic meropenem (pharmacy will call physician for order unless already ordered)

b. Enter all the doses into EPIC (Order Panel : IV Meropenem Desensitization Protocol) and deliver all desensitizing doses when everything is ready once the patient has an ICU bed (pharmacy will be notified by nurse).
c. Prepare dilutions from two 1000mg vials of meropenem
d. Compound the 2 vials by adding 10mL of sterile water for injection into each vial for a resulting concentration of 100mg/mL.
e. Use one vial (100mg/mL) to prepare stock solution #3 (10mg/mL)
    i. Remove 20mL (overfill + 10mL) from a 100mL NS bag.
    ii. Draw up 10mL from the reconstituted 100mg/mL vial (1000mg) and add to the NS bag to make a final concentration of 10mg/mL.
f. Use the other vial (100mg/mL) to prepare stock solution #2 (1mg/mL)
    i. Remove 11mL (overfill + 1mL) from a 100mL NS bag.
    ii. Draw up 1 mL from the reconstituted 100mg/mL vial (100mg) and add to the NS bag to make a final concentration of 1mg/mL.
g. Use stock solution #2 (1mg/mL) to prepare stock solution #1 (0.1mg/mL)
    i. Remove 20mL (overfill + 10mL) from a 100mL NS bag.
    ii. Draw up 10 mL from stock solution #2 and add to the NS bag to make a final concentration of 0.1mg/mL.
h. Follow the steps indicated in below table and QS doses #1-12 to 50mL NS IVPB. QS dose #13 to 100mL NS IVPB.

2. Nurse
    a. Administer each dose IVPB over 15min at 15min intervals, without interruption, through step #13. Flush line completely between each administration to ensure that the entire contents of each dose was received.
    b. Observe patient for hypersensitivity reactions after each dose administration
        i. If hypersensitivity reaction develops, stop desensitization dose administration
        ii. Call prescribing primary team for further instructions
    c. After step #13, observe the patient for 30min. If no hypersensitivity reactions, call the physician to arrange for transfer out of the ICU (unless patient has other indications to be in the ICU)
    d. The next dose of meropenem will be on the next dosing interval (ie: 8 to 12 hours later)

Dose #	Concentration (mg/mL)		Volume (mL) to QS to NS 50mL IVPB	Dose (mg)	Cumulative dose (mg)
1	0.1	Stock #1	0.5	0.05	0.05
2	0.1		1.25	0.125	0.175
3	0.1		2.5	0.25	0.425
4	0.1		5	0.5	0.925
5	1	Stock #2	1.25	1.25	2.175

6	1		2.5	2.5	4.675
7	1		5	5	9.675
8	1		10	10	19.675
9	10	Stock #3	2.5	25	44.675
10	10		5	50	94.675
11	10		10	100	194.675
12	10		20	200	394.675
13	10		60	600	994.675

References:
Castells M. "Rapid Desensitization for Hypersensitivity Reactions to Medications." *Immunol Allergy Clin North Am* 2009; 29:585.
Wilson, D. "Successful Meropenem Desensitization in a Patient with Cystic Fibrosis." *Ann Pharmacother* 2003; 37:1424-8.

Metronidazole Desensitization

Metronidazole PO Desensitization:

1. Pharmacy will prepare the following items:
    a. Physician to order 1st dose of full therapeutic metronidazole (pharmacy will call physician for order unless already ordered)
    b. Enter all doses inEPIC (Order Panel : Oral Metronidazole Desensitization Protocol) and deliver all doses plus the first therapeutic metronidazole dose when everything is ready once the patient has an ICU bed (pharmacy will be notified by nurse)
    c. Prepare dilutions with metronidazole 250mg tablets
        i. Extemporaneously compound 1st metronidazole tablet in Ora-Sweet or Ora-Plus to final concentration equivalent to stock #4 (2.5mg/mL, **final volume of 100mL**)
        ii. Directions for extemporaneous compounding:
            - Crush one 250 mg tablet in a mortar and triturate to a fine powder.
            - Wet powder with minimal amount of vehicle (~5ml) and levigate to form viscous, but smooth and uniform paste.
            - Continue adding vehicle, mixing well after each addition.
            - Transfer to a graduate.
            - Rinse mortar with vehicle, adding rinse to graduate, until almost final volume.
            - QS to final volume of **100 mL** with vehicle. Stir well.
    d. Use stock #4 to prepare stock solution #3 (0.25mg/mL):

i. Draw 1 ml from 2.5mg/mL bottle and dilute in 9 mL of vehicle to make a final concentration of 0.25mg/mL

e. Use stock solution #3 to prepare stock solution #2 (0.025mg/mL):
   i. Draw 1 ml from 0.25mg/mL bottle and dilute in 9 mL of vehicle to make a final concentration of 0.025mg/mL
f. Use stock solution #2 to prepare stock solution #1 (0.0025mg/mL):
   i. Draw 1 ml from 0.025mg/mL bottle and dilute in 9 mL of vehicle to make a final concentration of 0.0025mg/mL
g. Extemporaneously compound 2nd metronidazole tablet in Ora-Sweet or Ora-Plus to final concentration equivalent to stock #5 (25mg/mL, **final volume of 10mL**)
   i. Directions for extemporaneous compounding:
      - Crush one 250 mg tablet in a mortar and triturate to a fine powder.
      - Wet powder with minimal amount of vehicle (~5ml) and levigate to form viscous, but smooth and uniform paste.
      - Continue adding vehicle, mixing well after each addition.
      - Transfer to a graduate.
      - Rinse mortar with vehicle, adding rinse to graduate, until almost final volume.
      - QS to final volume of **10 mL** with vehicle. Stir well.

2. Nurse:
   a. Administer each dose at 30 minute intervals until step 12
   b. Observe patient for hypersensitivity reactions after each dose administration
   c. If hypersensitivity reaction develops, stop desensitization dose administration
      i. Call prescribing primary team for further instructions
   d. After giving the final dose in step 12, observe the patient for 30 minutes. If no hypersensitivity reaction occurs, call the physician to arrange for transfer out of the ICU (unless the patient has other indications to be in the ICU)

	Step	Dilution (mg/mL)	mL Administered	Dose/Step (mg)	Cumulative dose (mg)
Stock solution #1	1	0.0025	1	0.0025	0.0025
Stock solution #2	2	0.025	1	0.025	0.0275
Stock solution #3	3	0.25	1	0.25	0.2775
Stock solution #4	4	2.5	1	2.5	2.7775
	5	2.5	2	5	7.7775
	6	2.5	4	10	17.7775

Stock solution #5	7	25	1	25	42.7775
	8	25	2	50	92.7775
	9	25	4	100	192.7775
250 mg tab	10	-	-	250	442.7775
500 mg tab	11	-	-	500*	942.7775
500 mg tab	12	-	-	1000**	1942.7775

*if final dose is 500mg, can stop at this step and prescribe 500mg BID for full treatment dose
**continue to this dose if the prescribing dose is 2g orally x1 dose

References:

1. Gendelmen SR et al. Modified oral metronidazole desensitization protocol. All Rhinol (Providence). 2014 Summer; 5(2): e66-e69. PMCID: PMC4124580 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4124580/
2. Allen LV et al. Stability of ketoconazole, metolazone, metronidazole, procainamide hydrochloride, and spironolactone in extemporaneously compounded oral liquids. Am J Health-Syst. Pharm. 1996; (53): 2073-2078.
3. Irwin DB et al. The acceptability, stability, and relative bioavailability of an extemporaneous metronidazole suspension. Can J Hosp Pharm. 1987; (40): 42-46.

Nafcillin Desensitization

1. Pharmacy will prepare the following items
    a. Physician should order 1st dose of full therapeutic nafcillin (pharmacy will call physician for order unless already ordered)
    b. Enter all the doses in EPIC (Order Panel : IV Nafcillin Desensitiziation Protocol) and deliver all desensitizing doses when everything is ready once the patient has an ICU bed (pharmacy will be notified by nurse)
    c. Prepare dilutions with nafcillin 2gram inj vial
    d. Compound 2 vials of the following: 2gram in 10ml of NS
    e. After reconstitution, the original concentration of 2000mg/10mL is equivalent to stock solution #4 (200mg/mL)
        i. Keep one vial of this for dose #14 (draw 5mL out), #13 (draw 2.5mL out) and #12 (draw 1.25mL out)
        ii. Use the other vial to reconstitute stock solution #3
    f. Use stock solution #4 to prepare stock solution #3:
        i. Draw 2 mL from 200mg/mL bottle and dilute in 18mL of SW to make a final concentration of 20mg/mL
    g. Use stock solution #3 to prepare stock solution #2:
        i. Draw 1 mL from 20mg/mL bottle and dilute in 9mL of water to make a final concentration of 2mg/mL

h. Use stock solution #2 to prepare stock solution #1:
    i. Draw 1 mL from 2mg/mL bottle and dilute in 9mL of water to make a final concentration of 0.2mg/mL
i. Follow the steps indicated in below table and QS each dose to 50mL NS IVPB before sending the doses up to the floor

2. Nurse
    a. Administer each dose IVPB over 10min at 15 min intervals until step 14
    b. Flush line completely after each dose to ensure all medication is administered to patient
    c. Observe patient for hypersensitivity reactions after each dose administration
        i. If hypersensitivity reaction develops, stop desensitization dose administration
        ii. Call prescribing primary team for further instructions
    d. After step #14, observe the patient for 30min. If no hypersensitivity reactions, call the physician to arrange for transfer out of the ICU (unless patient has other indications to be in the ICU)
    e. After step 14, observe patient for 30 minutes then patient is ready to be transferred out, the next dose of nafcillin will be on the next dosing interval (i.e.: 4h later)

Dose #	Concentration (mg/mL)		Volume (mL)	Dose (mg)	Cumulative dose (mg)
1	0.2	Stock #1	0.5 (dilute to 50 IVPB)	0.1	0.1
2	0.2		1 (dilute to 50 IVPB)	0.2	0.3
3	2	Stock #2	0.25 (dilute to 50 IVPB)	0.5	0.8
4	2		0.5 (dilute to 50 IVPB)	1	1.8
5	2		1 (dilute to 50 IVPB)	2	3.8
6	2		2 (dilute to 50 IVPB)	4	7.8
7	2		4 (dilute to 50 IVPB)	8	15.8
8	20	Stock #3	0.8 (dilute to 50 IVPB)	16	31.8
9	20		1.5 (dilute to 50 IVPB)	30	61.8
10	20		3 (dilute to 50 IVPB)	60	121.8
11	20		6 (dilute to 50 IVPB)	120	241.8
12	200	Stock #4	1.25 (dilute to 50 IVPB)	250	491.8
13	200		2.5 (dilute to 50 IVPB)	500	991.8
14	200		5 (dilute to 50 IVPB)	1000	1991.8

Reference: Cash JH et al. Desensitization as a tool for beta-lactam antibiotic use in methicillin sensitive Staphylococcus aureus infections. J of Pharmaceutical Tech and Drug Research. 2013 ISSN 2050-120X (extrapolated recipe for nafcillin)

Penicillin PO Desensitization (PREFERRED OVER IV PENICILLIN DESENSITIZATION

1. Pharmacy will prepare the following items
    a. 1st dose of full therapeutic PCN PO (pharmacy will call physician for order unless already ordered)
    b. Enter all the doses in EPIC (EPIC: Oral Penicillin Desensitization Protocol) and deliver all doses plus the first therapeutic PCN dose when everything is ready once the patient has an ICU bed (pharmacy will be notified by nurse)
    c. Prepare dilutions with Pen-VK 250mg/5mL solution
    d. Follow instructions for reconstitution of Pen-VK 250mg/5mL per manufacturer's recommendations
    e. After reconstitution, the original concentration of 250mg/5mL is equivalent to stock solution #3 (50mg/mL)
    f. Use stock solution #3 to prepare stock solution #2:
        i. Draw 2 mL from 50mg/mL bottle and dilute in 18mL of water to make a final concentration of 5mg/mL
    g. Use stock solution #2 to prepare stock solution #1:
        i. Draw 2 mL from 5mg/mL bottle and dilute in 18mL of water to make a final concentration of 0.5mg/mL
    h. Follow the steps indicated below and QS each dose with sterile water to 30mL before sending the doses up to the floor

2. Nurse
    a. Administer each dose at 15 min intervals until step 14
    b. Observe patient for hypersensitivity reactions after each dose administration
        i. If hypersensitivity reaction develops, stop desensitization dose administration
        ii. Call prescribing primary team for further instructions
    c. After step 14, observe patient for 30 minutes then give full therapeutic dose by route of choice
    d. After giving the first therapeutic dose of penicillin, observe the patient for 30min. If no hypersensitivity reactions, call the physicians to arrange for transfer out of the ICU (unless patient has other indications to be in the ICU)

	Step	Dilution (mg/mL)	mL administered	Dose/Step (mg)	Cumulative dose (mg)
Stock soln #1	1	0.5	0.1	0.05	0.05
	2	0.5	0.2	0.1	0.15
	3	0.5	0.4	0.2	0.35
	4	0.5	0.8	0.4	0.75

	5	0.5	1.6	0.8	1.55
	6	0.5	3.2	1.6	3.15
	7	0.5	6.4	3.2	6.35
Stock soln #2	8	5	1.2	6	12.35
	9	5	2.4	12	24.35
	10	5	4.8	24	48.35
Stock soln #3	11	50	1	50	98.35
	12	50	2	100	198.35
	13	50	4	200	398.35
	14	50	8	400	798.35

Reference: The Sanford Guide to Antimicrobial Therapy 2013 (43rd edition). Penicillin Desensitization. Page 80

Penicillin IV Desensitization

1. Pharmacy will prepare the following items
    a. 1st dose of full therapeutic PCN IV (pharmacy will call physician for order unless already ordered)
    b. Enter all the doses in EPIC (Order Panel: IV Penicillin Desensitization) and deliver all doses plus the first therapeutic PCN dose when everything is ready once the patient has an ICU bed (pharmacy will be notified by nurse)
    c. Reconstitute one 5 million unit vial with 8.5 ml SWFI or NS for a stock concentration of 500,000 U/mL
    d. To prepare solution 1 (40,000 units/100 mL):
        i. Draw up 0.8 mL of stock solution and dilute in 9.2 mL of NS to make stock solution #2 (40,000 units/mL)
        ii. Draw 1 mL of stock solution #2 and QS to 100 mL NS IVPB
    e. To prepare solution 2 (400,000 units/100 mL), take 0.8 mL of the initial stock solution and QS to 100 mL NS IVPB
    f. To prepare solution 3 (4,000,000 units/100 mL), take 8 mL of the initial stock solution and QS to 100 mL NS IVPB
2. Nurse
    a. Administer each dose at 15 min intervals until step 12
    b. Flush line completely after each dose to ensure all medication is administered to patient
    c. Observe patient for hypersensitivity reactions after each dose administration
        i. If hypersensitivity reaction develops, stop desensitization dose administration
        ii. Call prescribing primary team for further instructions

d. After step 12, observe patient for 30 minutes then give full therapeutic dose by route of choice
e. After giving the first therapeutic dose of penicillin, observe the patient for 30min. If no hypersensitivity reactions, call the physicians to arrange for transfer out of the ICU (unless patient has other indications to be in the ICU)

Step	Concentration (units/mL) in 100 ml IVPB		Volume administered (mL)	Infusion rate (mL/h)	Time (min)	Dose/Step (units)	Cumulative dose (units)
1	400 units/mL	Solution 1	0.5	2	15	200	200
2			1.25	5	15	500	700
3			2.5	10	15	1,000	1,700
4			5	20	15	2,000	3,700
5	4,000 units/mL	Solution 2	1.25	5	15	5,000	8,700
6			2.5	10	15	10,000	18,700
7			5	20	15	20,000	38,700
8			10	40	15	40,000	78,700
9	40,000 units/mL	Solution 3	2.5	10	15	100,000	178,700
10			5	20	15	200,000	378,700
11			10	40	15	400,000	778,700
12			80.5	79	61	3,220,000	3,998,700

Reference:

1. Chastain DB, Hutzley VJ, Parekh J, Alegro JVG. Antimicrobial Desensitization: A Review of Published Protocols. Pharmacy (Basel). 2019;7(3):112. Published 2019 Aug 9. doi:10.3390/pharmacy7030112
2. Houston Methodist. Rapid Penicillin Desensitization Protocol – IV or Oral. Published 2022 Aug 9.

Trimethoprim-Sulfamethoxazole (TMP-SMX) PO Desensitization

1. Pharmacy will prepare the following items
   a. Physician should order 1st dose of full therapeutic PO trimethoprim-sulfamethoxazole (pharmacy will call physician for order unless already ordered)
   b. Enter all the doses in EPIC (Order Panel : Oral Sulfamethoxazole – Trimethoprim Desensitization Protocol) and deliver all desensitizing doses when everything is ready once the patient has an ICU bed (pharmacy will be notified by nurse)

c. Prepare dilutions with trimethoprim (TMP)-sulfamethoxazole (SMX) 40-200mg/5mL oral solution
d. This is also stock solution #1
e. To make stock solution #2
    i. Take 1ml from stock solution #1 (amount = TMP 8mg / SMX 40mg), add 9ml of sterile water, final concentration = TMP 0.8mg / SMX 4mg /ml, label this stock solution #2.
f. To make stock solution #3
    i. Take 1ml from stock solution #2 (amount = TMP 0.8mg / SMX 4mg), add 9ml of sterile water, final concentration = TMP 0.08mg / SMX 0.4 mg /ml, label this stock solution #3.
g. To make stock solution #4
    i. Take 1ml from stock solution #3 (amount = TMP 0.08mg / SMX 0.4mg), add 9ml of sterile water, final concentration = TMP 0.008mg / SMX 0.04mg /ml, label this stock solution #4.
    ii. Follow the steps indicated below and QS each dose to 30mL sterile water before sending the doses up to the floor
    iii. Follow the steps indicated in below table for the doses

Hour	Dose (TMP/SMX) (mg)	Dose	How to compound dose
0	0.004/0.02	Dose #1	Take 0.5ml from stock solution #4 = TMP 0.004mg/ SMX 0.02mg, label this Dose #1. Put this in 29.5mL of sterile water before sending to floor
1	0.04/0.2	Dose #2	Take 0.5ml from stock solution #3 = TMP 0.04mg / SMX 0.2mg, label this Dose #2. Put this in 29.5mL of sterile water before sending to floor
2	0.4/2	Dose #3	Take 0.5ml from stock solution #2 = TMP 0.4mg/ SMX 2mg, label this Dose #3. Put this in 29.5mL of sterile water before sending to floor
3	4/20	Dose #4	Take 0.5ml from stock solution #1 = TMP 4mg / SMX 20mg, label this Dose #4. Put this in 29.5mL of sterile water before sending to floor
4	40/200	Dose #5	Take 5mL from stock solution #1 = TMP 40mg / SMX 200mg. Put this in 25mL of sterile water before sending to floor
5	160/800	Dose #6	Give one TMP/SMX (Bactrim) DS tablet

2. Nurse
    a. Administer each dose 1 hour apart as indicated in above table until the completion of dose #6
    b. Observe patient for hypersensitivity reactions after each dose administration
        i. If hypersensitivity reaction develops, stop desensitization dose administration
        ii. Call prescribing primary team for further instructions

c. After dose #6, observe the patient for 30min. If no hypersensitivity reactions, call the physician to arrange for transfer out of the ICU (unless patient has other indications to be in the ICU)
d. After Dose #6, observe patient for 30 minutes then patient is ready to be transferred out, the next dose of TMP-SMX will be on the next dosing interval

Reference

Rapid oral TMP-SMX Desensitization over 5 hours. Sandford Guide 2014. Page 80, Table 7

Trimethoprim-Sulfamethoxazole (TMP-SMX) IV Desensitization

1. Pharmacy will prepare the following items
    a. Physician should order 1st dose of full therapeutic IV trimethoprim-sulfamethoxazole (pharmacy will call physician for order unless already ordered)
    b. Enter all the doses in EPIC (Order Panel: IV Sulfamethoxazole – Trimethoprim Desensitization Protocol) and deliver all desensitizing doses when everything is ready once the patient has an ICU bed (pharmacy will be notified by nurse)
    c. Prepare stock solution from the TMP-SMX 16-80mg/mL vial
    d. Stock solution #1= TMP-SMX 16-80mg/mL
    e. Stock solution #2
        i. Take 1mL from stock solution #1 TMP-SMX 16-80mg/mL, add **4**mL of D5W to make final concentration of TMP-SMX 16-80mg/5mL = 3.2-16mg/mL
    f. Stock solution #3
        i. Take 1mL from stock solution #2 TMP-SMX 3.2-16mg/mL, add **9**mL of D5W to make final concentration of TMP-SMX 3.2-16/10mL = 0.32-1.6mg/mL
    g. Stock solution #4
        i. Take 1mL from stock solution #3 TMP-SMX 0.32-1.6mg/mL, add **9**mL of D5W to make final concentration of TMP-SMX 0.32-1.6mg/10mL = 0.032-0.16mg/mL
    h. Stock solution #5
        i. Take 1mL from stock solution #4 TMP-SMX 0.032-0.16mg/mL, add **9**mL of D5W to make final concentration of TMP-SMX 0.032-0.16mg/10mL = 0.0032-0.016mg/mL
    i. Stock solution #6
        i. Take 1mL from stock solution #5 TMP-SMX 0.0032-0.016mg/mL, add **9**mL of D5W to make final concentration of TMP-SMX 0.0032-0.016mg/10mL = 0.00032-0.0016mg/mL

j. Follow the steps indicated in below table and QS each dose to 50mL D5W IVPB before sending the doses up to the floor

Dose	Concentration TMP-SMX (mg/mL)	Stock solution number	Stock solution vol (mL)	QS to final volume in D5W	Dose (TMP-SMX)/step (mg)	Cumulative dose (TMP-SMX) (mg)
1	0.00032-0.0016	6	1	50	0.00032-0.0016	0.00032-0.0016
2	0.0032-0.016	5	1	50	0.0032-0.016	0.00352-0.00176
3	0.032-0.16	4	1	50	0.032-0.16	0.036-0.18
4	0.32-1.6	3	1	50	0.32-1.6	0.36-1,78
5	3.2-16	2	1	50	3.2-16	3.56-17.78
6	16-80	1	2	50	32-160	35.56-177.8
7	16-80	1	5	50	80-400	115.56-577.8
8	Full therapeutic dose	N/A	N/A	500	Full therapeutic dose	

2. Nurse
    a. Administer doses 1-7 IVPB over 20min every 15 min (Total time from start of infusion to start of next infusion is 35min) until step 8, then infuse this final dose over 90 minutes
    b. Observe patient for hypersensitivity reactions after each dose administration
        i. If hypersensitivity reaction develops, stop desensitization dose administration
        ii. Call prescribing primary team for further instructions
    c. After step 8, observe the patient for 30min. If no hypersensitivity reactions, call the physician to arrange for transfer out of the ICU (unless patient has other indications to be in the ICU)
    d. After step 8, observe patient for 30 minutes then patient is ready to be transferred out, the next dose of TMP-SMX will be on the next dosing interval

References

1. Turvey SE, Cronin B, Arnold AD, Dioun AF. Antibiotic desensitization for the allergic patient: 5 years experience and practice. Ann Allergy Asthma Immunol. 2004. 92(4):426-32
2. Tidwell BH, Cleary JD, Lorenz KR. Antimicrobial desensitization: a review of published protocols. Hosp Pharm. 1997. 32:1362-9

Approvals

		System
Critical Care Committee	**Date:**	**4/2025**
Pharmacy and Therapeutics Committee	**Date:**	**4/2025**

Clinical Practice Council	**Date:**	**5/2025**
Medical Executive Committee	**Date:**	**5/2025**
Board of Trustees	**Date:**	**6/2025**

ALAMEDA HEALTH SYSTEM	Policy	
	ORAL AMOXICILLIN CHALLENGE POLICY AND PROCEDURE	**29917 1**
	LEVEL ☐ System ☐ Site	EFFECTIVE DATE: 5/2025

Purpose

To provide guidance to clinicians prescribing antibiotics for adult patients with known or suspected history of allergic reactions to penicillin or cephalosporin antibiotics

Policy

Penicillin/cephalosporin allergies will be assessed and, when appropriate, tested safely with multi-disciplinary instructions provided by this policy and procedures.

Population

This policy is for use in inpatient units, emergency departments, and for clinics on the Highland Hospital campus. It is not for use in perioperative units, neonatal units, obstetric units, or clinics outside the Highland campus.

Penicillin/Cephalosporin Allergy Evaluation Protocol

1. Prescribers to review medication administration record in electronic medical record to see if patient has tolerated beta-lactam antibiotic(s) in the past
2. Prescribers to review the history of adverse reactions for all agents in the beta-lactam class of antibiotics listed in the electronic medical record with the patient to determine the type of reaction. Update the type of reaction as necessary in the electronic medical record
3. Review the Amoxicillin Oral Challenge Inclusion/Exclusion criteria (Appendix 1). If patients meets criteria, follow the challenge procedure (Appendix 2).

Appendix 1: Amoxicillin Oral Challenge Inclusion/Exclusion

Inclusion Criteria:

- Non-immediate cutaneous reaction only (without features suggestive of severe cutaneous adverse reactions (SCAR)*)
- Immediate cutaneous reaction (hives only without symptoms of anaphylaxis such as bronchospasm or hypotension) AND occurred more than 5 years ago
- Patient does not recall the specific penicillin allergic reaction AND the event was long ago
- Patients with a history suggestive of intolerance and worried about an allergic reaction
    - No oral challenge needed in patients with only a history of intolerance (GI upset, headache, yeast infection, etc.) or if there is a record of having previously tolerated penicillin at a time after the allergic reaction

Exclusion criteria:

- History of anaphylaxis or a recent reaction (within 5 years) suspected to be IgE-mediated (e.g., immediate onset urticaria)
- SCAR* including Stevens-Johnson syndrome and toxic epidermal necrolysis; generalized exanthematous pustulosis; drug rash with eosinophilia with systemic symptoms (DRESS), serum sickness, hemolytic anemia or other immune related organ-specific reactions are no candidates for oral challenge
- Pregnancy
- Comorbidity (consider risk vs benefit)
- Recent Beta-blocker use

- Recent Antihistamine use

*SCAR: features include blistering over a large surface area, skin sloughing, mucosal involvement AND almost always involves systemic symptoms requiring hospitalization

Appendix 2: Amoxicillin Oral Challenge Procedure

Prescriber:

- Review patient history and assess for inclusion/exclusion criteria as above
- Discuss oral amoxicillin challenge purpose and procedure with patient prior to the challenge
- Hold beta-blockers on the day of the challenge
- Hold antihistamines for at least 3 days prior to the challenge
- Utilize "Oral Amoxicillin Challenge" order panel in EPIC to order:
    - Amoxicillin 250mg PO x1
    - Diphenhydramine 50mg PO as needed for allergic reaction during challenge
- Update allergies in EPIC per results of the amoxicillin challenge
- Provide patient counseling based on the results of the oral challenge and ability to receive a penicillin and future risk of an allergic reaction and/or adverse event, etc

Nurse:

- Administer oral amoxicillin dose
- Monitor vitals and for allergic reaction per orders (every 20 minutes x 3)
- Contact prescriber if an allergic reaction occurs
- Contact prescriber if no reaction occurred after the 60-minute observation period is completed

Appendix 3: Management of Side Effects During Oral Amoxicillin Challenge

Side Effects Which Do Not Constitute a Failed Challenge:	Management
Anxiety	Examination and reassurance, provide patient with opportunity for distraction with reading materials/television.
Throat itching	Perform visual examination of the throat and vital signs. In the absence of visible changes provide the patient with reassurance that no changes are visible, offer the patient water to drink, and recheck in fifteen minutes.
Nausea, Vomiting, Abdominal discomfort	Perform examination and vital signs. In the absence of further signs/symptoms provide the patient with reassurance. This can typically be both treated and preempted by making sure the patient has taken some food prior to or during the oral challenge. Amoxicillin causes stomach upset in between 10-20% of patients.
Itching without a visible rash	Perform examination. Note that at baseline, some patients have dermatographism of the skin, which means that pressure with a tongue depressor or scratching will produce linear urticaria and redness of the skin. This does not constitute a challenge failure, but will require closer monitoring. In the absence of visible changes provide the patient with reassurance that no changes are visible and that the itching will typically subside, and recheck in fifteen minutes. If the itching is bothersome, notify provider as they may want to consider an oral antihistamine. Oral antihistamines can be provided and the clinician and the patient should discuss whether the penicillin allergy label will be removed from the chart or whether an outpatient drug allergy evaluation is warranted, based upon patient preference.

ALAMEDA HEALTH SYSTEM	Policy	
	ORAL AMOXICILLIN CHALLENGE POLICY AND PROCEDURE	**29917 1**
	LEVEL ☐ System ☐ Site	EFFECTIVE DATE: 5/2025

Side Effects Which Constitute a Failed Challenge:	Penicillin allergy label should remain in the chart with documentation of symptoms and suggest
Symptom	Management
Isolated Urticaria	Note the timeframe in which the drug was given and the onset of symptoms. Urticaria within 1 hour of the drug should be considered causal. Urticaria within 1-4 hours of the drug may be causal. Urticaria which is more than 4 hours after the drug is unlikely to be related. Treat with oral diphenhydramine
Anaphylaxis New onset hypotension occurring in the setting of drug administration within 1 hour should be considered as possible anaphylaxis and treated with injectable epinephrine. Angioedema, shortness of breath, altered mental status should be managed similarly. The hallmark of anaphylaxis is the presence of multisystem involvement. In particular patients who have skin + respiratory + cardiovascular findings have anaphylaxis until proven otherwise. List of systemic symptoms that can occur with anaphylaxis: - Disseminated Hives/Urticaria - Angioedema/Swelling of Face/Throat - Shortness of Breath, Wheezing, Coughing - Shock - Weak Pulse - Loss of Consciousness/Confusion - Severe Gastrointestinal Symptoms (Diarrhea, Vomiting)	Provider to treat with injectable epinephrine as appropriate and repeat dosing as necessary. Provider may consider additional symptomatic management with oral diphenhydramine. Antihistamines should not be substituted for epinephrine in anaphylaxis management. Anaphylaxis constitutes a failed challenge

		SYSTEM	WCHH/SLH/JG/FM	AH
Antimicrobial Stewardship	**DATE:**	3/2025		
System Pharmacy and Therapeutics Committee	**DATE:**	4/2025		
Clinical Practice Committee	**DATE:**	5/2025		
Medical Executive Committee	**DATE:**	5/2025		
Board of Trustees	**DATE:**	6/2025		

ALAMEDA HEALTH SYSTEM

MEDICATION: ADVERSE DRUG REACTION (ADR) REPORTING

Site	Alameda Health System	***Previous Revision Dates***	
Effective Date	4/2022	***Date Revised***	Not Approved Yet
Document Owner	MGR SYS MED SAFETY-CLIN PHARM	***Next Scheduled Review***	No Review Date

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

PURPOSE

To provide guidelines for the identification, reporting, documentation and formal review of adverse drug reactions.

GOALS

1. To improve patient care through reporting ADRs:
   a. Provide standardize process for identifying, reporting and monitoring of ADRs
   b. Anticipatory surveillance for high risk medications
   c. Identification of significant or preventable ADRs
   d. Education of health professionals to increase their level of awareness regarding ADRs
   *An ADR is defined as an undesirable effect due directly to a specific medication whether expected or not.

POLICY

All AHS healthcare professionals have a responsibility to report ADRs and potential ADRs as a mean to assess and improve the medication use process and provide a safe environment for patient care.

PROCEDURE

1. Reporting

a. The person detecting the reaction, if other than nursing, will notify the registered nurse caring for the patient.
b. The registered nurse caring for the patient will:
   1) Notify the attending/prescribing Physician
      i. Document in the patient record if information known in the ADR tab of the electronic health record
         a. Name of the suspected medication
         b. Signs and symptoms caused by the suspected ADR
         c. Sequence of events
         d. Emergency action taken
         e. Notification of the Physician
c. The provider, nurse or any healthcare professional involved in the patients care will enter the ADR as an AHS Safety Alert into Midas.

2. Review
   a. When possible, ADRs will be reviewed using the following methods:

1) ADR Dashboard

2) Healthcare member reporting through the AHS Safety Alert

b. The ADRs will be gathered and reviewed at least quarterly by a team including at least a physician and pharmacist. The following will be reviewed:
   1) Severity
   2) Probability
   3) Avoidability or preventability
   4) ADRs related to high risk medications

c. A summary report will then be presented to The Medication Safety or Medication Error Reduction Team Subcommittee which will determine actions needed.

d. Possible recommendations from the Medication Safety or Medication Error Reduction Team Subcommittee can include but not limited to:
   1) Peer chart review.
   2) Staff education
   3) Remove, place restrictions, or develop a protocol for the use of the medication.
   4) Conduct a formal drug use evaluation
   5) Report the ADR to the FDA Medwatch

e. The Medication Safety Subcommittee or Medication Error Reduction Team Subcommittee determines methods to evaluate the effectiveness of actions and re-reviews the results on a quarterly basis.

REFERENCES

TJC MM.07.01.03

APPROVALS

		System	Alameda
Department: Pharmacy	**Date:**	4/2025	
Pharmacy and Therapeutics (P&T)	**Date:**	4/2025	
Clinical Practice Council (CPC)	**Date:**	5/2025	
Medical Executive Committee	**Date:**	5/2025	
Board of Trustees	**Date:**	6/2025	

ALAMEDA HEALTH SYSTEM

MEDICATION: HEPARIN CONTINUOUS INFUSION POLICY

Site	Alameda Health System	***Previous Revision Dates***	
Effective Date	5/2025	***Date Revised***	4/2025
Document Owner	MGR SYS MED SAFETY-CLIN PHARM	***Next Scheduled Review***	4/2028
Executive Responsible	PHARMACY DIRECTOR		

PURPOSE

To provide guidelines for the safe administration of continuous unfractionated heparin (UFH) infusion for the treatment of acute coronary syndromes (ACS) or venous thromboembolism (VTE).

This policy applies to the following indications:

1. Deep vein thrombosis (DVT),pulmonary embolism (PE), and atrial fibrillation
2. Unstable angina (UA)/non-ST-elevation myocardial infarction (NON-STEMI) and ST-elevation myocardial infarction (STEMI)
3. Heparin for patients with high bleeding risk, no bolus infusion protocol
4. Heparin for CRRT Systemic Anticoagulation to prevent clotting of extracorporeal circuit

POLICY

Continuous UFH infusion for will be ordered by a provider.

1. The UFH order will include IV bolus dose when indicated per protocol or per provider discretion, starting initial infusion rates, titration infusion rates and frequency of laboratory monitoring.
2. UFH infusion will be administered and maintained by a nurse who is competent to care for patients on continuous UFH infusion.

PROCEDURE AND RESPONSIBILITIES

1. General Precautions

a. Anti-Xa level is the lab test used to monitor Heparin unless the Anti-Xa test is down or switched determined by the provider in which the aPTT will then be used.
b. Avoid intramuscular injections
c. UFH infusion should not be interrupted unless indicated in order or discontinued by physician
d. Avoid in the presence or recent active bleeding, unless instructed by the provider
e. Avoid sharp debridement of wounds while patient is on UFH infusion
f. Do not administer oral direct thrombin inhibitor (e.g. dabigatran), or oral factor Xa inhibitors (e.g. rivaroxaban, edoxaban, and apixaban) except per provider order
g. Refer to AHS Anticoagulation Guide for administration of UFH infusion in patients who are receiving or about to receive neuraxial blockage (intrathecal or epidural analgesia)
h. Avoid use in patient with history or suspect of HIT

2. **Ordering Provider**
   a. Prior to initiation of UFH for treatment of of any indication, provider will screen the patients for any signs or symptoms of bleeding and relative contraindications (platelet defect, recent major surgery, cerebrovascular hemorrhage, and active ulcerative GI disorders, etc).
   b. The provider will evaluate if the UFH treatment is appropriate for the patient. If the provider determines the UFH treatment is necessary he/she will document in the progress notes.
   c. Upon ordering UFH for VTE or ACS, provider shall order baseline aPTT, PT/INR, and CBC
   d. Provider shall order the initial bolus dose (can be omitted per physician's discretion), the initial infusion rate, and adjust bolus doses based on patient's actual body weight (ABW). However,
      i. If the patient's ABW is 20% more than the ideal body weight (IBW), adjusted body weight should be utilized to calculate UFH dosing. The provider shall utilize the online calculator in EPIC to determine the dosing weight.

         Formula for ideal body weight (IBW)
         Men= 50kg + (2.3 x [inches >5 feet])kg
         Women=45.5kg + (2.3 x [inches >5feet])kg
         Adjusted body weight: IBW + 0.4 (ABW – IBW)

   e. Initial UFH bolus dose and initial infusion rate guidelines:
      i. limit to ≤ 10,000 units initial bolus dose for the treatment of VTE
      ii. limit to ≤ 4,000 units initial bolus dose and the initial infusion rate ≤ 1,000 units/hour for the treatment of ACS
      iii. Limit High Bleeding Risk Protocol to ≤1000 units/hr initial infusion rate
      iv. Limit CRRT protocol to maximum initial infusion dose of 500 units/hr

   f. The Provider is responsible for the discontinuation and re-initiation of UFH infusion in the event the patient needs an interventional procedure or the patient has reached therapeutic levels
   g. Provider shall ensure that outpatient anticoagulation management therapy is ordered for the patient prior to discharge, if applicable.

3. **Nursing**
   a. Nurses shall administer UFH infusion and document administration as per AHS Medication Administration Policy
   b. When a patient receives UFH infusion, **TWO** nurse verification is required to ensure the following:
      i. Accurate Anti-Xa or aPTT entered
      ii. Accurate titration dose entered in Epic based on the Heparin Calculator
      iii. Accurate unit/kg/hr dose entered into Infusion Pump
   c. Only standard concentration of 100 unit/mL UFH (25,000 units of heparin in 250 mL of diluents) shall be administered

d. Whenever heparin is administered as a continuous infusion, a programmable infusion pump will be utilized.
e. Nurses will round to the bolus dose to the nearest 1000 units Nurses shall ensure the laboratory tests are drawn as indicated per provider's order
    i. Baseline aPTT, PT/INR, and CBC should be available prior to initiation of heparin
    ii. Send Anti-Xa (or aPTT) every 6 hours after starting infusion or 6 hours after any dosage changes
    iii. Obtain Anti-Xa (or aPTT) every 6 hours and adjust infusion by the heparin dosage adustment until the Anti-Xa (or aPTT) is therapeutic
    iv. Obtain Anti-Xa (or aPTT) Q24 hours once two consecutive Anti-Xa (or aPTT) are therapeutic
    v. Obtain CBC every 3 days
f. Nurses should notify provider if any bleeding event or signs and symptoms of bleeding
g. Nurses will temporarily hold UFH infusion in the setting of acute signs/symptoms of bleeding or supratherapeutic coagulation test results as instructed by the order/protocol. Access to the protocol appears as a link on the MAR in Epic as "REFERENCE ONLY". Please note, it is the provider's ultimate responsibility to discontinue UFH infusion if condition is warranted

4. Pharmacist

a. Upon receiving UFH orders, pharmacist shall verify the accuracy of the bolus doses, and initial infusion rate based on appropriate weight.
b. Pharmacist should clarify with the provider if any dosing correction needs to be made.
c. Pharmacy shall prepare UFH infusion bag in either D5W/0.9%NS/0.45%NS (for patient with diabetes) in the concentration of 100 unit/mL UFH (25,000 units of heparin in 250 mL of diluents)

APPROVALS

		System	Alameda	AHS/Highland/John George/San Leandro
Department	**Date:**	4/2025		
Pharmacy and Therapeutics (P&T)	**Date:** 4/2025			
Clinical Practice Council (CPC)	**Date:**	5/2025		
Medical Executive Committee	**Date:**	5/2025		
Board of Trustees	**Date:**	6/2025		

ALAMEDA HEALTH SYSTEM

MARIJUANA: RECREATIONAL AND MEDICAL USE

Site	Alameda Health System	***Previous Revision Dates***	2/00, 1/03, 12/06, 7/2013, 2/2022
Effective Date	2/00	***Date Revised***	4/2025
Document Owner	MGR SYS MED SAFETY-CLIN PHARM	***Next Scheduled Review***	4/2028

Purpose

Alameda Health System (hereinafter "AHS") is committed to providing a safe, healthy, and productive environment. Consistent with this commitment, this policy establishes AHS's intent to maintain a marijuana free environment for our patients (except for those Eligible Patients as set forth by the Compassionate Access to Medical Cannabis Act or Ryan's law and described in the SB311 Compassionate Access to Medical Cannabis Policyresidents, visitors, and employees.

Policy

In accordance with State and Federal Law, it is the policy of AHS to expressly prohibit the use, possession, purchase, sale, transportation, or distribution of marijuana – including all derivative products not FDA approved for clinical use, legally use, possess, purchase, sell, conceal, transport, or distribute marijuana on any AHS property, or facility owned or under the managing authority of AHS, with the exception of those Eligible Patients as set forth by the Compassionate Access to Medical Cannabis Act or Ryan's Law, to the extent Eligible Patients may use medical cannabis as described in the SB311 Compassionate Access to Medical Cannabis Policy.[1]
It is important to acknowledge that AHS is a federal contractor (accepts Medicare, Medi-Cal and CHAMPUS) and therefore, must operate and provide services in compliance with all applicable federal laws and regulations. To this date, marijuana remains a Schedule I drug under the Federal Controlled Substance Act, and for that reason, the use, possession, purchase, sale, transportation, or distribution of marijuana remains illegal under federal law. Accordingly, marijuana's classification as a Schedule I drug dictates that AHS employees, medical staff members, contractors, residents, visitors and patients (other than those Eligible Patients as set forth by the Compassionate Access to Medical Cannabis Act or Ryan's Law to the extent such Eligible Patients are permitted to use Medical Cannabis under the SB311 Compassionate Access to Medical Cannabis Policy) cannot legally use, possess, purchase, sale, transport, distribute or authenticate marijuana on any AHS property, or facility owned or under the managing authority of AHS.

[1] *See 42 U.S.C.A. § 1395i-3; California Health & Safety Code § 11362.45. See also 21 U.S.C.A. § 801 and § 812. See also California Senate Bill No. 311, Compassionate Access to Medical Cannabis Act or Ryan's Law (Cal. Health & Safety Code §1649 et seq.); and see SB311 Compassionate Access to Medical Cannabis Policy.*

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; **however, this policy does not apply to an Eligible Patient to the extent an Eligible Patient is permitted to use medical cannabis under the SB311 Compassionate Access to Medical Cannabis Policy).** 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.

Eligible Patient - An individual who is (a) terminally ill, and (b) has provided a copy of the patient's valid medical cannabis identification card, as described in Cal. Health and Safety Code §11362.715, or a copy of the patient's written documentation of physician's recommendation as defined in Cal. Health and Safety Code §11362.7. Please see SB311 Compassionate Access to Medical Cannabis Policy.

Marijuana - includes both (a) "medical marijuana," as defined under California's Compassionate Use Act (CUA), and (b) "recreational marijuana" as defined under the Adult Use of Medical Marijuana Act (AUMA).

Prohibited Conduct

A. Patients, (not including Eligible Patients to the extent Eligible Patients may use Medical Cannabis under the SB311 Compassionate Use of Medical Cannabis Policy)Residents, and Visitors

i. **General Rule** - The use, possession, sale, purchase, transfer, concealment, storage, or distribution of marijuana - including all derivative products - by visitors, residents, and patients (regardless of service or category of patient) is strictly prohibited on AHS property

ii. **Procedure** - If an AHS employee has a reasonable suspicion that a patient, resident, or visitor is in possession of marijuana or in violation of this policy, the employee must notify the immediate Supervisor and follow the procedures set forth under the following policies:

i. Patient's Own Medications: Storage, Security, Handling And Administration;[2]

[2] *See* Section (B) "Patients in Possession of Illegal Drugs, Controlled Substances. . . "

ii. Patient Rights and Responsibilities; and
iii. Controlled Substances.[3]

iii. **Violation of this policy** - Unless otherwise provided by law, a violation of this policy (*e.g.*, patient insists upon possession or using marijuana) is subject to disciplinary action, which may include the revocation of visitation privileges or administrative discharge of the patient.

B. AHS Employees

i. **General Rule** - The manufacture, possession, sale, purchase, transfer, concealment, storage, or distribution of marijuana - including all derivative products -by AHS employees while at work or while conducting AHS business, and consumption or being under the influence of marijuana while at work or while conducting AHS business (either on or away from AHS property) is strictly prohibited.

ii. **Procedure** – When the Department Manager (includes Executives, Directors, Managers, and Supervisors) has a reasonable suspicion that an employee is in violation of this policy, the supervisor must notify the immediate supervisor and follow the procedures set forth under the following policies:

i. HR: Section 1.00 - Policy 1.35 Drug-Free Workplace;
ii. HR: Section 3.00 – Policy 3.20 Expectations of Conduct; and
iii. HR: Section 5.00 - Policy 5.12 Workplace Security.

iii. **Violation of this policy** – Unless otherwise provided by law, a violation of this policy is subject to disciplinary action, up to and including immediate termination of employment.

Reference

21 U.S.C.A. § 801 and § 812
42 U.S.C.A. § 1395i-3
California Health & Safety Code:

- § 11362.1;
- § 11362.3;
- § 11362.45(f);
- §11362.45(g); and

§ 11362.785(a)

Approvals

		System Approval Dates
Legal Department	**Date:**	**4/2025**

[3] *See* Section 17. "Controlled Drug Destruction"

Regulatory Department	**Date:**	
Pharmacy Department	**Date:**	**4/2025**
System Pharmacy &Therapeutics	**Date:**	**4/2025**
Clinical Practice Committee	**Date:**	**5/2025**
Medical Executive Committee	**Date:**	**5/2025**
Board of Trustees	**Date**	**6/2025**

ALAMEDA HEALTH SYSTEM

SYSTEM MEDICATIONS: LOOK ALIKE, SOUND ALIKE

Effective Date	5/1/2024	***Date Revised***	4/2025
Document Owner	PRIYA PATEL (MGR SYS MED SAFETY-CLIN PHARM)MGR SYS MED SAFETY-CLIN PHARM	***Next Scheduled Review***	4/2028
Executive Responsible	DIRECTOR, PHARMACY		

PURPOSE

To ensure Alameda Health System (AHS) has a system in place to eliminate medication errors caused by the procurement, storage, dispensing and administration of look alike, sound alike medications.

POLICY

- To assist with the reducing the likelihood of medication events associated with Look Alike/Sound Alike medications, AHS will make every effort to comply with the following risk reduction strategies:
  a. Pre-printed order forms or order sets will be used whenever possible.
  b. Prescribers should not give verbal or telephone orders for sound alike look alike medications and chemotherapeutics.
  c. Computer screen selection and automatic dispensing machine screens (ADM's) will use **Tallman Lettering** to display easily confused medications whenever possible.
  d. Medications labels will include both generic and trade names to make them easier to distinguish whenever possible.
  e. Separate look-alike or sound-alike medications in the pharmacy and in the automated dispensing machine in the units.

- Problematic medications and safety strategies identified will be instituted per the guidelines referenced below.

PROCEDURE

1. The Institute of Safe Medication Practices (ISMP) will be reviewed to identify those medications to add to AHS Sound Alike Look Alike List.

2. At least annually, AHS Pharmacy and Therapeutics Committee will review and update (if needed) the list of look-alike/sound alike drugs used by the organization

3. AHS will regularly provide information to professional staff on drugs that have been determined to be problematic through published reports or internal issues.

REFERENCES

1. The Joint Commission Medication Management MM.01.02.01

2. Institute for Safe Medication Practices: ISMP's List of Confused Drug Names

3. https://www.ismp.org/tools/confuseddrugnames.pdf

APPROVALS

		System
Departmental	**Date:**	4/2025
Pharmacy and Therapeutics (P&T)	**Date:**	4/2025
Clinical Practice Council (CPC)	**Date:**	5/2025
Medical Executive Committee	**Date:**	5/2025
Board of Trustees	**Date:**	6/2025

ACUTE CARE HOSPITALS

MEDICATIONS		SAFETY STRATEGY
ALPRAZolam	**LOR**azepam	• Store separately from each other in different cubies in the ADM. • Tallman lettering and Auxiliary label
aman**TADINE**	amio**DARONE**	• Store separately from each other in different cubies in the ADM. • Tallman lettering and Auxiliary label
bu**PROPion**	bu**SPIR**one	• Store separately from each other in different cubies in the ADM. • Tallman lettering and Auxiliary label
Captopril	Carvedilol	• Store separately from each other in different cubies in the ADM. • Tallman lettering and Auxiliary label
Ce**FAZ**olin **–** Cef**TRIAX**one – Ce**FOX**itin – Cefo**TE**tan – Cef**TRIAX**one - Cef**TAZ**Idime		• Store separately from each other in different cubies in the ADM. • Tallman lettering and Auxiliary label
CeleBREX	Cerebyx	• Store separately from each other in different cubies in the ADM. • Tallman lettering and Auxiliary label
carBAMazepine	**OX**carbazepine	• Store separately from each other in different cubies in the ADM. • Tallman lettering and Auxiliary label
CISplatin (Platinol)	**CARBO**platin (Paraplatin **)**	• Pre-printed order forms are used to clearly identify medication being ordered. • Stored solely in the pharmacy. • Products are separated by at least one shelf and clearly marked. • No medication abbreviations are accepted. • Orders are double checked by two pharmacists and two nurses prior to administration.
DOPamine	**DOBUT**amine	• Store separately from each other in different cubies in the ADM. • Tallman lettering and Auxiliary label
DOXOrubicin	**DAUNO**rubicin	• Pre-printed order forms are used to clearly identify medication being ordered. • Stored solely in the pharmacy. • Products are separated by at least one shelf and clearly marked. • No medication abbreviations are accepted. • Orders are double checked by two pharmacists and two nurses prior to administration.
FOSphenytoin (Cerebyx)	**PHENY**toin (Dilantin)	• Store separately from each other in different cubies in the ADM. • Tallman lettering and Auxiliary label
glipi**ZIDE**	gly**BURIDE**	• Store separately from each other in different cubies in the ADM.

MEDICATIONS		SAFETY STRATEGY
		• Tallman lettering and Auxiliary label
Heparin	HEPARIN (pediatric strength versus adult)	• Stored in limited supply in Automated Dispensing machines. • Double checked by pharmacy before restocking Automatic Dispensing Machine (ADM) • Heparin drip requires double RN signature during medication administration and each dose titration
hydr**ALAZINE**	hydr**OXY**zine	• Store separately from each other in different cubies in the ADM. • Tallman lettering and Auxiliary label
HYDROcodone	Oxy**CODONE** (immediate release)	• Store separately from each other in different cubies in the ADM. • Tallman lettering and Auxiliary label
HYDROmorphone (Dilaudid)	morphine (Astramorph, Duramorph)	• Dispensing of these medications are controlled and tracked through the Automated dispensing machines. • Stored in the ADM in different cubies and/or different drawers. • Tallman lettering.
Insulin products • Lantus and Lente • Humalog and • Humulin • Novolog and • Novolin • Humalog and • Novolog • Novolin 70/30 and • Novolog Mix • 70/30	**H**umu**LIN** **H**uma**LOG** **N**ovo**LOG** **N**ovo**LIN**	• Only approved insulin products are stocked in the nursing unit to limit the variety. • The removal of insulin doses are recorded and tracked through the automated dispensing machines. • All insulin short acting medications are available as vials while insulin long acting medications are available as pens whenever possible. • All insulin medications are patient specific and clearly marked with auxiliary labels to differentiate the products and are patient specific (except for the ED). • Tallman lettering
LamoTRIgine	LevETIRAcetam	• Store separately from each other in different cubies in the ADM. • Tallman lettering and Auxiliary label
Lev**ETIRA**cetam (Keppra)	Lev**OCARN**itine	• Store separately from each other in different cubies in the ADM. • Tallman lettering and Auxiliary label

MEDICATIONS		SAFETY STRATEGY
levo**FLOX**acin	lev**ETIRA**cetam	• Store separately from each other in different cubies in the ADM. • Tallman lettering and Auxiliary label
Met**FORMIN** (GLUCOPHAGE)	metro**NIDAZOLE** (**FLAGYL)**	• Store separately from each other in different cubies in the ADM. • Tallman lettering and Auxiliary label
Dexamethasone	Dexmedetomidine	• Store separately from each other in different cubies in the ADM. • Auxiliary Label
methylene blue	**V**ision**B**lue	• Store separately from each other in different cubies in the ADM. • Tallman lettering and Auxiliary label
MS Contin (morphine extended release)	Oxy**CONTIN** (extended Release)	• Store separately from each other in different cubies in the ADM. • Tallman lettering and Auxiliary label
niCARdipine	NIFEdipine	• Store separately from each other in different cubies in the ADM. • Tallman lettering and Auxiliary label
predni**SONE**	predniso**LONE**	• Store separately from each other in different cubies in the ADM. • Tallman lettering and Auxiliary label
PACLitaxel (Taxol)	**DOCE**taxel (Taxotere)	• Pre-printed order forms are used to clearly identify medication being ordered. • stored solely in the pharmacy. • Products are separated by at least one shelf and clearly marked. • No medication abbreviations are accepted. • Orders are double checked by two pharmacists and two nurses prior to administration.
PHENYLephrine (Neo-Synephrine)	**NOREPI**nephrine (Levophed)	• Store separately from each other in different cubies in the ADM. • Tallman lettering and Auxiliary label
ri**FAM**pin	ri**FAX**imin	• Store separately from each other in different cubies in the ADM. • Tallman lettering and Auxiliary label
solu**CORTEF**	solu**MEDROL**	• Store separately from each other in different cubies in the ADM. • Tallman lettering and Auxiliary label
Tdap	**D**tap	• Store separately from each other in different cubies in the ADM. • Tallman lettering and Auxiliary label
vin**CRIS**tine (Oncovin)	vin**BLAS**tine (VELBAN)	• Pre-printed order forms are used to clearly identify medication being ordered. • stored solely in the pharmacy. • Products are separated by at least one shelf and clearly marked. • No medication abbreviations are accepted.

MEDICATIONS		SAFETY STRATEGY
		• Orders are double checked by two pharmacists and two nurses prior to administration.
COVID-19 Monovalent vaccine	COVID-19 BIVALENT Vaccine	• Storage: Each vaccine has separate labeled bins (color specific bins) for monovalent vs. bivalent • Labeling: Each vaccine has a specific label in the fridge/freezers (color specific) and in Pyxis
COVID-19 Adult Vaccine	COVID-19 Pediatric Vaccine	• Storage: Each vaccine has separate labeled bins (color specific bins) specific for adult vs. peds • Labeling: Each vaccine has a specific label in the fridges/freezers (color specific labels) and in pyxis

Ambulatory Care, Behavioral Health, and Long Term Care

MEDICATIONS		SAFETY STRATEGY
bu**PROP**ion	bus**PIR**one	• Store separately from each other in different cubies in the ADM. • Tallman lettering and Auxiliary label
citalopram hydrobromide (Cele**XA**)	Celecoxib **(**Cele**BREX)**	• Prescribers will give verbal or telephone orders only when truly necessary. • Staff to read back all orders, spell the product name, and state its indication. • Whenever possible, prescribers will include brand and generic names when writing orders and use computer generated or typed prescriptions.
clo**NID**ine (Catapress)	Clonaze**PAM** (Klonopin)	• Prescribers will give verbal or telephone orders only when truly necessary. • Staff to read back all orders, spell the product name, and state its indication. • Whenever possible, prescribers will include brand and generic names when writing orders and use computer generated or typed prescriptions.
Concentrated: morphine oral liquid Roxanal, MSIR	**Conventional:** morphine oral liquid	• Concentrated oral morphine solutions are only dispensed upon receipt of an order for a specific patient (not as unit stock). • The concentrated solution is segregated from the other concentrations in the Pyxis C2 Safe. • Concentrated solutions are purchased and dispensed in dropper bottles and dispensed as unit dose for inpatients.
chlorpro**MAZINE**	chlordiaze**POXIDE**	• Store separately from each other in different cubies in the ADM.

MEDICATIONS		SAFETY STRATEGY
		• Tallman lettering and Auxiliary label
DULoxetine	**FLU**oxetine **PARoxetine**	• Store separately from each other in different cubies in the ADM. • Tallman lettering and Auxiliary label
Insulin products • Lantus and Lente • Humalog and • Humulin • Novolog and • Novolin • Humalog and • Novolog • Novolin 70/30 and • Novolog Mix • 70/30	**H**umu**LIN** **H**uma**LOG** **N**ovo**LOG** **N**ovo**LIN**	• Only approved insulin products are stocked in the nursing unit to limit the variety. • The removal of insulin doses are recorded and tracked through the automated dispensing machines. • All insulin short acting medications are available as vials while insulin long acting medications are available as pens. • All insulin medications are patient specific and clearly marked with auxiliary labels to differentiate the products and are patient specific (except for the ED). • Tallman lettering
lami**VUD**ine	lamo**TRI**gine	• Store separately from each other in different cubies in the ADM. • Tallman lettering and Auxiliary label
Terbinafine (Lam**ISIL**)	Lamotrigine (La**MIC**tal)	• Prescribers will give verbal or telephone orders only when truly necessary. • Staff to read back all orders, spell the product name, and state its indication. • Whenever possible, prescribers will include brand and generic names when writing orders and use computer generated or typed prescriptions.
Thio**THIX**ine	thio**RID**azine	• Store separately from each other in different cubies in the ADM. • Tallman lettering and Auxiliary label
tra**ZOD**one	tra**MAD**ol	• Store separately from each other in different cubies in the ADM. • Tallman lettering and Auxiliary label
Nefazodone (Serzone)	Quietapine (**SERO**quel)	• Prescribers will give verbal or telephone orders only when truly necessary. • Staff to read back all orders, spell the product name, and state its indication. • Whenever possible, prescribers will include brand and generic names when writing orders and use computer generated or typed prescriptions.
Olanzapine (Zy**PREXA**)	Cetirizine (Zyr**TEC**)	• Prescribers will give verbal or telephone orders only when truly necessary. • Staff to read back all orders, spell the product name, and state its indication. • Whenever possible, prescribers will include brand and generic names when writing orders and use computer generated or typed prescriptions.

MEDICATIONS		SAFETY STRATEGY
Hep A Vaccine Adult (HAVrix)	Hep A Vaccine Pediatric (HAVrix)	• For those campuses that carry both Adult and Pediatric doses, adult dosing syringes will be labeled “Adult” • ADULT dose syringes stored on separate shelf from pediatric dose syringes • Pharmacist to double check all syringes & dosage prior to loading in Pyxis • Nurses to confirm ADULT and dosage prior to administration
Hepatitis A Vaccine (HAVrix)	Hepatitis A/B Vaccine (TWINrix)	• Stored separately from each other on different shelves when possible in refrigerated • Pharmacist to double check all syringes & dosage prior to loading in Pyxis • Nursing to confirm name and dosage prior to administration
COVID-19 Monovalent vaccine	COVID-19 BIVALENT Vaccine	• Storage: Each vaccine has separate labeled bins (color specific bins) for monovalent vs. bivalent and separated by a shelf when possible • Labeling: Each vaccine has a specific label in the fridge/freezers (color specific) and in Pyxis
COVID-19 Adult Vaccine	COVID-19 Pediatric Vaccine	• Storage: Each vaccine has separate labeled bins (color specific bins) specific for adult vs. peds and try to limit the vaccine available and stocked in a particular area • Labeling: Each vaccine has a specific label in the fridges/freezers (color specific labels) and in pyxis identifying Adult vs Peds and what age range

SOUND ALIKE – LOOK ALIKE MEDICATIONS

(Ambulatory, Long Term Care and Psychiatry)

buPROPion – busPIRone

citalopram (CeleXA) – celecoxib (CeleBREX)

concentrated morphine oral liquid - conventional morphine liquid

chlorproMAZINE – chlordiazePOXIDE

DULoxetine – FLUoxetine

DULoxetine – PARoxetine

Insulin Products – HumuLIN, HumaLOG, NovoLOG, NovoLIN

lamiVUDine – lamoTRIgine

Terbinafine (LamISIL) – lamoTRIgine

thioTHIXine – thioRIDazine

traZODone – tramadol

nefazodone (Serzone) –quietapine (SEROquel)

olanzapine (zyPREXA) – Cetirizine (zytrTEC)

Hep A Vaccine **Adult** – Hep A Vaccine **Pediatric**

Hepatitis A Vaccine HAVrix - Hepatitis A/B Vaccine TWINrix

SOUND ALIKE – LOOK ALIKE MEDICATIONS

ALPRAZolam – **LOR**azepam
aman**TADINE** – amio**DARONE**
bu**PROP**ion - bu**SPIR**one
captopril - carvedilol
car**BAM**azepine – **OX**carbazepine
ce**FAZ**olin **–** cef**TRIAX**one – ce**FOX**itin – cef**TAZ**idime - cefo**TE**tan
celeBREX - cerebyx
CISplatin – **CARBO**platin
Dexamethasone - Dexmedetomidine
DOPamine – **DOBUT**amine
DOXOrubicin – **DAUNO**rubicin
glipi**ZIDE** – gly**BURIDE**
FOSphenytoin – **PHENY**toin
Heparin adult strength – Heparin Pediatric strength
hydr**ALAZINE** – hydr**OXY**zine
HYDROcodone –oxycodone
HYDROmorphone – morphine
Insulin Products – Humu**LIN**, Huma**LOG**, Novo**LOG**, Novo**LIN**
lev**ETIRA**cetam - lev**OCARN**itine
lamo**TRI**gine - lev**ETIRA**cetam
levo**FLOX**acin – lev**ETIRA**cetam
methylene blue - **V**ision**B**lue
metformin – metro**NIDAZOLE**

MS Contin – oxy**CONTIN**
ni**CAR**dipine - **NIFE**dipine
PACLitaxel – **DOCE**taxel
PHENYLephrine – **NOREP**Inephrine
predni**SONE** – predniso**LONE**
solu**CORTEF** - solu**MEDROL**
Tdap – **D**tap
vin**CRIS**tine – vin**BLAS**tine

SOCIAL MEDIA/NETWORKING AND OTHER WEB-BASED COMMUNICATIONS - INTERNAL

Site	AHS System	***Date Revised***	1/2018, 06/2020, 3/2025
Effective Date	9/2013	***Next Scheduled Review***	4/2028
Author	DIR, CORP COMMUNICA & MARKETING		
Responsible Person	VP of Public Affairs and Community Engagement		

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

Policy Statement

This policy is to define standards required for creating social media and other web-based content on behalf of Alameda Heath System (AHS) including messaging, promotion, public relations, and other digital communications.

Purpose

This SOCIAL MEDIA/NETWORKING AND OTHER WEB-BASED COMMUNICATIONS – INTERNAL policy is designed to provide guidance to AHS workforce members regarding the use of AHS sponsored social media accounts or personal use of social media, or web-based networking platforms and tools by workforce members as it pertains to AHS work related activities. AHS respects the use of social media by its workforce members.

Use of social media and other web-based platforms can pose risks to AHS, patients and workforce members' confidential, proprietary and sensitive information, can harm AHS's reputation in the community. In addition, it can expose AHS to discrimination and harassment claims, and can jeopardize AHS's compliance with business rules and laws, including but not limited to AHS's compliance with the Health Insurance Portability and Accountability Act (HIPAA) and related laws and regulations protecting patient protected health information (PHI). To minimize these business and legal risks, AHS workforce members shall adhere to the following policy regarding social media and web-based platforms.

Definitions

Electronic Communication or Electronic Information includes, but is not limited to: electronic mail (email) messages, attachments, or links; instant messages; voicemail messages; text messages; digital photos; telephone conversations; Internet histories; social media posts, conversations, or messages; facsimiles; or any other kind of files, data, documents, communications, or messages, transmitted to, received by or printed from, or stored or recorded on any electronic device or on any media.

Personally Identifiable Information (PII) is any individually identifiable information that is confidential regarding a person including: social security number, security code, driver's license number, financial or credit account numbers, and other personal confidential identifiers.

Protected Health Information (PHI) includes but is not limited to any and all individually identifiable information about the physical or mental health condition or treatment of any individual, including but not limited to any identifying information about a patient, such as a patient's name or a photo or video of the patient; any information about a patient's health condition or medication; and any information about payment for a patient's care and services.

Social Media/Networking Communications is any form of electronic communications or electronic information that uses a networking environment, including but not limited to all social media forums or platforms such as Facebook, LinkedIn, X, Instagram, Snapchat, YouTube, Pinterest, Tumblr, Reddit, WhatsApp, Little Red Book, chat rooms, non-AHS sponsored webpages, personal web sites, blogs and wikis.

Workforce members include employees, contracted staff, students, volunteers, medical staff and individuals representing or working at AHS.

Restrictions on Social media Use Related to Patient Privacy

1. Workforce members are absolutely prohibited from using social media in any way that would violate HIPAA or otherwise disclose or compromise patients' PHI. This includes but is not limited to the following:

    a. **DO NOT** use social media to post, upload, send, live stream or otherwise share or disclose a photo or video of any patient without prior written permission of the patient or the patient's authorized agent as required by applicable law and AHS policies. You must use AHS's authorization form to obtain such prior written permission. This prohibition includes photos and videos where the patient is not easily identifiable (e.g., a photo of the patient's hand, a close-up photo of any part of a patient's body, or a photo of the back of a patient in the far background of the photo).

    The prohibition also includes photos or video where the patient is easily identifiable, whether in the photo or video itself or through a caption. Similarly, photos and videos of patients participating in AHS-sponsored activities or events are prohibited without prior written permission from the patient(s). When in doubt, assume that you do not have permission to share a photo or video of the patient. Keep in mind that the patient or the patient's authorized agent may revoke the permission at any time, which could require you to destroy all such photos or videos, including where posted.

    Consent forms are available in multiple languages on the Public Affairs and Community Engagement intranet site.

    b. **DO NOT** use social media to post, upload, send, live stream or otherwise share or disclose the name of any patient (even if it's just the first name or a nickname) without prior written permission of the patient or the patient's authorized agent as required by applicable law and AHS policies. You must use the AHS authorization form to obtain such prior written permission. When in doubt, assume that you do not have permission to share the patient's name. Keep in mind that the patient or the patient's authorized agent may revoke the permission at any time, which could

require you to destroy all such photos or videos, including where posted. The patient's own postings about AHS or care at AHS do not constitute acceptable consent.

c. **DO NOT** use social media to post, upload, send, live stream or otherwise share or disclose ANY information about a specific patient or class of patients, even without a photo, video, or name, without prior written permission of the patient or the patient's authorized agent as required by applicable law. *(e.g. "Today we treated a young boy who came into the ER after a skateboarding accident. He was so brave during the stitches! Reminds me why I love pediatric care.)* You must use the AHS authorization form to obtain such prior written permission. This prohibition includes any patient's age, date of birth, biographical background information, unique medical condition, treatment or payment information, or other personal or identifiable information about a patient, whether alone or in concert with other information about the patient.

This prohibition also includes any photos, videos, or other identifying information about the family members of any patient. When in doubt, assume you do not have permission to share any information about a specific patient or class of patients. Keep in mind that the patient or the patient's authorized agency may revoke the permission at any time, which could require you to destroy all such photos or videos, including where posted.

2. Common Social media HIPAA violations that are prohibited by this Policy:

    a. Posting of images and videos of patients without written consent.
    b. Posting of gossip about patients.
    c. Posting of any information that could allow an individual patient to be identified.
    d. Sharing of photographs or images taken on an AHS facility premises in which patients or protected health information is visible.
    e. Sharing of patient information, photos or videos, in texts, on social media or in private group chats.

<u>Other Social Media Rules</u>

1. Workforce members should not use social media to make comments or otherwise communicate about coworkers, supervisors, vendors/suppliers in a manner that is vulgar, obscene, threatening, intimidating, harassing, libelous, discriminatory or unlawful.

2. You may not create a personal social media account using your AHS issued-email address.

3. You may share/repost content which initially appeared on AHS official social media platforms on your personal social media accounts.

4. Do not disclose PII of other AHS Workforce members.

5. Transparency: If you identify yourself as AHS's faculty or workforce member in any online social medium or network or your affiliation with AHS could be presumed, you must make

it clear that you are not speaking on behalf of AHS. Use this statement: "The views expressed here are my own and not those of my employer." "Identification" may not be explicit – photos taken on campus, within private employee areas, employees wearing badges, scrubs, lab-coats, or other AHS-branded material, identifiable break rooms and other non-work areas, are examples of non-explicit identification.

6. Workforce members shall respect the laws regarding copyrights, trademarks, rights of publicity and other third-party rights and other intellectual property rights, including AHS's own copyrights, trademarks, and brands. Users may not infringe on AHS logos, brand names, taglines, slogans, or other trademarks.

Use of AHS Sponsored Social media

All limitations on use of social media above apply to this section. The following additional requirements apply when using social media sponsored by AHS:

1. The creation of any website, blog, podcast, social media page, group, or any other digital asset that intends to represent AHS or any of its internal divisions, departments, or affiliated programs must be approved in advance by the Public Affairs and Community Engagement (PACE) Department.

2. AHS related or sponsored social media accounts may be appropriate tools for achieving organizational objectives; however, they must be coordinated with and authorized through the PACE Department.

3. AHS sponsored social media content shall be subject to administrative approval and AHS workforce members may be required to discontinue use if deemed inappropriate.

4. AHS workforce members must adhere to AHS rules of conduct and regulations when using or participating in AHS sponsored social media including protecting privacy of patient health information, privacy of other AHS Workforce members and affiliates and confidential hospital information.

5. Administrators of AHS sponsored interactive social media (such as Facebook) shall include a link to the Social Media Policy – Public.

6. The commission, sub-contracting, or building of websites, blogs, social platforms, digital content or other digital communications tools must be coordinated and approved through the PACE Department prior to its creation.

Conduct Not Prohibited by this Policy

Nothing in this policy is meant to limit your legal rights to use social media to speak about your political or religious views, lifestyle and personal issues, working conditions, wages, or union-related topics or activities with others inside or outside AHS, or to restrict any other legal rights. This policy is not intended to interfere with any rights provided by the National Labor Relations Act or your rights under the First Amendment of the United States Constitution including your right to free speech.

Compliance

AHS reserves the right to request to have online communications stop if AHS believes communications from any AHS workforce members are in violation of organizational policies, local, state or federal privacy laws. Violations will be investigated to determine the nature, extent and potential risk to the hospital. AHS workforce members who violate this policy will be subject to the appropriate disciplinary action as identified in the HIPAA Violations Sanctions policy or the Compliance Violations Sanctions policy.

References

1. The Health Insurance Portability and Accountability Act (HIPAA)
2. The Confidentiality of Medical Information Act (CMIA)
3. AHIMA Advantage e- Alert (Vol 12, Issue 40)
4. Dolan, Marsha; Wolter, Julie. "Using Social media to Promote the Use of a Personal Health Record (PHR) and the Management of Personal Health Information to Consumers." 2009

Approvals

Departmental	**Date: 1/2018**
Clinical Practice Council	**Date: 02/2022, 5/2025**
Medical Executive Committee	**Date: 5/2025**
Board of Trustees	**Date: 5/2025**

ALAMEDA HEALTH SYSTEM

INTERNAL COMMUNICATIONS

Effective Date	10/2021	***Date Revised***	10/06/2021, 3/2025
Document Owner	Victoria Balladares, Director of Corporate Communications & Marketing	***Next Scheduled Review***	4/2028
Executive Responsible	ALICE KINNER (VP, PUBLIC AFFAIRS- COMMUNITY ENGAGEMENT)		

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

Purpose

This policy applies to all Alameda Health System (AHS) employees, contractors, and affiliated staff and establishes clear expectations regarding effective formal and informal communication across all internal channels. It also establishes guidelines to mitigate communication overload, reduce noise and ensure relevant and timely communication.

Through this policy, AHS commits to delivering transparent, accessible, and effective communication that supports organizational goals and enhances the employee experience.

Policy

AHS' internal communications policy is to effectively communicate relevant and timely information that is clear and transparent to all employees through various approved internal communication channels. Further, AHS departments will work in collaboration to better inform employees.

All official AHS communications must follow brand, style and editorial guidelines. These guidelines and templates are available on the Public Affairs and Community Engagement (PACE) intranet page. Patient-facing posters, flyers and signs must submitted to PACE and the Signage and Wayfinding Steering Committee for review, approval and coordination.

During emergencies or crises, Alameda Health System will follow the Emergency Operations Management Plan. PACE supports systemwide emergencies or crises.

Principles of Internal Communication

1. Clarity and accuracy: All communications must be clear, accurate, and aligned with organizational values and policies.

2. Timeliness: Information must be shared promptly to ensure staff members have the necessary details to perform their roles effectively.

3. Confidentiality and compliance: Communications must adhere to HIPAA and other relevant regulations, ensuring patient and employee confidentiality.

4. Inclusivity and respect: Communications should be inclusive, respectful, and considerate of diverse perspectives and backgrounds.

5. Two-way communication: Employees should have opportunities to provide feedback, ask questions and engage in meaningful dialogue.

Internal Communication Guidelines

1. Professional tone and language: All internal communications should maintain a professional and respectful tone, free from offensive or discriminatory language.

2. Clear and concise messaging: Keep messages clear, relevant and concise to enhance comprehension and efficiency. Avoid jargon.

3. Use of approved channels: Employees should use designated communication platforms to ensure information security and consistency. An executive leader must approve all systemwide email distributions.

4. Response expectations: Emails and messages should be acknowledged within a reasonable timeframe (e.g., 24-48 hours for emails, sooner for urgent matters).

5. Personnel announcements: To reduce communication overload personnel announcements will only be shared systemwide for directors and above.

6. Posters and flyers: Public-facing posters, flyers and signs are reviewed by the Signage and Wayfinding Steering Committee. PACE approves branding and design. Facilities is responsible for posting and removing.

7. Confidentiality & data protection: Employees must not share confidential or sensitive information outside authorized channels.

8. Meeting etiquette: Virtual and in-person meetings should start and end on time, with an agenda provided in advance and cameras should be on.

9. Zoom backgrounds: Only approved branded Zoom backgrounds are allowed.

10. Emergency communication protocols: Employees should familiarize themselves with crisis communication procedures and ensure compliance during urgent situations.

Alameda Health System

BED BUGS, LICE, AND SCABIES MANAGEMENT PREVENTION PLAN.

Department	Infection Prevention and Control	***Effective Date***	5/2019
Campus	All	***Date Revised***	3/2019; 5/2022; 10/2024
Unit	All	***Next Scheduled Review***	5/2028
Author	Director Infection Prevention and Control	***Responsible Person***	VP of Quality

Table of Contents

Scope:

All Alameda Health System facilities

Background:

A parasite is defined as any organism living within or on another living creature and deriving advantage from doing so while causing disadvantage to the host. Healthcare-associated transmission has been reported with scabies, lice, and maggot infestations. Parasites may spend part or all their life cycle with the host. They are rarely spread by direct person-to-person contact; therefore, they usually require little attention from infection preventionists. However, infestations with ectoparasites or epidermal parasites are common among the community and healthcare facilities and can be responsible for infections of the epidermis or external layer of the skin.

Purpose:

To provide guidelines for management and prevention of Bed Bugs (Cimex lectularius Linnaes), Lice (Pediculosis humanus capitis), and Scabies (Sarcoptes scabiei var. humanus) in the healthcare setting.

Plan:

Management and prevention of Bed Bugs (Cimex lectularius Linnaes), Lice (Pediculosis humanus capitis), and Scabies (Sarcoptes scabiei var. humanus) guidelines are utilized when patients present to the facility or discovered after admission.
Transmission-Based Precautions are implemented when indicated for suspected or known infestation with Bed Bugs (Cimex lectularius Linnaes), Lice (Pediculosis humanus capitis), and Scabies (Sarcoptes scabiei var. humanus).

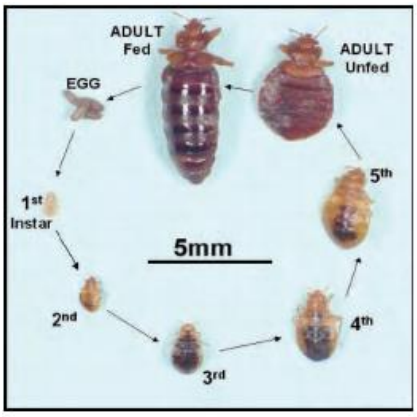
I. BED BUGS - CIMEX LECTULARIS LINNAES MANAGAMENT

1.1 Mechanism of Transmission

- Encounters with bed bugs occur most commonly when people **sleep in infested beds**, and often, **direct contact** to the **furniture and furnishings** in the same room will also be harboring the insect.
- Bed bugs are attracted to the host by the carbon dioxide exhaled, body heat, and various compounds emitted across the skin.
- Bed bugs tend **NOT TO LIVE on the human body**, and the only contact is for a blood meal, which occurs every few days. They preferred host is humans, but they will feed on other warm-blooded animals, including pets.
- Bed bugs **DO NOT LEAP or FLY.** They walk to feed off the host.

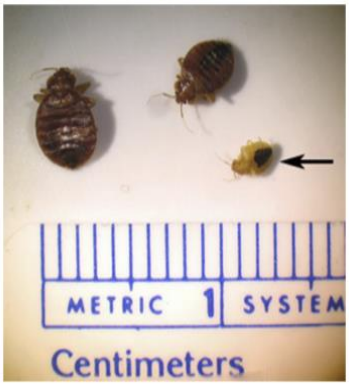
1.2 Survival on Fomites.

- Under average home and hotel living conditions at temperatures around 72°F (22°C), the life cycle takes around 2 months to complete.
- The adults can live up to 4.5 months and survive for long periods without feeding.
- Female bed bugs produce approximately 5 eggs daily.
- Eggs hatch in 4 -12 days and undergo 5 nymph stages.
- Each stage requires a 5 to 10 minutes blood meal before molting into the next stage.

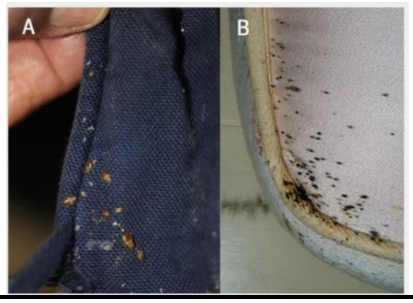


Bed Bug Life Stages Photo by Stephen L. Doggett

Figure 1. *Cimex lectularius* sizes (photo courtesy of the US Centers for Disease Control and Prevention).[11]



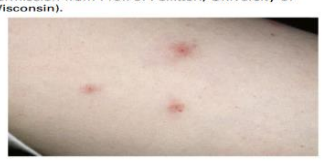
- Brown spots. Bedbugs are hard to see, so it's easier to identify them by their feces leave behind along mattress or box-spring inseam which is their natural habitat.



1.3 Clinical Presentation.

- **Bedbug bites often occur at night**, because the insects are nocturnal, with peak activity just before dawn. The incubation period is variable. Bed bug bite reactions may occur immediately, or up to 14 days after the bites.
- The most common clinical presentation for bed bugs is a **2- to 5-mm (pinprick size) pruritic maculopapular lesion** with a central hemorrhagic punctum located in areas typically uncovered by clothing when sleeping. It's painless lesson. The face, neck, hands, and arms are common sites for bed bug bites. Other symptoms include pruritus, papules, nodules, and bullous eruptions. If scratched, the bite areas can become infected.
- *Suspect bed bug bites whenever a patient consults for papules positioned in groups of three or four bites forming a "breakfast-lunch-dinner" curve or line (see a picture).*

Figure 4. *Cimex lectularius* bites (reprinted with permission from Prof. J. Pellitteri, University of Wisconsin).



1.4 Treatment.

Typically, no treatment is required for bed bug bites. If itching is severe, steroid creams or oral antihistamines may be used for symptom relief.
Secondary bacterial infections that develop over heavily scratched areas may require the use of antibiotics

1.5 Bed Bug Management:

Isolation/ Precaution:

- Standard Precautions.

Pest Control Services:

If a bed bug infestation is suspected in the health care facility, the following pest control and environmental procedures are recommended:

- Immediately (24/7) notify Environmental Services Manager/ Supervisor and log all incidents, and Nursing Supervisor and Infection Prevention during normal business hours.
- If possible, capture a bed bug and place it in a sealed container to assist pest management in their assessment. Have the patients change to new gowns/ clothes and place them in another room.
- Leave the suspect room intact without cleaning or removal of items (e.g., linens, furniture, equipment) to facilitate determination of the extent, if any, of the infestation and to prevent the spread of bugs to other areas. Close off the room or area from use, place signage ("Do Not Enter, Do Not Remove Equipment, Linen or Furniture from Room").
- Facility EVS Manager/ Supervisor contacts pest control to treat the room or area.
- The room shall be inspected, decontaminated, and determined safe for use by a certified pest management service company.

Environmental Services (EVS):

Cleaning Patient Room:

- Check mattress/ pillows for tears; if present, replace.
- Vacuum soft furniture and floors and surfaces.
- Room is to be terminally cleaned with AHS Environmental Services Cleaning Manual Terminally clean the room or area following these procedures:
- Staff person gowns up and also places disposable booties on feet.
- Remove all trash and double bag.
- Remove linen and double bag.
- Remove curtain and double bag.
- After the room is cleaned, the exterminator is to be called for inspection of the room before it is reopened.
- Special cleaning of the room, i.e., fumigation is not necessary.

Hospital linens:

Place all bed linen and patient gowns in a sealed plastic bag and send to a facility approved laundry facility.

Patient personal clothing/ items:

- Personal clothing can be washed: If on-site facility laundry is available: Send the clothes in sealed clear plastic bag with patient name tag and label "Bed Bug Infested belongings". Do NOT use RED biohazard bag. Remove clothes out of the bag and wash in hot water and dry on high heat cycle.
- If on-site facility laundry is not available: Place in a sealed plastic bag and send home with patient's family with instructions to wash in hot water and dry on high heat cycle.
- Otherwise it is to be bagged and marked as beg Bugs and disposed of

Personal clothing, including shoes, cannot be washed:

Place in a sealed plastic bag and send home with patient's family with instructions to place the items in a hot air dryer on the highest heat cycle (at minimum 1400F) for 30 minutes.
Otherwise, it is to be bagged and marked as Beg Bugs and disposed of.

II. LICE – PEDICULUS HUMANUS CAPITIS(HEAD LOUSE), P. HUMANUS CORPORIS(BODY LOUSE), AND PHTHIRUS PUBIS(CRAB OR PUBIC LOUSE)

Humans are the only natural reservoirs of the body, head, and pubic lice. Epidemics of pediculosis still occur and may be associated with poor hygiene, overcrowding, and inadequate facilities for keeping people and clothing clean. There appears to be increasing number of cases among persons of all socioeconomic levels. Likely contributing factors include communal living and widespread travel.

2.1 Mechanism of Transmission

- **Head lice** are usually spread among children crowded together in an urban daycare center and primary schools. They have **no wings, so they CANNOT JUMP, HOP or FLY from person to person**; they move by **crawling quickly** (Up to 30 cm/ minute) or by **grasping** a shaft of hair with tiny front claws and then **swinging** from one hair strand to another. In this way, they travel by:
- **Direct *head-to-head contact*** when children play with their heads close together.
- **Indirectly through *hats, coat hooks, scarves, bike helmets, headphones, hairbrushes, toys, or bedding***.
- **Body lice** are usually found among homeless people who live in situations in which bedding and clothing are not changed regularly. It can be transmitted ***indirectly through sharing towels and through sheets and clothing.***
- *Poor hygiene does play a role in body lice but does not in head lice.*
- **Pubic ("crab") lice** are transmitted by ***direct sexual contact***, mainly among adolescents and young adults, but also can be transmitted by ***sharing towels and through sheets and clothing***.

Lice will die within one or two days if removed or fallen off a human body

2.2 Survival on Fomites.

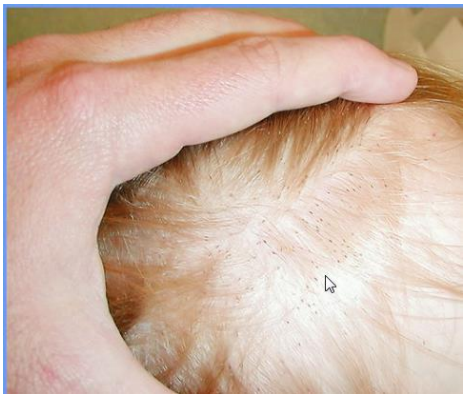
Head lice can survive on a human host for approximately 30 days.

2.3 Incubation Period.

With a first case of head lice, itching may not develop for 4 to 6 weeks, because it takes time to develop a sensitivity to louse saliva.

2.4 Clinical Presentation.

- Itching is the primary symptom of pediculosis. It is the result of an allergic reaction to louse saliva and takes two or more weeks to develop. By this time, the infestation is well established.
- Scratching leads to secondary bacterial skin infection.
- Body lice may be suggested by the presence of pruritus in homeless persons or in persons who live in situations in which bedding and clothing are not changed regularly. The examination may show generalized excoriations. Also, body lice should be confirmed in the seams of clothing.



A louse can crawl quickly! Up to 30 cm per minute, which makes them difficult to catch.
Nits are easier to spot, especially at the nape of the neck or behind the ears, within 1 cm of the scalp and most easily seen at the posterior hairline.

2.5 Isolation/ Precautions.

- **Contact Precautions**: perform hand hygiene and wear gown and gloves before entering infested patient room.
- Isolate for 24 hours after effective treatment. If possible, the patient should remain in the room during the isolation period.

2.6 Treatment.

- Medication-based treatment:
- Consult pharmacy for current treatment guidelines.
- For head lice: Do not use a combination shampoo/conditioner, or conditioner, before using lice medicine. Do not re–wash the hair for 1 – 2 days after removing the lice medicine.
- Hair-clipping
- When medically necessary, ensuring that a medication-based treatment works effectively.
- Cut hair with scissors, not clippers or a razor. Remove only enough hair to obtain medication efficacy, unless otherwise instructed by the physician.
- Electric clippers can be utilized as a substitute tool for patients who are combative or agitated.
- A consent must be obtained when the patient is capable of making a decision.

- If the patient is unable to participate in decision-making and the patient's surrogate is not present, physicians may make an order without prior informed consent. The reason of indication must be documented in a progress note.

2.7 Environmental Services Procedure.

- Only the items have been used or worn by the infested persons in the 2 days just before he or she was treated with lice-killing medicine need to be treated.

- **Hospital linens:** Place all bed linen and patient gowns in a sealed plastic bag and send to a facility approved laundry facility.

- **Patient personal clothing/ items:**
- Soak combs and brushes, and other hair accessories in hot water (at least 130°F) for 5–10 minutes.
- Personal clothing can be washed:
- If on-site facility laundry is available: Send the clothes in sealed clear plastic bag with patient name tag and label “Lice Infested belongings”. Do NOT use RED biohazard bag. Remove clothes out of the bag and wash in hot water and dry on high heat cycle.
- If on-site facility laundry is not available: Place in a sealed plastic bag and send home with patient’s family with instructions to wash in hot water and dry on high heat cycle.
- Otherwise it is to be bagged and marked as beg Bugs and disposed of.
- Personal clothing, including shoes, cannot be washed:
- These methods are for body lice infested patient.
- Place in a sealed plastic bag for 2 weeks to kill all stages of eggs, nymphs and lice
- Place in a sealed plastic bag and send home with patient’s family with instructions to place the items in a hot air dryer on the highest heat cycle (at minimum 140^0F) for 30 minutes.
- Otherwise it is to be bagged and marked as Beg Bugs and disposed of.

III. SCABIES - SARCOPTES SCABIEI (MITE)

Scabies is a skin condition caused by mites. It commonly leads to intense itching and a pimple-like skin rash that may affect various areas of the body. The contagion lasts until they are successfully treated, and the mites and eggs are destroyed.
Scabies is contagious and can spread quickly in areas where people are in close physical contact. Institutions such as nursing homes, extended-care facilities, and prisons are often sites of scabies outbreaks.

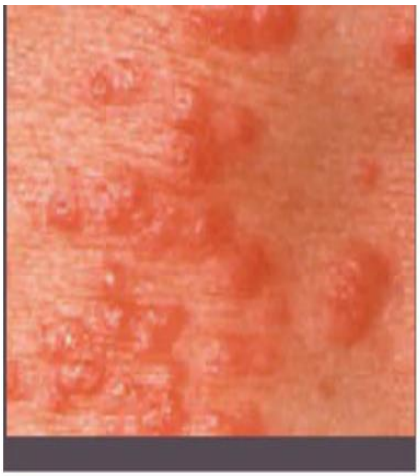
3.1 Mechanism of Transmission.

- Scabies usually is spread by skin-to-skin contact with a person who has scabies. The longer skin-to-skin contact, the more likely the spread happens. The infestation does not usually spread from brief contact.
- It sometimes is spread indirectly by sharing items such as clothing, towels, or bedding used by an infected person, but this is not as common.
- It can spread easily under crowded conditions where close body and skin contact is common and prolonged.
- Scabies mites do not survive more than 3 days away from a human body.

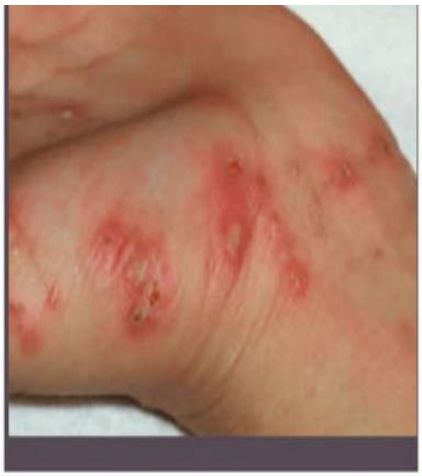
3.2 Clinical Presentation

- Common symptoms of itching and a pimple-like skin rash may affect much of the body or be limited to common places such as:
  - Between the fingers
  - Wrist
  - Elbow
  - Shoulder blades Armpit
  - Nipple
  - Waist
  - Genitals
  - Buttocks
- **Crusted scabies (formerly known as Norwegian scabies) is a severe form of scabies that is extremely contagious**.
- It is extremely contagious due to a large numbers of scabies mites and eggs—up to two million
- It is characterized by vesicles and formation of thick crusts over the skin rash and pruritus (itching) may be mild or absent.

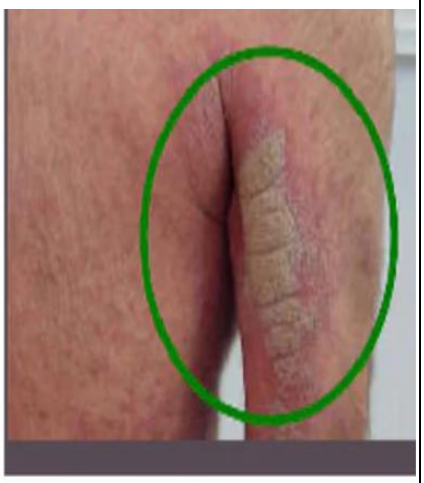
- Risk factors: the elderly; immunocompromised conditions (AIDS patient); or with conditions that prevent them from itching and/or scratching (spinal cord injury, paralysis, loss of sensation, severe mental or behavioral health conditions).



Typical scabies lesions on the skin



Scabies pustules on the wrist



Crusted scabies

3.3 Pathology Diagnosis:

- Scabies Preparation:
- Consult Pathology for specimen collection instructions.
- It is microscopic examination of the epidermis from sites that may harbor scabies mites.
- Because of the low mite burden in classic scabies, negative results do not exclude the diagnosis.

3.4 Incubation Period.

- **Primary Infestation**: The person did not have scabies before; symptoms usually do not appear for up to 2 to 6 weeks after being infested.
- **Subsequent Infestations**: If a person has had scabies before, symptoms appear 1-4 days after exposure.

3.5 Survival on Fomites.

- 2 to 3 days away from human skin

3.6 Isolation/ Precautions.

- **Contact Precautions**: perform hand hygiene and wear gown and gloves when entering patient room.
- Isolate for **24 hours** after effective treatment.

3.7 Treatment.

- Consult pharmacy or Infectious Disease physician for current treatment guideline.
- In addition to the infested person, treatment also is recommended for people they have been in contact with Consult pharmacy or Infectious Disease physician for current treatment guideline.

3.8 Environmental Services

- Hospital linens:
- Place all bed linen and patient gowns in a sealed plastic bag and send to a hospital approved laundry facility.
- Check mattress/ pillows for tears; if present, call Environmental Services to replace.
- Patient personal clothing/ items:
- Personal clothing that can be washed:
- If on-site facility laundry is available: Send the clothes in sealed clear plastic bag with patient name tag and label “Scabies Infested belongings”. Do NOT use RED biohazard bag. Remove clothes out of the bag and wash in very hot water and dry on high heat cycle for at least 20 minutes.
- If on-site facility laundry is not available: Place in a sealed plastic bag and send home with patient’s family with instructions to place both clothes and shoes in a hot air dryer on the high heat cycle for 20 minutes.
- Otherwise it is to be bagged and marked as Scabies and disposed of.

- <u>Personal clothing, including shoes, that cannot be washed:</u>
- Place in a sealed plastic bag for ONE week.
- Place in a sealed plastic bag and send home with patient’s family with instructions to place both clothes and shoes in a hot air dryer on the high heat cycle for 20 minutes or don’t open a sealed before ONE week.
- Otherwise it is to be bagged and marked as Scabies and disposed of.

- **<u>Environmental Services:</u>**
- Thoroughly clean and vacuum a patient room. Throw the vacuum bag away immediately after
- Vacuum soft furniture.

- Clean and disinfect a room, pillow/mattress with hospital approved disinfectant.
- Special cleaning of the room, i.e., fumigation or use of insecticidal sprays, is not necessary.

Related Policies:

Transmission Based Precautions Policy

References:

A. https://www.cdc.gov/lice/index.html
B. https://www.cdph.ca.gov/Programs/CID/DCDC/pages/headlice.aspx
C. https://cchealth.org/bedbugs/
D. http://www.cdc.gov/parasites/bedbugs/
E. http://www.cdc.gov/nceh/ehs/Publications/Bed_Bugs_CDC-EPA_Statement.htm
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I. https://www.uptodate.com/contents/scabies-epidemiology-clinical-features-and-diagnosis?search=scabies%20laboratory%20diagnosis&source=search_result&selectedTitle=1%7E102&usage_type=default&display_rank=1#H67764180
J. https://www.skabi-rid.co.za/pages/scabies
K. https://www.cdc.gov/infectioncontrol/pdf/guidelines/isolation-guidelines.pdf
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M. https://acvcsd.org/programs-services/
N. https://acvcsd.org/programs-services/bed-bugs/bed-bug-fact-sheets/
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Alameda Health System

CARBAPENEM-RESISTANT ORGANISM (CRO) INFECTION PREVENTION AND CONTROL PLAN

Department	Infection Prevention and Control	***Effective Date***	07/2016
Campus	All	***Date Revised***	08/2023, 03/2025
Unit	All	***Next Scheduled Review***	08/2027
Manual	Infection Prevention and Control	***Author***	Director, Infection Prevention and Control
Replaces the following policy: CRE Infection Prevention and Control Plan		***Executive Responsible***	Vice-President, Quality

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

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1. Background

Control of resistant organisms is a national problem and requires that facilities who share patients work together to prevent transmission.[1] This includes acute care facilities, long-term acute care hospitals, and nursing homes providing skilled nursing or rehabilitation services, but generally excludes assisted living facilities and nursing homes that do not provide more than long-term custodial care.

2. Purpose

To provide a plan for active surveillance of Carbapenem-resistant Organisms (CRO) and guidance for precautionary measures to prevent healthcare-associated transmission of CRO infection to patients, staff, and the community. This plan aligns with recommendations from recommendations from the Alameda County Public Health (ACPHD), California Department of Public Health (CDPH), and the Centers for Disease Control (CDC) CRE Toolkit.

3. Definitions

3.1 Multidrug-Resistant organisms (MDRO)

CDC defines for epidemiologic purposes, MDROs are defined as microorganisms, predominantly bacteria, that are resistant to one or more classes of antimicrobial agents.
Although the names of certain MDROs describe resistance to only one agent (e.g., MRSA, VRE, ESBL, CRO, CPO), these pathogens are frequently resistant to most available antimicrobial agents.

3.2 Carbapenem Resistant (CR) or Carbapenem-Resistant Organisms (CRO)

Organisms resistant to any carbapenem antimicrobial (i.e., minimum inhibitory concentrations of ≥4 mcg/ml for doripenem, meropenem, or imipenem OR ≥2 mcg/ml for ertapenem).

3.3 Carbapenemase Producer (CP) or Carbapenemase-Producing Organism (CPO)

- Only certain **CRO** produces carbapenemase enzyme which inactivate carbapenem antibiotics.
- The enzymes are coded by specific genes: KPC, IMP, NDM, VIM, OXA-48-like, OXA-23-like etc.
- Often, these genes are present on mobile genetic elements, which can be easily shared between bacteria, resulting in rapid spread and an outbreak in healthcare facilities.

3.4 Non-Carbapenemase Producer (Non-CP) or Carbapenemase Non-Producing Organism (CRO Non-CP)

- Organism resists carbapenem antibiotics but does not produce carbapenemase enzyme.
- The most common resistance mechanism often involves extended-spectrum beta-lactamase (ESBL) or AmpC beta-lactamase production in combination with alterations in the bacteria's cell membrane to cause permeability defects (e.g., porin mutations or efflux).

3.5 Colonization

Organisms can be found in or on the human body, but it is not causing any symptoms or disease. Colonization can increase a person's risk for infection. Also, people who are colonized can unknowingly spread these germs to others through person-to-person contact or contaminated surfaces in shared settings. Colonizing CRO/ CPO strains can go on to cause infections or spread to the other patients.
Risk factors transmission, infection, or colonization any MDRO included CRO/CPO include:

- History of extended hospitalizations
- High antimicrobial use, specially carbapenems treated recurrent infections
- Presence of indwelling devices (such as endotracheal tubes, feeding tubes, and catheters), open wounds, and multiple medical problems.
- History of receiving healthcare in a foreign country

3.6 Endogenous vs. Exogenous Infection

- **Endogenous**: When a person gets an infection caused by a pathogen that is already colonizing a part of their body (e.g., *S. aureus* in their nose).
- **Exogenous**: When a person gets an infection from a germ that recently spread to them from another person or from a shared contaminated surface.

3.7 High-risk factors facilitating MDRO (include CRO) transmission

- Ventilator dependence
- Stool and/or urine that is incontinent and not controlled
- Indwelling medical devices such as tracheostomy tube, central line, urinary catheter, feeding tube, surgical drains, etc.
- Draining wounds or uncontrolled secretions
- Unable to maintain personal hygiene because of cognitive impairment
- Total dependence: ADL score is 4, the highest.

4. Common Carbapenem-Resistant Organisms

4.1 Carbapenem Resistant Enterobacterales (CRE)

- Enterobacterales are bacteria group that as normally found in the human gut, and known to cause serious infections in the blood, lungs (pneumonia), urinary tract and wounds. *E. coli, Klebsiella pneumoniae, and Enterobacter cloacae.*
- CDC defines Carbapenem-resistant Enterobacterales (CRE) are resistant to any carbapenem antimicrobial (i.e., minimum inhibitory concentrations of ≥4 mcg/ml for doripenem, meropenem, imipenem OR ≥2 mcg/ml for ertapenem)
- Additionally, some Enterobacterales (e.g., *Proteus spp., Morganella spp., Providencia spp*.) have intrinsic elevated minimum inhibitory concentrations (MICs) to imipenem and therefore resistance to carbapenems other than imipenem is required to identify.
- KPC is the most identified carbapenemase of CP-CRE in the United States

4.2 Carbapenem-Resistant Acinetobacter baumannii (CRAB)

- Acinetobacter is a group of bacteria considered environmental organisms. It is commonly isolated from soil and water.
- Acinetobacter baumannii characteristics include:
    a. Almost exclusively found in health care environment.
    b. An opportunistic pathogen, affecting people who are immune-compromised due to other comorbidities or can cause serious, invasive healthcare-associated infections.
    c. "Colonize" or live in a patient without causing infections or symptoms, especially in

respiratory secretions (sputum) or open wounds.

- Carbapenem-resistant Acinetobacter baumannii (CRAB) is resistant to ertapenem, doripenem, imipenem and/or meropenem
- CRAB is often resistant to multiple antibiotics, or multidrug-resistant (MDRO).

4.3 Carbapenem-Resistant Pseudomonas aeruginosa (CRPA)

- Pseudomonas is another group of environmental organisms. The bacteria lives in soil and water.
- Pseudomonas aeruginosa is the one that most often causes infections in humans. The infections can be in the blood (patient with indwelling device), lungs (patient on ventilators), or other parts of the body after surgery (patient with wound from surgery or burns).
- Carbapenem-resistant Pseudomonas aeruginosa (CRPA) is resistant to ertapenem, doripenem, imipenem and/or meropenem

4.4 Comparing Enterobacterales, P. aeruginosa, and Acinetobacter spp.

Characteristic	Enterobacterales	Acinetobacter spp. (A. baumannii)	Pseudomonas aeruginosa
CRO/ CPO acronym	CRE (Non-CP) CRE (CP)	CRAB (Non-CP) CRAB (CP)	CRPA (Non-CP) CRPA (CP)
Common clinical specimen source	Gastrointestinal tract	Respiratory secretions, urine, wounds	Respiratory secretions, urine, wounds
Screening specimen	**Rectal** Swab	**Buccal** Swab AND Swab of **upper and lower extremities**	✓ **Sputum** for patients on mechanical ventilation ✓ **Wound** swab if a wound is present ✓ **Urine** for patients not mechanically ventilated or do not have a wound(s)
Epidemiology	Long-term acute care hospitals (LTACH) and skilled nursing facilities that provide ventilator care (vSNF) have the highest CRE prevalence	Some CRPA (CP) and CRAB (CP) isolates have been identified as pan-nonsusceptible to all tested antimicrobial drugs.	

Source: California Department of Public Health, Healthcare-Associated Infections Program, Guidance on investigating Carbapenem-Resistant Organisms (CRPA/CRAB) cases and clusters. Version 1.0, October 2020 CRO Quicksheet Oct 2020 (ca.gov) and Investigating CRE cases and clusters. Version 2.0, October 2019 CRE Quicksheet May 2021 (ca.gov)

5. Management Plan

All recommendations are subject to change case-by-case and are advised by the Infection Prevention and

Control department based on the most recent guidelines updated by State and Alameda County Public Health.

5.1 Facility wide actions

- Promote standard precautions for any care to every patient while emphasizing hand hygiene and proper PPE use.
- Promote Antimicrobial Stewardship
- Electronically flag patient records with CRO/ CPO infection or colonization
- Minimize the use of invasive devices
- Chlorhexidine bathing daily of patient in high-risk settings such as ICU and patients with indwelling medical devices
- Consider active surveillance such as admission screening of patient in high-risk settings such as ICU, patients with indwelling medical devices
- Consider preemptive isolation of patients who were transferred from known ongoing CRO outbreak Long-term care facilities

5.2 Room placement and patient cohorting

The decision of cohorting CRO/CPO patients should be consulted by Infection Preventionist.

A. Private room placement

It is important to prioritize private rooms for patients in a specific order below:

1. Patients who have been infected or colonized with Carbapenemase-producing organism (CPO)
2. Patients who have been infected or colonized with Carbapenemase-resistant organism (CRO)
3. Patients who have been transferred from an ongoing CRO outbreak facility that has been notified by the Alameda County Public Health Department.
4. Patients who have high-risk factors of MDRO transmission such as recent ICU admission, ventilator dependence, dependence on staff to perform ADLs, incontinence of stool or urine, draining wounds, or cognitive impairment that prevents maintenance of personal hygiene

B. Cohorting when private rooms are not available, but the organism is compatible.

California Public Health Department has issued a guidance of two types of cohorts can be implemented in a healthcare facility:

A within-room cohort is where patients or residents with **the same bacteria or carbapenemase (e.g., KPC, NDM) are placed within one room**, regardless of specimen source, infection, or colonization status.

A multi-room cohort is a designated area of the facility that contains multiple within-room cohorts with the same bacteria or carbapenemase enzymes, e.g., multiple within-room cohorts are placed together at the end of a hallway, unit, or floor.

A table listing the principles of patient or resident cohorting based on CRO/CPO type

Organism	Cohorting Recommendation

Carbapenemase producing (CPO) CP-CRE, CP-CRAB, or CP-CRPA	1. Prioritize by the same both bacteria and enzyme. Example: o KPC-E. coli with KPC-E. coli o NDM/KPC-E. coli with NDM/KPC-E. coli 2. If not possible, cohort by carbapenemase enzyme Example: o KPC with KPC o NDM/OXA-23 with NDM/OXA-23
Non-producing carbapenemase Non-CP-CRE, Non-CP-CRAB, Non-CP-CRPA **Carbapenemases not tested** CRE, CRAB, CRPA	By the same bacteria o CRE with CRE o CRAB with CRAB o CRPA with CRPA

C. Cohorting when neither private room nor compatible organism are available

The efforts should be made to cohort with the relatively healthy patients/residents who are at the lowest risk of acquiring MDRO/CRO (patients/ residents do not have indwelling devices, do not have open wounds, and are less dependent on staff for activities of daily living.

Source: California Department of Public Health, Healthcare-Associated Infections Program, Cohorting Guidance for Patients or Residents Infected or Colonized with Multidrug-resistant Organisms. Version March 2023 MDRO Patient Cohorting (ca.gov), and Cohorting Guidance for Residents Infected or Colonized with Multidrug-resistant Organisms for Skilled Nursing Facilities (SNF) MDRO SNF Cohorting (ca.gov)

5.3 Transmission-based Precautions during admission

A. Acute care setting

Table of Isolation indication for CRO/CPO infected or colonized patients in Acute care hospital

Organism	Precautions	Additional recommendation
CRO/CPO infection/ colonization	Contact	Encourage patient hand hygiene practice CPO infected patient must be isolated to their room
Outbreak investigation/ confirmed when Hospital-onset CRO/CPO that has epi-link transmission between patients has been identified	(*) Enhanced Contact	Encourage patient hand hygiene practice CPO infected patient must be isolated to their room Dedicated healthcare personnel might be recommended by ACPHD
CRO/CPO positive sputum	Contact & Droplet	Encourage patient hand hygiene practice

Personal Protective Equipment (PPE) including gloves and gowns should:

- be used, every time, by all staff and visitors entering the patient's room,
- be available outside the patient's room and donned before entering,
- be properly doffed (removed) and discarded directly before leaving a patient's room,
- also include masks and eye protection or face shields as indicated per standard precautions for MDROs and Droplet precautions with positive sputum.

Consider staff assigns to monitor and enforce hand hygiene and proper PPEs use during CPO outbreak

investigation or confirmed.

(*) Enhanced Contact isolation for CRO/CPO outbreak under investigation or confirmed

AHS Enhanced Contact precautions align with ACPHD CRE Packet of Caring for Patients with Carbapenem-resistant Enterobacteriaceae (CRE) in Acute-Care facilities published in March 2019.
In the occasion of Hospital-onset CRO/CPO infection and has epi-link transmission between patients has been identified, the hospital Infection Preventionist will conduct the risk assessment of CRO transmission and discuss with the unit manager to escalate Enhanced Contact Precautions. The objective is to ensure that everyone adhere to contact precautions when providing cares.

- A monitor person will be required at all times and be authorized to stop any personnel not complying with Enhanced Precautions requirement.
- A monitor log will be implemented to track all staff entering the patient's room.
- Dedicated healthcare personnel might be considered.

B. Post-acute care setting

Use the following **MDRO Transmission Risk Assessment Questions** to assess the current risk factors of your patient with a current infection/colonization or history of infection/colonization. Factors that affect the risk can change frequently in the long-term care environment, therefore these questions/factors should be frequently reassessed. If any YES answer, the resident is considered High Risk.

1. Is this patient **ventilator dependent?**
2. Is this patient **highly or totally dependent on staff for ADLs?**
3. Is this patient **incontinent AND stool and/or urine cannot be reliably contained?**
4. Does this patient have **indwelling medical devices** such as tracheostomy tube, urinary catheter, feeding tube, surgical drains, etc.?
5. Does this patient have **draining wounds or other secretions** that cannot be reliably contained?
6. Is this patient **cognitively unable to maintain personal hygiene?**

Based upon the patient's current risk factors for transmission, and the type of CRO organism identified (Non-CP vs CP), implement the following infection control measures to prevent the transmission.

Table of Isolation indication for CRO/CPO infected or colonized patients in post-acute facility

	Risk for spreading CRO/CPO (Based on questions			
	High-Risk		Not High-Risk	
Recommended Precautions	CP	Non-CP	CP	Non-CP
Enhanced Barrier (**)	-	-	Yes	Yes
Contact	Yes	Yes	-	-
CRO or CPO positive sputum	Contact & Droplet	Contact & Droplet		

Source: Care for patients with CRE in Long-term care facilities. Approved for use 08/23/1019 cre-packet-ltcf-20190823.pdf

(**) Enhanced Barrier precautions for Not High-Risk residents

California Department of Public Health has issued AFL 22-21 Enhanced Standard Precautions for Skilled Nursing Facilities, 2022 on October 5, 2022.
The guidance provides a practical, resident-centered and activity-based approach to implement measures to prevent MDRO transmission that are less restrictive than Contact Precautions. Recommendations for the use

of gowns and gloves by health care providers are based on assessments of a resident's risk for being colonized and likelihood of transmitting MDRO, whether or not the resident is known to be MDRO colonized or infected.
Sources: Enhanced Standard Precautions for Skilled Nursing Facilities (SNF), 2022

C. Discontinue Isolations

There is currently not enough information for CDC to make a general recommendation on when isolation can be discontinued for patients colonized or infected with Carbapenem-resistant organisms. The colonization can be prolonged (> 6 months). Across multiple studies, predictors of prolonged carriage have been found to include:

- Exposure to antibiotics
- Presence of an invasive device
- Number of hospital admissions
- Admission from another facility
- Admission from or discharge to a long-term care facility

The presence of these predictors should be considered when deciding whether to discontinue Contact Precautions.

- If considering discontinuing Contact Precautions based on the results of surveillance cultures, it is appropriate to wait for at least 3 to 6 months since the last positive culture or screen.
- In general, failure to identify CRO from at least 2 sets of screening cultures are the minimum criteria that should be met before an episode of colonization is considered resolved. Additionally, retesting of the site(s) that were positive initially from clinical cultures is usually indicated, particularly non-sterile sites such as a wound or urine.
- Infection Prevention & Control will make the decision in consultation with Alameda County Public Health.

Source: CDC Clinicians: Information about CRE

5.4 Patient care recommendations

Source link: MDRO Patient Cohorting

A. Staff assignment

Dedicated healthcare personnel (HCP), the term used to describe the staff who care for patients or residents with MDROs, including CRO/CPO. Dedicated HCP does not imply one-to-one staffing or primary nursing.

- It's preferable that the dedicated HCP can cohort with other CRO/CPO but not limited and can be assigned to other MDRO patients.
- Ensure dedicated HCP do not have responsibility to care for non-MDRO individuals.
- HCP who cannot be dedicated to patients or residents in cohort (e.g., respiratory therapist, physical therapist) should care for patients or residents without MDRO before those with MDRO, whenever feasible.
- Provide Staff education

B. Medical equipment and supplies

- It's strongly recommended to dedicate medical equipment (e.g., pulse oximeter) to CRO/CPO patients.
- Consider using single-use, disposable, non-critical devices. For example, commodes, thermometers, blood pressure cuffs, pulse oximeter probes, stethoscopes
- Limit supplies in resident's room to essential items; do not remove unused supplies or place them back with community supplies
- For medical equipment that cannot be dedicated (e.g., large physical therapy equipment), consider

scheduling patients with CRO to receive their treatment at the end of the day
- Examples of non-dedicated equipment that must be cleaned and disinfected between uses: Bladder scanner, Weigh scales, Glucometer, Holster lifts

C. Avoid excessive patient or resident movement as this can lead to additional transmission
- Wait for all pending test or colonization screening results before moving patients or residents into a cohort in a facility.

D. When cohorting patients or residents in a 3+ bedroom, choose rooms that can support greater physical separation, when possible.
- Provide 3-6 feet separation with a privacy curtain between beds.
- Avoid use of plastic barriers (including at the entrance to patient rooms) as these can become contaminated and a source of transmission
- Change personal protective equipment (PPE) and perform hand hygiene between each patient or resident.

E. Daily Chlorhexidine bathing is highly recommended for CPO infected or colonized patients in Acute Care hospital

5.5 Environmental Cleaning

- Prefer to AHS Cleaning and Disinfecting Procedure for Isolation Room Daily cleaning and Discharge Cleaning
- Focus on high-touch surfaces (e.g., screen of equipment, bed rails, light switches, call buttons) or any shared reusable items such as shower chairs, Geri chairs, wheelchairs, gurneys
- Use EPA-registered one-step hospital-grade disinfectants and follow the label instructions for proper use of cleaning and disinfecting products (e.g., accurate dilution, sufficient wet contact time, appropriate material compatibility, storage, shelf-life, safe use, and disposal)

5.6 Communicate CRO/CPO status clearly whenever transferring or discharging patients

Use the Interfacility Infection Control Transfer Form on page 12 to notify the receiving facility, the transport company, and the Alameda County Public Health Department.

5.7 Staff Education

Care Staff Education Materials/Resources:
- Carbapenem-resistant Enterobacteriaceae in Healthcare Settings: http://www.cdc.gov/HAI/organisms/cre/index.html
- CDC CRE Toolkit: http://www.cdc.gov/hai/pdfs/cre/CRE-guidance-508.pdf

EVS Staff Education Materials/Resources:
- Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008: https://www.cdc.gov/infectioncontrol/guidelines/disinfection/index.html
- CDC Environmental Checklist for Monitoring Terminal Cleaning (CDC, 2010) https://www.cdc.gov/hai/pdfs/toolkits/Environmental-Cleaning-Checklist-10-6-2010.pdf

6. Surveillance and Contact Investigation

6.1 Routine Surveillance

- Clinical labs immediately notify clinicians and infection prevention staff when CRO are identified from clinical specimens.

- Electronically flag patient record when CRO are identified
- When carbapenemase mechanism is unknown, perform or access carbapenemase testing.
- Maintain a running log of patients known to be infected or colonized with CRO/CPO
- Tracking CRE blood LabID events using the NHSN MDRO module

6.2 Active Surveillance

The Infection Prevention and Control Department can consider screen for CP-CRE and implement preemptive Contact precautions for patients at risk for CPO, including patients:

- Epidemiologically linked to a newly identified CRO or CPO case
- Admitted from facilities known to have ongoing CRO/CPO transmission
- Admitted from LTACH
- With history of receiving healthcare outside the United States during the past 12 months.

6.3 Contact Investigation

The decision on CPO colonization testing of epidemiologically-linked patient contacts will be made in consultation with Alameda County Public Health HAI Program. The factors that can be considered are:

- who shared a bathroom and roommates
- with shared primary healthcare personnel (HCP) (e.g., nursing assistant) or exposed to the same device
- not previously identified with CPO residing on unit(s) where transmission is suspected (point prevalence survey (PPS)).

- If one or more additional patients are identified with CPO, conduct serial PPS at 2-week intervals until 2 consecutive PPS are completely negative.

- If one or more CPO patients reside long-term in a healthcare facility, consider performing periodic follow-up PPS (e.g., monthly or quarterly PPS).

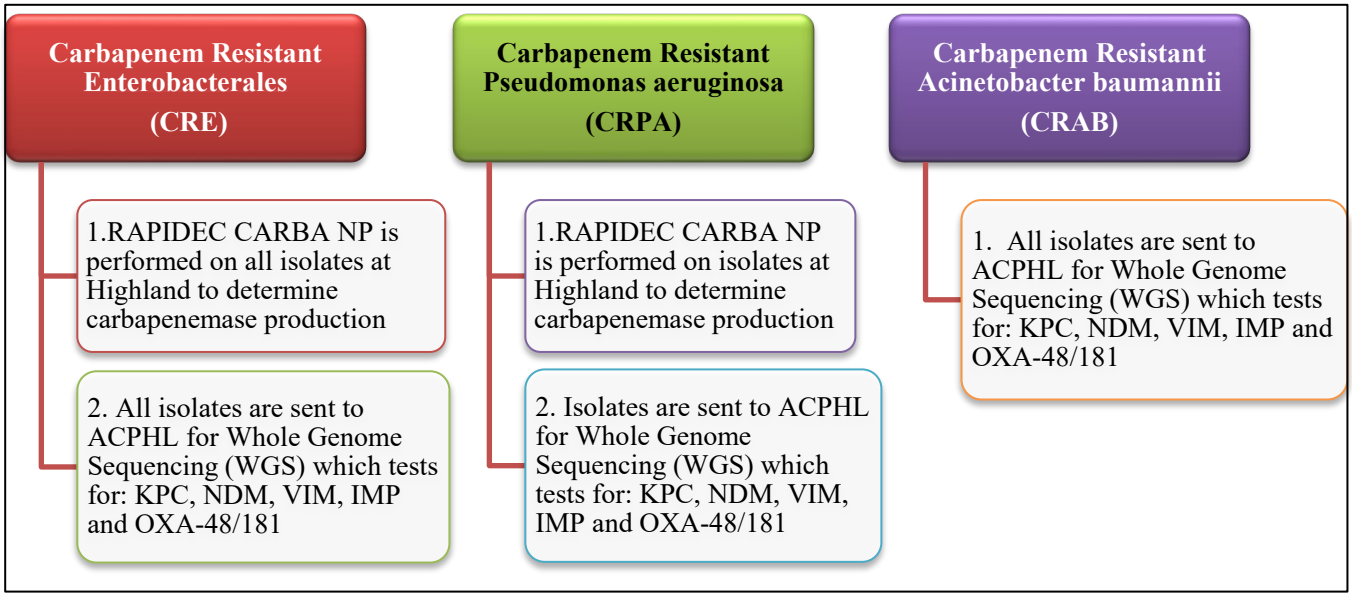
- CP-CRPA or CP-CRAB colonization testing of respiratory (if ventilated), axilla/groin (CP-CRAB only), wound (CP-CRPA only), and rectal (CP-CRE only) swab specimens. Rectal swabs for CP_CPRA and CP-CRAB are also tested but are typically lower-yielding since these bacteria don't naturally inhabit the gut.

Source: CPDH Carbapenem-Resistant Organisms Quicksheet

7. Investigation and Reporting

- Establish baseline CPO incidence at the facility; e.g., determine the number of patients newly identified with CPO per month.
- Investigate all CPO reports.
- Report CPO as unusual infectious disease occurrences or outbreaks to Alameda County public health under Title 17, and CDPH Licensing & Certification if in licensed healthcare facility per All Facilities Letters 19-18.

Current AHS testing performed on CRO/CPO



8. Appendix

8.1 Infection Control Transfer form

INFECTION CONTROL TRANSFER FORM

This form should be sent with the patient/resident upon transfer. It is NOT meant to be used as criteria for admission, only to foster the continuum of care once admission has been accepted.

Affix patient label here

Demographics		
Patient/Resident *(Last Name, First Name)*:		
Date of Birth:	**MRN:**	**Transfer Date:**
Sending Facility Name:		
Contact Name:	**Contact Phone:**	
Receiving Facility Name:		

Precautions and PPE

Currently in Isolation Precautions? ☐ **Yes**
If Yes, check: ☐ Contact ☐ Droplet ☐Airborne ☐ Other:

☐ **No** isolation precautions (currently)

PERSONAL PROTECTIVE EQUIPMENT CONSIDERATIONS

☐ ☐ ☐

CHECK ALL PPE TO BE CONSIDERED AT RECEIVING FACILITY

Organisms

If the patient currently or in the past had a culture positive for a multi-drug resistant (MDR) organism or other organism of significance to infection control/prevention, indicate organism details below and send culture report with susceptibilities to receiving facility.

Methicillin-resistant *Staphylococcus aureus* (MRSA)‡	☐	☐ No known MDR organism or communicable diseases
Vancomycin-resistant *Enterococcus* (VRE)‡	☐	
MDR *Acinetobacter* species, resistant to carbapenem antibiotic(s) ‡	☐	
MDR _____ *(organism name)* resistant to carbapenem antibiotic(s) without carbapenemase production (non-CP-CRE)‡	☐	
Carbapenemase-producing _____ *(organism name)* resistant to carbapenem antibiotic(s) (CP-CRE)#	☐	
Enterobacteriaceae† resistant to expanded-spectrum beta-lactam antibiotics (ESBL)‡	☐	
Clostridium difficile (C. diff)	☐	
Other (identify) ^:	☐ **(current or ruling out*)**	
***Additional information if known:**		

Symptoms/Risk Factors for Transmission

Check yes to any that currently apply:**

☐ Cough/uncontrolled respiratory secretions
☐ Incontinent of urine
☐ Vomiting
☐ Concerning rash (e.g., vesicular)
☐ Acute diarrhea or incontinent of stool
☐ Draining wounds
☐ Other uncontained bodily fluid/drainage

****NOTE: Appropriate PPE required if incontinent/drainage/rash NOT contained.**

☐ No Symptoms requiring additional PPE

Other MDRO Risk Factors

Is the patient currently on antibiotics? ☐ **Yes** ☐ **No**

Antibiotic:	Dose, Frequency:	Treatment for:	Start date:	Stop date:

Does the patient currently have any of the following devices? ☐ **Yes** ☐ **No**

☐ Tracheostomy/Endotracheal tube	☐ Suprapubic catheter	☐ Colostomy
☐ Central line/PICC, Date inserted:	☐ Percutaneous gastrostomy tube	☐ Rectal tube
☐ Urinary catheter, Date inserted:	☐ Hemodialysis catheter	

†includes *E.coli, Enterobacter, Klebsiella, Proteus, Serratia, Citrobacter* and others
‡MDRO infection prevention precautions: https://www.cdc.gov/infectioncontrol/guidelines/mdro/index.html
#Intensified MDRO Control Efforts: https://www.cdc.gov/infectioncontrol/guidelines/mdro/table3-2-intensified-control.html
^e.g. lice, scabies, disseminated shingles, norovirus, influenza, TB

8.2 Contact Precautions Sign for Acute Care setting

STOP

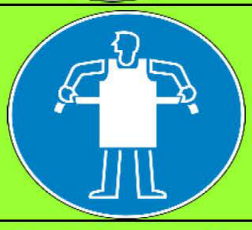
Contact Precautions

ALTO

(In addition to Standard Precautions)

VISITORS MUST CHECK WITH NURSE BEFORE ENTERING ROOM
VISITANTES POR FAVOR CONSULTE CON LA ENFERMERA ANTES DE ENTRAR

ALL PHYSICIANS, STAFF, VISITORS MUST:

• Limit 2 visitors at a time • No children under 12 yo		• Visitas: Solo 2 personas a la vez • No se admiten menores de 12 años
• Perform hand hygiene before **entering and leaving** room		• **Lavese** las manos o use el gel sanitario **antes** y **después** de salir
• **MUST** wear **gloves before** entering room • Perform **hand hygiene immediately after** removing gloves		• **DEBE** usar **guantes antes** de entrar • **Lavese** las manos o use el gel sanitario **antes** y **después** de usar guante
• **MUST** wear **gown before** entering room		• **DEBE** usar una **BATA antes** de entrar

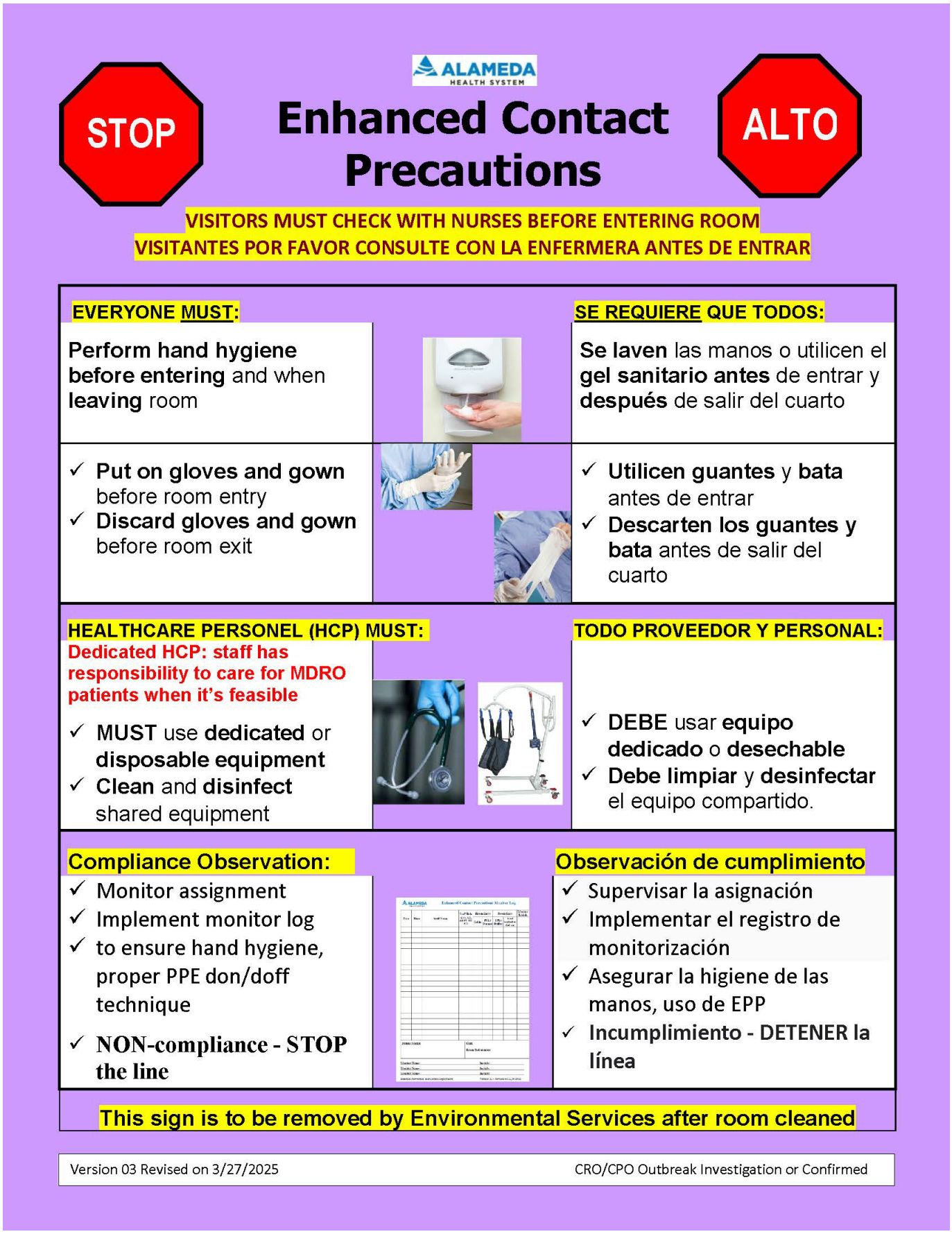
This sign is to be removed by Environmental Services after room cleaned

ALAMEDA HEALTH SYSTEM

8.3 Enhanced Standard Precautions Sign for Post-Acute Care setting

8.4 Enhanced Contact Precautions Sign for CRO outbreak investigation or confirmed for Acute Care

setting



8.5 Enhanced Contact Precautions Monitor Log

ALAMEDA HEALTH SYSTEM

Enhanced Contact Precautions Monitor Log

Date	Time	Staff Name	Staff Role (EVS, MD, OT/PT, RN, RT)	Room Entry		Room Exist		Monitor Initials
				Gel in	PPEs Donned	PPEs Doffed	hand washed or Gel out	

Patient Sticker	Unit: Room/Bed number:

Monitor Name: _____ **Initials:** _____

Monitor Name: _____ **Initials:** _____

Monitor Name: _____ **Initials:** _____

9. References

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    b. Care for patients with CRE in Long-term care facilities. Approved for use 08/23/1019 https://acphd-web-media.s3-us-west-2.amazonaws.com/media/programs-services/cre/docs/cre-packet-ltcf-20190823.pdf
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2. California Department of Public Health, Healthcare-Associated Infections Program,
    a. Investigating CRE cases and clusters. Version 2.0, October 2019 CRE Quicksheet May 2021 (ca.gov)
    b. Investigating Carbapenem-Resistant Organisms (CRPA/CRAB) cases and clusters. Version 1.0, October 2020 CRO Quicksheet Oct 2020 (ca.gov)
    c. Cohorting Guidance for Patients or Residents Infected or Colonized with Multidrug-resistant Organisms. Version March 2023 MDRO Patient Cohorting (ca.gov)
    d. Cohorting Guidance for Residents Infected or Colonized with Multidrug-resistant Organisms for Skilled Nursing Facilities (SNF) Version March 2023 MDRO SNF Cohorting (ca.gov)
    e. AFL 22-21 https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-22-21.aspx
    f. Enhanced Standard Precautions for Skilled Nursing Facilities, 2022 Enhanced Standard Precautions for Skilled Nursing Facilities (SNF), 2022
    g. CRE Infection Strategies, page last updated March 10, 2023. CRE Infection Prevention Strategies (ca.gov)
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    i. Reporting CPO to public health. September 2022 CPO Reporting FAQ (ca.gov)

3. Centers for Disease Control and Prevention,
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    b. CDC Clinicians: Information about CRE https://www.cdc.gov/hai/organisms/cre/cre-clinicians.html

APPROVALS

		System
Department:	Date:	4/2025
Pharmacy and Therapeutics (P&T)	Date:	N/A
Clinical Practice Council (CPC)	Date:	
Medical Executive Committee	Date:	01/2024
Board of Trustees	Date:	01/2024

ALAMEDA HEALTH SYSTEM *Pathology & Clinical Laboratory*		DOCUMENT № 1377
☑ ***Alameda Hospital (ALH)*** *2070 Clinton Ave* *Alameda CA 94501*	☑ ***Highland General Hospital (HGH)*** *1411 E. 31st Street* *Oakland CA94602*	☑ ***San Leandro Hospital (SLH)*** *13855 E. 14th St* *San Leandro CA 94578*
PROCEDURE **BLOOD PRODUCT ADMINISTRATION (TRANSFUSION)**		**PAGE 1 OF 16**

AUTHOR	**DATE CREATED** **JULY 2002**
REVISED BY **VALERIE NG, PhD MD** **HARRIS S. GOODMAN, MD**	**DATE REVISED** **05/08, 08/12, 08/15, 08/19, 08/21, 03/22, 3/25**
LABORATORY DIRECTOR **HARRIS S. GOODMAN, MD**	**APPROVAL**

PURPOSE

To instruct on the safe administration of blood products.

POLICY

1. All transfusions require informed consent.
    - Only one Transfusion Consent is required per inpatient admission.
    - The provider is responsible for obtaining informed consent.
        i. Verbal or telephone orders are not accepted
    - The patient or patient's surrogate decision maker shall be given a copy of the
        i. Completed informed consent
        ii. "Patient's guide to blood transfusion".
2. Any patient with decision making capacity has the right to refuse transfusion
    - They have the right to accept transfusion later if they change their mind → informed consent must be obtained.
3. In an emergency when consent cannot be obtained without delaying transfusion and would be harmful to the patient, a provider shall adhere to the Alameda Health System (AHS) consent policy for obtaining consent on behalf of the patient.
    - Discussion with and obtaining consent from the patient or surrogate decision maker for subsequent blood transfusion(s) shall occur at the earliest possible time.
4. Specimens collected for transfusion purposes shall contain the legible initials, date and time of collection of the phlebotomist.
    - Incompletely labeled specimens shall be rejected.

5. Two records of matching ABO Rh type, including one from the current encounter, are required prior to transfusion (exceptions: massive transfusion, “emergency” blood).
6. Only one unit of blood product shall be issued at a time (exceptions: massive transfusion, "emergency" blood)
7. A two person verification or electronic confirmation shall occur at each step of the transfusion process to assure the correct patient is receiving the correct blood product.
    - Exception: Anesthesiologists in the Operating Room require a single person verification and electronic confirmation only
8. Blood products shall not be stored outside of the Blood Bank except for within the continuously monitored and alarm-networked refrigerator in the Operating Room suite.
9. "Normal saline" [0.9% sodium chloride, injection (USP)] is the only acceptable fluid to be transfused along with and in the same intravenous line for a blood product
    - No medications or other solutions may be added to the line through which blood products are being transfused
10. All suspected transfusion reactions shall be reported as soon as possible to the Blood Bank.
11. Acute hemolytic transfusion reactions related to major blood group incompatibilities (ABO, Rh, other blood groups) shall be reported as a Safety Alert (Midas+ Care Management System, Conduent; available on the AHS intranet) regardless of patient outcome and in compliance with "sentinel event" reporting.

PRINCIPLE

A blood transfusion is a potentially hazardous procedure. Stringent procedures must be followed to ensure the correct blood product is given to the correct patient and any adverse reactions are managed promptly and correctly.

Blood products refer to

- Packed red blood cells (pRBCs)
- Plasma
- Plateletpheresis
- Cryoprecipitate
- RhIg (Rhogam; is actually a blood derivative but will be considered a blood product for the purposes of this

	policy & procedure)
CLINICAL SIGNIFICANCE	Transfusion should be given only when the clinical benefit outweighs the potential risks. Patient consent must be obtained prior to transfusion to assure the recipient has been informed of potential risks, benefits and possible alternatives to transfusion.
REAGENTS	Not applicable
EQUIPMENT	IV stand 18 gauge or larger needle for rapid infusion; patent intravenous access. *(See procedure notes for other acceptable needle gauge sizes)* Available only in select locations (e.g., HH OR, ED, ICU and L&D) • Rapid infuser (rapid infusion pump) & tubing • Blood warmer The routine intravenous fluid pump (e.g., Alaris) is also acceptable for transfusion. • Co-transfuse with 0.9% saline only. • Follow manufacturer's instructions for pump setup and use. • Use a blood administration infusion set (see supplies below)
SUPPLIES	0.9% sodium chloride (USP) Blood administration infusion set (includes filter) Usual patient care supplies
SPECIMEN	EDTA-anticoagulated blood - one large (6 mL) tube
SPECIAL SAFETY PRECAUTIONS	Use personal protective equipment (PPE) as necessary (e.g., gloves, labcoat, other)
QUALITY CONTROL	See procedure
PROCEDURE	
Informed Consent	**Obtaining informed consent:** The provider is responsible for obtaining informed consent and giving a copy of the completed consent form and the "Patient's Guide to Transfusion" to the patient (or surrogate decision maker).

Refusal:

1. If the patient or surrogate decision maker refuses to consent to transfusion, document such in the medical record.
    a. DO NOT TRANSFUSE
2. If the patient (or surrogate decision maker) subsequently agrees to transfusion, complete the Informed Consent process.

Nursing:

1. Verify the completed informed consent is present in the patient's medical record.
    a. If missing, alert the provider to obtain informed consent.
    b. DO NOT TRANSFUSE until the completed informed consent is in the medical record.

Specimen (pre-transfusion)

One large (6 mL) tube of EDTA-anticoagulated blood (lavender top tube)

Specimen labeling requirements - must include legible

- Patient's full name
- Medical Record Number
- Date of Birth
- Encounter number
- Initials of the phlebotomist,
- Date (mm/dd/yy) and
- Time (24 hour clock) of collection.

Incompletely labeled specimens shall be rejected.

Specimen stability for transfusion testing (including pre-operative testing)

- Three days for inpatients
- Seven days for outpatients only if the patient
    a. Has not been transfused in the preceding 3 months with a blood product containing allogeneic red cells,
    b. Has not been pregnant within the previous 3 months, AND
    c. Has a history that is certain and available.
- Day of collection is "day zero"

ABO/Rh records

Two records of ABO/Rh blood type are required for any transfusion, one of which must be from the current encounter.

1. If **two** records of blood type are already present, the Blood Bank will prepare the requested blood product.
2. If only **one** record is present, a second "ABO/Rh" confirmation specimen must be collected and sent.
    a. The Blood Bank will contact the ordering location and request collection and submission of a second specimen (6 mL lavender top EDTA-anticoagulated blood).
    b. The Blood Bank will place the ABO/Rh confirmation order.
3. If **no** records are present, two records can be obtained
    a. By two different phlebotomists at the same time collecting at two different sites, OR
    b. By a single phlebotomist collecting two specimens at least 15 minutes apart

Specimen labeling requirements - must include legible

- Patient's full name
- Medical Record Number
- Date of Birth
- Encounter number
- Initials of the phlebotomist,
- Date (mm/dd/yy)
- Time (24 hour clock) of collection.

Incompletely labeled specimens shall be rejected.

Indications for Transfusion

1. Packed RBCs
    a. Hemoglobin (Hgb) $\leq$ 7 g/dL
    b. Hgb $\leq$ 8 g/dL and hemodynamically unstable
    c. Clinically significant acute blood loss
    d. Other (specify)
2. Plasma
    a. Clinically significant bleeding AND INR > 2.2 (1.7 if bleed is in a closed space – e.g., eye or head)
    b. Emergent reversal of warfarin (coumadin)
    c. Other (specify)

3. Plateletpheresis
    a. Platelet count < 10,000/mcL and for hypoproliferative thrombocytopenia (prophylaxis)
    b. Platelet count < 20,000/mcL and percutaneous invasive planned (e.g., lumbar puncture)
    c. Platelet count < 50,000/mcL AND major invasive procedure planned (specify - e.g., exploratory laparotomy)
    d. Other (specify)
4. Cryoprecipitate
    a. Fibrinogen ≤ 100 mg/dL
    b. Dysfibrinogenemia WITH bleeding
    c. Other (specify)

Blood product ordering

If blood products are not needed immediately, order a Type & Screen.

If blood products are needed:

Provider

1. Places order(s) for blood products.
2. A blood product order includes
    a. What type of blood product (i.e., packed RBCs, plasma, plateletpheresis, and/or cryoprecipitate)
    b. How many units of each blood product ordered
    c. Medical necessity and justification for each ordered blood product
    d. Order to Blood Bank to prepare the requested blood products
    e. Order to nursing to transfuse the requested blood products

Blood Bank will

1. Prepare the ordered blood products(s) after contact by ward personnel preparing for transfusion.
2. Notify the patient's nurse or ordering location when the blood product(s) are ready for pickup/retrieval.

Pickup/retrieval of blood products from the Blood Bank

Ward personnel trained and competent in Blood Borne Pathogen Exposure (BBPE) are allowed to pickup/retrieve blood products from the Blood Bank.

Only one unit of a blood component will be issued at any one time.

- Exceptions:
  - "Massive Transfusion Protocol",
  - "OB-hemorrhage protocol",
  - "Emergency blood", or
  - More than one unit issued in a container (e.g., cooler) certified to maintain the desired temperature for at least two hours.
- Refer to the relevant specific policy & procedure for these exceptions.

1. Verify a completed Informed Consent to Transfusion is in the patient's medical record.
   a. If not, contact the provider to complete
2. Establish venous access with an appropriately sized needle, typically an 18 gauge needle (see procedure notes for needle gauge considerations)
3. Verify intravenous access is patent. This is to assure transfusion can start as soon as the blood product is delivered to the patient location.
4. Review the transfusion order and telephone the blood bank to verify the blood component is ready to issue.
5. Print and retrieve the hardcopy "Requisition for Crossmatched Blood" form which includes
   a. Patient's full name
   b. Medical record number
   c. Date of birth (if available)
   d. Patient location
   e. Type & number of blood products requested
   f. Initials of the person retrieving the requested blood products.
6. Bring hardcopy requisition form to the Blood Bank.
7. A two person verbal verification process will ensue between the Blood Bank Clinical Laboratory Scientist (CLS) and the ward personnel. The verification shall include patient information on the Requisition form, on the Transfusion record attached to each Blood Product unit, and on the patient label attached to the blood product itself.
   a. One person shall read aloud all patient information from the "Transfusion Record" attached to each blood

product unit to include
   i. Patient's full name
   ii. Medical record number
   iii. Date of birth (if available)
   iv. Patient's ABO group and Rh type
   v. Donor's identification number, ABO group, and, if require, the Rh type
   vi. The interpretation of crossmatch tests, if performed
   vii. Special transfusion requirements, if applicable
   viii. The expiration date and , if applicable, time
   ix. The date and time of issue

b. The other person shall simultaneously view and confirm the patient information matches that on the "Requisition for Crossmatched Blood" form.
c. The two will together review the label on the blood product itself to very all listed patient information and blood product information on the Transfusion Record match.
d. Blood product(s) shall be released from the Blood Bank only if all patient and blood product information match on all forms and blood product(s).
   i. Troubleshoot if information does not match. Do not release units until all information matches.
e. Blood product(s) must be delivered promptly to the patient's location to avoid delay in transfusion and to assure the blood product is maintained within acceptable storage conditions until transfusion.

Emergency release of uncrossmatched blood	See "Emergency Blood" Policy & Procedure.
Massive Transfusion Protocol (MTP)	See "Massive Transfusion Protocol" Policy & Procedure
OB-Hemorrhage protocol (OB-MTP)	This recipe was created to match that recommended by the California Maternal Quality Care Collaborative (CMQCC).

1. Order two units of packed RBCs as "emergency blood"
2. Order "round A" of the Massive Transfusion Protocol (MTP)
3. Order "round B" of the MTP
4. Continue ordering Rounds A or B of the MTP until bleeding is controlled.

Bleeding is usually controlled after transfusion of the two units of 'emergency blood' or after the first Round A has been issued.

Neonatal Transfusion

See "Neonatal Transfusion' Policy & Procedure

Transfusion

If transfusion cannot begin ***within 30 minutes***, return the blood product as soon as possible to the Blood Bank for storage:

1. Temperature will be verified to be within acceptable storage range (1-10°C).
    a. If within acceptable range, blood product will be placed back into inventory.
    b. If outside acceptable range, blood product will be discarded ("wasted") and reported in the occurrence reporting system.
2. Blood units returned to Blood Bank beyond 30 minutes after issuing must be quarantined, discarded and reported as an occurrence report.

Blood components cannot be stored in any refrigerator outside the Blood Bank. The only exception is a continuously temperature monitored and alarmed "Blood" refrigerator (e.g., "blood refrigerator" in the HH OR).

When ready to transfuse, the transfusionist

1. Reads and "acknowledge all" transfusion orders in the electronic health record (EHR).
2. Selects "flowsheets" on the left navigation menu
3. Selects the "blood" tab
4. Opens and reviews the information on the "Transfusion Release Report"
    a. Verifies the completed consent form is on record
    b. "Releases" the ordered blood product about to be transfused and closes the "Transfusion Release Report"

5. The flowsheet reappears with documentation fields for transfusion.
6. Click on the "syringe" symbol in the first "action" field
    a. Select ("link") the correct iv line through which the blood product will be transfused
    b. The blood product administration window will open. Follow the onscreen prompts to
        - Scan the patient's wristband
        - Scan the blood product unit # and product code
        - Verify the patient's ABO/Rh blood type on the screen matches that on the blood product
            1. If all matches, a green "thumbs up" appears signifying the blood product is correctly matched to the patient ("electronic confirmation").
            2. If all does not match, **STOP**. Return the blood product to the Blood Bank immediately for troubleshooting.
        - Enter patient's rate of administration and vital signs and click "accept".
    c. The dual signoff window opens if two person verification is required
        - Exception: Single person verification and electronic confirmation is permitted for anesthesiologists transfusing in the Operating Room (OR)
    d. Have another licensed provider review the transfusion documentation and "sign off" if all is correct.
    e. Blood components are typically administered through a standard in-line filter to remove macroaggregates. The administering provider must confirm that the IV tubing and filter are properly aligned so that the flow is in the appropriate direction for the in-line filter.
7. Start the transfusion
8. Document vital signs
    a. At the start of transfusion (already completed prior to "dual signoff")
    b. 15 minutes after the start of the transfusion
    c. At the end of transfusion
    d. Use the "add column" function to add columns for

documenting vital signs at these or other desired time points

e. At the end of transfusion, click on "accept and complete" at the bottom next to "Complete the transfusion?"

9. This "Transfusion group" is now hidden and no longer available for selection.
10. Start the process over again for each additional blood product to be transfused.
11. Discard the empty blood product bag into biohazardous waste (red bin).
12. Discard used infusion set into a biohazardous sharps container.

If vital signs become unstable during transfusion,

1. Stop the transfusion.
2. Contact the provider for instructions and orders.
3. If a transfusion reaction is suspected, follow the instructions for “Transfusion Reaction” (below).

Rapid infusion

1. Performed only with Rapid Infusers available in the ER, OR, ICU and L&D.
2. Monitor the patient throughout each transfusion.
3. Complete documentation as per rapid infusion protocol.
4. If a transfusion reaction is suspected, follow instructions below.

Transfusion Reaction

All transfusion reactions must be reported to the Blood Bank.

- The only exception is a mild allergic reaction, defined as “urticaria only and immediately responsive to and quickly resolved with diphenhydramine”.

Signs and symptoms concerning for an acute hemolytic transfusion reaction:

- Abdominal, chest, flank, and/or back pain; headache
- Burning sensation along the vein of infusion.
- Disseminated Intravascular Coagulation (DIC), abnormal bleeding.
- Facial flushing
- Fever (defined as >= 1° C rise in temp and >= 38°C)
- Chills, with or without rigors

- Hypotension (defined as a drop in systolic BP of greater than or equal to 30 mmHg **and** systolic BP less than or equal to 80 mmHg in adults, or greater than 25% drop in systolic BP from baseline in patients less than 18 years of age)
- Rapid, labored respirations
- New-onset hemoglobinuria.

If a transfusion reaction is suspected,

1. Stop the transfusion.
2. Stabilize the patient.
3. Remove blood product and infusion tubing down to the IV catheter hub to prevent infusion of any remainder blood product.
4. Notify the provider and complete any orders.
5. Order a "Transfusion Reaction Investigation" and a “Type and Screen”
    a. Collect a new specimen - one 6mL lavender top (EDTA anticoagulant).
    b. Label the specimens correctly and legibly to include phlebotomist's initials, date (mm/dd/yy) and time (24 hour clock)
        i. Incorrectly labeled specimens shall be rejected; care personnel at the ordering location will be notified.
6. Notify and return the remainder of the blood product to the Blood Bank.
7. Document the Transfusion Reaction symptoms in the "suspected reaction" section of the transfusion flowsheet
8. Monitor vital signs per routine practice for at least 24 hours

Known adverse effects of transfusion and time of onset for clinical manifestation:

Type of transfusion reaction	***Time of onset***
Allergic (more than mild urticaria)	Within 4 hours
Acute hemolytic transfusion reaction	Within 24 hours
Delayed hemolytic transfusion reaction	24 hours - 28 days
Delayed serologic transfusion reaction	24 hours - 28 days
Hypotensive transfusion reaction	Immediate -1 hour
Febrile non-hemolytic transfusion reaction	Within 4 hours

Post-transfusion purpura	5-12 days
Transfusion associated circulatory overload (TACO)	Within 6 hours
Transfusion associated dyspnea (TAD)	Within 24 hours
Transfusion associated Graft versus Host Disease (TAGVHD)	2 days - 6 weeks
Transfusion associated acute lung injury (TRALI)	Within 6 hours
Transfusion-transmitted infection	Variable

INTERPRETATION/ RESULTS

None

CALCULATIONS

None

EXPECTED VALUES

Transfusion without complication

METHOD LIMITATIONS

Not applicable

PROCEDURE NOTES

Needle gauge:

1. The AABB Circular of Information is silent on needle gauge size with the exception of noting nonimmunological hemolysis can occur "…transfusion under high pressure through small-gauge or defective needles" (7).
2. The AABB Technical Manual states:
   "Acceptable IV catheter sizes for use in transfusing cellular blood components range from 22 to 14 gauge. A 20- to 18- IV catheter is suitable for the general adult population and provides adequate flow rates without excessive discomfort to the recipient. When an infant of a toddler is transfused, a 25- to 24-gauge IV catheter may be suitable, but a constant flow rate using an infusion device should be applied. When using smaller-gauge catheters, it is recommended that the rate be slowed. The pressure or force used during the transfusion is more likely than the needle gauge to cause hemolysis of red cells." (1)
3. The Canadian Blood Services notes "Gauge or lumen size: this should be large enough to allow the flow of the component/product within the specified administration time and to prevent damage to the cells. In adults, a 20–22 gauge or 3 French catheter is often recommended as the minimum

size to infuse red blood cells (16–18 gauge for rapid transfusions). In pediatric patients the minimum size is a 22-25 gauge catheter." (8)

REFERENCES

1. AABB Technical Manual, current edition.
2. College of American Pathologists (CAP), Transfusion Medicine checklist, current edition.
3. The Joint Commission, National Patient Safety Goals, current listing.
4. The Joint Commission, "Sentinel Events", current listing.
5. CDC. The National Healthcare Safety Network (NHSN) Manual. Biovigilance component. Hemovigilance module. Current version.
6. California Maternal Quality Care Collaborative (CMQCC), OB Hemorrhage Toolkit. Current version at www.CMQCC.org.
7. Circular of Information for the use of human blood and blood components. AABB. Current edition.
8. Blood Administration. Chapter 9 in Clinical Guide to Transfusion. Canadian Blood Services. Available at https://professionaleducation.blood.ca/en/transfusion/guide-clinique/blood-administration (accessed 03/12/2022).

RELATED DOCUMENTS

AHS Blood Bank Policy & Procedures
- 1310 - Neonatal Transfusion (HGH)
- 1355 - Massive Transfusion Protocol (HGH)
- 1370 - Emergency Blood

APPENDICES (FORMS, LABELS, TAGS, TABLES)

Appendix: Comparison of Trauma and OB-hemorrhage MTPs

DISTRIBUTION

AHS PolicyTech
AHS hardcopy Blood Bank Manuals at ALH, HGH and SLH

REVISION HISTORY

July 2002: New Policy & Procedure
May 2008, August 2012
August 2015: Title changed from "Blood Administration" to "Transfusion", removed Plasmalyte "A" a solution permissible to use with transfusion, included instructions on the two person verification process between Blood Bank and patient care personnel, included instructions on disposal of transfusion related paraphernalia at the site of transfusion and removed requirement to return empty blood component bags to the Blood Bank, updated Transfusion Reaction categories, updated references.

July 2019: Revised in anticipation of SAPPHIRE (Epic) implementation 09/28/19, placed into Clinical Laboratory P&P template to meet policy & procedure requirements specified in the Clinical Laboratory Improvement Amendments (CLIA), and major revision to meet AABB (formerly known as the American Association of Blood Banks) and The Joint Commission (TJC) requirements. Specific changes: Renamed from "Transfusion" to "Blood Product Administration" to harmonize with TJC language, removed 3rd unique identifier & associated wristband at each site (HH - predent; AH - Secureline; SLH - Typenex) as the SAPPHIRE (Epic) process will replace this step by performing additional unique identifier matching (blood product code and blood product unit #) at the time of barcode scanning (patient wristband, blood component label) at the point of service, included SAPPHIRE-related instructions for blood component administration, introduction of “electronic confirmation” versus two person verification at the bedside, and transfusion -related vital sign documentation, included detail on needle gauge size for transfusion in Procedure notes, included listing and comparison of the various MTPs (Appendix), updated references.

August 2021: Officially extended P&P to all acute care hospitals (header updated); specified specimen stability applies to pre-operative testing, included new section listing Indications for Transfusion, included signs & symptoms concerning for acute hemolytic transfusion reactions, updated references, removed reference to “Low volume MTP” policy & procedure previously at SLH and ALH (retired 2020), revised MTP comparison (appendix) to update OB hemorrhage with latest design (Rounds to match Trauma MTP recipe) and removed “low volume” MTP comparisons at SLH (10/19/2020 approval to eliminate by SLH leadership committee) and ALH (10/16/2020 approval to eliminate by ALH MEC).

March 2022: Revised specimen requirement for transfusion reaction investigation (one 6mL EDTA tube), updated approval table to reflect approval by key AHS committees.

March 2024: Added specific criteria for transfusion reactions to meet JC inspection requirements.

Approvals:

		AHS System	Alameda Hospital
Departmental	**Date:**	**03/2022**	**03/2022**
Clinical Practice Council	**Date:**	**04/2022**	
Medical Executive Committee	**Date:**	**04/2022**	**04/2022**
Board of Trustees	**Date:**	**05/2022**	

BLOOD PRODUCT ADMINISTRATION (TRANSFUSION) - APPENDIX: MTP comparison

	HGH (Trauma)			HGH OB-hemorrhage		
Blood component	***pRBC***	***Plasma***	***Other***	***pRBC***	***Plasma***	***Other***
Lab response to Level I trauma (Lab delivers to ED)	2 O Rh-neg	2 liquid A	--	n/a	n/a	n/a
OB Emergency Blood (Lab delivers to L&D/4ACT upon request)	n/a	n/a	n/a	2*	0	0
OR Emergency Blood (stored in the OR)	4 O Rh-pos	6 liquid A	--	n/a	n/a	n/a
1st response	***Round A***			***Round A*#***		
	6 O Rh-pos	6 liquid A	1 pltpher	same as Trauma		
2nd response	***Round B***			***Round B*#***		
	6 O Rh-pos	6 liquid A	10 units cryoppt	same as Trauma		
3rd response	***same as Round A***			***not expected***		
Ongoing	Round A or Round B is prepared			not expected		
Authorized to activate MTP	Trauma service only (ED, OR, ICU)			OB service only		

*electronic crossmatched (eXM) **OR**
- uncrossmatched type-specific (if not eXM suitable) **OR**
- uncrossmatched O Rh-negative

#Thawed type-specific FP/FFP (20 minute delay) **OR**
- Liquid A if cannot wait

ALAMEDA HEALTH SYSTEM *Pathology & Clinical Laboratory*		DOCUMENT № 550
☑ ***Alameda Hospital (ALH)*** *2070 Clinton Ave* *Alameda CA 94501*	☑ ***Highland General Hospital (HGH)*** *1411 E. 31st Street* *Oakland CA94602*	☑ ***San Leandro Hospital (SLH)*** *13855 E. 14th St* *San Leandro CA 94578*
PROCEDURE **CRITICAL RESULTS AND COMMUNICATION OF CRITICAL RESULTS**		**PAGE 1 OF 12**

AUTHOR **VALERIE NG, PhD MD**	**DATE CREATED** **JUNE 2006**
REVISED BY **VALERIE NG, PhD MD and HARRIS S. GOODMAN, MD** **(SEE DOCUMENT REVISION HISTORY SECTION)**	**DATE REVISED**
LABORATORY DIRECTOR **HARRIS S. GOODMAN, MD**	**APPROVAL**

PURPOSE

- To define the critical laboratory results for the various AHS Clinical Laboratories (HGH, ALH, SLH).
- To provide clear instructions for communicating critical laboratory results.

POLICY

- A critical laboratory result shall be reported to a physician or licensed caregiver (e.g,. MD, DO, RN, NP, PA, etc., not a medical assistant or an administrative assistant) as soon as it is recognized by the Clinical Laboratory Scientist (CLS) or other testing personnel performing the test.
- The critical laboratory result shall be communicated from the Laboratory to the appropriate caregiver or patient care location within 15 minutes of its initiation.
- Readback shall be documented for each critical result communicated.
- Critical results cannot be left on voicemail or sent via EPIC secure chat.
- This policy and procedure apply to all patients having laboratory testing performed by any of the AHS Clinical Laboratories.

PRINCIPLE

Timely recognition and communication of a critical result can promote patient safety and avert adverse patient outcomes.

CLINICAL SIGNIFICANCE

A “critical result” is

- an abnormal laboratory result of potentially life-threatening consequences and for which immediate action is needed because the patient is in imminent danger, OR
- a drug resistant organism which poses a public health transmission risk and must be reported timely to Public Health entities in accordance with regulatory reporting

requirements.

Critical results must be communicated quickly to a physician or licensed caregiver for optimal patient care and safety. At AHS, the reporting of a critical laboratory result from the laboratory to a licensed caregiver or patient care location is expected to be within 15 minutes of initiation.

The Critical Results for each clinical laboratory are displayed in the Appendices.

REAGENTS

None

EQUIPMENT

Telephone
Laboratory Information System (LIS) to document communication.

PROCEDURE

See Flow Diagram (Appendix I)

Point of Care Testing (POCT) Critical Results

For critical glucose POCT results:

1. **Ensure that the POCT critical result is accurate.**
   a. Repeat the POCT patient test within 10 minutes and/or
   b. Send a specimen to the laboratory as soon as possible, for confirmation of the result**.**

2. **Report the POCT critical value result to the physician immediately.**
   a. All POCT critical value results shall be reported within 15 minutes directly to the primary care provider and/or the attending in the POCT test site.
   b. POCT critical value results must never be left on voicemail.

3. **Document the POCT critical result and your actions.**
   c. **The notification documentation shall include the following:**
      i) POCT critical test result
      ii) Date and time critical result was reported to the physician.
      iii) First and last name of the physician that was notified.
      iv) Name and title of the reporting caregiver.
      v) Actions taken per physician's orders relevant to the critical result.

The location where the notification information and the critical result are documented is determined by the policy of each unit/clinic.

For patients with known diabetes or who are on a glycemic control protocol – follow the protocol instructions for managing critical glucose results.

For non-glucose POCT critical results:

Document the POCT critical result and your actions.

The notification documentation shall include the following:

1. POCT critical test result
2. Date and time critical result was reported to the physician.
3. First and last name of the physician that was notified.
4. Name and title of the reporting caregiver.
5. Actions taken per physician's orders relevant to the critical result.

The location where the notification information and the critical result are documented are determined by the policy of each unit/clinic.

Inpatient	Notify licensed personnel caring for the patient. Document the notification in the LIS – first and last name, licensure, read back.
Discharged patient	**HGH**: Patient care differs from that at SLH or ALH because of HGH-based residency training programs, care teams instead of single responsible providers, and frequent non-synchronous rotation of care team members on each care team. Because of this team approach, a care team and not a single provider is responsible for accepting a critical result. **HGH discharged patient:** A critical result for an HGH discharged patient must be communicated to the Attending of the care team who cared for the patient during the encounter from which the specimen yielding a critical result was obtained. It does not matter if team members have changed; the Attending for the specific team is the one to whom these critical results must be

communicated.

How to find the Attending for the specific care team:

1. Open the electronic medical record (Epic).
2. Open the patient record.
3. Click on "orders" on the top menu bar.
4. Review the information in the top box "Admit/Discharge/Transfer" (see screenshot below). The team caring for the patient during this admission is listed (i.e., Medicine Team 5 in this example).
5. Open Amion.
6. Identify the same team (e.g., Medicine Team 5 in this example).
7. Contact the attending on call for the team.
8. Document full name/date/time of critical result communication in the Laboratory Information System.

SLH: Contact the SLH Hospitalist Triage Pager 510-231-3449

ALH: Contact the provider caring for the patient during his/her inpatient stay**.** S/he can be identified by reviewing information in the HIS corresponding to the correct encounter.

Critical result obtained in one laboratory and patient is located at a different campus – interlaboratory communication

Some laboratory testing is performed at a different location than where the patient is located. When a critical result is obtained

1. Notify the clinical laboratory from which the specimen was sent (and is presumably co-located with the patient).
2. The originating clinical laboratory is responsible for communicating the critical result to the primary provider or location.

Example: Critical potassium obtained at HGH for a specimen originating from SLH.

- HGH Clinical Laboratory communicates to SLH Clinical Laboratory.
- SLH Clinical Laboratory communicates to appropriate caregiver (inpatient) or physician's office (outpatient) at SLH.
- Each communication is documented in the LIS

DRUG RESISTANT **VRE (vancomycin resistant enterococcus)**

ORGANISMS WHICH MUST BE REPORTED AS CRITICAL RESULTS

MRSA (methicillin resistant *Staphylococcus aureus*)
ESBL (Extended-spectrum beta-lactamase resistant organisms: *Klebsiella pneumoniae, Klebsiella oxytoca, Proteus mirabilis,* or *Escherichia coli* resistant to cefotaxime, ceftazidime, ceftriaxone, or cefepime and a beta-lactamase inhibitor, usually clavulanate)

- Inpatient – Notify the patient's nurse
- Outpatient or discharged from AHS – No notification

CRE (carbapenem resistant *Enterobacterales*)
CRPA (carbapenem resistant *Pseudomonas aeruginosa*)
CRAB (carbapenem resistant *Acinetobacter baumannii*)

- Inpatient
  - Notify the patient's nurse AND
  - Email Infection Control
- Outpatient or discharged from AHS – Email Infection Control

METHOD LIMITATIONS

CLS is unable to reach a provider that will accept the critical result. Regardless, attempts to reach a provider (even if unsuccessful) must be documented in the Comm Log associated with the specimen.

PROCEDURE NOTES

The precent of critical results successfully communicated is monitored regularly. Corrective action is undertaken when performance is below expected threshold.

REFERENCES

1. 2023 National Patient Safety Goal (NPSG) NPSG.02.03.01, "Get important test results to the right staff person on time"; The Joint Commission, Oakbrook Terrace IL. Available at https://www.jointcommission.org/-/media/tjc/documents/standards/national-patient-safety-goals/2023/2023-cah-npsg-goals-102122_simple.pdf (accessed 11/22/2-22)
2. Department of Health and Human Services, Centers for Medicare and Medicaid Services. Clinical laboratory improvement amendments of 1988 (CLIA '88); final rule. Fed Register. 2003(Jan 24): [42CFR493.1291(g)].
3. California Business and Professions Code, Division 2, Chapter 3, Article 2, Section 1220.
4. Magiorakos A-P, Srinivasan A, Carey RB et al. Multi-drug resistant, extensively drug-resistant and pandrug-resistant bacteria: An international expert proposal for interim standard definitions for acquired resistance. Clin. Microbiol. Infect. 2012;18:268-81.

RELATED DOCUMENTS

AHS Clinical Laboratory Genera Policy & Procedure

- 550a - "Ambulatory Clinics Back Office Line",

APPENDICES (FORMS, LABELS, TAGS, TABLES)

Appendix 1: HGH Notification Flow diagram
Appendix 2: Contact telephone #'s for EWC/HWC/NWC and SLH inpatient
Appendix 3: Critical Results

DISTRIBUTION

AHS Clinical Laboratory Manuals (HGH, SLH, ALH)
Flow diagrams posted throughout the AHS Clinical Laboratories as needed

REVISION HISTORY

April 2007: inclusion of Pediatrician on call as a resource.
October 2007:
1. Revised Medicine Resident on Call information. Previous version had single pager # to contact. This single pager # is no longer in use. P&P revised to instruct CLS to contact the hospital operator for the correct pager # of the Medicine Resident on call.
2. Revised the instructions for Highland Campus AIC, Procedure 3.b.vi.
3. Inclusion of notification for multi-drug resistant organisms (MDRO).

April 2008: inclusion of Eastmont, Newark and Winton critical result contact information.
July 2008: inclusion of rapid HIV antibody "preliminary positive" result as Labor & Delivery critical result
December 2008: Inclusion of the definition of a "critical test"; clarification of the distinction between "Critical Tests" and "Critical results" and how results of each should be communicated; inclusion of ED for notification of "preliminary positive" as a critical result.
April 1, 2010: Removal of all references to "critical tests" because The Joint Commission removed the requirement for organizations to define "critical tests"; updated procedure for contacted ED providers; included instructions to not leave critical results on voicemail; replaced reference to Meditech with Novius; updated references to include Joint Commission reference removing "critical tests" from accreditation requirement.
April 2, 2010: Removed EtOH as a critical result needing to be communicated to ED. This was at the request of the ED (Barry Simon, Chair, EM, email to VNg, 04/02/10).
July 27, 2010: Revised the Medicine after hours contact person from "Medicine Resident on call" to "Medicine Admitting Resident (pager 308-0232)" to align with changes in Medicine housestaff scheduling effective July 2, 2010.
March 2011: Revised to include lactate $\geq$ 4.0 mmol/L as a critical result, to eliminate calling certain critical results to the ED (any EtOH, any high glucose), to contact resident on call for specific services to communicate critical results for discharged inpatients, included instructions for follow-up of Point of Care Testing critical results, updated references.
April 2012: updated communication process for the Emergency Department since the previous method of communication, Vocera, is no longer active; included abnormal amniotic fluid result(s) as a critical result, and process for communicating; included centralized process through the pediatrician

in the ICN for communicating pending or critical results for specimens from AHS neonates transferred to a local pediatric acute care hospital. This revision was approved by AHS MedExec 06/20/12.

August 2012 revision – added cord gas pH < 7.0 and revised cord gas base excess from ≥ 12 to ≥ 10 at the request of Bob Savio, MD, Chief, Pediatrics; renamed "pediatrician on call" to "in house pediatrician", included cord gas critical results to be communicated to in house Pediatrician, included pager # of in house Pediatrician (633-7087). Revision submitted to September 2012 AHS Medical Executive Committee meeting for approval. Addendum: Approved by AHS Medical Executive Committee 09/19/12.

November 2012 – updated for newly implemented Emergency Department communication process (11/26/12 email from Barry Simon to Valerie Ng); included contact information for Healthcare for the Homeless van program.

December 2012 – added new Blood Bank critical result (Rh-negative mom with Rh-positive newborn) and captured existing process (newborn with positive DAT) with instructions to notify the Pediatrician on-call or ICN.

February 2013 – added ≥ 20% bands at the request of the Emergency Department. This critical result applies to the ED only.

April 29 2013 – revised ED critical notification to contact the ED Charge Nurse at telephone # (510) 867-5379, added internet URL on critical result flow sheet to identify physician on-call and contact information.

August 1 2013 - revised to include backup notification contact information for HGH General Medicine (HGM) Clinic, as requested by HGM leadership.

November 20 2013 – revised to include a changed beta-human chorionic gonadotropin (b-hCG) as a critical result upon request from MCH related to an unusual occurrence event because a change in b-hCG can change diagnosis, designated the communication flow diagram as Appendix I, moved display of critical results to Appendix II to accommodate formatting issues and group according to lab work assignments. Approved at 12/18/13 Medical Executive Committee meeting.

December 2013 – revised to remove specific pager numbers and refer users to Amion for listing of providers currently on duty and contact information. Administrative changes only, not submitted to Medical Executive committee for approval.

July 2014 – revised to reflect new process of notification of HH outpatient clinic critical results when the HH clinic is closed → communicate to the ED charge nurse with introductory contextual “script”, removed the redundant text (duplicated the flow chart), included instructions for discharged patients, updated HGM contact to include Dr. Blake Gregory, updated all contact information for non-HH sites. Submitted to Aug 20 2014 AHS/HH Medical Executive Committee for approval.

November 2014 – revised to detail Microbiology MDROs requiring critical communication for inpatients only, to document Infection Control regular retrieval and review of LIS-generated MDRO reports, to include malaria in the Hematology critical result list capturing existing practice.

February 2015: Clarified instructions for Microbiology critical results (inpatient versus outpatient), revised ED critical communication to include direct telephone #s of ED MDs for critical results from ED patients (changed from previous process of notifying the ED charge nurse).

June 2015: Revised ED critical result communication from notifying ED MD to ED Charge nurse; modified process for contacting outpatient clinics during normal working hours (i. e., changed from ED Charge nurse to Attending on call for clinic, service or specialty as listed on Amion → back office telephone # → ED charge nurse), revised flow diagram to reflect changes, updated mobile health program contact person from Damon Francis MD to Dipankar Ghosh MD. Approved AHS/HH Medical Executive Committee Jun 17 2015.

June 23 2015: Revised MDRO definition and requirement for Microbiology staff to inform patient location and Infection Control of MDRO recovery for isolation purposes; decreased critical result threshold for digoxin from ≥ 2.5 to ≥ 2.0 ng/mL and theophylline from ≥ 25 to ≥ 20 mcg/mL at request of Pharmacy.

July 2016: Clarified process for communicating outpatient critical results for all clinics other than Adult Medicine clinic after regular hours, updated contact information for Adult Medicine Clinic, created flow process for discharged patients, included instructions for identifying the clinical team caring for the now-discharged patient so that the current team attending can be notified, updated references and included new reference for the definition of MDROs, renumbered from 14.0 → 550 secondary to Lab General P&P manual reorganization.

February 2017: Clarified Same Day Clinic (SDC) after hours critical results are to be communicated to the ED charge nurse. Updated P&P #s for related and renumbered #550a - ambulatory clinics back office line (previously P&P #14.0a), updated MDRO definition to eliminate previous reference to ESBL organisms since laboratory no longer performs ESBL testing, added CRE as a critical result, included detail that freestanding clinic on-call pager/phone does not accept text paging and must be paged with conventional historical paging practice to a telephone #.

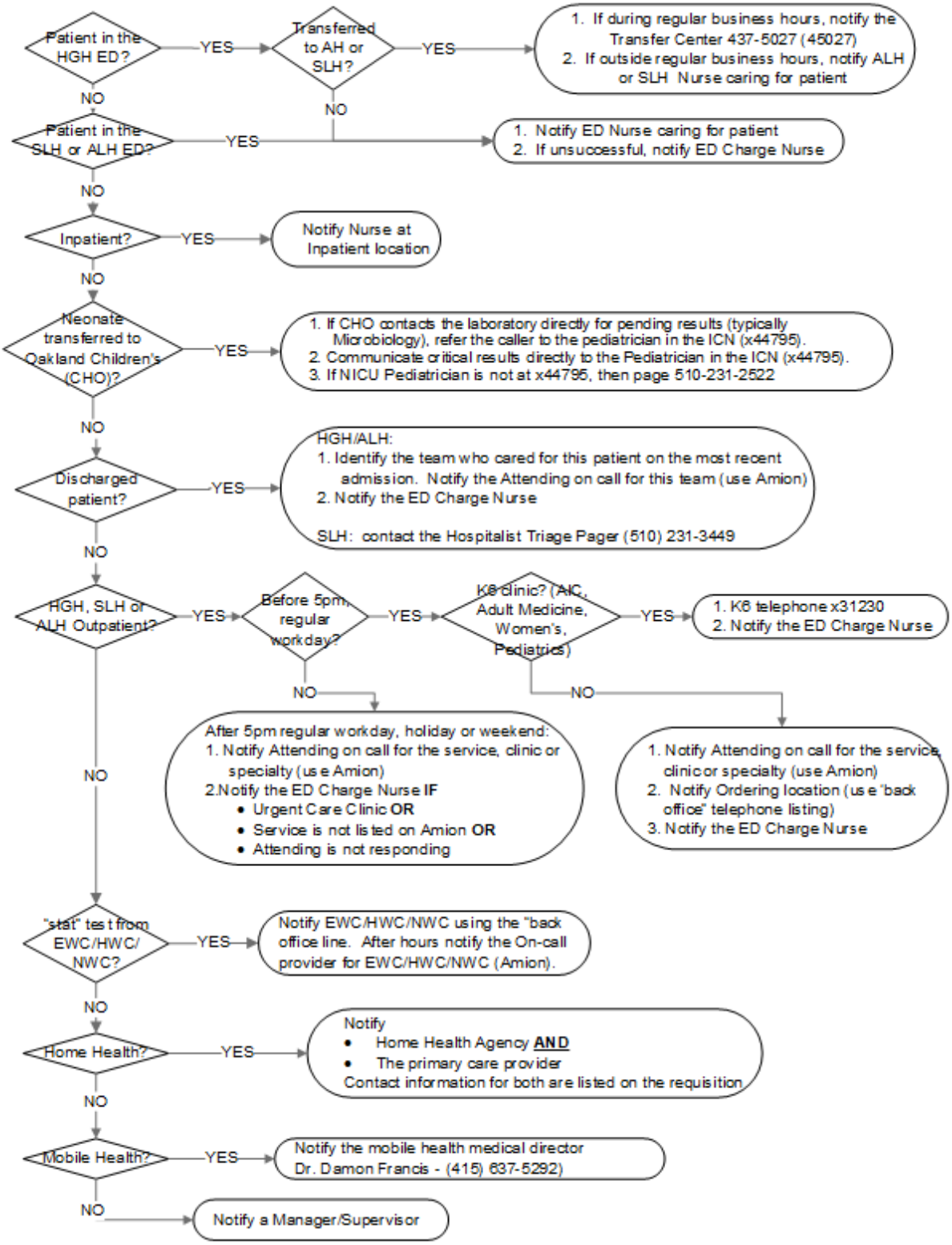
June 2017: Updated Adult Medicine Clinic contact information; updated flow diagram to include instructions for patients transferred from HH to AH or SLH, revised policy for EWC, HWC and NWC coincident with AHS/HH Clinical Laboratory providing services to them effective June 26 2017, included policy for any 'stat' test request from EWC/HWC/NWC to have result communicated as a critical result regardless of result/value.

January 2018: Revised critical result threshold for hemoglobin (from 6 g/dL to ≤ 7 g/dL, at request of Dept. of Medicine), troponin (from 1.0 ng/mL to 0.3 ng/mL, at request of Dept. of Emergency Medicine), removed urinalysis critical results of ketones or glucose for newborns as replaced by expanded newborn screening and non-availability of Clinitek tablets to confirm "reducing substances", removed amniotic fluid critical results as this testing has been replaced by NIPT, added positive smear-negative AFB culture, updated MDRO definition of Acinetobacter and Pseudomonas spp. in accordance with AHS/HH Antimicrobial Stewardship Program (ASP) recommendations; updated Adult Medicine Clinic call hierarchy.

December 2020: Converted to an AHS "system" policy & procedure and updated header accordingly, standardized critical results AHS-wide, removed references specific to AHS/HH, updated to reflect current HIS (Epic) processes, updated Microbiology to remove AFB smear-positive as a critical result since implementation of the AHS-ACPHL bidirectional interface with real time transmission of orders & results, removed requirement to notify Infection Prevention & Control (IPC) of MDROs/VRE/MRSA/CRE/CRAB/CRPA as Epic IPC module (Bugsy) captures these for regular review by IPC, updated HGH flow diagram (appendix 1) accordingly, included new appendix 2 for key non-HGH contact #s, updated references.

April 2022: Revised policy to state critical results should not be sent via EPIC secure chat; included "hospitalist triage pager" for notification of critical results for patients discharged from SLH; updated notification instructions for CRE/CRPA/CRAB; revised communication flow diagram for updated K6 clinic notification process and to be inclusive of all campuses; included new critical results for direct bilirubin $\geq$ 1 mg/dL for neonates $<$ 15 days old at request of NICN.

March 2024: Updated CO2 and blood gas values; refined drug-resistant organisms; updated POCT to include all POCT critical results; added phosphorus.


Patient in the HGH ED?
YES
Transferred to AH or SLH?
YES
1. If during regular business hours, notify the Transfer Center 437-5027 (45027)
2. If outside regular business hours, notify ALH or SLH Nurse caring for patient
NO
NO
Patient in the SLH or ALH ED?
YES
1. Notify ED Nurse caring for patient
2. If unsuccessful, notify ED Charge Nurse
NO
Inpatient?
YES
Notify Nurse at Inpatient location
NO
Neonate transferred to Oakland Children's (CHO)?
YES
1. If CHO contacts the laboratory directly for pending results (typically Microbiology), refer the caller to the pediatrician in the ICN (x44795).
2. Communicate critical results directly to the Pediatrician in the ICN (x44795).
3. If NICU Pediatrician is not at x44795, then page 510-231-2522
NO
Discharged patient?
YES
HGH/ALH:
1. Identify the team who cared for this patient on the most recent admission. Notify the Attending on call for this team (use Amion)
2. Notify the ED Charge Nurse
SLH: contact the Hospitalist Triage Pager (510) 231-3449
NO
HGH, SLH or ALH Outpatient?
YES
Before 5pm, regular workday?
YES
K6 clinic? (AIC, Adult Medicine, Women's, Pediatrics)
YES
1. K6 telephone x31230
2. Notify the ED Charge Nurse
NO
NO
After 5pm regular workday, holiday or weekend:
1. Notify Attending on call for the service, clinic or specialty (use Amion)
2.Notify the ED Charge Nurse IF
• Urgent Care Clinic OR
• Service is not listed on Amion OR
• Attending is not responding
1. Notify Attending on call for the service, clinic or specialty (use Amion)
2. Notify Ordering location (use "back office" telephone listing)
3. Notify the ED Charge Nurse
NO
"stat" test from EWC/HWC/NWC?
YES
Notify EWC/HWC/NWC using the "back office line. After hours notify the On-call provider for EWC/HWC/NWC (Amion).
NO
Home Health?
YES
Notify
• Home Health Agency AND
• The primary care provider
Contact information for both are listed on the requisition
NO
Mobile Health?
YES
Notify the mobile health medical director Dr. Damon Francis - (415) 637-5292)
NO
Notify a Manager/Supervisor

Acute Care Hospitals:

- **John George Psychiatric Hospital:** contact the MD on duty* in the Psychiatric Emergency Services (PES)
- **Fairmont Hospital:** Contact ordering location during business hours. After hours - contact the Nursing Supervisor on Duty
- **San Leandro Hospital –**
  - **Any admission, transfer or discharge:** Triage pager 510–231-3449
  - **Outpatient:** Physician's office
- **Alameda Hospital:**
  - **Inpatient:** Nurse at inpatient location → Charge Nurse or supervisor of unit if nurse not available
  - **Outpatient:** Physician's office. Do not FAX results without telephoning.
  - **Unable to reach physician:** Emergency Room Physician

Freestanding Wellness Centers:

- **Eastmont Wellness Center**: x75785, x75704 during regular business hours
- **Hayward Wellness Center**: (510) 912-5423 during regular business hours
- **Newark Wellness Center**: Triage RN (510) 418-4832 during regular business hours

Outside regular working hours – use Amion. Note there is a single listing for all three Wellness Centers, but there are three different specialties on call. Select the most appropriate one to contact. If you've selected the incorrect one, the recipient might direct you to the correct one and/or try the others. Sample Amion screenshot

Mobile Health: Damon Francis, MD (415) 637-5292

Chemistry	Low	High
Bilirubin, Total, ≤ 15 days old	-	≥ 15 mg/dL
Bilirubin, Direct, ≤ 15 days old	-	≥ 1 mg/dL
Beta-hCG (qual, urine)	Changed result (e.g. neg. to pos.)	
Calcium	≤ 6 mg/dL	≥ 14 mg/dL
CO_2, total	< 11 mmol/L	> 42 mmol/L
Glucose, CSF	≤ 25 mg/dL	-
Lactate	-	≥ 4.0 mmol/L
Magnesium	≤ 0.8 mg/dL	> 5.0 mg/dL
Phosphorus	< 1.0 mg/dL	> 9.0 mg/dL
Potassium	≤ 2.5 mmol/L	> 6.5 mmol/L
Sodium	≤ 120 mmol/L	> 160 mmol/L
Glucose	< 50 mg/dL	> 500 mg/dL ***ED excluded***
Troponin I	-	> 0.10 ng/mL
Hepatitis C Antibody	**ED ONLY: Reactive result**	
HIV Ag/Ab combo (HIV p24 antigen & HIV antibody)	**L&D and ED only: Presumptive positive** Call when you are repeating an initial positive and call again with the final	
Coagulation	**Low**	**High**
Prothrombin time	-	≥ 47 seconds
INR	-	≥ 4.0
PTT	-	≥ 100 seconds
Fibrinogen	≤ 90 mg/dL	-
anti-Xa	-	> 0.7 IU/mL
Hematology	**Low**	**High**
Hemoglobin	≤ 7 mg/dL	≥ 20 mg/dL (> 1 day old)
Platelet count	≤ 20,000/mcL	≥ 1,000,000/mcL
WBC (blood)	≤ 1,500/mcL	≥ 35,000/mcL
WBC (CSF)	-	≥ 9 WBC's/mcL
WBC count (synovial fluid)	-	≥ 10,000/mcL
% bands	-	**ED only**: ≥ 20%
Malaria screen	*Plasmodium* spp. detected and % parasitemia	

Toxicology	Low	High
Acetaminophen	-	> 50 mcg/mL
Digoxin	-	≥ 2.0 ng/mL
Ethanol	-	≥ 400 mg/dL ***ED excluded***
Gentamicin, peak	-	≥ 12 mcg/mL
Gentamicin, trough	-	≥ 2.0 mcg/mL
Iron	-	≥ 400 mg/dL
Lithium	-	≥ 2 mEq/L
Osmolality, Serum	≤ 240 mOsm/kg	≥ 340 mOsm/kg
Phenobarbital	-	≥ 40 mcg/mL
Phenytoin (Dilantin)	-	≥ 30 mcg/mL
Salicylate	-	≥ 40 mg/dL
Theophylline	-	≥ 20 mcg/mL
Vancomycin, random	-	≥ 80 mcg/mL
Vancomycin, trough	-	≥ 20 mcg/mL
Valproic Acid	-	≥ 150 mcg/mL
Blood Gases and Cooximetry	**Low**	**High**
pH	< 7.20	> 7.55
pH-neonate	< 7.20	> 7.55
pCO_2 (mmHg)	-	-
pCO_2 (mmHg) – neonate	-	-
HCO_3 (mmol/L)	< 11	> 42
HCO_3 (mmol/L) – neonate	< 11	> 42
BE (mmol/L)	≤ -10	≥ 10
BE (mmol/L) – neonate	≤ -10	≥ 10
SO_2 (%)	-	-
FO_2Hb (%)	-	-
FCOHb (%)	-	≥ 20%
FMetHb (%)	-	-
FHHb	-	-
tHb	-	-

Blood Bank

- Rh-negative mom with an Rh-positive newborn
- Newborn with a positive Direct Antiglobulin Test (DAT)

Microbiology – All patients

- Positive blood culture
- Positive CSF gram stain
- Positive sterile site culture
- Positive newborn or infant culture
- Recovery of Salmonella or Shigella spp.
- Recovery of Clostridium perfringens from a wound culture
- Recovery of Candida auris

Microbiology – Inpatient only

ESBL (Extended-spectrum beta-lactamase resistant organisms): Klebsiella pneumoniae, Klebsiella oxytoca, Proteus mirabilis, or Escherichia coli resistant to cefotaxime, ceftazidime, ceftriaxone, or cefepime and a beta-lactamase inhibitor, usually clavulanate.
VRE: Enterococcus faecium or Enterococcus faecalis resistant to vancomycin
MRSA: Methicillin (oxacillin) resistant Staphylococcus aureus
CRE*: Enterobacterales spp. resistant to ertapenem, doripenem, imipenem, and/or meropenem. NOTE: For organisms with imipenem intrinsic non-susceptibility (i.e. Morganella morganii, Proteus spp., and Providencia spp.), resistance to carbapenems other than imipenem is required
CRPA*: Pseudomonas aeruginosa resistant to doripenem, imipenem, and/or meropenem
CRAB*: Acinetobacter baumanii group resistant to doripenem, imipenem, and/or meropenem

*Notify Infection Prevention and Control in addition to RN/MD | Use Amion for all provider contact information

PATIENT IDENTIFICATION

Department	Clinical Practice, Nursing	***Effective Date***	5/27/03
Campus	All	***Date Revised***	5/03, 10/08, 8/2013, 4/2025
Unit	All	***Next Scheduled Review***	4/2028
Manual	Clinical Practice	***Author***	DON
Replaces the following Policies:		***Responsible Person***	CNE

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

Purpose

The use of two (2) unique patient identifiers is required prior to providing care, treatment and service and when collecting specimens. To actively engage the patient in the identification process and patient safety process when appropriate, name and date of birth should be requested from the patient independently and without prompting by asking the question and allowing a verbal response when able.

A. Two unique identifiers are required prior to:
   - administering medications
   - administering blood/blood products (components)
   - perform any treatment / test
   - perform any procedures
   - collecting specimens

B. Services should be withheld until two (2) unique identifiers are established. The only exception is interventions during life-threatening emergencies. In this case, the patient is assigned a first name with last name unknown and a medical record number is generated until the patient can be properly identified.

C. The two identifiers for inpatient and outpatients who can actively participate in the identification process by verbally responding when asked are:

   1. Patient name (first and last name)
   2. Date of birth (month, day, and year)

D. The two identifiers for inpatient and outpatients who cannot actively participate in the identification process.

1. Patient name (first and last name)
2. Date of birth (month, day, and year)
3. Lab uses name and MRN

E. The two identifiers for Newborns:

1. Mother's name (Last name and First name) and date of birth (DOB)
2. Newborn- Mother's name (Last name, First name), Baby Boy/Girl and date of birth (DOB) (month, day, and year) **e.g.- Doe, Jane, Baby Boy 04/27/25**

F. Patient identification bands will be place on the following types of patients immediately after information is obtained.

1. Inpatients
2. Emergency Department patients
3. Trauma patients
4. Newborn Patients (Two Baby Bands: One on a wrist and one on an ankle)
5. Surgery or Procedure Room Outpatients
6. Observation Patients
7. Any unresponsive, confused, incompetent or mentally challenged patients regardless of their status

G. Outpatients who do not require a patient identification band will be asked to state:
1. Patient name (first and last)
2. Date of birth (month, day, and year)

Staff will match the above information with the medical document containing the information, i.e., face sheet, Laboratory requisition, Radiology requisition, etc.

References

The Joint Commission Comprehensive Accreditation Manual for Hospitals - NPSG.01.01.01

Approvals

Departmental	**Date: 10/2013, 4/2025**
Chief Nurse Executive	**Date: 11/2013, 4/2025**
Clinical Practice Council	**Date: 5/2025**
Medical Executive Committee	**Date: 11/2013, 5/2025**
Board of Trustees	**Date: 1/2014, 6/2025**

ALAMEDA HEALTH SYSTEM	Policy	
	HR Section 3.00 – Policy 3.24 **Compliance Enforcement and Discipline**	**Reference # tbd**
	LEVEL ☐ System ☐ Site	EFFECTIVE DATE: 4/2025

POLICY STATEMENT

AHS is committed to a policy of fair dealing and integrity in the conduct of all business. This commitment is based on a fundamental belief in law, honesty, and fairness and is consistent with AHS' values, mission and vision which include integrity as a distinct component. AHS expects its employees and its affiliate practitioners to share its commitment to high legal, ethical, and moral standards. All AHS employees and its affiliate practitioners are expected to comply with the Standards for Business Conduct and related policies concerning regulatory requirements applicable to our business.

PURPOSE

Alameda Health System (AHS) is subject to the possibility of irregularities or misinterpretations concerning the rules which govern our industry. This is not usual or common but due to the complexity of our business, is a possibility. This policy states AHS' position on enforcement and discipline when irregularities have been identified.

GUIDELINES

Standards for Business Conduct and related polices will be consistently enforced through appropriate supervisory and disciplinary mechanisms, including, as appropriate, discipline of AHS employees and its affiliate practitioners responsible for the failure to detect and correct violations. All violations will be investigated, and appropriate disciplinary action will be applied pursuant to law, labor agreement, policy and practice. Decisions to prosecute or turn matters over to appropriate law enforcement and/or regulatory agencies for independent investigations will be made in conjunction with the Compliance Department, AHS Legal Department and Senior Management.

Alameda Health System

METHICILLIN-RESISTANT STAPHYLOCOCCUS AUREUS (MRSA) MANAGEMENT PLAN

Department	Infection Prevention and Control	Effective Date	New
Campus	All	Date Revised	New
Unit	All	Next Scheduled Review	08/2028
Manual	Infection Prevention and Control	Author	System Director, Infection Prevention and Control
		Executive Responsible	Vice-President, Quality

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

Table of Contents

1 Definitions

- Multidrug-resistant organisms (MDROs) are microorganisms that exhibit resistance to multiple antimicrobial agents.
- Methicillin-Resistant Staphylococcus Aureus (MRSA) is a type of gram-positive bacteria that is resistant to several antibiotics, including methicillin.
- MRSA colonization means a person/patient is known carrier of MRSA bacteria on their skin or in their nose, but they do not have an active infection. Essentially, the bacteria are present but not causing illness.
- MRSA infection: MRSA infection occurs when the Methicillin-resistant Staphylococcus aureus bacteria invade the body, causing illness. This means the bacteria are actively multiplying and damaging tissues, leading to symptoms that vary depending on the location of the infection
- MRSA is a common organism that causes hospital acquired infections such as Surgical Site Infections, Bacteremia, Device associated infections. MRSA is also prevalent in community acquired infections, osteomyelitis, skin, and soft tissue infections among others.
- Resistance to vancomycin, linezolid, and daptomycin is a growing concern in staph bacteria.
- Healthcare-Associated Infections are infections that develop while a patient is receiving care in a hospital or other healthcare facility.
- Community-acquired infection is an infection contracted outside of a hospital setting or diagnosed within 48 hours of hospital admission, provided the patient has had no recent hospital exposure or contact with hospitalized individuals.

2 Background

Methicillin-resistant Staphylococcus aureus (MRSA) is a significant contributor to healthcare-associated infections. Given the high prevalence of MRSA within the population served by Alameda Healthcare System, the risk of transmission and infectious complications are a serious concern. However, it's crucial to acknowledge that MRSA infections and their associated complications are preventable. Alameda Health System has available the necessary technology, resources, and evidence-based practices to effectively prevent hospital-onset MRSA infections. AHS has commitment from leadership, clinicians and bedside staff to implement and sustain comprehensive interventions aimed at preventing the spread of MRSA, Hospital onset of MRSA infections, ensuring the safety of our patients and staff.

2.1 Key points about nasal MRSA colonization and infection

- Adhesion to nasal lining: MRSA bacteria naturally adhere to the lining of the nasal cavity, making it a common colonization site.
- Transmission through direct and indirect contact: MRSA spreads through direct contact with an infected person or indirectly through contaminated surfaces. Patients carrying MRSA in their nose can transfer the bacteria, and if it enters a susceptible site such a wound, in another person, it can cause an incubation and lead to infection.
- Surgical site infections: Nasal colonization with MRSA is a significant risk factor for surgical site infections, as the bacteria can be transferred to the surgical wound during surgery.
- Other infection routes: MRSA can also spread from the nose to other body sites like the respiratory tract through coughing or sneezing, potentially causing pneumonia or other infections in vulnerable individuals.

2.2 Factors that can increase the risk of infection from nasal MRSA colonization.

- Frequent hand-to-nose contact: Not washing hands regularly after touching the nose can facilitate the spread of bacteria.
- Impaired immune system: People with weakened immune systems are more susceptible to infections

from MRSA. Elders, dialysis, post-surgical patients, and patients with extensive wounds are at higher risk of MRSA infection.

- Presence of open wounds or skin breaks: Any open wound or break in the skin can serve as a potential entry point for MRSA.

2.3 Evidence Base Interventions to prevent MRSA associated healthcare infections.

2.3.1 CDC: Strategies to Prevent Hospital Onset of MRSA infection in Acute Care facilities.

Below, is the summary of strategies recommended by the CDC regarding MRSA interventions:

Prevent Transmission of MRSA:
Maintain contact precautions for patients colonized or infected with MRSA, including private rooms and the use of gowns and gloves. Emphasize proper hand hygiene, environmental cleaning, and the use of dedicated patient-care equipment.
Implement Decolonization and Pathogen Reduction Strategies:
Employ decolonization strategies for high-risk patients, particularly those in intensive care units (ICUs) and those undergoing high-risk surgeries. This typically involves intranasal antiseptic and bathing with chlorhexidine gluconate.
Reduce Device and Procedure-Related Infections:
Implement evidence-based guidelines for preventing central line-associated bloodstream infections (CLABSIs), surgical site infections (SSIs), hemodialysis bloodstream infections, and ventilator-associated pneumonia (VAP). This includes strict adherence to infection control practices during device insertion and maintenance.

2.3.2 SHEA/IDSA/APIC: Recommendations to prevent MRSA infection and transmission in Acute Care Hospital:

Summary of SHEA/IDSA/APIC recommendations to prevent MRSA infections and transmission:

Essential Practices:	
Recommendation	Quality of Evidence
Implement a MRSA monitoring program.	LOW
Conduct a MRSA risk assessment.	LOW
Promote compliance with the CDC or WHO hand hygiene recommendations.	MODERATE
Use contact precautions for MRSA-colonized and MRSA-infected patients.	MODERATE
Ensure cleaning and disinfection of equipment and the environment.	MODERATE
Implement a laboratory-based alert system that notifies HCP of new MRSA-colonized or MRSA-infected patients in a timely manner.	LOW
Implement an alert system that identifies readmitted or transferred MRSA-colonized or MRSA-infected patients.	LOW
Provide MRSA data and outcome measures to key stakeholders, including senior leadership, physicians, nursing staff, and others.	LOW

Educate healthcare personnel about MRSA.	LOW
Educate patients and families about MRSA.	LOW
Implement an antimicrobial stewardship program.	LOW
Additional Approaches	
Active Surveillance Testing (AST):	
Target specific populations. (ICU, Dialysis, Long term care)	MODERATE
AST with Decolonization in targeted population prior surgery.	MODERATE
AST with Contact precautions is superior to Nasal Decolonization	HIGH
AST Hospital wide with Contact precautions.	MODERATE
AST as part of outbreak management.	MODERATE
Screen Healthcare Personnel for MRSA infection or colonization	
Screen HCP if they are linked to MRSA outbreak	LOW
MRSA Decolonization Therapy	
Universal decolonization and daily CHG bathing for all ICU patients	HIGH
Pre-operative Nasal decolonization and CHG Bathing in MRSA carries to reduce SSI	MODERATE
AST, targeted decolonization with daily CHG bathing to MRSA carriers in surgical units involving implantation of hardware.	MODERATE
AST, Nasal Decolonization with CHG bathing in surgical units in MRSA carriers.	MODERATE
CHG Bathing plus nasal decolonization to known MRSA carriers outside of ICU with medical devices, central and mid lines, lumbar drains.	MODERATE
Post discharge nasal decolonization in MRSA carriers to prevent readmission.	HIGH
Consider targeted or universal decolonization of hemodialysis patients.	MODERATE
Decolonization as part of multimodal approach to control MRSA outbreaks	MODERATE
Universal Gowns and Gloves	
Use of gowns and gloves when providing care to all ICU patients regardless of MRSA status.	MODERATE

2.4 California Senate Bill 1058, Senate Bill 158 – Medical Facility Infection Control and Prevention Act.

In accordance with California State Senate Bill 158 (Chapter 294, Statutes of 2008) and Assembly Bill 1058 (Chapter 296, Statutes of 2008), effective January 1, 2009, Acute Care hospitals are required to implement procedures aimed at reducing healthcare-associated infections, including Methicillin-resistant Staphylococcus aureus (MRSA). To comply with these statutes, all patients admitted to this general acute care hospital meeting the following criteria must be screened for MRSA within 24 hours of admission:

- Patients scheduled for inpatient surgery with documented medical conditions that increase their

susceptibility to infection, as defined by the Centers for Disease Control and Prevention or the Healthcare Associated Infection Advisory Committee (or its successor).

- Patients discharged from any general acute care hospital within 30 days prior to the current admission.
- Patients admitted to an intensive care unit (ICU) or burn unit.
- Patients receiving inpatient dialysis treatment.
  Patients transferred from a skilled nursing facility.

In response to this mandate, AHS implemented universal active surveillance testing to all patients admitted as inpatients, with exception of outpatient surgery patients who are admitted as inpatient after the surgery due to nasal decolonization initiated in the pre-operative setting.

3 Purpose of this management plan:

This policy outlines procedures to prevent MRSA transmission and infection, ensuring patient and staff safety within Alameda Health System. It adheres to CDC guidelines, and California law, mandating screening and implementing core infection control measures.

4 Management Plan:

4.1 Active Surveillance Testing (Nasal Swab).

4.1.1 Screening for MRSA.

All admitted patients must be screened within 24 hours of admission to Acute Care services. The assigned nurse is responsible for ensuring this screening is completed.

If the nasal screening was not collected within 24 hours, collect the sample and send it immediately to the lab.

4.1.2 Procedure for MRSA Screening:

Samples must be collected within 24 hours of admission.

The nurse will obtain a MRSA top nasal swab culture tube from the clean supply room.

Tube Preparation:

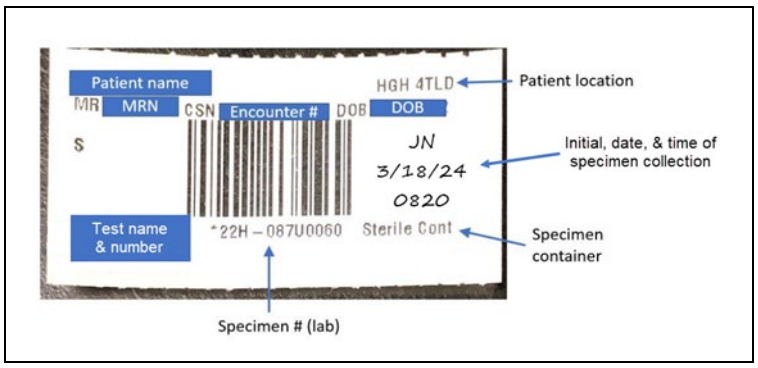
- Remove the red top cap to place the swab sticks inside the tube.
- Press on the bottom of the tube to release the liquid and moisten the swab.

Collect Sample from patient's Nares:

- Carefully insert one of the swabs into the patient's nostril (about one inch)
- Roll the swab about five times.
- Insert the second swab into the other nostril and repeat the sampling.
- Return swab sticks to the tube.

Labeling:

- From EPIC, print a label to the nearby Zebra printer. Note that EPIC "Zebra" labels are required for lab specimens; do not use patient labels.
- Verify Patient Information: Check that the patient identification information on the printed label matches the patient armband (using 2 identifiers).
- Document Collection: Record the collection in EPIC from the specimen collection screen.
- Scan the patient and then scan the "zebra" specimen label. Click "accept."
- Collector's Initials: Handwrite the collector's initials.



4.2 Lab and Result reporting:

- MRSA-positive screening and culture results are classified as critical lab results. The lab will immediately notify bedside staff by phone and update the lab reports in EPIC.

- The Chair of the Department of Laboratory Medicine and Pathology is responsible for maintaining current standards in MRSA identification methodologies.

4.3 Transmission based precautions, contact precautions and cohorting:

4.3.1 Active MRSA infections:

Patients with recent MRSA-positive cultures will be placed in private rooms and require contact precautions.

4.3.2 Contact Precautions for patients with positive MRSA cultures:

Source	Risk level	Contact Precautions
MRSA Nares Positive	If low Risk: No lines, tubes, devices, dialysis, surgeries. No extensive wounds.	Depends on Risk assessment
MRSA Nares Positive	If high Risk: Dialysis, Post recent surgery, O2 supplementation. Multiples lines/tubes/devices. IV Drug users, Diabetic.	Yes
Respiratory Tract	If high Risk: if recent or pass respiratory cultures positive for MRSA in the last 12 months. ICU, O2 supplementation (BiPAP, CPAP, Vent support, NC> FIO28%). Dialysis, Chronic active wounds.	Yes
	If low risk: Decannulated, extubated. Recovering high functionality	No
Wounds	If high Risk: Extensive wounds with current or past cultures positive for MRSA in the last 12 months.	Yes
	If low risk: Wound has healed, no other devices, drains or central lines.	No
Blood	Depending on the suspected primary source.	Yes
Urine	Depending on if infection resolved and other risk factors such as bedbound, extensive wounds, etc.	Yes
	Infection has resolved. No other lines, high risk conditions.	No
Other drains/fluids	High risk	Yes

4.3.3 MRSA colonization:

For patients with a history of MRSA-positive cultures (more than 12 months), an Infection Preventionist will assess the need for transmission-based precautions and further interventions based on transmission risk and risk assessment which will vary in each facility of AHS. The bedside staff must contact the Infection Control department for further guidance in determining if contact precautions apply.

Transmission Risk: Patients with a history of MRSA-positive cultures and/or nasal swab within the past 12 months, and who present with active or worsening wounds, sepsis, dialysis, or symptoms of acute infection, may require contact isolation. CHG bathing may be added as a strategy to manage bacteria burden.

Consult the Infection Prevention Department for further evaluation and guidance.

4.3.4 Discontinuation of Isolation (Contact Precautions):

Decisions regarding the continuation or discontinuation of contact precautions in MRSA colonization patients, depends on the patient's clinical condition, the prevalence of MRSA-HO in the facility, and the compliance of Infection control practices such as hand hygiene, correct use of PPE, surface cleaning practices.

Patients with a history of MRSA-positive cultures and who have healed wounds, resolved sepsis, and are independent and high-functioning, without indwelling devices, lines, or tubes, may be considered for discontinuation of contact precautions. The infection control risk assessment for each facility determines the level of intervention needed. The department/unit must consult the Infection Prevention Department for final determination to assess the isolation status.

4.3.5 Cohorting patients with MRSA colonization or MRSA active infections:

Patients with active MRSA infection will require private room contact precautions.

Cohorting with other patients will be considered in the following cases.

- There are no single rooms available.
- Single rooms are prioritized for respiratory isolation.
- Potential roommates are known with active MRSA infection determined by less than 12 months old culture report, or they are known MRSA colonization in the last 12 month by positive MRSA screening.

Cohorting of patients known carriers of MRSA in the nares, must be kept from sharing rooms with post operative patients. If required to share rooms, contact precautions, nasal decolonization and CHG Bathing may be necessary.

4.3.6 Patient Care Recommendations:

A. Staffing:

Compliance with contact precautions is mandatory. Staff must wear gowns and gloves for all patient interactions and maintain strict hand hygiene when contact precautions status was established. Designated staff is not required for patients with known MRSA active infections or known MRSA colonization.

B. Medical Equipment:

Disposable medical equipment is required. Elements such as stethoscope, Blood pressure cuffs, pulse oximeter probes, side rail pads, among others.

Shared Medical Equipment must be thoroughly cleaned with special attention in contact time. Two-minute contact time for purple and grey wipes.

- If there are further C. difficile infections, shared equipment must be cleaned with bleach.
- When C. auris is added to an existing MRSA infection, patient equipment must be dedicated to preventing cross-contamination.

4.4 Nasal Decolonization:

The nasal vestibule harbors pathogenic bacteria like S. aureus, and nasal carriage increases healthcare-associated infection risk. Nasal antisepsis reduces colonization, decreasing HAIs, particularly surgical site, and bloodstream infections. Non-antibiotic, alcohol-based nasal antisepsis offers a practical approach to reduce bacterial carriage, minimizing antimicrobial resistance and streamlining implementation.

The decision of nasal decolonization for MRSA nares colonization patients is based on the risk assessment, targeted population for each facility.

The facility should develop protocols to describe in which cases MRSA decolonization applies.

4.4.1 Procedure for Nasal Decolonization with Topical antiseptic:

1. Assess for Contraindications:
    a. Verify the absence of a known allergy.
    b. Confirm the lack of epistaxis or mucosal irritation.
    c. Ensure no intranasal packing is present and the nostrils are patent.
2. Administration of Topical Disinfectant:
    a. Inform the patient regarding the nature of the nasal disinfectant and its purpose (the prophylactic value of nasal microbial reduction).
    b. Execute hand hygiene and Don protective gloves.
    c. Clear the nasal passages with a disposable tissue and discard.
    d. Agitate the vial vigorously for 5 seconds.
    e. Detach the cardboard sheath from the vial to expose the applicator tip, invert, and completely reinsert the vial into the sheath with the applicator tip visible. Refrain from touching the applicator tip.
    f. Grasping the vial by the cardboard sheath, exert firm pressure at the azure mark to fracture the internal ampule and release solution into the applicator tip.
    g. Direct the applicator tip downward and compress the vial to saturate the applicator tip.
    h. Introduce the applicator tip into the RIGHT naris. Do not advance beyond the applicator tip's extent.
    i. Applying moderate force, swab the right naris EIGHT (8) times in a single direction, encompassing all surfaces, including the internal margin of the naris.
    j. Withdraw the vial from the naris. Invert and delicately compress to re-saturate the applicator tip.
    k. Reintroduce the applicator tip into the RIGHT naris and swab eight (8) times in the opposing direction.
    l. Withdraw the vial from the naris. Invert and delicately compress to re-saturate the applicator tip.
    m. Employing the same vial, replicate the complete application in the LEFT naris.
    n. Applying moderate force, swab the left naris EIGHT (8) times in a single direction, encompassing all surfaces, including the internal margin of the naris.
    o. Withdraw the vial from the naris. Invert and delicately compress to re-saturate the applicator tip.
    p. Reintroduce the applicator tip into the LEFT naris and swab eight (8) times in the opposing direction.
    q. Withdraw the vial from the naris.
    r. Dispose of the vial and sheath post-use.

Warning: Do not insert the vial into the nose beyond the applicator tip. Apply exclusively to the cutaneous tissue of the nasal vestibule (nares).

3. Specific Scenarios for Topical Antiseptic Application in Patients with Nasal Apparatus:
    a. a. Oxygen Nasal Cannulas
        i. If the patient tolerates removal, they temporarily extract nasal prongs from the nares.
        ii. Administer nasal disinfectant (according to the manufacturer's instructions for use).
        iii. Sanitize the nasal cannula prongs per manufacturer's directives or substitute with a fresh set prior to reinsertion into the nares.
    b. b. Endotracheal Tube/Nasogastric Tube
        i. Apply nasal disinfectant carefully around the tube, covering the maximum achievable area.
        ii. Administer to the nares devoid of a nasogastric tube.
    c. c. Nasal Injury
        i. Abstain from using nasal disinfectant if the nares are packed and/or exhibit an open lesion or hemorrhage.
        ii. If only one naris is affected, apply nasal disinfectant to the contralateral (unaffected) naris.

4.5 Chlorhexidine Gluconate (CHG) Bathing:

Chlorhexidine Gluconate (CHG) bathing has been demonstrated to reduce the cutaneous burden of microorganisms, including Methicillin-resistant Staphylococcus aureus (MRSA). This practice is an important component of infection prevention strategy against MRSA. CHG antimicrobial properties effectively target and minimize the presence of MRSA on patient skin, thereby reducing the risk of infections and transmission. Recognizing its efficacy, both the Society for Healthcare Epidemiology of America (SHEA) and the Centers for Disease Control and Prevention (CDC) recommend CHG bathing as a co-strategy in the prevention of MRSA-associated healthcare infections, supported by moderate quality of evidence.

Detailed procedures, protocols, and specific instructions for CHG bathing are comprehensively outlined in the dedicated CHG policy, ensuring consistent and effective implementation across all AHS facilities.

4.6 Other Preventive strategies and Management:

4.6.1 Hand Hygiene:

Recognizing that hand hygiene is the paramount strategy for preventing healthcare-associated infections, in general and MRSA transmission in particular, AHS is committed to fostering a culture of adherence to established hand hygiene protocols among all members of the AHS community. To facilitate this commitment, AHS ensures the strategic placement and consistent availability of handwashing stations and alcohol-based hand sanitizer dispensers throughout all facilities. Furthermore, to reinforce compliance and maintain optimal standards, AHS will conduct regular, comprehensive hand hygiene campaigns. The Quality Division will implement a monitoring program at the unit level to assess and enhance adherence to hand hygiene practices, ensuring the effectiveness of our infection prevention initiatives.

In addition, ongoing risk assessments and monitoring of MRSA infection trends will be conducted to identify units demonstrating poor outcomes. Based on these assessments, targeted interventions will be implemented to reinforce hand hygiene compliance in those specific areas

4.6.2 Environmental Cleaning and Disinfection:

Thorough environmental cleaning and disinfection are critical components of MRSA prevention and management plan. To ensure effectiveness against MRSA, all cleaning products used for surface disinfection will be EPA-approved with registered claims against MRSA. Environmental Services conduct regular audits to assess compliance with daily room cleaning and terminal room cleaning procedures, with a particular focus on high-touch surfaces.

EVS and Infection Control continuously evaluate and assess new technologies and products that demonstrate effectiveness against MRSA and contribute to the reduction of healthcare-associated infections.

4.7 Annual Risk Assessment:

MRSA Trends Analysis: To ensure effective MRSA management, AHS acute care facilities will: 1) include MRSA trend analysis in their annual risk assessments, and 2) monitor hospital-onset MRSA bloodstream infections and no-in blood MRSA infections, as reported to the NHSN. Further interventions will be considered if surveillance indicates persistent hospital-onset MRSA bloodstream infections.

Comprehensive Infection Trend Monitoring: Risk assessments will expand to include trends in other MDROs and device-related infections. This integrated approach will provide a holistic view of the infection landscape, enabling informed decisions on adjusting or reinforcing MRSA management and overall infection prevention strategies.

INFECTION EVENT	PROBABILITY OF OCCURRENCE				LEVEL OF HARM FROM EVENT				IMPACT ON CARE				READINESS TO PREVENT			RISK LEVEL
	(How likely is this to occur?)				(What would be the most likely?)				(Will new treatment/care be needed for Patients/staff?)				(Are processes/resources in place to identify/address this event?)			(Scores ≥ 8 are considered highest priority for improvement efforts.)
Score	High	Med.	Low	None	Serious Harm	Moderate Harm	Temp. Harm	None	High	Med.	Low	None	Poor	Fair	Good	
	3	2	1	0	3	2	1	0	3	2	1	0	3	2	1	
Facility-onset Infections(s)																
Device- care- or Procedure related																
Catheter Associated Blood Stream infections																
Catheter Associated Urinary tract infections																
SSI																
Resistant Microorganism																
CROs																
Candida Auris																
MRSA																
VRE																
VRSA/VISA																
ESBL																
Other MDROs																
Date Completed:																
3/5/2025																

- Education and Training:

AHS incorporates comprehensive education on MRSA management and the prevention of healthcare-associated infections into its educational programs, including orientation and annual competency assessments. Special emphasis is placed on proper hand hygiene, recognized as the cornerstone of MRSA infection prevention. Training will also cover active surveillance testing (nasal swabs) and decolonization protocols utilizing topical antiseptics.

5 APPROVALS

		System	Alameda	AHS/Highland/John George/San Leandro
Department:	Date:			
Infection Control	Date:			
Clinical Practice Council (CPC)	Date:			
Medical Executive Committee	Date:			
Board of Trustees	Date:			

B3. Medical Staff Policies and Procedures listed below_

ALAMEDA HEALTH SYSTEM

May 28, 2025

TO: Quality Professional Services Committee

FROM: Bhrett Lash, M.D., Alameda Health System Vice Chief of Staff
Catherine Pyun, D.O., Alameda Hospital Chief of Staff

SUBJECT: **Agenda Item:** A3

Meeting Date: May 28, 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 Ongoing Professional Practice Evaluation (OPPE) Policy and Procedure
- Telemedicine Credentialing By Proxy

AHS Medical Staff:
- Medical Staff Committees
- Medical Staff Department Structure and Division Leadership

AH Medical Staff:
- Medical Staff Committees

Alameda Health System

MEDICAL STAFF ONGOING PROFESSIONAL PRACTICE EVALUATION (OPPE)

Department	AHS Medical Staff	***Effective Date***	1/2022
Campus	AHS, AH	***Date Revised***	1/2023, 5/2025
Unit	All	***Next Scheduled Review***	5/2028
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

This policy establishes a systematic process for conducting Ongoing Professional Practice Evaluation (OPPE) for Alameda Health System (AHS) and Alameda Hospital (AH) Medical Staffs. The process uses objective tools and meaningful data to assess and evaluate provider performance.

Definition

The term "Ongoing Professional Practice Evaluation (OPPE) and Focused Professional Practice Evaluation (FPPE)" are terms used for evaluation of a Provider's performance. OPPE is the continuous evaluation of a Providers' performance, intended to identify professional practice trends that may impact the quality and safety of care and applies to all practitioners granted privileges. FPPE is a process whereby the organization evaluates the privilege-specific competence of the Provider when new privileges are granted, when clinical activity is insufficient to evaluate competence or there is a particular question regarding a Provider's care or professional conduct (FPPE for Cause).

Policy Statement

Alameda Health System conducts ongoing monitoring and evaluation of the quality and safety of care delivered to patients by its Medical Staff and Advanced Practice Providers. The OPPE process is designed to ensure privileging decisions remain objective and summarizes provider's activity data and performance on identified indicators relevant to their specialty enabling comparison to their peers and to available benchmarks.

Any data or information contained within or as part of the OPPE process are protected by California Evidence Code section 1157 and factored into the decision to renew/maintain existing clinical privilege(s), to revise, or to revoke an existing clinical privilege before or at the time of reappointment.

Procedure

1. Medical Staff Departments develop OPPE indicators which may be acquired through, but not limited to, information from the following sources:
   - Peer Review
   - Billing and coding data
   - Periodic chart review (concurrent and/or retrospective)

- Electronic Health Record/Database Reporting

2. These indicators are grouped based on the Accreditation Council for Graduate Medical Education (ACGME) Core Competencies:
    - Systems-based practice
    - Patient care
    - Medical/clinical knowledge
    - Practice-based learning and improvement
    - Interpersonal and communication skills and
    - Professionalism

    OPPE reports will be produced no less frequently than every twelve (12) months to continuously assess provider's performance in providing quality and safe care to our patients. OPPE score cards include specialty specific indicators as determined by individual departments and approved by the Medical Executive Committee (MEC) (see appendix for Department/Specialty Specific indicators).

No Volume Providers

1. Providers with potentially no volume activity will be identified during the OPPE process to allow the providers an opportunity to provide clinical activity reports from other facilities to supplement their OPPE reports.

2. OPPE for No Volume Providers will be achieved via one of the mechanisms below:
    a. Completed OPPE Form from the Provider's primary facility (see attachment A) at the time of reappointment.
        i. No Volume Providers are required to complete a signed release to provide the Medical Staff Department with authorization to collect documentation on the OPPE Form from the providers primary facility representative of their clinical practice.

Department Chair Responsibilities

1. The Department Chair or designee reviews the OPPE reports and makes recommendations to consider regarding maintenance or modification of the provider's privileges.

2. If the data in the OPPE report determined by the Department Chair is favorable, no further action will be necessary. If a determination is made by the Department Chair that the data is unfavorable, it will be forwarded to the IPPC (for AHS only), Credentials Committee, or MEC for further review and recommendation.

3. Actions by the Department Chair, IPPC, Credentials Committee or MEC may include a recommendation for FPPE for cause to evaluate current competency of the provider for either specific privileges or for more in-depth review of performance.

4. After review and approval by the Department Chair, the OPPE report will be maintained as part of the providers' confidential credential file.

Provider Responsibilities

1. The provider must provide clinical activity and/or OPPE from another facility upon request to supplement no volume at AHS/AH.

2. The provider may be expected to make reasonable accommodation to be available for a personal interview upon request.

3. OPPE is made available to the provider upon request or via electronic access.

Quality Outcomes and Quality Analytics Responsibilities

1. Collect the OPPE indicators that comprise the provider reports.

2. Aggregate summary of OPPE indicators from the following sources:
    a. Peer review
    b. Billing and coded data
    c. Periodic chart review (concurrent and/or retrospective)
    d. Electronic Health Record/Database Reports
    e. Patient Satisfaction surveys
    f. Adherence to Bylaws, Rules and Regulations and policies

3. Collaborate with Department Chairs to develop specialty-specific OPPE indicators.

4. Coordinate and support OPPE review process with Department Chairs.

5. Provide OPPE program updates to the Medical Staff Credentials Committee(s).

References: The Joint Commission, 2023, MS.08.01.03.

Approvals

		AHS	AH
Medical Executive Committee	**Date:**	**5/21/2025**	**5/16/2025**
QPSC	**Date:**		

ALAMEDA HEALTH SYSTEM

ONGOING PROFESSIONAL PRACTICE EVALUATION (OPPE) for No Volume Practitioner

PRACTITIONER NAME: _____ EVALUATION PERIOD: _____

INSTRUCTIONS: OPPE is a requirement of the Medical Staff Bylaws, Rules, and Regulations as well as The Joint Commission (TJC) for all privileged practitioners.

You have been identified to have limited patient contact for the past two years at: ☐ Alameda Health System ☐ Alameda Hospital

In addition, we have no or limited access to your patient volume, so please have the 1) Department Chair, 2) Division Chief, 3) Credentials Chair/Quality Review Chair, or 4) Supervising Physician (APPs only) from your primary hospital where you are an active medical staff member complete this form and return it to ***Medical Staff Services via email medicalstaff@alamedahealthsystem.org or via fax (510) 379-7440.***

FOCUS AREAS	***EVALUATION***			***Data Source Indicate all applicable:***
	Acceptable	***Unacceptable***	***Not Applicable***	☐ ***Chart Review (CR)*** ☐ ***Review of File (RF)*** ☐ ***Observation (0B)*** ☐ **** Other (OT) Comments***
Patient Care: Practitioner must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and promotion of health. • *Complete assessment and documentation of new admissions within 24 hours* • *Compliance with procedure protocol following best practice guidelines* • *Demonstrated clinical competence, judgment, and appropriate/timely utilization of consultants*	☐	☐	☐	☐ ***Chart Review (CR)*** ☐ ***Review of File (RF)*** ☐ ***Observation (0B)*** ☐ ***Other (OT) Comments:***
Medical Knowledge: *Practitioner must be able to demonstrate knowledge about established and evolving biomedical, clinical, and cognate sciences and the application of this knowledge to patient care.* • *Evaluate, treat, and manage the patient following best practices guidelines* • *Demonstrate knowledge of basic and discipline-specific medicine* • *Timely ordering appraisal, and follow-up of diagnostic tests*	☐	☐	☐	☐ ***Chart Review (CR)*** ☐ ***Review of File (RF)*** ☐ ***Observation (0B)*** ☐ ***Other (OT) Comments:***
System-based Practice: *Practitioner must be able to demonstrate an awareness of and responsiveness to the large context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value.* • *Appropriate use of test and procedures* • *Appropriate use of consultants/ timeliness of consults*	☐	☐	☐	☐ ***Chart Review (CR)*** ☐ ***Review of File (RF)*** ☐ ***Observation (0B)*** ☐ ***Other (OT) Comments:***
Interpersonal & Communication Skills: *Practitioner must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patient, patient's families and professional associates.* • Forms a therapeutic and ethical relationship with patients and families • Forms and maintains a collegial and ethical relationship with members of the healthcare team	☐	☐	☐	☐ ***Chart Review (CR)*** ☐ ***Review of File (RF)*** ☐ ***Observation (0B)*** ☐ ***Other (OT) Comments:***

****For Other (OT) Please add any comments on page 2 of this form***

ALAMEDA HEALTH SYSTEM

ONGOING PROFESSIONAL PRACTICE EVALUATION (OPPE) for No Volume Practitioner

PRACTITIONER NAME: _____ EVALUATION PERIOD: _____

FOCUS AREAS	EVALUATION			Data Source Indicate all applicable:
	Acceptable	Unacceptable	Not Applicable	☐ Chart Review (CR) ☐ Review of File (RF) ☐ Observation (0B) ☐ * Other (OT) Comments
• Effective communication when providing patient hand offs to prevent loss of information				
Professionalism: Practitioner must be able to demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles and sensitivity to diverse patient population. • Timely response to patient care inquiries and questions from members of the healthcare team • Demonstrates ethical principles (i.e., provision/withholding of clinical care, confidentiality, informed consent, and clinical practices) • Adherence to policies and procedures	☐	☐	☐	☐ ***Chart Review (CR)*** ☐ ***Review of File (RF)*** ☐ ***Observation (0B)*** ☐ ***Other (OT)***
• Patient Satisfaction ☐ No Comments on file ☐ *Comments on file: Positive #_____ Negative #_____* ☐ *Complaints* ☐ *Trends*				
• Approximate Case Volume_____ Number *of Mortalities* _____				

COMMENTS *(Include focus area # as appropriate. Please explain each unacceptable score):*

_____

_____

_____

_____

_____

Evaluation completed by: _____ _____ _____

Printed Name / Signature *Title* *Date*

Review performed when received by AHS Medical Staff Services

☐ Reviewed with no concerns identified ☐ Concerns need to be address with Credentials Committee & Medical Executive Committee

Assessment reviewed by: _____ _____

Department Chair/Designee *Date*

For Other (OT) Please add any comments on page 2 of this form

Alameda Health System

TELEMEDICINE CREDENTIALING BY PROXY

Department	Medical Staff	***Effective Date***	1/2023
Campus	AHS, AH	***Date Revised***	3/2025; 5/2025
Unit	Medical Staff	***Next Scheduled Review***	5/2028
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

To provide a method and process for the credentialing and privileging "by proxy" of a practitioner who provides telemedicine services to our patients.

Policy Statement

Practitioners who provide patient care, treatment, and services via a telemedicine link shall be credentialed and privileged to do so in accordance with the Medical Staff Bylaws. policies, accreditation requirements and applicable law.

Definitions

Telemedicine: Provision of clinical services to patients by physicians and practitioners from a distance via electronic communications. *Source: CMS Memo 7/15/11.*
The use of medical information exchanged from one site to another via electronic communication to improve patients' health status. Telemedicine is a subcategory of telehealth. *Source: The Joint Commission*

Telehealth: A collection of means or methods for enhancing health care, public health, and health education delivery and support using telecommunications technologies. *Source:*

Telehealth Resource Centers (www.telehealthresourcecenter.org).
The use of electronic information and telecommunications technologies to support long- distance clinical health care, patient and professional health-related education, public health, and health administration. *Source: The Joint Commission.*
The mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while the patient is at the originating site and the health care provider is at a distant site. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers. *Source: State of California.*

Telemedicine Entity: Provider of telemedicine services in a manner that allows the originating site hospital or critical access hospital to comply with all applicable CoPs and standards. This is not a Medicare- participating hospital.

Distant Site: Location where the physician or other licensed practitioner who is delivering the services via telemedicine.

Originating Site: Location of the patient at the time the service is being furnished via telemedicine. This must be a designated healthcare facility.

Credentialing: The process used by health care organizations to obtain, verify, assess and validate previous experience and qualifications.

Privileging: The process used by organizations, after review of credentials, to grant authorization for a practitioner to provide a specific scope of patient care services.

Procedure

Practitioners providing telemedicine services to Alameda Heath System and Alameda Hospital patients shall be credentialed and privileged to do so through one of the following mechanisms:

1. The Practitioner shall be credentialed and privileged by Alameda Heath System and Alameda Hospital in accordance with the applicable procedure set forth in the Medical Staff Bylaws. ***OR***
2. The Practitioner shall be credentialed and privileged by Alameda Heath System and Alameda Hospital in accordance with the applicable procedure set forth in this policy with the exception that the credentialing information and/or privileging decision from the distant site may be relied upon by the Medical Staff and Board in making its recommendations/decision provided that Alameda Heath System and Alameda Hospital has entered into a written agreement with the distant site and all of the following requirements are met:
    a) The distant site is accredited by The Joint Commission.
    b) The distant site is a Medicare-participating hospital or a facility that qualifies as a "distant-site telemedicine entity." A "distant-site telemedicine entity" is defined as an entity that (1) provides telemedicine services, (2) is not a Medicare-participating hospital, and (3) provides contracted services in a manner that enables hospitals using its services to meet all applicable *Conditions of Participation,* particularly those requirements related to the credentialing and privileging of practitioners providing telemedicine services to patients of the hospitals.
        i. When the distant site is a Medicare-participating hospital, the written agreement shall specify that it is the responsibility of the distant-site hospital to meet the credentialing requirements of 42 *CFR* 482.12 (a)(1)–(a) and 42 *CFR* 485.616 (c)(1)(i)–(c)(1)(vii), as such provisions may be amended from time to time, with regard to the distant-site hospital Practitioners providing telemedicine services.
        ii. When the distant site is a "distant-site telemedicine entity," the written agreement shall specify that the distant-site telemedicine entity is a contractor of services to the Hospital and, in accordance with the requirements set forth in 42 *CFR* §485.635(c)(4)(ii), furnishes the contracted services in a manner that permits the Hospital to comply with all applicable *Conditions of Participation* for the contracted services

including, but not limited to, 42 *CFR* 485.616 (c)(1)(i)– (c)(1)(vii) with regard to the distant-site telemedicine entity Practitioners providing telemedicine services. The written agreement shall further specify that the distant-site telemedicine entity's medical staff credentialing and privileging process and standards will, at minimum, meet the standards at 42 *CFR* 485.616 (c)(1)(i)–(c)(1)(vii), as that provision may be amended from time to time.

c) The individual distant-site Practitioner is privileged at the distant site for those services to be provided to Alameda Heath System and Alameda Hospital patients via telemedicine link and the Alameda Heath System and Alameda Hospital is provided with a current list of practitioners along with his/her privileges at the distant site.

4. The individual distant-site Practitioner holds an appropriate license issued by the State Medical Board of California as well as in the State for which the Practitioner is located, if not California.
5. Upon notification of a new provider to be added to the roster, acknowledgement will be obtained by the respective Department Chair/Division Chief, if preferred.
6. The distant site provides the following:
    i. Profile
    ii. CA license pocket card
    iii. Malpractice COI
    iv. ID form (at time of initial appointment)
    v. Distant-site board approval letter
    vi. OPPE report (at time of reappointment)
7. Alameda Heath System and Alameda Hospital shall conduct the following primary source verification at time of initial and reappointment:
    i. Medical Board of California Breeze Public License Verification Site
    ii. Medical Board of California License Verification System – 805
    iii. Query the National Practitioner Databank
    iv. Office of the Inspector General Exclusion Database (OIG)
    v. System for Award Management (SAM)
8. Practitioners providing Telemedicine only services will not prescribe medications, therefore do not need to maintain a valid DEA registration in California.
9. The Board, upon recommendation of the Medical Executive Committee, shall grant privileges.
10. Alameda Heath System and Alameda Hospital maintains documentation of its internal review of the performance of each distant-site Practitioner and sends the distant site such performance information for use in the distant site's periodic appraisal of the distant-site Practitioner. At a minimum, this information must include:
    i. All adverse events that result from the telemedicine services provided by the distant-site Practitioner to Alameda Heath System and Alameda Hospital patients; and,
    ii. All complaints Alameda Heath System and Alameda Hospital receives about the distant-site Practitioner.
11. Alameda Heath System and Alameda Hospital shall maintain record of practitioners privileged to provide telemedicine services.

i. A separate file on each telemedicine physician shall be maintained via the credentialing database.
ii. Privileges shall be made available to the Alameda Heath System and Alameda Hospital staff.

Related Documents/References

- The Joint Commission MS 13.01.01.01; MS 13.01.03; LD.04.03.09; LD.04.03.09, EP23
- Code of Federal Regulations Sections 482.12, 482.22, and 485.616 of Title 42
- Business & Professions Code 2290.5(h)(1)
- California Department of Health All Facilities Letter 12-05

Approvals

		AHS Core	AH
Credentials Committee	**Date**	**5/8/25**	
Medical Executive Committee	**Date:**	**5/21/25**	**5/16/25**
QPSC	**Date:**	**5/28/25**	

Alameda Health System

MEDICAL STAFF COMMITTEES

Department	Medical Staff	***Effective Date***	4/2022
Campus	AHS	***Date Revised***	10/2023, 2/2024, 3/2025, 5/2025
Unit	All	***Next Scheduled Review***	5/2028
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 supplement the Bylaws regarding Medical Staff's committees, including but not limited to committee membership, duties, frequency of meetings and structure.

Policy: The Alameda Health System (AHS) Medical Staff uses medical staff committees to review, assess, improve, measure, maintain quality, safety and performance on the individual medical staff level and on an organization wide basis.
Each independent Medical Staff is self-governing and responsible for making its own decisions and recommendations in accordance with their Medical Staff Bylaws, Rules & Regulations and Policies and Procedures. While the Medical Staffs may engage in information sharing agreements, each medical staff shall independently determine their own action.

Combining medical staff committees between two or more medical staffs for some or all functions may be preferred for the purpose of alignment of system operations, shared clinical services, quality and patient safety.

Procedures

Committee Membership: With the exception of membership defined by regulatory requirements, the Bylaws or Rules and Regulations, the Committee Chair shall determine the membership eligibility, number of members, purposes, and frequency of meetings. Members of the House Staff shall be encouraged to participate on committees of the Medical Staff.

Confidentiality and Conduct: Each committee member shall adhere to the AHS Medical Staff Code of Conduct and AHS Medical Staff confidentiality requirements.

Minutes: Committee meeting minutes shall be prepared and shall include a record of the attendance of Members, the decision/conclusion and action that was carried. Each committee shall maintain a permanent file of the minutes of each meeting and any documents that were discussed during the meeting. When meetings are held with outside entities, access to minutes shall be limited as necessary to preserve protection from discovery, as provided by California law.

Reporting: Standing Committees and Special Committees shall report to the Medical Executive Committee or other designated committee as may be required by regulatory requirements and the Bylaws, or as requested by the MEC.

Standing Committees of the Medical Staff in Addition to Those Specified in Bylaws:

- Clinical Practice Council
- *Committee on Interdisciplinary Practice (CIDP)
- Continuing Medical Education (CME)
- Disaster Action Response Team (DART)
- Ethics
- Graduate Medical Education (GME)
- Human Subjects Protection Committee/Institutional Review Board (HSPC/IRB)
- Interdepartmental Professional Practice Committee (IPPC)
    - Departmental Quality Review Committees (QRCs)
        - Morbidity & Mortality Conference
    - Tumor Board
- Operating Room Committee
- Patient Safety Committee
- Provider Wellbeing
- Quality Steering Committee
    - Code Blue Committee
    - Critical Care Committee
    - Infection Prevention & Control
    - Pharmacy, Therapeutics and Nutritional Care Committee (P&T)
    - Procedural Sedation Committee
    - Sepsis Committee
    - Stroke Committee
    - Transfusion Committee
- Utilization Management Committee

*The CIDP Committee reports to the Credentials Committee.

Consent Agendas:

Medical Staff Committees that distribute materials in advance of the meeting may utilize a consent agenda for succinct approval of items without discussion. Any committee member is able to request removal of an item from the consent agenda for discussion.

Combined Medical Staff Committees:

Subject to the ultimate authority of each of the applicable Medical Executive Committees, a medical staff committee may include functions on behalf of two or more independent Medical Staffs. The Medical Staff may choose to combine a committee to review, assess, improve, measure, maintain quality, safety and performance on the individual medical staff level and on an organization wide basis. The Chiefs of Staff shall work together to recommend combined committees, which shall be approved by the

affected Medical Executive Committees. When deemed appropriate, a combined committee may be limited by purpose or duration.

Membership for combined medical staff committees shall include representation from each medical staff and comply with the composition defined in each medical staff's respective Bylaws or policy and procedures.

Quorum: A quorum is defined in the Bylaws. Voting members are defined within the Bylaws and may be supplemented within the committee's charter.

Attendance: Annual attendance of voting members shall be tracked with the goal of having 50% attendance.

Procedure to Propose Additional Medical Staff Standing Committees

1. The Medical Staff becomes aware of the need for a new committee.
2. A proposal is created by the committee champion including the reason for the committee, a draft committee charter and suggested membership.
3. The proposal is submitted to the Chief of Staff.
4. The Chief of Staff reviews the proposal with the Medical Staff Officers to assess whether to forward the proposal to the Medical Executive Committee (MEC). If MEC
    a. Agrees the committee is needed and approves the charter, the Chief of Staff in collaboration with the new committee champion determines
        i. the committee membership,
        ii. appoints the committee members, and
        iii. the reporting frequency to MEC.
    b. Does not agree the committee is needed, the proposal is rejected.

Procedure to Propose Combined Medical Staff Committees

1. The Chiefs of Staff shall work together to support combined committees as may be appropriate for the proper functioning of the Medical Staffs. The recommendation to combine a standing or special committee shall be approved by the applicable Medical Executive Committees.
2. Meeting minutes shall include a record of the attendance and quorum for each represented medical staffs.
3. Recommended actions shall be routed in accordance with the applicable Medical Staff governing documents for each independent medical staff.

Approvals

		AHS
Medical Executive Committee	**Date:**	**5/21/2025**
QPSC/Board of Trustees	**Date:**	

Alameda Health System Medical Staff Committees
Appendix A

Clinical Practice Council

The Clinical Practice Council is a multidisciplinary committee consisting of members from the medical staff, quality, nursing, pharmacy, informatics, infection control, and other members as deemed necessary and appropriate to fulfill its function. Please see table for committee membership. Committee members are appointed by the Chief of Staff (COS) and co-chairs are appointed in consultation with the Chief Medical Officer (CMO) and the Chief Clinical Officer (CCO).

The membership guidelines are as follows:

- Members serve a minimum of four years with staggered end dates.
- Members must attend at least 75% of scheduled meetings annually.
- Inactive members (failing to meet attendance requirements) will be replaced to maintain continuity.
- A proxy may vote only when attending in an official capacity for a designated member.

The duties and responsibilities of the Clinical Practice Council shall be to:

a. The primary purpose of the AHS CPP is to review and approve all organization or clinical policies, cross-departmental protocols , and plans that impact or affect the delivery of patient care;
b. CPC will review department-level procedure guidelines;
c. Ensure all policies, procedures, guidelines, protocols, and plans within CPC's scope are evidence-based and align with the best patient care and highest safety standards;
d. Reflect consensus-driven patient care across disciplines and departments and are easily accessible to all employees.
e. Support continuous performance improvement and patient safety throughout Alameda Health System.
f. All policies, procedures, guidelines, cross-department protocols, and plans that impact or affect the delivery of patient care will be reviewed in their respective committee prior to submission to CPC for review.
g. Reviews all submissions based on its guiding principles. Policies, protocols, and plans approved by CPC will be sent for approval.
h. Reviews and provide guidance on department procedures and guidelines.

The CPC shall maintain a permanent record of its proceedings and shall submit reports and recommendations to the Medical Executive Committee, Quality Professional Services Committee and Board for approval.

Code Blue Committee

The Code Blue Committee shall be a multidisciplinary team composed of clinical leaders including physicians, nurses and administration and other assigned members as may be necessary and appropriate.

The duties and responsibilities of the Code Blue Committee shall be to:

a. To collect and review Code Blue Events and Data for Process Improvement, Quality Assurance and Patient Safety Priorities;

b. Capture data from various sources for process improvement;

c. Approval the crash cart contents and checklists;

d. Review Code Blue documenation;

e. Review and revise the Code Blue policy and procedures;

f. Shall maintain a permanent record of its proceedings and shall submit reports of its activities and recommendations to the Quality and Safety Committee.

The Code Blue Committee shall meet quarterly or as often as necessary at the call of its Chairperson.

Committee on Interdisciplinary Practice (CIDP)

The Committee on Interdisciplinary Practice shall include the Chief Executive Officer (or their designee), the Chief Nursing Executive (or their designee), an equal number of physicians appointed by the Chief of Staff as registered nurses appointed by the Chief Nursing Executive, and one or more clinical psychologists. Advanced Practice Providers (APPs), other than registered nurses, who practice at the Health System may be appointed to serve on the CIDP by the Chief of Staff. The Chair of the CIDP shall be a physician. All members of the CIDP are voting members.

The duties of the CIDP shall be to:

a. evaluate and make recommendations regarding the need for and appropriateness of the performance of services in the Health System by APPs;

b. evaluate and make recommendations to develop policies and procedures relevant to the formation and approval of standardized procedures;

c. periodically review and approve all standardized procedures and clinical protocols utilized by nurses practicing in expanded roles and/or practitioners providing clinical services utilizing protocols under the supervision of a medical staff member;

d. evaluate and make recommendations regarding the qualifications and credentials of APPs who are eligible to apply for and provide services either utilizing standardized procedures or protocols.

The CIDP shall maintain a permanent record of its proceedings and shall submit reports of its activities and recommendations to the Credentials Committee.

The CIDP shall meet as often as necessary at the call of its Chairperson.

Continuing Medical Education Committee (CME)
The Continuing Medical Education Committee shall be composed primarily of physicians and the chair of the CME Committee should be a physician. If available, representatives from Graduate Medical Education (GME) and Medical Staff Services may serve on the CME Committee. The CME Committee may also include other AHS staff as determined appropriate by the committee, for example, nurses, advance practice providers, staff from quality and other administration. CME staff (CME manager and coordinator) are non-voting members. The addition/appointment of new CME Committee members requires a vote of approval from existing members.

The duties of the CME Committee shall be to:

a. Review and approve AHS educational activities to award *AMA PRA Category 1 Credit™* (CME credit) to physicians.

b. Ensure that AHS CME activities and the overall AHS CME program meets the CME accreditation requirements and standards set by the Accreditation Council for CME (ACCME), California Medical Association (CMA), American Medical Association (AMA), Medical Board of CA (MBC) and other regulatory agencies.

c. Ensure CME activities are planned to address the practice gaps and educational needs of AHS attending/faculty physicians and are designed to change or improve patient care practices and professional skills of the medical staff.

d. Assess AHS systemwide organizational goals and assist with setting priorities for CME activities and resources.

e. Periodically review evaluation data and feedback from individual CME activities and conduct an overall program evaluation at least once annually to determine if meeting the CME program's mission and goals.

f. Update and approve CME policies, procedures/processes and forms as needed, including approval of speaker/presenter honoraria and reimbursement as outlined in the policy.

g. It is recommended that the CME Committee meet at least once a quarter (four times a year) to approve activities and review evaluation data, policies and procedures. However, in order to provide timely approvals for new activities or

actions on policies or procedures, the CME Committee can approve activities and/or policy/process updates via email vote. The CME Committee shall maintain a permanent record of its proceedings and submit periodic reports of its activities and recommendations to the Medical Executive Committee and to other departments and committees as requested.

Critical Care Committee

The Critical Care Committee shall be a multidisciplinary team composed of clinical leaders including physicians, nurses and administration and other assigned members as may be necessary and appropriate.
ers as may be necessary and appropriate.

The duties and responsibilities of the Critical Care Committee shall be to:

a. Capture data from various sources for process improvement related to patients in the intensive care unit;

b. Develops clinical practice guidelines related to critical care;

c. Recommends policies, procedures and process improvements for appropriate delivery of critical care services including oversight

d. Shall maintain a permanent record of its proceedings and shall submit reports of its activities and recommendations to the Quality and Safety Committee.

The Critical Care Committee shall meet quarterly or as often as necessary at the call of its Chairperson.

Disaster Action Response Team (DART)

The Disaster Action Response Team shall be a multidisciplinary team composed of clinical leaders including physicians, nurses and administration and other assigned members as may be necessary and appropriate.

The duties and responsibilities of the Disaster Action Response Team shall be to:

a. Help develop an integrated system response to mass casualty care within AHS

b. Create and implement education for all members of staff and administration to manage mass casualty incidents.

c. Supervise drills to test efficacy of MCI training curriculum.

d. Review how system responds to actual mass casualty incidents

e. Use review of performance in drills and actual incidents to revise and improve training efforts

f. Members also additionally meet on an as-needed basis to train staff and design training infrastructure for the system.

g. Maintain a permanent record of its proceedings and submit reports of its activities and recommendations to the Medical Executive Committee.

The Disaster Action Response Team shall meet as often as necessary at the call of its chairperson.

Ethics Committee

The Ethics Committee shall be composed of physicians, nurses, administration, and other assigned members as may be necessary and appropriate. It should include diverse members, such as lay representatives, social workers, chaplains, other clergy, ethicists and/or an attorney.

The duties and responsibilities of the Ethics Committee shall be to:

a. participate in the development of guidelines for consideration of cases having bioethical implications;

b. develop and implement procedures for the review of such cases;

c. develop and/or review institutional policies regarding care and treatment of such cases;

d. retrospectively review cases for the evaluation of bioethical policies;

e. consult with concerned parties to facilitate communication and aid bioethical conflict resolution;

f. educate the Health System staff on bioethical matters; and

g. maintain a permanent record of its proceedings and submit periodic and timely reports of its activities and recommendations to the Medical Executive Committee.

The Ethics Committee shall meet as often as necessary at the call of its chairperson.

Graduate Medical Education Committee

The Graduate Medical Education (GME) Committee shall be composed of physicians, which include, at a minimum, the, Designated Institutional Official (DIO), Director of GME, the Program Directors, Program Associate Directors, representatives of faculty,

and resident physicians, and other assigned members from graduate medical education training programs within our institution as may be necessary and appropriate.

The duties of the Graduate Medical Education Committee shall be to:

a. oversee and direct all graduate medical education activities at the Health System; establish and implement policies and procedures regarding the quality of education and the work environment for the residents of AHS;

b. To review at least annually the salary and benefits afforded to the resident physicians employed by AHS;

c. To establish and implement formal written policies and procedures to ensure compliance by all programs and institutions utilized in GME for AHS with all aspects of the ACGME duty hour requirements;

d. To regularly monitor compliance of programs and institutions with the established duty hour requirements.

e. To ensure that resident physicians have appropriate supervision for all patient care and educational activities within the program curriculum.

f. To establish and monitor policies for the selection, evaluation, promotion and dismissal of resident physicians at AHS;

g. To ensure that all programs have both a written curriculum and a formal evaluation system based on the established ACGME core competencies;

h. To review and approve all communications with the ACGME for all programs including, but not limited to:
    1. applications for new programs
    2. requests for changes in resident complement
    3. changes in length of training
    4. changes in participating institutions
    5. appointments of all program directors
    6. requests for either inactive status or reactivate status
    7. requests for voluntary withdrawal
    8. and appeals of adverse action

i. regularly review ethical, socio-economic, medical/legal, and cost containment issues that affect graduate medical education;

j. act as a forum for communication between the graduate medical education program, the Medical Staff, Health System Administration, and the Board of Trustees related to the monitoring and improvement of graduate medical education programs;

k. maintain a permanent record of its proceedings and submit biannual reports of its activities and recommendations to the Medical Executive Committee and an annual report to the Board of Trustees regarding safety, quality of patient care, and

l. To conduct internal self-study and review for all programs at approximately mid- cycle of scheduled ACGME site visits and review reports and make recommendations to the program directors to address areas of concern and ensure substantial compliance with the institutional, common program and specialty specific ACGME requirements.

The GME Committee meeting shall meet at a minimum quarterly or as needed.

Human Subjects Protection Committee/Institutional Review Board (HSPC/IRB)

The HSPC/IRB Committee shall be a multidisciplinary team composed of clinical leaders including physicians and other assigned members as may be necessary and appropriate. The membership shall include:

- At least 5 members with varying backgrounds to promote complete and adequate review of research activities.
- At least 1 member whose primary concerns are in scientific areas.
- At least 1 member whose primary concerns are in nonscientific areas.
- At least 1 member who is not otherwise affiliated with AHS and who is not part of the immediate family of a person who is affiliated with AHS.

The duties of the Human Subject Protection/IRB Committee shall be to:

a. Ensure the protection of the rights and welfare of the individual human beings who serve as the subjects of research, following ethical principles and guidelines outlined in "The Belmont Report."
b. Review and have authority to approve, require modifications in (to secure approval), or disapprove all research activities including exempt research activities in accordance with 45CFR46 and 21CFR50&56
c. Require documentation of informed consent or may waive documentation
d. Have authority to observe or have a third party observe the consent process and the research.
e. Serve as the Privacy Board for AHS related to the use/disclosure of Protected Health Information (PHI) in human subjects research including the following processes:
    a. Approval of written authorizations from the subject (or, where appropriate, from the subject's legally authorized representative) that meet HIPAA regulations and ethical guidelines for the use/disclosure of PHI for research and;
    b. Approval of alterations to, or waivers of (in whole or in part), the authorization requirement, and maintenance of documentation of the same.

f. Establish and follow written procedures for:
    a. Conducting its initial and continuing review of research.
    b. Determining which projects require review more often than annually.
    c. Ensuring prompt reporting to the IRB of proposed changes in a research activity, and ensuring that investigators conduct research in accordance with IRB approval unless changes are needed to eliminate apparent immediate hazards to subjects.
g. Establish and follow written procedures for ensuring prompt reporting to the IRB; appropriate institutional officials; Medical Executive Committee; the department or agency head; and the Office for Human Research Protections, HHS, or any successor office, or the equivalent office within the appropriate Federal department or agency of
    a. Any unanticipated problems involving risks to subjects or others or any serious or continuing noncompliance with this policy or the requirements or determinations of the IRB; and
    b. Any suspension or termination of IRB approval.
h. Prepare and maintain a permanent record of its proceedings and shall submit periodic and timely reports of its research activities and recommendations to the Medical Executive Committee.

The HSPC/IRB shall meet as often as necessary at the call of its chairperson or when full board review and approval of research protocols are required.

Infection Prevention and Control Committee

The Infection Prevention and Control Committee is a multidisciplinary committee with the overall authority and responsibility for the Infection Prevention and Control Program. The Infection Prevention and Control Committee shall be composed of staff including physicians, to include members of the Medical Hours Staff (ad hoc), nurses, clinical laboratory, pharmacy, sterile processing, infection prevention, administration, infectious disease, facilities, environmental services, quality, and other Ad Hoc members as necessary and appropriate.

The IPCC shall be chaired by a physician (or designee) who has credentials, knowledge, and special experience in infection prevention and control. The MD chairperson must complete the infection control educational requirements mandated by the State of California (SB 1058).

Infection Preventionist, Chair of the Infection Control Committee, along with the System Director of Infection Prevention and Control, has authority to institute any surveillance, prevention and control measures or studies when there is reason to believe that any patient or personnel may be in danger from a potential or actual outbreak of, or exposure to, infectious disease.

The duties of the Infection Prevention and Control Committee shall include:

a. develop, implement and assess appropriate quality control and performance improvement measures for the Infection Control program;

b. develop a Health System wide infection control program and maintain surveillance over the program;

c. develop a system for reporting, identifying and analyzing the incidence and cause of healthcare associated infections, and assign responsibility for the ongoing collection and analytic review of such data, and follow-up activities;

d. develop and implement a preventive and corrective program designed to minimize infection hazards, including establishing, reviewing and evaluating aseptic, body substance precaution and sanitation techniques;

e. develop written policies defining special indications for body substance precaution;

f. act on recommendations related to infection control received from the Chief of the Medical Staff, the Medical Executive Committee, the departments and other committees;

g. review susceptibility of organisms specific to the Health System and its campuses; and

h. Review and maintain policies and procedures pertaining to the infection control program in accordance with accrediting or governing organization requirements);

i. Update annually the IC Program Plan and Risk Assessments;

j. Develop and implement a preventive program designed to identify and minimize infection risks;

k. Review the antimicrobial susceptibility/resistance trends in conjunction with the Antimicrobial Stewardship Committee;

l. Review proposals, protocols, epidemiology outcomes, or special infection control studies to be conducted throughout the hospital;

m. maintain a permanent record of its proceedings and submit quarterly reports of its activities and recommendations to the Quality Steering Committee, the Medical Executive Committee, and other hospital specific and system-wide committees as needed.

The Infection Prevention and Control Committee shall meet monthly, with a minimum of six meetings per year.

Interdepartmental Professional Practice Committee (IPPC)

The Medical Executive Committee has delegated the oversight of the individual QRCs to the Interdepartmental Professional Practice Committee (IPPC). The IPPC ensures consistent standards of quality and safe patient care across departments and fosters inter-departmental collaboration. It serves as a medical staff peer review body for cases that involve multiple medical staff departments and when deemed appropriate to achieve the highest standards of quality and safe patient care.

The IPPCs voting members shall include at least one member from each medical staff department. The IPPC chair shall be a member of the medical staff and be appointed by the Chief of Staff. The IPPC chair shall ensure that the duties of IPPC are fulfilled. The Chief of Staff may appoint more than one chair to ensure the appropriate expertise and experience. The IPPC's non-voting members may include representatives from administration and such other assigned individuals as the Chief of Staff determines are necessary or appropriate for the IPPC to fulfill its functions. All members shall sign confidentiality agreements and kept in the permanent records. 1-2 non-voting members may be present in the closed session as deemed appropriate by the Chief of Staff to support the physician peer review process.

The duties and responsibilities of the IPPC shall be to:

a. Assure that a fair and just culture is maintained in the functioning of all the QRC's

b. Promote and maintain consistent quality review standards across all departments.

c. Work closely with the medical staff Patient Safety Committee to review cases that undergo a Root Cause Analysis if appropriate.

d. Review of cases that involve multiple medical staff departments to advance quality and safe patient care across departments.

e. Identify and monitor systems issues that impede quality patient care and refer to the appropriate med staff or administrative committee for evaluation and resolution.

f. Provide oversight for the external peer review process.

g. Oversee the Ongoing Professional Practice Evaluation / Focused Professional Practice Evaluation process as well as other provider performance reviews.

h. Oversee the Ongoing Professional Practice Evaluation / Focused Professional Practice Evaluation process as well as other provider performance reviews.

i. Maintain a permanent record of its proceedings and submit reports of its activities and recommendations to the Medical Executive Committee or as requested by the Chief of Staff.

The Interdepartmental Professional Practice Committee shall meet at minimum quarterly or as needed.

Morbidity & Mortality (M&M) Conference

Each department of the Medical Staff may form a Morbidity and Mortality (M&M) Conference. The M&M Conference Committee may be a combined meeting of the divisions of the department, or the divisions may meet separately.

The M&M Conference shall be a subcommittee of the Quality Review Committee of the department. The chairperson of the M&M Conference shall be the Chair of the Department or the appropriate Division Chief unless the Chair of the Department appoints a chairperson who is a member and holds clinical privileges in the appropriate department/division.

The M&M Conference shall be composed of physician members who hold clinical privileges in the department/division, house staff and other assigned members as may be necessary and appropriate.

The duties shall be to:

a. review patient care activities related to the department/division;

b. develop practice management guidelines related to the department/division;

c. report and recommend practitioner specific cases with significant concerns in patient care to the appropriate departmental QRC;

The M&M Conference shall meet as often as necessary at the call of the Chairperson.

Pharmacy, Therapeutics and Nutritional Care Committee (P&T)

The Pharmacy, Therapeutics and Nutritional Care Committee shall be composed of physicians, nurses, House Staff, administration (including representation from Pharmacy Services, and Nutrition Care) and other assigned members as may be necessary and appropriate.

The duties of the Pharmacy, Therapeutics and Nutritional Care Committee shall be to:

a. develop, implement and assess appropriate quality control and performance improvement measures for professional practices and policies regarding nutrition care and the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures, and all other matters relating to drugs in the Health System, including antibiotic usage;

b. review and recommend to the Medical Executive Committee, relevant

policy, procedures, and protocols that may be necessary for the operation of medication usage and nutritional care programs;

c. evaluate and improve the quality of patient care provided to patients related to medication usage and nutritional care;

d. advise the Medical Staff and Pharmacy Services on matters pertaining to the choice of available drugs;

e. make recommendations concerning drugs to be stocked on the nursing unit floors and by other services;

f. annually review and revise, as necessary, the formulary or drug list for use in the Health System.

g. evaluate clinical data concerning new drugs or preparations requested for use in the Health System;

h. monitor and review adverse drug reactions;

i. to review aggregate data relevant to medication errors;

j. to oversee clinical care related to the nutritional needs of patients; and

k. maintain a permanent record of its proceedings and submit quarterly reports of its activities and recommendations to the Medical Executive Committee

The Pharmacy, Therapeutics and Nutritional Care Committee shall meet quarterly or as often as necessary at the call of its Chairperson.

Operating Room Committee

The Operating Room Committee, a subcommittee of the Medical Executive Committee and shall be composed of physicians, nursing leadership, surgical department representatives, infection control, regulatory affairs, quality, and other assigned members as may be necessary and appropriate.

The duties of the OR Committee shall be to:

a. ratify new policies and procedures and disseminate information to the surgical services;

b. Monitor and assess the quality of care provided in the operating rooms, including tracking and analyzing surgical outcomes, infection rates, and patient satisfaction;

c. monitor the activity and efficiency of services provided;

d. Ensure proper credentialing and privileging process for surgeons, anesthesiologists, and other personnel using the operating rooms. Ensure compliance with hospital bylaws and regulatory requirements;

e. Organize educational programs and training sessions for operating room staff to enhance their skills, knowledge, and awareness of best practices;

f. Evaluate and recommend the purchase, maintenance, and proper usage of surgical equipment, instruments, and technology to ensure the highest quality of care and safety for patients and staff;

g. develop and implement infection control protocols to minimize the risk of surgical site infections and other healthcare-associated infections in the operating rooms;

h. develop and maintain protocols for handling emergency situations in the operating rooms, ensuring staff readiness and patient safety during crises;

i. collaborate with other hospital committees, departments, and external organizations to improve interdisciplinary communication and coordination in the delivery of surgical services.

j. initiate changes necessary to maintain the quality of patient care and to maximize patient safety;

k. maintain a permanent record of its proceedings and submit quarterly reports of its activities and recommendations to the Medical Executive Committee.

The Operating Room Committee shall monthly or as needed at the call of its Chairperson.

Patient Safety Committee

The Patient Safety Committee shall be composed of physicians, nurses, administration (including representation from Risk Management, Quality Services and the Safety Department) and other assigned members as may be necessary and appropriate.

The Patient Safety Committee has been established as an interdisciplinary committee of the Medical Staff to coordinate organization-wide safety and risk management activities and to oversee the development of organizational error reduction programs. The duties of the Patient Safety Committee shall be to:

a. establish measurable objectives for improving patient safety and reducing medical errors;

b. review all sentinel events including the development of a thorough and credible root cause analysis, appropriate plan of correction, and follow-up plan;

c. oversee the organizational safety program;

d. oversee all organizational risk management activities;

e. work with staff in the development of programs to enhance involvement by the patient and the patient's family as a partner in the healthcare process; and

f. maintain a permanent record of its proceedings and submit quarterly reports of its activities and recommendations to the Medical Executive Committee.

The Patient Safety Committee shall meet quarterly or as often as necessary at the call of its chairperson.

Provider Wellbeing Committee

The Provider Wellbeing Committee shall be composed of three (3) physician members of the Medical Staff. Members of the Provider Wellbeing Committee shall not serve as active participants on other peer review or performance improvement committees while serving on the Provider Wellbeing Committee.

The committee shall not have disciplinary function with respect to a physician's staff membership or privileges and shall not be responsible for any investigation leading to disciplinary action against staff membership or privileges/practice prerogatives.

The duties of the Provider Wellbeing Committee shall be to:

a. provide education about physician health, addressing prevention of physical, psychiatric, or emotional illness;

b. facilitate confidential diagnosis, treatment, and rehabilitation of physicians who suffer from potentially impairing conditions;

c. aid the physician regaining or retaining optimal professional functioning consistent with protection of patients;

d. educate the Medical Staff and other organizational staff about illness and impairment recognition issue-specific to physicians;

e. allow for self-referral by physicians and referral by other organizational staff;

f. referral of affected physicians to appropriate professional internal or external resources for diagnosis and treatment of physical, emotional, or drug dependency related conditions;

g. maintenance of the confidentiality of the physician seeking referral or referred for assistance except as limited by law, ethical obligation, or when the safety of a patient is threatened;

h. evaluate the credibility of any complaint, allegation, or concern regarding the physical or emotional health of a physician;

i. monitor impaired physicians during programs of treatment and rehabilitation;

j. report to the appropriate Medical Staff committee, at any time during diagnosis, treatment, or rehabilitation, if it is determined that the physician may be unable to safely perform the privileges he or she has been granted;

k. monitor compliance with any mandatory drug treatment programs; and

l. maintain only such records of its proceedings, as it deems advisable and submit quarterly reports of its activities and recommendations to the Medical Executive Committee.

m. Initiating appropriate actions when a licensed independent practitioner fails to complete the required rehabilitation program.

The Provider Wellbeing Committee shall meet at least quarterly and as often as necessary at the call of its Chairperson.

Procedural Sedation Committee

The Procedural Sedation Committee is a multidisciplinary committee composed of physicians, nurses, pharmacists, operational leaders, and other content experts charged with overseeing the safety and quality of procedural sedation in all AHS locations.

The fundamental responsibilities and duties of the Procedural Sedation Committee shall be to:

a. Create and revise guidelines for clinical practice that are based on current guidelines, evidence-based practice, standards, and recommendations.

b. Create and maintain a comprehensive systemwide policy regarding Procedural Sedation.

c. Monitor compliance with policy and procedures using data derived from retrospective reviews and observation.

d. Perform active case review to monitor outcomes and identify system issues.

e. Assist with the development of multidisciplinary training program and

competency for Procedural Sedation.

f. Remain current with regulatory agency and professional organization standards, recommendations and guidelines.

g. Shall maintain a permanent record of its proceedings and shall submit reports of its activities and recommendations to the Quality and Safety Committee.

The Procedural Sedation Committee shall meet quarterly or as often as necessary at the call of its Chairperson.

Quality Steering Committee

The Quality and Steering Committee shall be composed of the Chief of Staff, the Vice Chief of Staff and two (2) at large members of the Medical Staff appointed by the Chief of the Medical Staff. Non-Physician members shall include the Chief Medical Officer, Chief Financial Officer, Chief Operations Officer, Chief Nursing Executive, Vice President of Quality, Ambulatory Quality Services Director, and the Risk Manager. The Committee shall be Co-Chaired by a medical staff member and an administrative member of the committee.

The Quality Steering Committee has a central role in the initiation, performance and maintenance of the organization's performance improvement program. The fundamental responsibilities and duties of the Quality Steering Committee shall be to:

a. set priorities for organizational performance improvement activities that are designed to improve patient care processes and outcomes;

b. develop performance improvement training programs for the organization's staff;

c. foster communication among all departments and services;

d. prioritize and select specific performance improvement team projects;

e. receive aggregate reports related to performance improvement activities from Health System support services, Medical Staff clinical function committees and all organizational performance improvement teams;

f. receive reports from the following:
   i. Code Blue Committee
   ii. Critical Care Committee
   iii. Health Information Management
   iv. Procedural Sedation
   v. Sepsis Committee
   vi. Stroke Committee
   vii. Transfusion Committee

g. have direct oversight of the following functions:
    i. Improving Organizational Performance
    ii. Leadership

h. prepare an annual appraisal of the organization's performance improvement program; and

i. maintain a permanent record of its proceedings and submit quarterly reports of its activities and recommendations to the Medical Executive Committee.

The Quality Steering Committee shall meet quarterly or as often as necessary at the call of its Chairperson.

Quality Review Committees (QRC)

Each department of the Medical Staff shall have a Quality Review Committee (QRC). Each department's QRC may meet separately or jointly with the QRCs of other departments at the discretion of the Chair of the Department and as approved by the Medical Executive Committee.

Each departmental QRC shall monitor the quality and appropriateness of clinical services provided by those holding clinical privileges in its department related to the divisions represented by the QRC. When requested, the QRC shall also make recommendations to the Credentials and/or Medical Executive Committees related to specific credentialing issues. The Chair of the Department, however, shall have the ultimate duty and responsibility to make recommendations regarding credentialing issues to the Credentials and/or Medical Executive Committees.

The duties and responsibilities of the QRC's shall be to:

a. evaluate and improve the quality of care provided to Health System patients which may include accurate and timely medical record documentation;

b. conduct patient care reviews for the purpose of analyzing and evaluating the quality and appropriateness of care and treatment including practitioner specific data for medication usage, medical records, transfusion review and operative and invasive care, provided by practitioners within the divisions of the departments represented by the QRC;

c. perform peer review and/or other physician specific intensified assessments when indicated or requested by an appropriate Medical Staff committee;

d. identify system problems requiring process improvement activity and make such recommendations to the Quality and Safety Committee;

e. take appropriate actions when important problems in patient care or opportunities to improve patient care are identified;

f. recommend to the Chairperson of the Department, those Medical Staff policies and procedures as may be necessary to conduct patient care and administrative Medical Staff activities;

g. communicate the significant results of peer review and performance improvement activities to relevant practitioners;

h. implement programs that assess compliance with clinical practice guidelines and other recognized standards of care;

i. assume all duties and responsibilities of the departments related to quality assessment, peer review and performance improvement, which have not been otherwise assigned to the Chair of the Department and as may be described in the Bylaws and/or Rules and Regulations; and

j. maintain a permanent record of its proceedings and submit periodic and quarterly reports of its activities and recommendations to the Medical Executive Committee.

The Quality Review Committees shall meet quarterly or as often as necessary at the call of its chairperson.

Stroke Committee

The Stroke Committee shall be composed of the Stroke Team which includes physicians, nurses, administration, other representation from the Emergency Department and Neurology Division and EMS and other assigned members as may be necessary or appropriate.

The duties of the Stroke Committee shall be to:

a. develop, implement and assess appropriate quality control and performance improvement measures for the Stroke program;
b. demonstrate conformity with clinical practice guidelines or evidence-based practice
c. maintain a permanent record of its proceedings and submit quarterly reports of its activities and recommendations to the Quality and Safety Council.

The Stroke Committee shall meet at least quarterly or as often as necessary at the call of its Chairperson.

Transfusion Committee

The Transfusion Committee shall be composed of physicians including representation from pathology, medicine, surgery, anesthesiology, nursing, administration and other assigned members as may be necessary and appropriate.

The duties of the Transfusion Committee shall be to:

a. develop, implement and assess appropriate quality control and performance improvement measures for Blood Bank and transfusion review;

b. monitor standards for transfusion practice, distribution, handling, use and administration to promote appropriate use of blood and blood products;

c. monitor and evaluate the appropriateness of transfusions for blood and blood products, transfusion reactions and physician ordering practices; and

d. maintain a permanent record of its proceedings and submit quarterly reports of its activities and recommendations to the Medical Executive Committee.

The Transfusion Review Committee shall meet quarterly or as often as necessary at the call of its Chairperson.

Tumor Board

The Tumor Board shall be composed of physicians, nurses, administration and other assigned members as may be necessary and appropriate to fulfill the requirements for cancer designation by the American College of Surgeons and the Cancer Commission of the California Medical Association.

The duties of the Tumor Board shall be to:

a. conduct multidisciplinary, patient-oriented treatment planning cancer conferences to improve the care of patients with cancer. Conferences shall focus on:
    i. pretreatment evaluation
    ii. staging
    iii. treatment strategy
    iv. rehabilitation
    v. problem cases

b. provide relevant educational programs related to cancer care to the Medical Staff.

The Tumor Board shall meet as often as required according to the Standards on the

Commission of Cancer but at least biannually.

Utilization Management Committee

The Utilization Management Committee shall be composed of physicians, nurses and administration including representation from the Utilization Review Department, Medical Social Services and other assigned members as may be necessary and appropriate.

The duties of the Utilization Management Committee shall be to:

a. develop, implement and assess appropriate quality control and performance improvement measures for the Utilization Review Program;

b. to maintain utilization review and quality control measurements and to conduct utilization review studies designed to evaluate the appropriateness of admissions to the hospital, lengths of stay, discharge practices, use of medical and hospital services and related factors that may contribute to the effective and efficient utilization of resources and services;

c. to obtain, review and evaluate information and data generated by the hospital's case management service;

d. act on recommendations related to utilization review received from the Chief of the Medical Staff, the Medical Executive Committee, the Departments and other committees;

e. maintain a permanent record of its proceedings and submit quarterly reports of its activities and recommendations to the Medical Executive Committee.

The Utilization Management Committee shall meet quarterly or as often as necessary at the call of its Chairperson.

Alameda Health System

MEDICAL STAFF DEPARTMENT STRUCTURE AND DIVISION LEADERSHIP

Department	Medical Staff	***Effective Date***	9/2023
Campus	AHS	***Date Revised***	1/29/25, 5/21/25
Unit	All	***Next Scheduled Review***	5/2028
Manual	Medical Staff	***Author***	Vice Chief of Staff
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 outline the organization of Clinical Departments and their Divisions within the Alameda Health System Medical Staff and define the process for their Leadership.

Policy

The Alameda Health System Medical Staff (AHS) divides the governance of the Medical Staff into Clinical Departments and their Divisions.

The Medical Executive Committee will periodically review the designation of the Departments and what action is desirable in creating, eliminating, or combining them for better organizational efficiency and improved patient care. Subsequent action shall be solely effective upon approval by the Medical Executive Committee.

Procedure

The Medical Staff shall be divided into clinical departments. Each department shall be organized as a separate component of the Medical Staff and shall have a Chair selected and entrusted with the authority, duties, and responsibilities specified in the Medical Staff Bylaws.

A department may be further divided, as appropriate, into divisions which shall be directly responsible to the department within which they function, and a Division Chief shall be selected and entrusted with the authority, duties and responsibilities specified. When appropriate, the affected Department Chair(s) may recommend to the Medical Executive Committee the creation, elimination, modification, or combination of divisions.

Clinical Departments

Clinical departments and Divisions shall be approved by the Medical Executive Committee and be under the supervision of the Chief of Staff. Their scope of services shall include leadership roles to assure their adequacy for quality of care, patient safety, and clinical efficiency of services.

The Medical Executive Committee will periodically review the designation of the Departments in creating, eliminating, or combining Departments for better

organizational efficiency and improved patient care. Action shall be solely effective upon approval by the Medical Executive Committee.

There shall be the following Departments and Divisions under the supervision of the Chief of Staff:

a. Ambulatory Care and Preventive Medicine
    i. Urgent Care
b. Anesthesiology, Perioperative and Pain Medicine
    i. Pain Medicine
c. Emergency Medicine
    i. Addiction Medicine
    ii. Community Emergency Medicine
d. Medicine
    i. HIV Services
    ii. Cardiology
    iii. Pulmonary and Critical Care Medicine
    iv. Dermatology
    v. Endocrinology
    vi. Gastroenterology
    vii. Geriatrics
    viii. Hematology and Oncology
    ix. John George and Fairmont Internal Medicine
    x. Infectious Disease
    xi. Hospital Medicine
    xii. Nephrology
    xiii. Neurology
    xiv. Palliative Care
    xv. Primary Care Medicine
    xvi. Rheumatology
e. Obstetrics, Midwifery and Gynecology
    i. Family Planning
    ii. Gynecology
    iii. GYN Oncology
    iv. Maternal Fetal Medicine
    v. Obstetrics
    vi. Urogynecology
f. Orthopaedic Surgery
    i. Podiatry
    ii. Physical Medicine and Rehabilitation (PM&R)
g. Pathology & Laboratory Medicine
    i. Anatomical Pathology
    ii. Laboratory Medicine (Clinical Pathology)
h. Pediatrics

    i. Ambulatory Pediatrics
    ii. Newborn Services
i. Psychiatry
    i. Inpatient Psychiatry
    ii. Psychiatry Emergency Services
j. Radiology/Imaging
    i. Breast Imaging
    ii. Interventional Radiology
k. Surgery
    i. Dentistry
    ii. General Surgery
    iii. Neurological Surgery
    iv. Ophthalmology
    v. Optometry
    vi. Oral Maxillofacial Surgery
    vii. Otolaryngology
    viii. Plastic Surgery
    ix. Surgical Critical Care
    x. Trauma Surgery
    xi. Urology

Creation of Divisions

Departments may propose a new division to the Medical Executive Committee. The designation of a Division Chief is designed to effectively assist the Department Chair in leading credentialing and privileging, clinical care, operations and education within the specialty.

Consideration and the criteria for a new division shall be determined by the Department Chair in consultation with the Chief of Staff (COS) for quality and peer review considerations, and the Chief Medical Officer (CMO) for allocation of administrative time and support. This shall be summarized in a written request to the COS. The MEC shall review the request, may request a presentation and further details, and vote to approve the new division by majority vote (as defined in the Medical Staff Bylaws). The COS will report on the creation of a division to the BOT.

Elimination of Divisions

Consideration for eliminating a division shall be presented to MEC. MEC may request further details and/or a presentation and vote to approve the elimination by majority vote (as defined in the Medical Staff Bylaws).

Assignment to Departments and Divisions
Each member shall be assigned primary membership in at least one department, and to a division, if any, within such department. They may also be granted clinical privileges in other departments or divisions consistent with practice privileges granted.

Functions of Divisions
Subject to the approval of the Medical Executive Committee, each Division Chief shall perform the functions assigned to it by the Chair of Department. Such functions may include, without limitation, retrospective patient care reviews, evaluation of patient care practices, credentials review, privilege delineation, and continuing education programs. The Division Chief shall transmit regular reports to the Chair of the Department on the performance of their assigned functions.

Division Chief Qualifications
Each Division Chief must be an Active Staff member or a Provisional Staff member and a member of the division. The Division Chief must be qualified by training, experience, and demonstrated current ability in the clinical area covered by the Department/Division.

All Division Chiefs appointed after May 1, 2003, shall be:

a. board certified by an appropriate specialty board approved by the American Board of Medical Specialties or American Osteopathic Association, **or** have successfully completed an Accreditation Council for Graduate Medical Education or American Osteopathic Association approved residency training program and achieve board certification within three (3) years of board eligibility; or

b. be board certified by the American Board of Podiatric Surgery **or** have completed a podiatric residency program approved by the Council on Podiatric Medical Education and achieve board certification within three (3) years of board eligibility; or

c. be board certified by the American Board of Oral and Maxillofacial Surgery as recognized by the American Dental Association **or** have successfully completed a residency program in an accredited oral and maxillofacial surgery program recognized by the American Dental Association and achieve board certification within three (3) years of board eligibility.

Division Chief Appointment and Removal
A Division Chief shall be appointed by the Chair of the Department after careful review of the candidate's qualifications. Such appointments shall be made in consultation with the CMO and the COS, and with approval of the Medical Executive Committee.

The Division Chief's performance shall be periodically reviewed by the Chair of the Department and the appointment shall continue if performance is satisfactory.

A Division Chief will immediately cease being the Division Chief upon any of the following:

a. They resign.

b. They are no longer an Active or Provisional Staff member.

c. They are removed by the Chair of the Department with the concurrence of the Chief of Staff and reported to the Medical Executive Committee.

- Such removal shall have no effect on the individual's clinical privileges or Medical Staff membership and is not subject to hearing procedures described in Article 9 of the Bylaws.

d. Their Division is eliminated.

Division Chief Duties

a. act as presiding officer at Division meetings;

b. assist in the development and implementation, in cooperation with the Chair of the Department, of programs to carry out the quality review, and evaluation and monitoring functions assigned to the Division;

c. evaluate the clinical work performed in the Division;

d. conduct inquiries and investigations and submit reports and recommendations to the Chair of the Department;

e. recommend to the Chair of the Department, specific clinical privileges for providers requesting clinical privileges in the department/division; and

f. perform such other duties commensurate with the office as may from time to time be reasonably requested by the Chair of the Department, the Chief of Staff or the Medical Executive Committee.

Approvals

		AHS
Bylaws Committee	**Date:**	**N/A**
Medical Executive Committee	**Date:**	**5/21/2025**
Quality Professional Services Committee of the Board	**Date:**	**5/28/2025**

Alameda Hospital

MEDICAL STAFF COMMITTEES

Department	Medical Staff	***Effective Date***	9/2022
Campus	AH	***Date Revised***	3/2025, 5/2025
Unit	All	***Next Scheduled Review***	5/2028
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 supplement the Bylaws regarding Medical Staff's committees, including but not limited to committee membership, duties, frequency of meetings and structure.

Policy: The Alameda Hospital (AH) Medical Staff uses medical staff committees to review, assess, improve, measure, maintain quality, safety and performance on the individual medical staff level and on an organization wide basis. This policy governs medical staff committees not included in the Medical Staff Bylaws.

Each independent Medical Staff is self-governing and responsible for making its own decisions and recommendations in accordance with their Medical Staff Bylaws, Rules & Regulations and Policies and Procedures. While the Medical Staffs may engage in information sharing agreements, each medical staff shall independently determine their own action.

Combining medical staff committees between two or more medical staffs for some or all functions may be preferred for the purpose of alignment of system operations, shared clinical services, quality and patient safety.

Procedures

Committee Membership: With the exception of membership defined by regulatory requirements, the Bylaws or Rules and Regulations, the Committee Chair shall determine the membership eligibility, number of members, purposes, and frequency of meetings.

Confidentiality and Conduct: Each committee member shall adhere to the AHS Medical Staff Code of Conduct and AHS Medical Staff confidentiality requirements.

Minutes: Committee meeting minutes shall be prepared and shall include a record of the attendance of Members, the decision/conclusion and action that was carried. Each committee shall maintain a permanent file of the minutes of each meeting and any documents that were discussed during the meeting. When meetings are held with outside entities, access to minutes shall be limited as necessary to preserve protection from discovery, as provided by California law.

Reporting: Standing Committees and Special Committees shall report to the Medical

Executive Committee or other designated committee as may be required by regulatory requirements and the Bylaws, or as requested by the MEC.

Standing Committees of the Medical Staff in Addition to Those Specified in the Bylaws:
In addition to the committees established in the Medical Staff Bylaws, the following committees shall be established:

- *Committee on Interdisciplinary Practice (CIDP)
- Departmental Quality Review Committees (QRCs)
- Ethics
- Patient Safety Committee
- Provider Wellbeing
- Quality Steering Committee
    - Code Blue Committee
    - Infection Prevention & Control
    - Pharmacy, Therapeutics Committee (P&T) & MERP
- Stroke Committee

*The CIDP Committee reports to the Credentials Committee.

Consent Agendas:
Medical Staff Committees that distribute materials in advance of the meeting, may utilize a consent agenda for succinct approval of items without discussion. Any committee member is able to request removal of an item from the consent agenda for discussion.

Combined Medical Staff Committees:
Subject to the ultimate authority of each of the applicable Medical Executive Committees, a medical staff committee may include functions on behalf of two or more independent Medical Staffs. The Medical Staff may choose to combine a committee to review, assess, improve, measure, maintain quality, safety and performance on the individual medical staff level and on an organization wide basis. The Chiefs of Staff shall work together to recommend combined committees, which shall be approved by the affected Medical Executive Committees. When deemed appropriate, a combined committee may be limited by purpose or duration.

Membership for combined medical staff committees shall include representation from each medical staff and comply with the composition defined in each medical staff's respective Bylaws or policy and procedures.

Quorum: A quorum is defined in the Bylaws. Voting members are defined within the Bylaws and may be supplemented within the committee's charter.

Attendance: Annual attendance of voting members shall be tracked with the goal of having 50% attendance.

Procedure to Propose Additional Medical Staff Standing Committees

1. The Medical Staff becomes aware of the need for a new committee.
2. A proposal is created by the committee champion including, the reason for the committee, a draft committee charter and suggested membership.

3. The proposal is submitted to the Chief of Staff.
4. The Chief of Staff reviews the proposal with the Medical Staff Officers to assess whether to forward the proposal to the Medical Executive Committee (MEC). If MEC
    a. Agrees the committee is needed and approves the charter, the Chief of Staff in collaboration with the new committee champion determines
        i. the committee membership,
        ii. appoints the committee members, and
        iii. the reporting frequency to MEC.
    b. Does not agree the committee is needed, the proposal is rejected.

Procedure to Propose Combined Medical Staff Committees

1. The Chiefs of Staff shall work together to support combined committees as may be appropriate for the proper functioning of the Medical Staffs. The recommendation to combine a standing or special committee shall be approved by the applicable Medical Executive Committees.
2. Meeting minutes shall include a record of the attendance and quorum for each represented medical staffs.
3. Recommended actions shall be routed in accordance with the applicable Medical Staff governing documents for each independent medical staff.

Approvals

		AH
Medical Executive Committee	**Date:**	**5/16/2025**
QPSC/Board of Trustees	**Date:**	

Alameda Hospital Medical Staff Committees

Appendix A

Committee on Interdisciplinary Practice (CIDP)

The Committee on Interdisciplinary Practice shall include the Chief Executive Officer (or their designee), the Chief Nursing Executive (or their designee), an equal number of physicians appointed by the Chief of Staff as registered nurses appointed by the Chief Nursing Executive, and one or more clinical psychologists. Advanced Practice Providers (APPs), other than registered nurses, who practice at the Health System may be appointed to serve on the CIDP by the Chief of Staff. The Chair of the CIDP shall be a physician. All members of the CIDP are voting members.

The duties of the CIDP shall be to:

a. evaluate and make recommendations regarding the need for and appropriateness of the performance of services in the Health System by APPs;
b. evaluate and make recommendations to develop policies and procedures relevant to the formation and approval of standardized procedures;
c. periodically review and approve all standardized procedures and clinical protocols utilized by nurses practicing in expanded roles and/or practitioners providing clinical services utilizing protocols under the supervision of a medical staff member;
d. evaluate and make recommendations regarding the qualifications and credentials of APPs who are eligible to apply for and provide services either utilizing standardized procedures or protocols.

The CIDP shall maintain a permanent record of its proceedings and shall submit reports of its activities and recommendations to the Credentials Committee.

The CIDP shall meet as often as necessary at the call of its Chairperson.

Code Blue Committee

The Code Blue Committee shall be a multidisciplinary team composed of clinical leaders including physicians, nurses and administration and other assigned members as may be necessary and appropriate.

The duties and responsibilities of the Code Blue Committee shall be to:

a. To collect and review Code Blue Events and Data for Process Improvement, Quality Assurance and Patient Safety Priorities;
b. Capture data from various sources for process improvement;
c. Approval the crash cart contents and checklists;
d. Review Code Blue documenation;
e. Review and revise the Code Blue policy and procedures;
f. Shall maintain a permanent record of its proceedings and shall submit reports of its activities and recommendations to the Quality and Safety Committee.

The Code Blue Committee shall meet quarterly or as often as necessary at the call of its Chairperson.

Ethics Committee

The Ethics Committee shall be composed of physicians, nurses, administration, and other assigned members as may be necessary and appropriate. It should include diverse members, such as lay representatives, social workers, chaplains, other clergy, ethicists and/or an attorney.

The duties and responsibilities of the Ethics Committee shall be to:

a. participate in the development of guidelines for consideration of cases having bioethical implications;
b. develop and implement procedures for the review of such cases;
c. consult with concerned parties to facilitate communication and aid bioethical conflict resolution;
d. maintain a permanent record of its proceedings and submit periodic and timely reports of its activities and recommendations to the Medical Executive Committee.

The Ethics Committee shall meet at the call of its Chairperson at such intervals as the chair or the Medical Executive Committee may deem appropriate.

Infection Prevention & Control Committee

The Infection Prevention and Control Committee is a multidisciplinary committee with the overall authority and responsibility for the Infection Prevention and Control Program. The Infection Prevention and Control Committee shall be composed of staff including physicians, to include members of the Medical Hours Staff (ad hoc), nurses, clinical laboratory, pharmacy, sterile processing, infection prevention, administration, infectious disease, facilities, environmental services, quality, and other Ad Hoc members as necessary and appropriate.

The IPCC shall be chaired by a physician (or designee) who has credentials, knowledge, and special experience in infection prevention and control. The MD chairperson must complete the infection control educational requirements mandated by the State of California (SB 1058).

Infection Preventionist, Chair of the Infection Control Committee, along with the System Director of Infection Prevention and Control, has authority to institute any surveillance, prevention and control measures or studies when there is reason to believe that any patient or personnel may be in danger from a potential or actual outbreak of, or exposure to, infectious disease.

The duties of the Infection Prevention & Control Committee shall be to:

a. develop, implement and assess appropriate quality control and performance improvement measures for the Infection Prevention & Control program;

b. develop a Hospital wide infection control program and maintain surveillance over the program;
c. develop a system for reporting, identifying and analyzing the incidence and cause of healthcare associated infections, and assign responsibility for the ongoing collection and analytic review of such data, and follow-up activities;
d. develop and implement a preventive and corrective program designed to minimize infection hazards, including establishing, reviewing and evaluating aseptic, body substance precaution and sanitation techniques;
e. develop written policies defining special indications for body substance precaution;
f. act on recommendations related to infection control received from the Chief of Staff, the Medical Executive Committee, the departments and other committees;
g. review susceptibility of organisms specific to the hospital and its campuses; and

h. Review and maintain policies and procedures pertaining to the infection control program in accordance with accrediting or governing organization requirements);

i. Update annually the IC Program Plan and Risk Assessments;

j. Develop and implement a preventive program designed to identify and minimize infection risks;

k. Review the antimicrobial susceptibility/resistance trends in conjunction with the Antimicrobial Stewardship Committee;

l. Review proposals, protocols, epidemiology outcomes, or special infection control studies to be conducted throughout the hospital;

m. maintain a permanent record of its proceedings and submit quarterly reports of its activities and recommendations to the Quality Steering Committee, the Medical Executive Committee, and other hospital specific and system-wide committees as needed.

The Infection Control Prevention & Committee shall meet at monthly, with a minimum of six meetings per year.

Patient Safety Committee

The Patient Safety Committee shall be composed of physicians, nurses, administration (including representation from Risk Management, Quality Services and the Safety Department) and other assigned members as may be necessary and appropriate.

The Patient Safety Committee has been established as an interdisciplinary committee of the Medical Staff to coordinate organization-wide safety and risk management activities and to oversee the development of organizational error reduction programs. The duties of the Patient Safety Committee shall be to:

a. establish measurable objectives for improving patient safety and reducing medical errors;
b. review all sentinel events including the development of a thorough and credible root cause analysis, appropriate plan of correction, and follow-up plan;
c. oversee the organizational safety program;
d. oversee all organizational risk management activities;
e. work with staff in the development of programs to enhance involvement by the patient and the patient's family as a partner in the healthcare process; and
f. maintain a permanent record of its proceedings and submit monthly reports of its activities and recommendations to the Medical Executive Committee.

The Patient Safety Committee shall meet quarterly or as often as necessary at the call of its chairperson.

Pharmacy, Therapeutics and Nutritional Care Committee (P&T) and MERP

The Pharmacy, Therapeutics and Nutritional Care Committee shall be composed of physicians, nurses, administration (including representation from Pharmacy Services, and Nutrition Care) and other assigned members as may be necessary and appropriate.

The duties of the Pharmacy, Therapeutics and Nutritional Care Committee shall be to:

a. develop, implement and assess appropriate quality control and performance improvement measures for professional practices and policies regarding nutrition care and the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures, and all other matters relating to drugs in the hospital, including antibiotic usage;
b. review and recommend to the Medical Executive Committee, relevant policy, procedures, and protocols that may be necessary for the operation of medication usage and nutritional care programs;
c. evaluate and improve the quality of patient care provided to patients related to medication usage and nutritional care;
d. advise the Medical Staff and Pharmacy Services on matters pertaining to the choice of available drugs;
e. make recommendations concerning drugs to be stocked on the nursing unit floors and by other services;
f. annually review and revise, as necessary, the formulary or drug list for use in the hospital.
g. evaluate clinical data concerning new drugs or preparations requested for use in the hospital;
h. monitor and review adverse drug reactions;
i. to review aggregate data relevant to medication errors;
j. to oversee clinical care related to the nutritional needs of patients; and
k. maintain a permanent record of its proceedings and submit quarterly reports of its activities and recommendations to the Medical Executive Committee.

The Pharmacy, Therapeutics and Nutritional Care Committee shall meet quarterly or as often as necessary at the call of its Chairperson.

Provider Wellbeing Committee

The Provider Wellbeing Committee shall be composed of three (3) physician members of the Medical Staff. Members of the Provider Wellbeing Committee shall not serve as active participants on other peer review or performance improvement committees while serving on the Provider Wellbeing Committee.

The committee shall not have disciplinary function with respect to a physician's staff membership or privileges and shall not be responsible for any investigation leading to disciplinary action against staff membership or privileges/practice prerogatives.

The duties of the Provider Wellbeing Committee shall be to:

a. provide education about physician health, addressing prevention of physical, psychiatric, or emotional illness;
b. facilitate confidential diagnosis, treatment, and rehabilitation of physicians who suffer from potentially impairing conditions;
c. aid the physician regaining or retaining optimal professional functioning consistent with protection of patients;
d. educate the Medical Staff and other organizational staff about illness and impairment recognition issue-specific to physicians;
e. allow for self-referral by physicians and referral by other organizational staff;
f. referral of affected physicians to appropriate professional internal or external resources for diagnosis and treatment of physical, emotional, or drug dependency related conditions;
g. maintenance of the confidentiality of the physician seeking referral or referred for assistance except as limited by law, ethical obligation, or when the safety of a patient is threatened;
h. evaluate the credibility of any complaint, allegation, or concern regarding the physical or emotional health of a physician;
i. monitor impaired physicians during programs of treatment and rehabilitation;
j. report to the appropriate Medical Staff committee, at any time during diagnosis, treatment, or rehabilitation, if it is determined that the physician may be unable to safely perform the privileges he or she has been granted;
k. monitor compliance with any mandatory drug treatment programs; and
l. maintain only such records of its proceedings, as it deems advisable and submit quarterly reports of its activities and recommendations to the Medical Executive Committee.
m. Initiating appropriate actions when a licensed independent practitioner fails to complete the required rehabilitation program.

The Provider Wellbeing Committee shall meet at the call of its Chairperson at such intervals as the chair or the Medical Executive Committee may deem appropriate.

Quality Steering Committee

The Quality Steering Committee shall be composed of the Chief of Staff, the Vice Chief of Staff and two (2) at large members of the Medical Staff appointed by the Chief of Staff. Non-physician members may include the Chief Medical Officer, Associate Chief Medical Officer, Chief Operations Officer, Vice President of Patient Care Services, Vice

President of Quality, and the Director of Risk Management. The Committee shall be Co-Chaired by a medical staff member and an administrative member of the committee.

The Quality Steering Committee has a central role in the initiation, performance and maintenance of the organization's performance improvement program. The fundamental responsibilities and duties of the Quality Steering Committee shall be to:

a. set priorities for organizational performance improvement activities that are designed to improve patient care processes and outcomes;
b. develop performance improvement training programs for the organization's staff;
c. foster communication among all departments and services;
d. prioritize and select specific performance improvement team projects;
e. receive aggregate reports related to performance improvement activities from Hospital support services, Medical Staff clinical function committees and all organizational performance improvement teams;
f. receive aggregate tissue and transfusion reports;
g. have direct oversight of the following functions:
    i. Improving Organizational Performance
    ii. Leadership
h. prepare an annual appraisal of the organization's performance improvement program; and
1. maintain a permanent record of its proceedings and submit quarterly reports of its activities and recommendations to the Medical Executive Committee.

The Quality Steering Committee shall meet quarterly or as often as necessary at the call of its Chairperson.

Quality Review Committees (QRC)

Each department of the Medical Staff shall have a Quality Review Committee (QRC). Each department's QRC may meet separately or jointly with the QRCs of other departments at the discretion of the Chair of the Department and as approved by the Medical Executive Committee.

Each departmental QRC shall monitor the quality and appropriateness of clinical services provided by those holding clinical privileges in its department related to the divisions represented by the QRC. When requested, the QRC shall also make recommendations to the Credentials and/or Medical Executive Committees related to specific credentialing issues. The Chair of the Department, however, shall have the ultimate duty and responsibility to make recommendations regarding credentialing issues to the Credentials and/or Medical Executive Committees.

The duties and responsibilities of the QRC's shall be to:

a. evaluate and improve the quality of care provided to Hospital patients which may include accurate and timely medical record documentation;
b. conduct patient care reviews for the purpose of analyzing and evaluating the quality and appropriateness of care and treatment including practitioner specific data for medication usage, medical records, transfusion review and operative and

invasive care, provided by practitioners within the divisions of the departments represented by the QRC;
c. perform peer review and/or other physician specific intensified assessments when indicated or requested by an appropriate Medical Staff committee;
d. identify system problems requiring process improvement activity and make such recommendations to the Quality and Safety Committee;
e. take appropriate actions when important problems in patient care or opportunities to improve patient care are identified;
f. recommend to the Chairperson of the Department, those Medical Staff policies and procedures as may be necessary to conduct patient care and administrative Medical Staff activities;
g. communicate the significant results of peer review and performance improvement activities to relevant practitioners;
h. implement programs that assess compliance with clinical practice guidelines and other recognized standards of care;
i. assume all duties and responsibilities of the departments related to quality assessment, peer review and performance improvement, which have not been otherwise assigned to the Chair of the Department and as may be described in the Bylaws and/or Rules and Regulations; and
j. maintain a permanent record of its proceedings and submit periodic and quarterly reports of its activities and recommendations to the Medical Executive Committee.

The Quality Review Committees shall meet quarterly or as often as necessary at the call of its chairperson.

Stroke Committee

The Stroke Committee shall be composed of the Stroke Team which includes physicians, nurses, administration, other representation from the Emergency Department and Neurology Division and EMS and other assigned members as may be necessary or appropriate.

The duties of the Stroke Committee shall be to:

a. develop, implement and assess appropriate quality control and performance improvement measures for the Stroke program;
b. demonstrate conformity with clinical practice guidelines or evidence-based practice
c. maintain a permanent record of its proceedings and submit quarterly reports of its activities and recommendations to the Quality and Safety Council.

The Stroke Committee shall meet at least quarterly or as often as necessary at the call of its Chairperson.

B4. Revised Medical Staff Application Forms and Privilege Form listed below_

ALAMEDA HEALTH SYSTEM

May 28, 2025

TO: Quality Professional Services Committee

FROM: Bhrett Lash, M.D., Alameda Health System Vice Chief of Staff
Catherine Pyun, D.O., Alameda Hospital Chief of Staff

SUBJECT: **Agenda Item:** A4

Meeting Date: May 28, 2025

Item Description: Medical Staff Application & Specialty Privilege Forms

COMMITTEE ACTION: Approval of revised Medical Staff Privilege Forms

Background:
The specialty privilege form(s) listed in the analysis section are revised privileges forms, designed to offer a systematic approach for care across our facilities (AHS, SLH, AH) as applicable.

Analysis:
The Medical Staff application includes questionnaires intended to collect documentation used in the decision-making process for credentialing applicants that are applying to the Medical Staff.

Whether new or revised, the Medical Staff privilege forms are updated through a succinct process using best practice and clinical evidence.

Board Action Requested:
Approval of application form revisions and revised privilege forms, that offer a system-wide approach for credentialing and privileging providers that support patient care at AHS.

Revised Application Forms for AHS & AH:
- Provider Initial Application: Events to Report to the Chief of Staff Memo

Revised Privilege Forms for AHS:
- Pediatrics
- Pediatric Cardiology
- Pediatric Neonatology-Perinatal Medicine

Revised Privilege Forms for AHS & AH:
- Family Medicine – Multifacility

- Internal Medicine – Multifacility
- Neurology – Multifacility
- Pathology – Multifacility
- Teleneurology – Multifacility

ALAMEDA HEALTH SYSTEM

TO: Alameda Health System and Alameda Hospital Medical Staff and Advanced Practice Providers

FROM: Cherie Hargis, M.D., AHS Credentials Committee Chair
William Lowery, M.D., AH Credentials Committee Chair
(AHS/AH Credentials Committee Chairs – when included in applications)

DATE: May 21, 2025 *(remove date when including with initial/reapplications)*

SUBJECT: Events to Report to the Chief of Staff

On behalf of the Credentials Committee, this is a friendly reminder to all affiliated providers of their duty to notify the Chief of Staff, in writing, within 7 days of any of the following events[1]:

1. The revocation, limitation, or suspension of their professional license or DEA registration, any court order to cease or restrict their professional practice, any reprimand or other disciplinary action taken by any state or federal governmental agency relating to their professional license, or the imposition of terms of probation by any state.
2. Loss, summary suspension or summary restriction or denial of staff membership or privileges at any hospital or other health care institution, whether temporary or permanent.
3. Change in employment status such as termination and/or administrative leave.
4. Inability to provide clinical care for more than thirty (30) days *(notify the Department Chair or Division Chief and the Medical Staff Office in writing five (5) working days in advance of resuming clinical care within our health system.)*
5. Lapse, cancellation or change of professional liability coverage including any change of carrier or amount of coverage.
6. Receipt of a quality inquiry letter, an initial sanction, or notice of the commencement of an investigation, the filing of charges relating to health care matters or exclusion from any federally funded health care organization including Medicare or Medicaid (Medi-Cal), or other action by a Medicare peer review organization, the Department of Health Human Services, or any law enforcement agency or health regulatory agency of the United States or the State of California.
7. Receipt of notice of the filing of any suit against the practitioner alleging professional liability in connection with the treatment of any patient.
8. The development of any mental or physical condition or other situation that could compromise the practitioner's ability to perform the functions associated with their clinical privileges in a safe and effective manner.
9. The filing of any criminal misdemeanor or felony charges, including but not limited to DUI charges.

Should you encounter any of these events, please direct your written notification to the respective facility Chief of Staff(s) via the Medical Staff Office at medicalstaff@alamedahealthsystem.org

[1]*AHS & AH Medical Staff Bylaws, Section 2.5, Basic Responsibilities of Medical Staff Members*

Pediatrics - Alameda Health System

Delineation of Privileges

Applicant's Name:

Instructions:

1. Click the **Request** checkbox to request a group of privileges such as *Core Privileges* or a *Special Privileges*.
2. Uncheck any privileges you do not want to request in that group.
3. Check off any special privileges you want to request.
4. Sign form and submit with any required documentation.

Required Qualifications	
Membership	Meet all requirements for Medical Staff membership.
Education/Training	For initial applicants, effective January 1, 2020, completion of an ACGME or AOA accredited Residency training program in Pediatrics, Internal Medicine/Pediatrics, or Family Medicine.
Certification	Current certification or board eligibility in the examination process leading to certification in Pediatrics by the American Board of Pediatrics or by the American Osteopathic Board of Pediatrics or in Family Medicine by the American Board of Family Medicine or by the American Osteopathic Board of Family Physicians.
Clinical Experience (Initial/Reappointment)	Applicant must provide documentation of provision of pediatrics services representative of the scope and complexity of the privileges requested during the previous 24 months (waived for applicants who completed training within the previous year).

Telemedicine Privileges Inpatient or Outpatient Care

Description: These privileges are intended to support existing specialty privileges for physicians and Advanced Practice Providers who are not otherwise classified as Telemedicine ONLY providers.

Qualifications	
Qualifications	Clinical services are limited to only those aspects of existing privileges granted that can be provided remotely.

Request	***Request all privileges listed below.*** *Uncheck any privileges that you do not want to request.*	Div Chief Rec	Dept Chair Rec
	Telehealth initial and follow up consultations		
	Virtual Check-ins		
	E-Visits		

Core Privileges in Outpatient Pediatrics

Description: Pediatricians practice the specialty of medical science concerned with the physical, emotional, and social health of children from birth to young adulthood. Pediatric care encompasses a broad spectrum of health services ranging from preventive health care to the diagnosis and treatment of acute and chronic diseases.

Qualifications	
Additional Qualifications	Current BLS (Basic Life Support) or PALS (Pediatric Advanced Life Support) certification.

Request	***Request all privileges listed below.*** *Uncheck any privileges that you do not want to request.*	Div Chief Rec	Dept Chair Rec
	Evaluation and Management		
	Outpatient care of patients 0-21 years of age		
	Evaluate, diagnose, treat and provide primary care to patients from birth to young adulthood with acute and chronic disease including health promotion (immunizations) - includes ordering and interpretation of radiographs and laboratory data		
	Office-Clinic Procedures		
	Anterior nasal cautery and/or packing to control nasal hemorrhage (epistaxis)		
	Arthrocentesis, aspiration, and/or injection- knee		
	Reduction of simple dislocations and immobilization of simple fractures by casting or splinting and sprains by splinting		
	Circumcision of infant less than 1 month of age (corrected for prematurity) with local anesthetic		
	ECG Interpretation-Preliminary		
	Excision of lingual frenum (frenectomy)		
	Removal of non-penetrating foreign body from the eye, ear, or nose		

	Removal of skin tag(s)		
	Skin excision, including biopsy and lesion removal		
	Suprapubic bladder aspiration for infants greater than 2500 grams		
	Treatment of partial thickness burns		
	Trephination, avulsion, or excision of nail, partial or complete		
	Destruction of benign lesion (wart)		
	Urinary catheterization		
	Wound care, incision and drainage of abscess, simple debridement, aspiration, wound closure, and local anesthetic techniques		

Focused Professional Practice Evaluation (FPPE)/Routine Initial Proctoring

Three (3) retrospective case reviews that are representative of the scope and complexity of privileges requested.

Core Privileges in Inpatient Pediatrics (Pediatric Hospitalist)

Qualifications

Clinical Experience (Initial/Reappointment)

Applicant must provide documentation of provision of pediatric services representative of the scope and complexity of the privileges requested during the previous 24 months (waived for applicants who completed training during the previous year).

Additional Qualifications

Current NRP (Neonatal Resuscitation Program) certification.

AND

Current PALS (Pediatric Advanced Life Support) certification.

Request	***Request all privileges listed below.*** *Uncheck any privileges that you do not want to request.*	Div Chief Rec	Dept Chair Rec
	Evaluation and Management		
	Admit to inpatient or appropriate level of care		
	Care and management of newborn in the normal newborn nursery		
	Critical Care Admission and management of patient in NICU		
	Evaluate, diagnose, provide consultation, medically manage, and provide care, treatment or services, to patients from birth to young adulthood presenting with various acute and chronic diseases, disorders, and conditions		
	Procedural Privileges		
	Anterior nasal cautery and/or packing to control nasal hemorrhage (epistaxis)		
	Arterial puncture for arterial blood gas (ABG) sampling		
	Attend delivery of anticipated normal newborn and assume care		
	Immobilization of simple fractures by casting or splinting and sprains by splinting		
	Catheterization of umbilical vessels for diagnosis or therapy		
	Circumcision of infant less than 1 month of age (corrected for prematurity) with local anesthetic		
	Destruction of benign lesion (wart)		
	Endotracheal intubation		
	Excision of lingual frenum (frenectomy)		
	Hyperalimentation		
	Lumbar puncture (without fluoroscopy)		
	Removal of non-penetrating foreign body from the eye, ear, or nose		

	Removal of skin tag(s)		
	Skin excision, including biopsy and lesion removal		
	Urinary catheterization of any infant or suprapubic bladder aspiration for infants greater than 2500 grams		
	Trephination, avulsion, or excision of nail, partial or complete		
	Treatment of partial thickness burns		
	Wound care, incision and drainage of abscess, simple debridement, aspiration, wound closure, and local anesthetic techniques		

Focused Professional Practice Evaluation (FPPE)/Routine Initial Proctoring

Three (3) retrospective case reviews that are representative of the scope and complexity of privileges requested.

Acknowledgment of Applicant

I have requested only those privileges for which by education, training, current experience, and demonstrated competency I believe that I am competent to perform and that I wish to exercise at Alameda Health System and I understand that:

A. In exercising any clinical privileges granted, I am constrained by applicable Hospital and Medical Staff policies and rules applicable generally and any applicable to the particular situation.

B. Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of the Medical Staff Bylaws or related documents.

Practitioner's Signature

Date

Department Chair Recommendation - Privileges

I have reviewed the requested clinical privileges and supporting documentation and make the following recommendation(s):

Privilege	Condition/Modification/Deletion/Explanation

Division Chief Recommendation - FPPE Requirements

Signature of Division Chief/Designee

Date

Signature of Department Chair/Designee

Date

Pediatric Cardiology - AHS

Delineation of Privileges

Applicant's Name:

Instructions:

1. Click the **Request** checkbox to request a group of privileges such as *Core Privileges* or a *Special Privileges*.
2. Uncheck any privileges you do not want to request in that group.
3. Check off any special privileges you want to request.
4. Sign form and submit with any required documentation.

Required Qualifications	
Membership	Meet all requirements for Medical Staff membership.
Education/Training	Completion of an ACGME accredited Residency training program in Pediatrics **AND** Completion of an ACGME accredited Fellowship training program in Pediatric Cardiology.
Certification	Current certification or board eligibility in the examination process leading to certification in Pediatric Cardiology by the American Board of Pediatrics.
Clinical Experience (Initial/Reappointment)	Applicant must provide documentation of provision of pediatric cardiology services representative of the scope and complexity of the privileges requested during the previous 24 months (waived for applicants who completed training during the previous year).

Telemedicine Privileges Inpatient or Outpatient Care

Description: These privileges are intended to support existing specialty privileges for physicians and Advanced Practice Providers who are not otherwise classified as Telemedicine ONLY providers.

Qualifications	
Qualifications	Clinical services are limited to only those aspects of existing privileges granted that can be provided remotely.

Request	***Request all privileges listed below.*** *Uncheck any privileges that you do not want to request.*	Dept Chair Rec
	Telehealth initial and follow up consultations	
	Virtual Check-ins	
	E-Visits	

Core Privileges in Pediatric Cardiology

Description: Pediatric Cardiology is the subspecialty of Pediatrics focused on the evaluation, diagnosis, and treatment of heart conditions in infants, children, and young adults.

Request	***Request all privileges listed below.*** *Uncheck any privileges that you do not want to request.*	Dept Chair Rec
	Evaluation and Management	
	Admit to inpatient or appropriate level of care	
	Evaluate, diagnose, provide consultation, medically manage, and provide treatment to pediatric patients presenting with cardiovascular diseases, disorders, and conditions. Privilege holder may also provide clinical services to young adults with congenital heart problems persisting into adulthood. Privileges include medical management of general medical conditions which are encountered in the course of caring for the cardiovascular patient	
	Procedures - Non-Invasive (includes interpretation where applicable)	
	Comprehensive EP (electrophysiologic) studies	
	Elective cardioversion	
	Electrocardiogram (EKG) interpretation	
	Fetal echocardiography	
	Transthoracic echocardiography	
	Procedures - Invasive (includes interpretation where applicable)	
	Pericardial drainage, including pericardiocentesis and percutaneous catheter drainage	
	Thoracentesis, needle, or catheter	
	Vascular access, including insertion and management of central venous catheters, arterial lines, and pulmonary artery catheterization	

Focused Professional Practice Evaluation (FPPE)/Routine Initial Proctoring

Three (3) retrospective case reviews that are representative of the scope and complexity of privileges requested.

Acknowledgment of Applicant

I have requested only those privileges for which by education, training, current experience, and demonstrated competency I believe that I am competent to perform and that I wish to exercise at Alameda Health System and I understand that:

A. In exercising any clinical privileges granted, I am constrained by applicable Hospital and Medical Staff policies and rules applicable generally and any applicable to the particular situation.

B. Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of the Medical Staff Bylaws or related documents.

Practitioner's Signature

Date

Department Chair Recommendation - Privileges

I have reviewed the requested clinical privileges and supporting documentation and make the following recommendation(s):

Privilege	Condition/Modification/Deletion/Explanation

Division Chief Recommendation - FPPE Requirements

Signature of Department Chair/Designee

Date

Pediatric Neonatal-Perinatal Medicine - AHS

Delineation of Privileges

Applicant's Name:

Instructions:

1. Click the **Request** checkbox to request a group of privileges such as *Core Privileges* or a *Special Privileges*.
2. Uncheck any privileges you do not want to request in that group.
3. Check off any special privileges you want to request.
4. Sign form and submit with any required documentation.

Required Qualifications	
Membership	Meet all requirements for Medical Staff membership.
Education/Training	Completion of an ACGME accredited Residency training program in Pediatrics. **AND** Completion of an ACGME accredited Fellowship training program in Neonatal-Perinatal Medicine.
Certification	Current certification or board eligibility in the examination process leading to certification in Neonatal-Perinatal Medicine by the American Board of Pediatrics.
Clinical Experience (Initial/Reappointment)	Applicant must provide documentation of provision of neonatal-perinatal services representative of the scope and complexity of the privileges requested during the previous 24 months (waived for applicants who completed training during the previous year).
Additional Qualifications	Current NRP (Neonatal Resuscitation Program) certification.

Telemedicine Privileges Inpatient or Outpatient Care

Description: These privileges are intended to support existing specialty privileges for physicians and Advanced Practice Providers who are not otherwise classified as Telemedicine ONLY providers.

Qualifications	
Qualifications	Clinical services are limited to only those aspects of existing privileges granted that can be provided remotely.

Request	***Request all privileges listed below.*** *Uncheck any privileges that you do not want to request.*	Dept Chair Rec
	Telehealth initial and follow up consultations	
	Virtual Check-ins	
	E-Visits	

Core Privileges in Neonatal-Perinatal Medicine

Description: Neonatal-Perinatal Medicine is a subspecialty of Pediatrics that focuses on the diagnosis, treatment, and management of health issues in newborn infants, particularly those born prematurely, with low birth weight, or with medical complications. This field encompasses care during the perinatal period, which extends from the 20th week of gestation through the first 28 days after birth.

Request	***Request all privileges listed below.*** *Uncheck any privileges that you do not want to request.*	Dept Chair Rec
	Evaluation and Management	
	Admit to inpatient or appropriate level of care (includes neonatal intensive care unit)	
	Evaluate, diagnose, provide consultation, medically manage, and provide treatment to newborns presenting with severe and complex life-threatening problems such as respiratory failure, shock, congenital abnormalities, and sepsis	
	Attendance at both normal newborn and high-risk deliveries	
	Provide consultation to pediatric hospitalists and birthing families with high-risk pregnancies	
	Procedures	
	Abdominal paracentesis (diagnostic or therapeutic)	
	Arterial Puncture	
	Circumcision of infant less than 1 month of age (corrected for prematurity) with local anesthetic	
	ECG Interpretation-Preliminary	
	Exchange transfusion, blood or partial exchange transfusion, blood, plasma, or crystalloid	
	Hyperalimentation	
	Insertion and management of umbilical artery, umbilical vein, and peripheral artery catheter	
	Lumbar puncture, diagnostic or therapeutic with drainage (without fluoroscopy)	
	Management of airway, including intubation, CPAP, Ventilatory management	
	Pericardial drainage, including pericardiocentesis and percutaneous catheter drainage	

	Skin tag or extra digit removal	
	Suprapubic bladder aspiration	
	Thoracentesis and thoracostomy tube placement	
	Urinary Catheterization	
	Ventilator management (all modes)	

Focused Professional Practice Evaluation (FPPE)/Routine Initial Proctoring

Three (3) retrospective case reviews that are representative of the scope and complexity of privileges requested.

Moderate (Procedural) Sedation

Description: Moderate Sedation/Analgesia ("Conscious Sedation") is a drug-induced depression of consciousness. No interventions are required to maintain a patent airway, spontaneous ventilation is adequate and cardiovascular function is maintained.

Qualifications

Clinical Experience (Initial) Applicant must provide documentation of provision of clinical services representative of the scope and complexity of the privileges requested during the previous year (waived for applicants who completed training during the previous year).

OR

Documentation of participation and completion of approved training through Alameda Health System Chair of Procedural Sedation Committee.

Additional Qualifications Current NRP (Neonatal Resuscitation Program) certification.

AND

Completion of AHS Procedural Sedation Competency, initially and at time of reapplication.

Request	***Request all privileges listed below.*** *Uncheck any privileges that you do not want to request.*	Dept Chair Rec
	Moderate Sedation	

Focused Professional Practice Evaluation (FPPE)/Routine Initial Proctoring

Three (3) Moderate Sedation case reviews. Concurrent evaluation required for providers without recent clinical experience.

Acknowledgment of Applicant

I have requested only those privileges for which by education, training, current experience, and demonstrated competency I believe that I am competent to perform and that I wish to exercise at Alameda Health System and I understand that:

A. In exercising any clinical privileges granted, I am constrained by applicable Hospital and Medical Staff policies and rules applicable generally and any applicable to the particular situation.

B. Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of the Medical Staff Bylaws or related documents.

Practitioner's Signature

Date

Department Chair Recommendation - Privileges

I have reviewed the requested clinical privileges and supporting documentation and make the following recommendation(s):

Privilege	Condition/Modification/Deletion/Explanation

Division Chief Recommendation - FPPE Requirements

Signature of Department Chair/Designee

Date

Family Medicine - Multifacility

Delineation of Privileges

Applicant's Name:

Instructions:

1. Click the **Request** checkbox to request a group of privileges such as *Core Privileges* or a *Special Privileges*.
2. Uncheck any privileges you do not want to request in that group.
3. Check off any special privileges you want to request.
4. Sign form electronically and submit with any required documentation.

Required Qualifications	
Membership	Meet all requirements for Medical Staff membership.
Education/Training	For initial applicants, effective January 1, 2020, completion of an ACGME or AOA accredited Residency program in Family Medicine.
Certification	Current certification or board eligibility in the examination process leading to certification in Family Medicine by the American Board of Family Medicine or American Osteopathic Board. **AND** Applicant must be active in the MOC program in Family Medicine by the American Board of Family Medicine or American Osteopathic Board (waived for providers currently board eligible or who hold Lifetime certification status).
Clinical Experience (Initial)	Applicant must provide documentation of provision of Family Medicine (50 cases) representative of the scope and complexity of the privileges requested during the previous year (waived for applicants who completed training during the previous year). **OR** Alternative pathway recommended by the Department Chair and further approved by the Medical Executive Committee.
Clinical Experience (Reappointment)	Applicant must provide documentation of provision of clinical services (25 cases) representative of the scope and complexity of privileges requested during the previous 24 months.
Additional Qualifications:	Ambulatory & Urgent Care Providers: Current BLS Hospital Medicine Providers: Current ACLS

General Cognitive Privileges

Description: Provision of general medical/primary care managing both common and complex illnesses.

Request		***Request all privileges listed below.***
AHS Core	AH	Click **shaded blue check box** to Request all privileges. Uncheck any privileges you do not want to request.
		- Currently granted privileges
		Admit and attend to inpatient and outpatient setting (including Adolescents 14-21 years of age)
		Perform history and physical examination
		Evaluate, diagnose, and management of the Internal Medicine patients, including preliminary interpretation of diagnostic studies
		Stroke care

Focused Professional Practice Evaluation (FPPE)/Routine Proctoring Requirements	
AHS Core	AH
	Two (2) case reviews representative of the scope and complexity of privileges requested.

Procedural Privileges

Description: This listing includes procedures typically performed by physicians in this specialty. Other procedures that are extensions of the same techniques and skills may also be performed.

Request		***Request all privileges listed below.***
AHS Core	AH	Click **shaded blue check box** to Request all privileges. Uncheck any privileges you do not want to request.
		- Currently granted privileges
		General Procedures
		Thrombolytic Therapy - Standard Protocol
		Lumbar puncture
		Administration of local anesthetics
		Abdominal paracentesis
		Management of burns
		Intraosseous Line Placement
		Inpatient Setting Procedures

		Placement and management of arterial lines
		Placement and management of central venous lines and dialysis catheters
		IV immunoglobulin therapy
		Ventilator management (CPAP, BiPAP, and standard ventilator modes)
		Thoracentesis
		Cardioversion
		Pericardiocentesis
		Temporary transvenous pacemaker
		Hemodialysis
		Cancer Chemotherapy

Focused Professional Practice Evaluation (FPPE)/Routine Proctoring Requirements		
AHS Core	**AH**	
		Five (5) retrospective case reviews that are representative of the scope and complexity of privileges requested.

Other Procedural Privileges

Request		***Request all privileges listed below.***
AHS Core	**AH**	Click **shaded blue check box** to Request all privileges. Uncheck any privileges you do not want to request.
		- Currently granted privileges
		Bones and Joints
		Arthrocentesis
		Skeletal procedures including stabilization of fractures, sprains and dislocations including use of immobilization techniques
		Trigger point injection
		Joint injections, including carpal tunnel injections
		Musculoskeletal injections
		Skin
		Wound care including wound closure; selection of specialized dressings; drain insertion and removal; debridement and minor surgical excisions
		Skin excision, including biopsy and lesion removal
		Laceration repair not involving tendons, major vessels, or major nerves
		Incision and drainage or aspiration of palpable, superficial soft tissue mass
		Nail removal
		Ear, Nose, and Throat
		Management of epistaxis including posterior nasal packing
		Dental Block
		Tonometry
		Cautery of anterior nares

		Ear wick placement
		GI/Rectal
		Anoscopy
		Other
		Foreign body removal

Focused Professional Practice Evaluation (FPPE)/Routine Proctoring Requirements		
AHS Core	**AH**	
		Five (5) retrospective case reviews that are representative of the scope and complexity of privileges requested.

Gynecology and Reproductive Health

Qualifications	
Clinical Experience (Initial)	Applicant must provide documentation of provision of clinical services (5 cases) representative of the scope and complexity of privileges requested during the previous year (waived for applicants who completed training during the previous year).
Clinical Experience (Reappointment)	Applicant must provide documentation of provision of clinical services (5 cases) representative of the scope and complexity of privileges requested during the previous 24 months.
Additional Qualifications	IUD placement and removal: documentation of provision of clinical services (10 cases) representative of the scope and complexity of privileges requested during the previous 24 months. - Contraception implant insertion: completion of Clinical Training Program required along with documentation of provision of clinical services (5 cases) representative of the scope and complexity of privileges requested during the previous 24 months.

Request		***Request all privileges listed below.***
AHS Core	**AH**	Click **shaded blue check box** to Request all privileges. Uncheck any privileges you do not want to request.
		- Currently granted privileges
		Pap smear and endocervical culture
		Contraception implant insertion and removal
		IUD placement
		IUD removal
		Prenatal Care

Focused Professional Practice Evaluation (FPPE)/Routine Proctoring Requirements		
AHS Core	AH	
		Five (5) concurrent observation of IUD placement and/or removal.
		Five (5) concurrent observation of Contraception implant insertion.

Point of Care Ultrasound

Description: Point of Care Ultrasound is performed to immediately answer specific clinical questions and help establish a diagnosis to expedite the care of patients.

Qualifications	
Education/Training	Documentation of training and experience during Residency in accordance with Society of Hospital Medicine, ACP, American Academy of Family Physicians, or similar medical specialty organizational guidelines. **OR** Physicians who did not receive training during Residency should demonstrate at a minimum 25 proctored ultrasounds per primary indication or a minimum of 150 ultrasounds for Internal Medicine or Critical Care Ultrasound. **OR** Letter from Ultrasound Director certifying training and experience that meet Society of Hospital Medicine, ACP, American Academy of Family Physicians, or similar medical specialty organizational guidelines.
Clinical Experience (Initial)	Applicant must provide documentation of provision of clinical services representative of the scope and complexity of the privileges requested during the previous year (waived for applicants who completed training during the previous year).
Clinical Experience (Reappointment)	Applicant must provide evidence of ongoing clinical practice representative of the scope of POCUS privileges requested during the past 24 months.

Request		***Request all privileges listed below.***
AHS Core	AH	
		Click **shaded blue check box** to Request all privileges. Uncheck any privileges you do not want to request.
		- Currently granted privileges
		Perform and interpret emergent, limited, or investigational ultrasound

Focused Professional Practice Evaluation (FPPE)/Routine Proctoring Requirements		
AHS Core	AH	
		Five (5) retrospective case reviews.

Telemedicine Privileges Inpatient or Outpatient Care

Description: Clinical services are limited to only those aspects of existing privileges granted that can be provided remotely.

Qualifications	
Qualifications	These privileges are intended to support existing specialty privileges for physicians and Advanced Practice Providers who are not otherwise classified as Telemedicine ONLY providers.

Request		***Request all privileges listed below.***
AHS Core	AH	Click **shaded blue check box** to Request all privileges. Uncheck any privileges you do not want to request.
		- Currently granted privileges
		Telehealth initial and follow up consultations
		Virtual Check-ins
		E-Visits

Acknowledgment of Applicant

I have requested only those privileges for which by education, training, current experience, and demonstrated competency I believe that I am competent to perform and that I wish to exercise at Alameda Health System hospital(s) and I understand that:

A. In exercising any clinical privileges granted, I am constrained by applicable Hospital and Medical Staff policies and rules applicable generally and any applicable to the particular situation.

B. Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of the Medical Staff Bylaws or related documents.

Practitioner's Signature _____ Date _____

Department Chair Recommendation - Privileges

I have reviewed the requested clinical privileges and supporting documentation and make the following recommendation(s):

Privilege	Condition/Modification/Deletion/Explanation

Department Chair Recommendation - FPPE Requirements

Signature of Chief/Designee

Date

Signature of Department Chair/Designee

Date

Internal Medicine - Multifacility

Delineation of Privileges

Applicant's Name:

Instructions:

1. Click the **Request** checkbox to request a group of privileges such as *Core Privileges* or a *Special Privileges*.
2. Uncheck any privileges you do not want to request in that group.
3. Check off any special privileges you want to request.
4. Sign form electronically and submit with any required documentation.

Required Qualifications	
Membership	Meet all requirements for Medical Staff membership.
Education/Training	For initial applicants, effective January 1, 2020, completion of an ACGME or AOA accredited Residency program in Internal Medicine.
Certification	Current certification or board eligibility in the examination process leading to certification in Internal Medicine by the American Board of Internal Medicine or American Osteopathic Board. **AND** Applicant must be active in the MOC program in Internal Medicine by the American Board of Internal Medicine or American Osteopathic Board (waived for providers currently board eligible or who hold Lifetime certification status).
Clinical Experience (Initial)	Applicant must provide documentation of provision of Internal Medicine (50 cases) representative of the scope and complexity of the privileges requested during the previous year (waived for applicants who completed training during the previous year). **OR** Alternative pathway recommended by the Department Chair and further approved by the Medical Executive Committee.
Clinical Experience (Reappointment)	Applicant must provide documentation of provision of clinical services (25 cases) representative of the scope and complexity of privileges requested during the previous 24 months.
Additional Qualifications:	Ambulatory & Urgent Care Providers: Current BLS Hospital Medicine Providers: Current ACLS

General Cognitive Privileges

Description: Provision of general medical/primary care managing both common and complex illnesses.

Request		***Request all privileges listed below.***
AHS Core	AH	Click **shaded blue check box** to Request all privileges. Uncheck any privileges you do not want to request.
		- Currently granted privileges
		Admit and attend to inpatient and outpatient setting (including Adolescents 14-21 years of age)
		Perform history and physical examination
		Evaluate, diagnose, and management of the Internal Medicine patients, including preliminary interpretation of diagnostic studies
		Stroke care

Focused Professional Practice Evaluation (FPPE)/Routine Proctoring Requirements	
AHS Core	AH
	Two (2) case reviews representative of the scope and complexity of privileges requested.

Procedural Privileges

Description: This listing includes procedures typically performed by physicians in this specialty. Other procedures that are extensions of the same techniques and skills may also be performed.

Request		***Request all privileges listed below.***
AHS Core	AH	Click **shaded blue check box** to Request all privileges. Uncheck any privileges you do not want to request.
		- Currently granted privileges
		General Procedures
		Thrombolytic Therapy - Standard Protocol
		Lumbar puncture
		Administration of local anesthetics
		Abdominal paracentesis
		Management of burns
		Intraosseous Line Placement
		Inpatient Setting Procedures

		Placement and management of arterial lines
		Placement and management of central venous lines and dialysis catheters
		IV immunoglobulin therapy
		Ventilator management (CPAP, BiPAP, and standard ventilator modes)
		Thoracentesis
		Cardioversion
		Pericardiocentesis
		Temporary transvenous pacemaker
		Hemodialysis
		Cancer Chemotherapy

Focused Professional Practice Evaluation (FPPE)/Routine Proctoring Requirements		
AHS Core	**AH**	
		Five (5) retrospective case reviews that are representative of the scope and complexity of privileges requested.

Other Procedural Privileges

Request		***Request all privileges listed below.***
AHS Core	**AH**	Click **shaded blue check box** to Request all privileges. Uncheck any privileges you do not want to request.
		- Currently granted privileges
		Bones and Joints
		Arthrocentesis
		Skeletal procedures including stabilization of fractures, sprains and dislocations including use of immobilization techniques
		Trigger point injection
		Joint injections, including carpal tunnel injection
		Musculoskeletal injections
		Skin
		Wound care including wound closure; selection of specialized dressings; drain insertion and removal; debridement and minor surgical excisions
		Skin excision, including biopsy and lesion removal
		Laceration repair not involving tendons, major vessels, or major nerves
		Incision and drainage or aspiration of palpable, superficial soft tissue mass
		Nail removal
		Ear, Nose, and Throat
		Management of epistaxis including posterior nasal packing
		Dental Block
		Tonometry
		Cautery of anterior nares

		Ear wick placement
		GI/Rectal
		Anoscopy
		Other
		Foreign body removal

Focused Professional Practice Evaluation (FPPE)/Routine Proctoring Requirements		
AHS Core	**AH**	
		Five (5) retrospective case reviews that are representative of the scope and complexity of privileges requested.

Gynecology and Reproductive Health

Qualifications	
Clinical Experience (Initial)	Applicant must provide documentation of provision of clinical services (5 cases) representative of the scope and complexity of privileges requested during the previous year (waived for applicants who completed training during the previous year).
Clinical Experience (Reappointment)	Applicant must provide documentation of provision of clinical services (5 cases) representative of the scope and complexity of privileges requested during the previous 24 months.
Additional Qualifications	IUD placement and removal: documentation of provision of clinical services (10 cases) representative of the scope and complexity of privileges requested during the previous 24 months. - Contraception implant insertion: completion of Clinical Training Program required along with documentation of provision of clinical services (5 cases) representative of the scope and complexity of privileges requested during the previous 24 months.

Request		***Request all privileges listed below.***
AHS Core	**AH**	Click **shaded blue check box** to Request all privileges. Uncheck any privileges you do not want to request.
		- Currently granted privileges
		Pap smear and endocervical culture
		Contraception implant insertion and removal
		IUD placement
		IUD removal
		Prenatal Care

Focused Professional Practice Evaluation (FPPE)/Routine Proctoring Requirements		
AHS Core	AH	
		Five (5) concurrent observation of IUD placement and/or removal
		Five (5) concurrent observation of Contraception implant insertion.

Point of Care Ultrasound

Description: Point of Care Ultrasound is performed to immediately answer specific clinical questions and help establish a diagnosis to expedite the care of patients.

Qualifications	
Education/Training	Documentation of training and experience during Residency in accordance with Society of Hospital Medicine, ACP, American Academy of Family Physicians, or similar medical specialty organizational guidelines. **OR** Physicians who did not receive training during Residency should demonstrate at a minimum 25 proctored ultrasounds per primary indication or a minimum of 150 ultrasounds for Internal Medicine or Critical Care Ultrasound. **OR** Letter from Ultrasound Director certifying training and experience that meet Society of Hospital Medicine, ACP, American Academy of Family Physicians, or similar medical specialty organizational guidelines.
Clinical Experience (Initial)	Applicant must provide documentation of provision of clinical services representative of the scope and complexity of the privileges requested during the previous year (waived for applicants who completed training during the previous year).
Clinical Experience (Reappointment)	Applicant must provide evidence of ongoing clinical practice representative of the scope of POCUS privileges requested during the past 24 months.

Request		***Request all privileges listed below.***
AHS Core	AH	
		Click **shaded blue check box** to Request all privileges. Uncheck any privileges you do not want to request.
		- Currently granted privileges
		Perform and interpret emergent, limited, or investigational ultrasound

Focused Professional Practice Evaluation (FPPE)/Routine Proctoring Requirements		
AHS Core	AH	
		Five (5) retrospective case reviews.

Telemedicine Privileges Inpatient or Outpatient Care

Description: Clinical services are limited to only those aspects of existing privileges granted that can be provided remotely.

Qualifications	
Qualifications	These privileges are intended to support existing specialty privileges for physicians and Advanced Practice Providers who are not otherwise classified as Telemedicine ONLY providers.

Request		***Request all privileges listed below.***
AHS Core	AH	Click **shaded blue check box** to Request all privileges. Uncheck any privileges you do not want to request.
		- Currently granted privileges
		Telehealth initial and follow up consultations
		Virtual Check-ins
		E-Visits

Acknowledgment of Applicant

I have requested only those privileges for which by education, training, current experience, and demonstrated competency I believe that I am competent to perform and that I wish to exercise at Alameda Health System hospital(s) and I understand that:

A. In exercising any clinical privileges granted, I am constrained by applicable Hospital and Medical Staff policies and rules applicable generally and any applicable to the particular situation.

B. Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of the Medical Staff Bylaws or related documents.

Practitioner's Signature _____ Date _____

Department Chair Recommendation - Privileges

I have reviewed the requested clinical privileges and supporting documentation and make the following recommendation(s):

Privilege	Condition/Modification/Deletion/Explanation

Department Chair Recommendation - FPPE Requirements

Signature of Chief/Designee

Date

Signature of Department Chair/Designee

Date

Neurology - Multifacility

Delineation of Privileges

Applicant's Name:

Instructions:

1. Click the **Request** checkbox to request a group of privileges such as *Core Privileges* or a *Special Privileges*.
2. Uncheck any privileges you do not want to request in that group.
3. Check off any special privileges you want to request.
4. Sign form electronically and submit with any required documentation.

Required Qualifications	
Membership	Meet all requirements for Medical Staff membership.
Education/Training	Completion of an ACGME or AOA accredited Residency training program in Neurology.
Certification	Current certification or board eligibility in the examination process leading to certification in Neurology by the American Board of Psychiatry and Neurology or primary certification Neurology by the American Osteopathic Board of Neurology and Psychiatry.
Clinical Experience (Initial)	Applicant must provide documentation of provision of neurology services (50 cases) representative of the scope and complexity of the privileges requested during the previous year (waived for applicants who completed training during the previous year).
Clinical Experience (Reappointment)	Applicant must have provided clinical services (25 cases) representative of the scope and complexity of privileges requested during the past 24 months.
Stroke Care Qualifications	NIH Stroke Scale Certification documentation required at initial request.

Core Privileges in Neurology

Description: Neurology focuses on and specializes in the evaluation and treatment of all types of disease or impaired function of the brain, spinal cord, peripheral nerves, muscles, and autonomic nervous system, as well as the blood vessels that relate to these structures. Disorders include stroke, brain and spinal tumors, muscular dystrophy, headache and other pain, meningitis, encephalitis, epilepsy, Parkinson's disease, Alzheimer's disease, and other memory disorders, multiple sclerosis, and effects of systemic diseases, such as high blood pressure and diabetes, on the nervous system.

Request		***Request all privileges listed below.***
AHS Core	**AH**	Click **shaded blue check box** to Request all privileges. Uncheck any privileges you do not want to request.
		- Currently granted privileges
		Admit to inpatient or appropriate level of care
		Perform history and physical examination
		Evaluate, diagnose, provide consultation, medically manage, and treat patients with acquired or congenital disease, disorders, or impaired function of the neurological system
		Stroke Care (see initial qualification requirement)
		Procedures
		EEG/Video monitoring
		Performance and interpretation of basic neurophysiology tests including EEG and evoked potential studies (auditory, visual, and somatosensory).
		Performance and interpretation of EMG, nerve conduction, and autonomic testing
		Perform muscle or nerve biopsy
		Lumbar puncture including administration of intrathecal medications (without fluoroscopy)

Focused Professional Practice Evaluation (FPPE)/Routine Proctoring Requirements		
AHS Core	**AH**	
		Three (3) retrospective Neurology case reviews that are representative of the scope and complexity of privileges requested.

Telemedicine Privileges Inpatient or Outpatient Care

Description: These privileges are intended to support existing specialty privileges for physicians and Advanced Practice Providers who are not otherwise classified as Telemedicine ONLY providers.

Qualifications	
Qualifications	Clinical services are limited to only those aspects of existing privileges granted that can be provided remotely.

Request		*Request all privileges listed below.*
AHS Core	AH	Click **shaded blue check box** to Request all privileges. Uncheck any privileges you do not want to request.
		- Currently granted privileges
		Telehealth initial and follow up consultations
		Virtual Check-ins
		E-Visits

Acknowledgment of Applicant

I have requested only those privileges for which by education, training, current experience, and demonstrated competency I believe that I am competent to perform and that I wish to exercise at Alameda Health System hospital(s) and I understand that:

A. In exercising any clinical privileges granted, I am constrained by applicable Hospital and Medical Staff policies and rules applicable generally and any applicable to the particular situation.

B. Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of the Medical Staff Bylaws or related documents.

Practitioner's Signature _____ Date _____

Department Chair Recommendation - Privileges

I have reviewed the requested clinical privileges and supporting documentation and make the following recommendation(s):

Privilege	Condition/Modification/Deletion/Explanation

Department Chair Recommendation - FPPE Requirements

Signature of Chief/Designee

Date

Signature of Department Chair/Designee

Date

Pathology - Multifacility Privileges

Delineation of Privileges

Applicant's Name:

Instructions:

1. Click the **Request** checkbox to request a group of privileges such as *Core Privileges* or a *Special Privileges*.
2. Uncheck any privileges you do not want to request in that group.
3. Check off any special privileges you want to request.
4. Sign form electronically and submit with any required documentation.

Required Qualifications	
Membership	Meet requirements for Medical Staff membership.
Education/Training	For initial applicants, effective January 1, 2020, completion of an ACGME or AOA accredited Residency training program in Pathology - Anatomic and Clinical.
Certification	Current certification or board eligibility in Pathology-Anatomic/ Pathology-Clinical by the American Board of Pathology. **OR** Applicants requesting Anatomic Pathology Privileges only, current certification or board eligibility in Pathology-Anatomic-General by the American Board of Pathology or in Anatomic Pathology by the American Osteopathic Board of Pathology. **OR** Applicants requesting Clinical Pathology Privileges only, current certification or board eligibility in Pathology-Clinical-General by the American Board of Pathology or in Clinical Pathology/Laboratory Medicine by the American Osteopathic Board of Pathology.
Clinical Experience (Initial/Reappointment)	Applicant must provide documentation of provision of clinical services representative of the scope and complexity of the privileges requested during the previous 24 months (waived for applicants who completed training during the previous year).
Additional Qualifications	Applicant must have a contract with or be employed by Alameda Health System to provide services for the Department of Pathology and Laboratory Medicine.

Primary Privileges in Pathology - Anatomic and/or Clinical

Description: Pathologists practice medicine by establishing diagnoses, monitoring disease progression and treatment, determining disease risk and cause of death, and overseeing blood and cellular transfusions. They direct the clinical laboratory, provide established analyses, and develop new testing methods using patient tissues, blood, cells, and body fluid specimens. Pathologists serve as expert consultants to other physicians and are integral to patient care decision-making processes.

Request		***Request all privileges listed below.***
AHS Core	AH	Click **shaded blue check box** to Request all privileges. Uncheck any privileges you do not want to request.
		- Currently granted privileges
		Anatomic Pathology: (General anatomical and surgical pathology.)
		Autopsy Pathology - Gross and Microscopic interpretation and consultation
		Cytopathology
		Surgical Pathology - Gross and microscopic, including use of frozen sections, and bone marrow biopsies
		Clinical Pathology: (General clinical pathology including clinical chemistry, hematology, coagulation and urinalysis, immunology and serology, clinical microbiology, blood banking and transfusion medicine, and molecular pathology.)
		Clinical Chemistry
		Hematology, Coagulation and Urinalysis
		Immunology and Serology
		Clinical Microbiology
		Blood Banking and Transfusion Medicine
		Molecular Pathology
		Procedures
		Perform fine needle aspiration of palpable soft tissue mass

Focused Professional Practice Evaluation (FPPE)/Routine Initial Proctoring		
AHS Core	AH	
		Anatomical Pathology: Review of first twenty (20) tissue/cytology pathology reports.
		Anatomical Pathology: Review of first five (5) frozen section diagnoses.
		Clinical Pathology: Review of first twenty (20) interpretations and appropriate clinical consultations/recommendations that are representative of the scope and complexity of privileges requested.
		Review of first three (3) fine needle aspirations.

Acknowledgment of Applicant

I have requested only those privileges for which by education, training, current experience, and demonstrated competency I believe that I am competent to perform and that I wish to exercise at Alameda Health System hospital(s) and I understand that:

A. In exercising any clinical privileges granted, I am constrained by applicable Hospital and Medical Staff policies and rules applicable generally and any applicable to the particular situation.

B. Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of the Medical Staff Bylaws or related documents.

Practitioner's Signature

Date

Department Chair Recommendation - Privileges

I have reviewed the requested clinical privileges and supporting documentation and make the following recommendation(s):

Privilege	Condition/Modification/Deletion/Explanation

Department Chair Recommendation - FPPE Requirements

Signature of Department Chair/Designee

Date

Teleneurology - Multifacility

Delineation of Privileges

Applicant's Name:

Instructions:

1. Select checkbox to request privileges.
2. Sign form and submit with any required documentation.

Required Qualifications	
Licensure	Applicant must be licensed to practice medicine in California.
Education/Training	Completion of an ACGME or AOA accredited Residency training program in Neurology.
Certification	Current certification in Neurology by the American Board of Psychiatry and Neurology or primary certification in Neurology by the American Osteopathic Board of Neurology and Psychiatry.
Clinical Experience (Initial)	Applicant must provide documentation of provision of neurology services (50 cases) representative of the scope and complexity of the privileges requested during the previous year (waived for applicants who completed training during the previous year).
Clinical Experience (Reappointment)	Applicant must have provided clinical services (25 cases) representative of the scope and complexity of privileges requested during the past 24 months.
Stroke Care Qualifications	NIH Stroke Scale Certification documentation required at initial request.
Additional Qualifications	Applicant must be contracted to provide teleneurology services.

TELEMEDICINE - NEUROLOGY

Description: The interpretation and/or consultation by a Neurologist at a remote location.

Request		***Request all privileges listed below.***
AHS Core	AH	Select checkboxes to request all privileges.
		- Currently granted privileges
		Evaluation and treatment of patients 18 years of age or older presenting with emergent neurological illnesses including, but not limited to, acute stroke, stroke, and threatened stroke (TIA or Transient Ischemic Attack)
		Administration of thrombolytics
		Obtaining orderly and detailed history from the patient, family, and staff
		Conducting a thorough and timely neurological examination via two-way audio- and two-way video-conferencing technology
		Reviewing and personally interpreting relevant brain imaging studies
		Reviewing and correlating the results of other relevant diagnostic tests with the patient clinical history and examination to formulate a differential diagnosis and to recommend an evaluation and management plan
		Evaluation and treatment of patients greater than 18 years of age or older, in an inpatient or outpatient setting, presenting with neurological illnesses including, but not limited to, cerebrovascular disease, seizure disorders, movement disorders, mental status changes, demyelinating conditions, peripheral nervous system dysfunction

Focused Professional Practice Evaluation (FPPE)/Routine Initial Proctoring		
AHS Core	AH	
		Three (3) retrospective Teleneurology case reviews that are representative of the scope and complexity of privileges requested.

EEG Procedures

Request		***Request all privileges listed below.***
AHS Core	AH	Select checkboxes to request all privileges.
		- Currently granted privileges
		EEG/Video monitoring

		Performance and interpretation of basic neurophysiology tests including EEG and evoked potential studies (auditory, visual, and somatosensory)

Focused Professional Practice Evaluation (FPPE)/Routine Initial Proctoring		
AHS Core	**AH**	
		Two (2) retrospective case reviews that are representative of the scope and complexity of privileges requested.

Acknowledgment of Applicant

I have requested only those privileges for which by education, training, current experience, and demonstrated competency I believe that I am competent to perform and that I wish to exercise at Alameda Health System hospital(s) and I understand that:

A. In exercising any clinical privileges granted, I am constrained by applicable Hospital and Medical Staff policies and rules applicable generally and any applicable to the particular situation.

B. Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of the Medical Staff Bylaws or related documents.

Practitioner's Signature

Date

Department Chair Recommendation - Privileges

Medical staff rely upon the credentialing verifications made by the distant-site telemedicine entity when making recommendations on privileges for the individual distant-site physicians through its written agreement with the distant-site telemedicine entity.

Privilege	Condition/Modification/Deletion/Explanation

Department Chair Recommendation - FPPE Requirements

Signature of Chief/Designee

Date

Signature of Department Chair/Designee

Date

C. Medical Staff Reports

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

SUBJECT: **Agenda Item:** B

Meeting Date: May 28, 2025
Item Description: Medical Staff Executive Committee Combined Report

FROM: Bhrett Lash, M.D., Alameda Health System Vice Chief of Staff
Catherine Pyun, D.O., Alameda Hospital Chief of Staff

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

Federal & State Budget Landscape

The combined Medical Executive Committee (MEC) was presented an overview of Federal & State Budget Landscape Implications For Public Health Care Systems by Erica Murray, President & CEO, California Association of Public Hospitals.

Intersection of Medical Staff Governance and Employment

The combined Medical Executive Committee (MEC) was presented with education on the Intersection of Medical Staff Governance and Employment by Ann Mary Olson, Sr. Assoc. General Counsel. The report highlighted the background and structure that we are one system with multiple legal entities. This included the reporting structure of the system and the Medical Staffs in accordance with the governance structure of the Board, Medical Staff Bylaws and Policies and Procedures.

AHS Medical Staff Quality & Safety Committee

The committee reported on the Quality Objectives and Key Results (ORK)/ Key Performance Indicators (KPI) Dashboards with March 2025 data.

1. **Quality Objectives and Key Results Dashboards (Feb 2025)** —33 harm events (falls, HAPI, behavioral events with physical injury) were reported. ED Boarding Time for Admitted Patients performance slightly increased, HGH 13.35 hours were reported for February 2025, above goal of 8:32. For SLH, 3.19 hours, above goal of 2.20 hours.
2. **Stroke Program Certification Survey** — As of March 2025, 70% of HGH stroke inpatients had a data order set used, an average of 84% received a swallow screen, and 100% received individualized stroke patient education. Action plan includes Charge Nurses and Assistant Nurse Managers to review stroke list in EPIC, continue to reinforce process in shift huddles, and develop a Stroke dashboard. Stroke patients boarded in the ED trended up and intracranial hemorrhage mortalities remained at 0%.

ALAMEDA HEALTH SYSTEM

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

AHS Medical Staff Patient Safety Committee

The committee reported on the causes, contributing factors and process improvement plans of three Root Cause Analysis.

AHS Clinical Practice Committee

The Medical Executive Committee (MEC) reviewed and approved multiple policies and physician order sets, which have been included in the QPSC consent agenda for Board approval.

AHS & AH Department of Surgery Report

Dr. Greg Victorino, MD provided the annual report highlighting the Department's Strengths, Weaknesses, Opportunites and Threats. These align with a focus on the Department's Quality and Patient Safety, Structure, and Operations.

Strengths

- Surgery Divisions
- Level 1 Trauma Center
- Eastmont Dental Expansion
- Expanding Vascular Services
- EPIC Physician Builder
- GPR Dental Residency
- OMFS Residency
- General Surgery Residency

Weakness

- Incomplete coverage for all surgical subspecialties at all 3 sites
- Incomplete coverage for Vascular Surgery at HGH

Opportunities

- Billing
- Surgical Robot
- Cancer Center

Threats

- Interventional Radiology
- Surgical Referrals

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

AH Medical Staff

The Medical Executive Committee discussion identified facility-specific concerns impacting access, patient care, and operations, including:

- Patient transfers and nurse staffing challenges
- Limited availability of specialty consults – Urology
- Inconsistent downtime notifications for imaging services (Ultrasound, MRI, CT)

D. Quality Reports

BOT Executive Summary: Quality Report
Ana Torres, Vice President of Quality
May 28, 2025

Key Point 1: Five of the eight metrics on the OKR Dashboard met or performed better than baseline.

	Performance		
Key Result	**Met goal**	**≥ Baseline**	**Did not meet goal**
Total Patient Harms			✓
Sepsis Mortality (O/E)		= baseline	
Readmission, All Cause			✓
Waitlist Time – New Primary Care	✓		
ED Boarding – Community Hospitals		✓	
ED Boarding- WCHGH		✓	
Health-Related Social Needs Assessment Screening		✓	
Likelihood to Recommend			✓

The Harm, Readmission, and Likelihood to Recommend are underperforming.

HARMS

- There were no Hospital Acquired Infections (HAIs) across the system from December through February 2025.
- Hospital Acquired Pressure Injuries (HAPI) are the most frequented reported harm. HAPI events peaked in December but have decreased the following three months.

READMISSIONS

Alameda Hospital and San Leandro Hospital are not meeting the goal. Alameda Hospital readmissions are primarily due to pain management needs and readmissions from SNFs. San Leandro Hospital readmissions are primarily patients with pain management needs and substance abuse disorder. The readmissions team has developed targeted action plans. SNF readmissions are being addressed through the SNF Collaborative. Pain management and substance use readmissions are being addressed by improving palliative care and pain management needs.

LIKELIHOOD TO RECOMMEND:

None of the hospitals met the Likelihood to Recommend goal for inpatient care.
The improvement plan is focused on addressing responsiveness of staff, leader rounding, the discharge communication process which addresses several patient satisfaction areas, continued huddles around use of GIFT, and standards of behavior with accompanying customer service in-service training.

Key Point 2: AHS has achieved successes at the individual hospital level.

Improvement Goal = 50% gap closure to the benchmark
Benchmark Goal = CMS 50th percentile; 20% improvement from baseline (HAPI, Behavior Events); national mean (sepsis mortality); 75th percentile (Patient Experience)

Highland

- No central line associated bloodstream infections (CLABSI) for FYTD 2025.
- No catheter associated urinary tract infections (CAUTI) in over 90 days.
- Falls with Injury is on track to achieve the improvement goal.
- Readmissions for FYTD is better than the benchmark goal.
- Likelihood to Recommend for ED and Ambulatory Surgery is better than the improvement goal.

Alameda Hospital

- No CLABSI, CAUTI or MRSA for the past two fiscal years.
- C. difficile infection is on track to achieve the benchmark goal.
- Falls with Injury is on track to achieve the benchmark goal.
- Likelihood to Recommend for ED is better than the improvement goal.

San Leandro Hospital

- No CAUTI and CLABSI events this fiscal year.
- Fall with Injury rate is on track to achieve improvement goal.
- Health Care Related Social Needs Screening is better than the benchmark goal.
- Likelihood to Recommend for ED and Ambulatory Surgery is better than the improvement goal.

John George Hospital

- Behavior Events with Injury is on track to meet the improvement goal.

Key Point 3: Regulatory activity for April 2025 included self-reported events and regulatory visits.

The following regulatory activities occurred in April 2025:

- Self-reported events: There were three self-reported events. One each from San Leandro Hospital, Highland Hospital, and John George Hospital.
- Surveys:
    - A four-day unannounced CDPH/CMS Validation survey at Highland Hospital and John George Hospital.
    - A five-day unannounced CMS EMTALA survey at Highland Hospital.
    - National Committee for Quality Assurance (NCQA) Accreditation virtual survey.
    - Alameda Alliance Facility Site Review at Highland and Eastmont Wellness Center.

May
2025

Regulatory Affairs QPSC Report

- OPEN Session

Nilda Perez – System Director of Regulatory Affairs
ALAMEDA HEALTH SYSTEM

I. Regulatory Events Summary – OPEN Session

A. Site Visits and Complaints

1. Highland Hospital and John George Psychiatric Hospital: combined CMS & CDPH Complaint Validation Survey 04/07/25 – 4/10/25. Categories surveyed: Nursing Services, Pt. Rights, Pharmacy Services
   There were 3 State (CDPH) and 2 Federal (CMS) complaints investigated. The survey concluded with deficiencies cited under Medication Management. AHS is pending official report in the CMS 2567 from CMS and CDPH. John George Psychiatric Hospital Leadership have begun the immediate corrective actions related to addressing patient pain levels per provider orders.

2. The National Committee for Quality Assurance (NCQA) Accreditation 04/21/2025 – 04/22/2025 virtual survey.

3. Highland Hospital 04/28/2025 – 05/02/2025 CMS EMTALA Survey: Highland Emergency Department, PACU, Family Birthing Center. *Outcome of the survey pending.*

4. Alameda Alliance Facility Site Review (FSR) site visits. Highland Hospital 03/17/2025 & Eastmont Wellness Center 04/29/2025.

B. CDPH Self-Reported Events

1. 04/04/25 – San Leandro Hospital – Hospital Acquire Pressure Injury

2. 04/09/25 – Highland Hospital – Patient Allegation of Sexual Assault

3. 04/11/25 – John George Psychiatric Hospital – Assault

C. Joint Commission Complaints

1. No Joint Commission Complaints in April 2025.

D. Joint Commission Sentinel Events

1. No Joint Commission Sentinel Events reported in April 2025.

E. Joint Commission Survey

1. No Joint Commission Surveys in April 2025.

F. AHS Licensing Projects

1. No active licensing projects currently.

FY 2025 QPSC OKR Dashboard

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.

Safe Care - Caring, Healing, Teaching All		Performance			Goals		
OBJECTIVES	KEY RESULTS	Feb 2025	FY25 YTD	FY2024 Actual	Improvement	Benchmark	Accountable Leaders
Provide safe care	Total Patient Harms*	41	365	410	353	293	R. Lofton, E. Mahler
	Sepsis Mortality O/E Ratio	1.11	1.05	1.05		1.04	R. Lofton, E. Mahler
Timely, Effective, and Efficient Care							
OBJECTIVES	KEY RESULTS	Feb 2025	FY25 YTD	FY2024 Actual	Improvement	Benchmark	Accountable Leaders
Promote wellbeing	All Cause 30-day readmission rate	13.90%	12.43%	12.05%	11.56%	11.12%	D. Littlepage, E. Mahler
Provide accessible care	Waitlist time - New Primary Care Adult	91	61	94	71	30	T. Fitzgerald-Shaw, P. Mack
	ED Boarding Time for Admitted Patients Community Hospital	3:10	3:01	3:10	2:20	1:30	R. Lofton, A.Wu
	ED Boarding Time for Admitted Patients Highland	16:56	13:03	13:05	8:30	4:00	R. Lofton, A. Wu
Equitable Care							
OBJECTIVES	KEY RESULTS	Feb 2025	FY25 YTD	FY2024 Actual	Improvement	Benchmark	Accountable Leaders
Serving all: Deliver equitable care	Health-related Social Needs Assessment Completed on Inpatients	72.50%	70.70%	64.58%	75.00%	90.00%	R. Lofton
Patient-Centered Care							
OBJECTIVES	KEY RESULTS	Feb 2025	FY25 YTD	FY2024 Actual	Improvement	Benchmark	Accountable Leaders
Be the most welcoming system to receive care	Likelihood to recommend care composite	77.39%	77.17%	77.24%	78.28%	79.16%	R. Lofton, A. Ng

Fiscal Year Starts in July 1 and Ends June 30

FY25 YTD is results from July 2024 to FY25YTD

* AHS' ultimate goal is Zero Hospital Acquired Harm

Fiscal Year 2025

OKR Metric Definitions for QPSC

Metric	Definition	GOAL	
		Improvement	Benchmark
Patient Harm	The number of potential health-care acquired patient harms Includes: CLABSI, CAUTI, MRSA BSI, C-Diff, SSI for Acute Med-Surg/Critical Care, and Patient Falls with injuries, Hospital Acquired Pressure Injuries and Behavior Events that result in Injury for all areas (practically, not inclusive of ambulatory)	353 50% gap reduction to the 50th Percentile	293 NHSN 2022 50th Percentile
Sepsis Mortality O/E Ratio	The observed to expected (O:E) sepsis mortality ratio is a comparison of the actual number of sepsis-related deaths in a hospital (observed) to the predicted number of deaths (expected). Performance is considered better than expected if the O:E ratio is less than 1, and worse than expected if the ratio is greater than 1. A lower O:E ratio indicates that more people are surviving conditions that would otherwise be fatal.	NA	1.04 National Mean per Vizient
All-cause 30 day Readmissions Rate	Percentage of inpatient acute med-surg encounters, regardless of payer type, with an unplanned readmission to any AHS facility within 30 days for any cause among encounters for acute care inpatients with a principal discharge diagnosis/procedure for a clinical classification category in the Cardiorespiratory, Cardiovascular, Medicine, Neurology, or Surgery/Gynecology cohort. *Note:* This measure approximates, but likely does not match, the value of the corresponding CMS readmission measure.	11.56% 50% gap reduction to the 50th Percentile CMS Hospital Compare	11.12% 50th Percentile CMS Hospital Compare
Waitlist time - New Primary Care Adult	The amount of days between when a new patient to AHS requests an intial primary care appointment to the day of appointment.	84 Days 25% Reduction	30 Days Eliminates waitlist as most clinics schedule up to 30 days out
ED Boarding Time Time in ED from Decision to Admit to Inpatient Bed	Median time from Decision to Admit to departure from the emergency department for admitted patients. Decision to Admit = First Admit Disposition Admit = Time patient admitted to Inpatient Unit	2:20 Community Hospitals: 50% gap closure to pre=pandemic performance 8:30 Highland: 50% gap closure to TJC benchmark	1:30 Community Hospitals: Pre-pandemic Performance 4:00 Highland: TJC guidance for max boarding time
Rate of Inpatients screened for health-related social needs (food, housing, transportation, safety, utilities) ↑	The percentage of inpatient acute medical/surgical admissions where the patient is screened for social determinents of health: food insecurity, housing, transportation, safety and utilites	75% Internal Benchmark: Best Performing Campus rate for FY24	90% Internal Benchmark: Monthly Rate achieve by Best Performing Campus
Rate of patients who reported they would “definitely” recommend AHS	Percentage of patients who would recommend AHS (includes rehab, acute, ambulatory, ED, outpatient surgery, dental, radiology)	78.78% 2% Improvement over FY24 Baseline	79.16% 75th Percentile for Inpatient Med Surg 50th Percentile for all other areas based on Press Ganey National Database

QPSC BOT Executive Summary: Post-Acute Quality Report
Richard Espinoza, NHA, CAO Post-Acute Services
5/28/25

Key Point 1: **Quality Star ratings – Overall and Quality Measures:**
All Skilled Nursing Facilities/Sub-Acute (SNF/SA) sites 5-star CMS rated for Overall Quality.

New quality metrics released from CMS,

Fairmont achieved 5 stars in every CMS category – the highest outcome possible.

The top 10% of skilled nursing facilities in the United States receive a 5-star rating from the Centers for Medicare and Medicaid Services (CMS)

Key Point 2: **New CMS Metrics** – teams focused on short stay flu and pneumonia prevention – low Medicare payors sway percentages, reducing QM star.

Key Point 3: **New CMS Metrics -** In many of the new metrics, we do not have enough Medicare residents to be weighted – disadvantages the facilities – lower score**,** reducing QM star.

Key Point 4: **CDPH/CMS visits** – non to AHS sites – St. Rose had a federal survey with no findings and a Life Safety CDPH visit with 3 findings – state average is 6.9 findings**.**

Key Point 5: **AHS support to St. Rose Sub-Acute:**
CAO of PA and Director of Executive Clinical Operations leadership
Several accomplishments made by the St. Rose team. Several surveys passed successfully. CDPH recommends certification to CMS.

Key Point 6: **ARU dashboard:**
8 metrics meet or surpassed of 11 metrics.
3 not meet:

- External % - more internal referrals received.
- Functional efficiency: has been increasing and continues to move in the right direction.
- D/C to community: clinically complex patients and SDOH affect this metric.

Key Point 7: **ARU Admission sources**: 63.5% of admissions come from within AHS.

E. FY 2026 OKR Metric Discussion

OKR Metric Planning FY2026

EXECUTIVE SUMMARY

Alameda Health System is committed to continuous quality improvement in pursuit of its strategic objective to be a *Safe Place to Receive Exceptional and Compassionate Care*. To this end the following revisions to the FY25 Quality OKR metrics are recommended for FY26.

The table below demonstrates the AHS Quality Objectives, the quantifiable Key Results that measure our progress towards our objectives, a definition of the key result, the link between the key results and industry standards and best practice, and recommendation to **keep**, **revise**, or remove key results for Fiscal Year 2026.

Summary of recommendations by OKR domain:

1) Safe Care - Caring, Healing, Teaching All
    a. Total Patient Harms – **Revise** Reportable HAPIs - Focus 6 Surgical Categories for SSI (Colon, C-Section, Gallbladder, Hysterectomy, Spinal Fusion, Small Bowel)
    b. Sepsis mortality O/E ratio – **Keep**

2) Timely, Effective, and Efficient Care
    a. All-Cause 30-day Readmission Rate – **Keep**
    b. Waitlist Time New Primary Care Adult
        i. **Revise** the Key Result to include new specialty referrals
        ii. **Revise** the goal: % of Primary Care Clinics at Goal / % of Specialty Clinics at Goal
    c. ED Boarding Time for Admitted Patients – **Keep**

3) Equitable Care
    a. Health Related Social Needs Assessments
        i. **Revise** to include hospital outpatient encounters
        ii. **Add** second outcome - Screening Positivity Rate

4) Patient-Centered Care
    a. Likelihood to Recommend Care Composite – **Keep**

OKR Metric Planning FY2026

OBJECTIVES	KEY RESULTS	Definition	Strategic Key Results Link	Recommendation
Safe Care - Caring, Healing, Teaching All				
Provide safe care	Total Patient Harms	The number of potential healthcare acquired patient harms Includes: CLABSI, CAUTI, MRSA BSI, C-Diff, SSI, Patient Falls with injuries, Hospital Acquired Pressure Injuries and Behavior Events that result in Injury	Leapfrog, CMS Star Rating, HAC Penalty, QIP	**Revise** Reportable HAPIs, Focus 6 Surgical Categories for SSI (Colon, C-Section, Gallbladder, Hysterectomy, Spinal Fusion, Small Bowel)
	Sepsis Mortality O/E Ratio	The observed to expected ratio is a comparison of the actual number of sepsis-related deaths in a hospital (observed) to the predicted number of deaths (expected).	CMS Star Rating	**Keep**
Timely, Effective, and Efficient Care				
Promote wellbeing	All Cause 30-day readmission rate	Percentage of inpatient acute med-surg encounters, regardless of payer type, with an unplanned readmission to any AHS facility within 30 days for any cause for acute care inpatients	CMS Star Rating, Readmission Penalty	**Keep**
Provide accessible care	Waitlist time - New Primary Care Adult and New Specialty Referral	The amount of days between when a new patient to AHS requests an initial primary care appointment or is referred for a new specialty appointment to the day of appointment.	Ambulatory Access	**Revise** % of Primary Clinics at Goal % of Specialty Clinics at Goal
	ED Boarding Time for Admitted Patients Community/ HGH	Median time from Decision to Admit to departure from the emergency department for admitted patients.	CMS Star Rating	**Keep**

ALAMEDA HEALTH SYSTEM

OKR Metric Planning FY2026

Equitable Care				
Serving all: ~~Deliver equitable care~~ Deliver Whole Person Care	Health-related Social Needs Assessment Completed on Hospital Inpatient and Outpatient Encounters	The percentage of inpatient acute medical/surgical admissions where the patient is screened for social determinants of health: food insecurity, housing, transportation, safety and utilities	Process Readmissions Link Stewardship: Grow and optimize resources for the patient care continuum to meet the community need	**Revise** Expand to Hospital Based Outpatient Encounters (ED, OBS, Same Day Surgery, Imaging, Testing) **Add 2nd Metric** Screening Positivity Rate
Patient-Centered Care				
Be the most welcoming system to receive care	Likelihood to recommend care composite	Percentage of patients who would recommend AHS (includes rehab, acute, ambulatory, ED, outpatient surgery, dental, radiology)	Leapfrog, Star Rating	**Keep**

BOT Executive Summary: Perioperative Services Update – May 28, 2025

Submitted by: Jaimie Weber, System Director, Perioperative Services

Date: May 28, 2025

Key Point 1: Strategic Alignment of Perioperative Services

Ongoing efforts to align perioperative practices with national standards (AORN, ASPAN) and internal strategic goals. Ensures consistency, safety, and quality across all sites. Standardized policies, education, and service line optimization are foundational to improving patient outcomes and operational efficiency.

Key Point 2: Operational and Quality Metric Improvements

Focus on key metrics such as Surgical Site Infections (SSI), block utilization, first case on-time starts (FCOTS), and turnover time (TOT). These metrics directly impact patient safety, satisfaction, and system efficiency. Dashboards and scorecards are being revised to improve transparency and accountability. FTI Consulting is assisting with creation of physician-specific scorecards to benchmark their metrics to the service lines and system.

Key Point 3: Surgical Site Infection (SSI) Reduction Initiatives

A dedicated SSI workgroup has implemented documentation improvements, Epic optimization, and procedural bundles and best practices. SSIs are a major quality and safety concern. Early results show a reduction in events. The group is expanding its focus to additional procedures and aims to reduce the Standardized Infection Ratio (SIR) to system goals and national benchmarks.

Key Point 4: Enhancing Patient and Family Experience

New leader rounding protocols, patient/support person surveys, and Epic-based communication tools. Patient satisfaction is a core quality metric. Discharge-related satisfaction scores are trending positively, with a goal to sustain Top Box Scores above 88%.

Key Point 5: Enhanced Charge Capture

An opportunity to ensure industry-standard procedure level charges was identified. An updated procedure complexity matrix was implemented and the system procedure catalogue was reviewed and updated. An additional level was created to capture trauma cases. This was implemented with the March 26, 2025 Epic upgrade. It has shown significant charge capture improvements compared to previous state. FY25 April showed just over $2M compared to the previous charge averages through this change alone.

Key Point 6: Capital Projects and Technology Integration

Investments in Sterile Processing Department (SPD) remodels, planning for robotic surgery expansion, and a hybrid OR are in process or under evaluation to support advanced surgical capabilities and standard of care practices. Investments in material management organization and standardization aim to reduce waste and improve charge capture, documentation. These initiatives are expected to enhance both clinical outcomes and operational efficiency.

Ageda Item C, Medical Staff Reports Presentation

Alameda Health System
and
Alameda Hospital
Medical Executive Committee
Report to
Quality Professional Services Committee of the Board

Bhrett Lash, MD, AHS Vice Chief of Staff

Cathy Pyun, DO, AH Chief of Staff

Federal and State Budget Landscape

Presentation from Erica Murray, President & CEO, California Association of Public Hospitals

Presented an overview of Federal and State Budget Landscape Implications

Intersection of Medical Staff Governance and Employment

Presentation by Ann Mary Olson, Sr. Assoc General Counsel, AHS

Highlighted the background and structure that we are one system with multiple legal entities.

Reviewed reporting structure of AHS and Medical Staffs in accordance with:
- Governance structure of the Board
- Medical Staff Bylaws, Policies and Procedures

AHS Medical Staff Quality and Safety Committee – March 2025

OKR Dashboards

(Feb 2025)

33 harm events (falls, HAPI, behavioral events with physical injury)

ED boarding time for Admitted Patients performance slightly increased

- HGH 13.35 hours (Goal: 8.32)
- SLH 3.19 hours (Goal: 2.20)

Stroke Program Certification (March 2025)

70% of HGH stroke inpatients had data order set used

84% received swallow screen

100% received individualized stroke patient education

Staff education Action Plan implemented

Stroke patients boarded in ED trended up

Intracranial hemorrhage mortalities remain 0%

AHS Medical Staff Patient Safety Committee– March 2025

- Report on causes, contributing factors, and improvement plans of three Root Cause Analysis.

AHS Clinical Practice Committee – March 2025

- Reviewed and approved multiple policies and physician order sets, which have been included in the consent agenda for Board approval.

AHS and AH Department of Surgery Report
Dr. Gregory Victorino, MD

The Surgery Department's annual report was presented in a SWOT (Strengths, Weaknesses, Opportunities, Threats) format to succinctly highlight key insights and strategic considerations.

Strengths

- Surgery Divisions
- Level 1 Trauma Center
- Eastmont Dental Expansion
- Expanding Vascular Services
- EPIC Physician Builder
- GPR Dental Residency
- OMFS Residency
- General Surgery Residency

Weaknesses

- Incomplete coverage for all surgical subspecialties at all 3 sites
- Incomplete coverage for Vascular Surgery at HGH

AHS and AH Department of Surgery Report – Cont.

Opportunities

- Billing
- Surgical Robot
- Cancer Center

Threats

- Interventional Radiology
- Surgical Referrals

Alameda Hospital Medical Staff

Operational and Patient Care Concerns

- **Access & Staffing:**
  - Challenges with patient transfers
  - Ongoing nursing staffing constraints
- **Specialty Coverage:**
  - Limited availability of urology consults
- **Imaging Services:**
  - Inconsistent downtime notifications for Ultrasound, MRI, and CT impacting care coordination

Addendum Item D, OKRs

Alameda Hospital FY 2025 Detailed Quality OKR and KPI Dashboard

Vision: Alameda Health System will be recognized as a world-class patient and family centered system of care that promotes wellness, eliminates disparities and optimized the health of our diverse communities.

Safe Care - Caring, Healing, Teaching All			Performance			FY25 Goals		
OBJECTIVES	KEY RESULTS	Detailed KPIs	Feb 2025	FY25 YTD	FY24 Actual	Improvement	Benchmark	Accountable Leaders
Provide safe care	Eliminate Patient Harms	Total Patient Harms	3	55	38	28	22	
		CLABSI # Events/SIR	NA/0	0/0	0/0	0/0.378	1/0.756	
		CAUTI # Events/SIR	NA/0	0/0	0/0	0/0.323	1/0.646	
		MRSA # Events/SIR	NA/0	0/0	0/0	0/0.397	0/0.793	
		C. Difficile # Events/SIR	NA/0	2/0.55	8/81.48	5/0.944	2/0.417	
		SSI # Events/SIR	NA/0	1/1.81	0/0	0/0.38	0/0.756	
		Falls with Injury/% Per 1000 Days	1/0.85	6/0.33	13/0.94	9/0.71	6/0.49	
		HAPI #/% per 1000 Discharges	1/4.032	40/21.69	15/4.98	11/3.89	10/3.46	
		Behavior Events with Physical Injury	1/0.85	6/0.66	2/0.03	1/0.13	1/0.11	
		Serious Safety Events (F or Greater)	0	0	0			
	Reduce Mortality from Sepsis	Sepsis Mortality Observed:Expected & Total Deaths	Pending	1.05	1.04		1.04	
		Bundle Compliance Sepsis Early Management	77.78%	71.83%	51.10%			
	Embed Critical Behaviors	Hand Hygiene Compliance	78.95%	85.39%	83.30%			

Fiscal Year Starts in July 1 and Ends June 30

FY25 YTD is results from July 2024 to Feb 2025

Timely, Effective, and Efficient Care			Performance			FY25 Goals		
OBJECTIVES	KEY RESULTS	Detailed KPIs	Feb 2025	FY25 YTD	FY24 Actual	Improvement	Benchmark	Accountable Leaders
Promote wellbeing	Provide the right care at the right time	All Cause 30-Day Readmission Rate	13.78%	16.12%	14.42%	12.46%	11.12%	
Provide accessible care	Minimize Time Spent Waiting for our Patients	ED Boarding Time for Admitted Patients	3:41	3:05	3:15	2:20	1:30	
Equitable Care			Performance			FY25 Goals		
OBJECTIVES	KEY RESULTS	Detailed KPIs	Feb 2025	FY25 YTD	FY24 Actual	Improvement	Benchmark	Accountable Leaders
Serving all: Deliver equitable care	Health-related social needs recognized and addressed	Health-related social needs assessment completed on inpatients	46.40%	44.00%	38.67%	75%	90%	
		Health-related social needs referrals placed	NA	NA	NA	Pending	Pending	
Patient-Centered Care			Performance			FY25 Goals		
OBJECTIVES	KEY RESULTS	Detailed KPIs	Feb 2025	FY25 YTD	FY24 Actual	Improvement	Benchmark	Accountable Leaders
Be the most welcoming system to receive care	Optimize performance regarding patient experience	Likelihood to recommend Acute	61.11%	59.96%	64.62%	65.91%	77.80%	
		Likelihood to recommend ED	54.76%	65.60%	58.92%	60.02%	70.10%	
		Communication with Nurses	82.46%	67.79%	72.89%	74.35%	76.41%	
		Communication with Providers	77.19%	76.02%	79.13%	80.71%	83.40%	

Fiscal Year Starts in July 1 and Ends June 30

FY25 YTD is results from July 2024 to Feb 2025

Fiscal Year 2025

OKR Metric Definitions for QPSC

Metric	Definition	GOAL	
		Improvement	Benchmark
Patient Harm	The number of potential health-care acquired patient harms Includes: CLABSI, CAUTI, MRSA BSI, C-Diff, SSI for Acute Med-Surg/Critical Care, and Patient Falls with injuries, Hospital Acquired Pressure Injuries and Behavior Events that result in Injury for all areas (practically, not inclusive of ambulatory)	50% gap reduction to the 50th Percentile	NHSN 2022 50th Percentile NDNQI 50th Percentile
CLABSI # Events/ SIR	A primary bloodstream infection (that is, there is no apparent infection at another site) that develops in a patient with a central line in place . #: Number of infections that occurred SIR: Standardized Infection Ratio compares the actual number of infections to the predicted number of infections. The predicted number is risk adjusted. Results less 1 are desirable	50% gap reduction to the 50th Percentile	NHSN 2022 50th Percentile
CAUTI # Events/ SIR	an infection of the urinary tract caused by a tube (urinary catheter) that has been placed to drain urine from the bladder. #: Number of infections that occurred SIR: Standardized Infection Ratio compares the actual number of infections to the predicted number of infections. The predicted number is risk adjusted. Results less 1 are desirable	50% gap reduction to the 50th Percentile	NHSN 2022 50th Percentile
MRSA # Events/ SIR	Potential hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA) staph infection that is difficult to treat because of resistance to some antibiotics. #: Number of infections that occurred SIR: Standardized Infection Ratio compares the actual number of infections to the predicted number of infections. The predicted number is risk adjusted. Results less 1 are desirable	50% gap reduction to the 50th Percentile	NHSN 2022 50th Percentile
C. Difficile # Events/ SIR	Potential hospital acquired infection that causes diarrhea and colitis (an inflammation of the colon). #: Number of infections that occurred SIR: Standardized Infection Ratio compares the actual number of infections to the predicted number of infections. The predicted number is risk adjusted. Results less 1 are desirable	50% gap reduction to the 50th Percentile	NHSN 2022 50th Percentile
SSI # Events/ SIR	an infection that occurs after surgery in the part of the body where the surgery took place. Excludes superficial infections. Attributed to date of procedure. #: Number of infections that occurred attributed to month procedure performed SIR: Standardized Infection Ratio compares the actual number of infections to the predicted number of infections. The predicted number is risk adjusted. Results less 1 are desirable	50% gap reduction to the 50th Percentile	NHSN 2022 50th Percentile
Falls with Injury/ # % Per 1000 Days	Patient Fall reported via Midas Safety Alert. # of Events / Rate: Number of events divided by number of patient days times 1000	50% gap reduction to the 50th Percentile	NDNQI 50th Percentile
HAPI #/ % per 1000 DCs	Hospital Acquired Pressure Ulcers reported via Midas Safety Alert. # of Events / Rate: Number of events divided by number of patient discharges times 1000	10% improvement as compared to Fiscal Year 2024	20% improvement as compared to Fiscal Year 2024
Behavior Events with Physical Injury	Behavior events that resulted in physicial injury via Midas Safety Alerts # of Events/Rate: Number of events divided by number of patient days times 1000	10% improvement as compared to Fiscal Year 2024	20% improvement as compared to Fiscal Year 2024
Serious Safety Events (F or Greater)			

Fiscal Year 2025

OKR Metric Definitions for QPSC

Metric	Definition	GOAL	
		Improvement	Benchmark
Sepsis Mortality O/E Ratio	The observed to expected (O:E) sepsis mortality ratio is a comparison of the actual number of sepsis-related deaths in a hospital (observed) to the predicted number of deaths (expected). Performance is considered better than expected if the O:E ratio is less than 1, and worse than expected if the ratio is greater than 1. A lower O:E ratio indicates that more people are surviving conditions that would otherwise be fatal.	NA	1.04 National Mean per Vizient
Bundle Compliance Sepsis Early Management	A set of guidelines that hospitals use to manage patients with severe sepsis or septic shock. The guidelines focus on early recognition and intervention to save lives and limbs. This is an "all-or-nothing" measure, meaning that hospitals must adhere to all elements of the bundle to receive credit. Follows CMS/TJC SEP 1 Definition		
Hand Hygiene Compliance	Hand hygiene is a leading way to reduce the spread of pathogens in healthcare settings. It includes: Washing hands with soap and water and Using an antiseptic handrub. Hand hygiene compliance is the percentage of times that a person performs hand hygiene when an opportunity arises. It's calculated by dividing the number of hand hygiene actions performed by the total number of opportunities.		
All-cause 30 day Readmissions Rate	Percentage of inpatient acute med-surg encounters, regardless of payer type, with an unplanned readmission to any AHS facility within 30 days for any cause among encounters for acute care inpatients with a principal discharge diagnosis/procedure for a clinical classification category in the Cardiorespiratory, Cardiovascular, Medicine, Neurology, or Surgery/Gynecology cohort. *Note:* This measure approximates, but likely does not match, the value of the corresponding CMS readmission measure.	50% gap reduction to the 50th Percentile CMS Hospital Compare	50th Percentile CMS Hospital Compare
NTSV Cesarean Section Rate	he NTSV C-section rate is the percentage of live babies born to women in their first pregnancy who meet the following criteria: Born at or after 37 weeks gestation Singleton (no twins or more) In the vertex presentation (no breech or transverse positions)		
ED Boarding Time Time in ED from Decision to Admit to Inpatient Bed	Median time from Decision to Admit to departure from the emergency department for admitted patients. Decision to Admit = First Admit Disposition Admit = Time patient admitted to Inpatient Unit	2:20 Community Hospitals: 50% gap closure to pre=pandemic performance 8:30 Highland: 50% gap closure to TJC benchmark	1:30 Community Hospitals: Pre-pandemic Performance 4:00 Highland: TJC guidance for max boarding time
Rate of Inpatients screened for health-related social needs (food, housing, transportation, safety, utilities) ↑	The percentage of inpatient acute medical/surgical admissions where the patient is screened for social determinents of health: food insecurity, housing, transportation, safety and utilites	75% Internal Benchmark: Best Performing Campus rate for FY24	90% Internal Benchmark: Monthly Rate achieve by Best Performing Campus
Health-related social needs referrals placed	A "health-related social needs referral" means directing a patient to a community service or organization that can address social issues impacting their health, such as food insecurity, housing instability, lack of transportation, or financial hardship, identified through a screening process within a healthcare setting; essentially, referring a patient to support that can help address social factors that could be affecting their health outcomes.	TBD	TBD
Acute: Rate of patients who reported they would “definitely” recommend AHS	Percentage of discharged inpatients who would recommend AHS	2% improvement as compared to Fiscal Year 2024	75th Percentile per Press Ganey
Same Day Surgery:Rate of patients who reported they would “definitely” recommend AHS	Percentage of same day surgery patients who would recommend AHS	2% improvement as compared to Fiscal Year 2024	50th Percentile per Press Ganey

Fiscal Year 2025

OKR Metric Definitions for QPSC

Metric	Definition	GOAL	
		Improvement	Benchmark
Emergency: Rate of patients who reported they would “definitely” recommend AHS	Percentage of Emergency patients who would recommend AHS	2% improvement as compared to Fiscal Year 2024	50th Percentile per Press Ganey
Communication with Nurses	A domain of HCAHPS which measures patients' perceptions of how well patients feel that their nurses: explained things clearly, listened carefully, and treated the patient with courtesy and respect. Percent of surveyed Inpatient discharges where patient response was highest of the scale	2% improvement as compared to Fiscal Year 2025	50h Percentile per Press Ganey
Communication with Providers	A domain of HCAHPS which measures patients' perceptions of how well patients feel that their provider(s): explained things clearly, listened carefully, and treated the patient with courtesy and respect. Percent of surveyed Inpatient discharges where patient response was highest of the scale	2% improvement as compared to Fiscal Year 2026	Per Press Ganey Community Hospitals: 75th Percentile Highland Hospital: 90th Percentile

Ambulatory FY 2025 Detailed Quality OKR and KPI Dashboard

Vision: Alameda Health System will be recognized as a world-class patient and family centered system of care that promotes wellness, eliminates disparities and optimized the health of our diverse communities.

Safe Care - Caring, Healing, Teaching All			Performance			FY25 Goals		
OBJECTIVES	KEY RESULTS	Detailed KPIs	Feb 2025	FY25 YTD	FY24 Actual	Improvement	Benchmark	Accountable Leaders
Provide safe care	Eliminate Patient Harms	Total Patient Harms	0	0	2	1	0	
		Behavior Events with Physical Injury	0/	0/0	2	1	0	
		Serious Safety Events (F or Greater)	0	1	0	1	0	
	Embed Critical Behaviors	Hand Hygiene Compliance	80.56%	80.19%	80.40%	88.44%	90%	
Timely, Effective, and Efficient Care			Performance			FY25 Goals		
OBJECTIVES	KEY RESULTS	Detailed KPIs	Feb 2025	FY25 YTD	FY24 Actual	Improvement	Benchmark	Accountable Leaders
Promote wellbeing	Provide the right care at the right time	All Cause 30-Day Readmission Rate	10.78%	12.62%	12.05%	11.56%	11.12%	
		MyChart Activation Rate	32.00%	31.00%	27.00%			
	Find and treat conditions early	Breast Cancer Screening	58.67%		54.88%	53.99%	62.67%	
		Cervical Cancer Screening	44.22%		41.94%	50.85%	66.48%	
		Colorectal Cancer Screening	61.58%		61.35%	60.04%	61.32%	
	Achieve the best health outcomes	Glycemic status assessment of patients with diabetes	31.28%		32.00%	32.83%	29.44%	
		Controlling High Blood Pressure	62.34%		63.40%	62.18%	72.22%	
		Child and Adolescent Well-Care Visits	49.93%		43.96%	45.80%	61.15%	

Fiscal Year Starts in July 1 and Ends June 30

FY25 YTD is results from July 2024 to Feb 2025

Timely, Effective, and Efficient Care (continued)			Performance			FY25 Goals		
OBJECTIVES	KEY RESULTS	Detailed KPIs	Feb 2025	FY25 YTD	FY24 Actual	Improvement	Benchmark	Accountable Leaders
	Minimize Time Spent Waiting for our Patients	TNAA Primary Care - Return	9	9	10	10	2	
		TNAA Specialty Care -Return	1	1	7	15	2	
		Waitlist time - Primary Care Review	91	91	94	71	30	
		Waitlist time - Specialty Care	38	38	36	30	N/A	

Equitable Care			Performance			FY25 Goals		
OBJECTIVES	KEY RESULTS	Detailed KPIs	Feb 2025	FY25 YTD	FY24 Actual	Improvement	Benchmark	Accountable Leaders
Serving all: Deliver equitable care	Health-related social needs recognized and addressed	Health-related social needs referrals placed	NA	NA	NA			

Patient-Centered Care			Performance			FY25 Goals		
OBJECTIVES	KEY RESULTS	Detailed KPIs	Feb 2025	FY25 YTD	FY24 Actual	Improvement	Benchmark	Accountable Leaders
Be the most welcoming system to receive care	Optimize performance regarding patient experience	Likelihood to recommend (Dental)	67.05%	63.64%	61.05%	62.27%	63.49%	
		Likelihood to recommend (Primary/Specialty)	71.94%	72.67%	75.93%	75.16%	94.40%	
		Communication with Care Provider (Primary/Specialty)	72.80%	73.48%	76.48%	76.28%	78.01%	

Fiscal Year Starts in July 1 and Ends June 30

FY25 YTD is results from July 2024 to Feb 2025

Highland FY 2025 Detailed Quality OKR and KPI Dashboard

Vision: Alameda Health System will be recognized as a world-class patient and family centered system of care that promotes wellness, eliminates disparities and optimized the health of our diverse communities.

Safe Care - Caring, Healing, Teaching All			Performance			FY25 Goals		
OBJECTIVES	KEY RESULTS	Detailed KPIs	Feb 2025	FY25 YTD	FY24 Actual	Improvement	Benchmark	Accountable Leaders
Provide safe care	Eliminate Patient Harms	Total Patient Harms	12	139	173	145	119	
		CLABSI # Events/SIR	NA/0	0/0	7/0.78	6/0.766	6/0.756	
		CAUTI # Events/SIR	NA/0	6/1.23	13/1.54	9/1.093	5/0.646	
		MRSA # Events/SIR	NA/0	1/0.97	3/1.01	2/1.034	1/0.793	
		C. Difficile # Events/SIR	NA/0	7/0.52	20/0.77	15/0.599	10/0.417	
		SSI # Events/SIR	NA/0	22/2.55	24/1.68	18/1.13	12/0.756	
		Falls with Injury/% Per 1000 Days	4/0.65	22/0.39	35/0.6	32/0.56	30/0.52	
		HAPI #/% per 1000 Discharges	4/4.551	60/8.03	46/3.95	41/3.55	36/3.16	
		Behavior Events with Physical Injury	4/0.87	22/0.58	27/0.51	22/0.39	19/0.34	
		Serious Safety Events (F or Greater)	0	9	6			
	Reduce Mortality from Sepsis	Sepsis Mortality Observed:Expected & Total Deaths	Pending	1.20	1.07		1.04	
		Bundle Compliance Sepsis Early Management	50.00%	57.30%	46.30%			
	Embed Critical Behaviors	Hand Hygiene Compliance	90.46%	89.85%	91.05%			

Fiscal Year Starts in July 1 and Ends June 30

FY25 YTD is results from July 2024 to Feb 2025

Timely, Effective, and Efficient Care			Performance			FY25 Goals		
OBJECTIVES	KEY RESULTS	Detailed KPIs	Feb 2025	FY25 YTD	FY24 Actual	Improvement	Benchmark	Accountable Leaders
Promote wellbeing	Provide the right care at the right time	All Cause 30-Day Readmission Rate	8.62%	11.02%	12.14%	11.36%	11.12%	
	Achieve the best health outcomes	NTSV Cesarean Section Rate	NA	23.15%	22.60%			
Provide accessible care	Minimize Time Spent Waiting for our Patients	ED Boarding Time for Admitted Patients	16:56	12:56	13:05	8:32	4:00	
Equitable Care			Performance			FY25 Goals		
OBJECTIVES	KEY RESULTS	Detailed KPIs	Feb 2025	FY25 YTD	FY24 Actual	Improvement	Benchmark	Accountable Leaders
Serving all: Deliver equitable care	Health-related social needs recognized and addressed	Health-related social needs assessment completed on inpatients	73.40%	73.60%	62.31%	75%	90%	
		Health-related social needs referrals placed	NA	NA	NA	Pending	Pending	
Patient-Centered Care			Performance			FY25 Goals		
OBJECTIVES	KEY RESULTS	Detailed KPIs	Feb 2025	FY25 YTD	FY24 Actual	Improvement	Benchmark	Accountable Leaders
Be the most welcoming system to receive care	Optimize performance regarding patient experience	Likelihood to recommend Acute	74.12%	72.39%	74.75%	76.25%	77.80%	
		Likelihood to recommend ED	60.34%	56.21%	52.97%	54.03%	70.10%	
		Likelihood to recommend Amb Surg	93.48%	80.91%	77.82%	79.43%	86.00%	
		Communication with Nurses	72.34%	72.43%	74.53%	76.02%	76.41%	
		Communication with Providers	81.42%	81.88%	83.40%	85.07%	85.93%	
Fiscal Year Starts in July 1 and Ends June 30			FY25 YTD is results from July 2024 to Feb 2025					

Fiscal Year 2025

OKR Metric Definitions for QPSC

Metric	Definition	GOAL	
		Improvement	Benchmark
Patient Harm	The number of potential health-care acquired patient harms Includes: CLABSI, CAUTI, MRSA BSI, C-Diff, SSI for Acute Med-Surg/Critical Care, and Patient Falls with injuries, Hospital Acquired Pressure Injuries and Behavior Events that result in Injury for all areas (practically, not inclusive of ambulatory)	50% gap reduction to the 50th Percentile	NHSN 2022 50th Percentile NDNQI 50th Percentile
CLABSI # Events/ SIR	A primary bloodstream infection (that is, there is no apparent infection at another site) that develops in a patient with a central line in place . #: Number of infections that occurred SIR: Standardized Infection Ratio compares the actual number of infections to the predicted number of infections. The predicted number is risk adjusted. Results less 1 are desirable	50% gap reduction to the 50th Percentile	NHSN 2022 50th Percentile
CAUTI # Events/ SIR	an infection of the urinary tract caused by a tube (urinary catheter) that has been placed to drain urine from the bladder. #: Number of infections that occurred SIR: Standardized Infection Ratio compares the actual number of infections to the predicted number of infections. The predicted number is risk adjusted. Results less 1 are desirable	50% gap reduction to the 50th Percentile	NHSN 2022 50th Percentile
MRSA # Events/ SIR	Potential hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA) staph infection that is difficult to treat because of resistance to some antibiotics. #: Number of infections that occurred SIR: Standardized Infection Ratio compares the actual number of infections to the predicted number of infections. The predicted number is risk adjusted. Results less 1 are desirable	50% gap reduction to the 50th Percentile	NHSN 2022 50th Percentile
C. Difficile # Events/ SIR	Potential hospital acquired infection that causes diarrhea and colitis (an inflammation of the colon). #: Number of infections that occurred SIR: Standardized Infection Ratio compares the actual number of infections to the predicted number of infections. The predicted number is risk adjusted. Results less 1 are desirable	50% gap reduction to the 50th Percentile	NHSN 2022 50th Percentile
SSI # Events/ SIR	an infection that occurs after surgery in the part of the body where the surgery took place. Excludes superficial infections. Attributed to date of procedure. #: Number of infections that occurred attributed to month procedure performed SIR: Standardized Infection Ratio compares the actual number of infections to the predicted number of infections. The predicted number is risk adjusted. Results less 1 are desirable	50% gap reduction to the 50th Percentile	NHSN 2022 50th Percentile
Falls with Injury/ # % Per 1000 Days	Patient Fall reported via Midas Safety Alert. # of Events / Rate: Number of events divided by number of patient days times 1000	50% gap reduction to the 50th Percentile	NDNQI 50th Percentile
HAPI #/ % per 1000 DCs	Hospital Acquired Pressure Ulcers reported via Midas Safety Alert. # of Events / Rate: Number of events divided by number of patient discharges times 1000	10% improvement as compared to Fiscal Year 2024	20% improvement as compared to Fiscal Year 2024
Behavior Events with Physical Injury	Behavior events that resulted in physicial injury via Midas Safety Alerts # of Events/Rate: Number of events divided by number of patient days times 1000	10% improvement as compared to Fiscal Year 2024	20% improvement as compared to Fiscal Year 2024
Serious Safety Events (F or Greater)			

Fiscal Year 2025

OKR Metric Definitions for QPSC

Metric	Definition	GOAL	
		Improvement	Benchmark
Sepsis Mortality O/E Ratio	The observed to expected (O:E) sepsis mortality ratio is a comparison of the actual number of sepsis-related deaths in a hospital (observed) to the predicted number of deaths (expected). Performance is considered better than expected if the O:E ratio is less than 1, and worse than expected if the ratio is greater than 1. A lower O:E ratio indicates that more people are surviving conditions that would otherwise be fatal.	NA	1.04 National Mean per Vizient
Bundle Compliance Sepsis Early Management	A set of guidelines that hospitals use to manage patients with severe sepsis or septic shock. The guidelines focus on early recognition and intervention to save lives and limbs. This is an "all-or-nothing" measure, meaning that hospitals must adhere to all elements of the bundle to receive credit. Follows CMS/TJC SEP 1 Definition		
Hand Hygiene Compliance	Hand hygiene is a leading way to reduce the spread of pathogens in healthcare settings. It includes: Washing hands with soap and water and Using an antiseptic handrub. Hand hygiene compliance is the percentage of times that a person performs hand hygiene when an opportunity arises. It's calculated by dividing the number of hand hygiene actions performed by the total number of opportunities.		
All-cause 30 day Readmissions Rate	Percentage of inpatient acute med-surg encounters, regardless of payer type, with an unplanned readmission to any AHS facility within 30 days for any cause among encounters for acute care inpatients with a principal discharge diagnosis/procedure for a clinical classification category in the Cardiorespiratory, Cardiovascular, Medicine, Neurology, or Surgery/Gynecology cohort. *Note:* This measure approximates, but likely does not match, the value of the corresponding CMS readmission measure.	50% gap reduction to the 50th Percentile CMS Hospital Compare	50th Percentile CMS Hospital Compare
NTSV Cesarean Section Rate	he NTSV C-section rate is the percentage of live babies born to women in their first pregnancy who meet the following criteria: Born at or after 37 weeks gestation Singleton (no twins or more) In the vertex presentation (no breech or transverse positions)		
ED Boarding Time Time in ED from Decision to Admit to Inpatient Bed	Median time from Decision to Admit to departure from the emergency department for admitted patients. Decision to Admit = First Admit Disposition Admit = Time patient admitted to Inpatient Unit	2:20 Community Hospitals: 50% gap closure to pre=pandemic performance 8:30 Highland: 50% gap closure to TJC benchmark	1:30 Community Hospitals: Pre-pandemic Performance 4:00 Highland: TJC guidance for max boarding time
Rate of Inpatients screened for health-related social needs (food, housing, transportation, safety, utilities) ↑	The percentage of inpatient acute medical/surgical admissions where the patient is screened for social determinents of health: food insecurity, housing, transportation, safety and utilites	75% Internal Benchmark: Best Performing Campus rate for FY24	90% Internal Benchmark: Monthly Rate achieve by Best Performing Campus
Health-related social needs referrals placed	A "health-related social needs referral" means directing a patient to a community service or organization that can address social issues impacting their health, such as food insecurity, housing instability, lack of transportation, or financial hardship, identified through a screening process within a healthcare setting; essentially, referring a patient to support that can help address social factors that could be affecting their health outcomes.	TBD	TBD
Acute: Rate of patients who reported they would “definitely” recommend AHS	Percentage of discharged inpatients who would recommend AHS	2% improvement as compared to Fiscal Year 2024	75th Percentile per Press Ganey
Same Day Surgery:Rate of patients who reported they would “definitely” recommend AHS	Percentage of same day surgery patients who would recommend AHS	2% improvement as compared to Fiscal Year 2024	50th Percentile per Press Ganey

Fiscal Year 2025

OKR Metric Definitions for QPSC

Metric	Definition	GOAL	
		Improvement	Benchmark
Emergency: Rate of patients who reported they would “definitely” recommend AHS	Percentage of Emergency patients who would recommend AHS	2% improvement as compared to Fiscal Year 2024	50th Percentile per Press Ganey
Communication with Nurses	A domain of HCAHPS which measures patients' perceptions of how well patients feel that their nurses: explained things clearly, listened carefully, and treated the patient with courtesy and respect. Percent of surveyed Inpatient discharges where patient response was highest of the scale	2% improvement as compared to Fiscal Year 2025	50h Percentile per Press Ganey
Communication with Providers	A domain of HCAHPS which measures patients' perceptions of how well patients feel that their provider(s): explained things clearly, listened carefully, and treated the patient with courtesy and respect. Percent of surveyed Inpatient discharges where patient response was highest of the scale	2% improvement as compared to Fiscal Year 2026	Per Press Ganey Community Hospitals: 75th Percentile Highland Hospital: 90th Percentile

John George FY 2025 Detailed Quality OKR and KPI Dashboard

Vision: Alameda Health System will be recognized as a world-class patient and family centered system of care that promotes wellness, eliminates disparities and optimized the health of our diverse communities.

Safe Care - Caring, Healing, Teaching All			Performance			FY25 Goals		
OBJECTIVES	KEY RESULTS	Detailed KPIs	Feb 2025	FY25 YTD	FY24 Actual	Improvement	Benchmark	Accountable Leaders
Provide safe care	Eliminate Patient Harms	Total Patient Harms	7	42	68	61	54	P. Espeseth R. Delaney
		Falls with Injury/% Per 1000 Days	1/0.48	13/0.73	9/0.68	8	7	R. Delaney
		Behavior Events with Physical Injury	6/2.85	29/1.63	59/2.15	53	47	P. Espeseth R. Delaney
		Serious Safety Events (F or Greater)	0	0	0	0	0	P. Espeseth R. Delaney
Patient-Centered Care			**Performance**			**FY25 Goals**		
OBJECTIVES	KEY RESULTS	Detailed KPIs	Feb 2025	FY25 YTD	FY24 Actual	Improvement	Benchmark	Accountable Leaders
Be the most welcoming system to receive care	Optimize performance regarding patient experience	Overall Rating of Care	50.62%	56.23%	61.60%	62.83%	68.50%	P. Espeseth R. Delaney

Fiscal Year Starts in July 1 and Ends June 30

FY25 YTD is results from July 2024 to Performance

Fiscal Year 2025

OKR Metric Definitions for QPSC

Metric	Definition	GOAL	
		Improvement	Benchmark
Total Patient Harms	The number of potential health-care acquired patient harms Includes: Patient Falls with injuries, H Behavior Events that result in Injury	10% reduction compared to FY24 overall	20% reduction compared to FY24 overall
Falls with Injury/% Per 1000 Days	Patient Fall reported via Midas Safety Alert. # of Events / Rate: Number of events divided by number of patient days times 1000	10% reduction compared to FY24 overall	20% reduction compared to FY24 overall
Behavior Events with Physical Injury	Behavior events that resulted in physicial injury via Midas Safety Alerts # of Events/Rate: Number of events divided by number of patient days times 1000	10% reduction compared to FY24 overall	20% reduction compared to FY24 overall
Serious Safety Events (F or Greater)			
Overall Rating of Care	A question on the Behavioral Health Dashboard which measures patients' perceptions of how well patients feel that their overall care experience Percent of surveyed discharges where patient response was highest of the scale	2% improvement over FY24 score	50th Percentile

San Leandro Hospital FY 2025 Detailed Quality OKR and KPI Dashboard

Vision: Alameda Health System will be recognized as a world-class patient and family centered system of care that promotes wellness, eliminates disparities and optimized the health of our diverse communities.

Safe Care - Caring, Healing, Teaching All			Performance			FY25 Goals		
OBJECTIVES	KEY RESULTS	Detailed KPIs	Feb 2025	FY25 YTD	FY24 Actual	Improvement	Benchmark	Accountable Leaders
Provide safe care	Eliminate Patient Harms	Total Patient Harms	14	67	83	67	54	
		CLABSI # Events/SIR	NA/0	0/0	2/1.69	1/1.224	0/0.756	
		CAUTI # Events/SIR	NA/0	0/0	2/1.75	1/1.199	0/0.646	
		MRSA # Events/SIR	NA/0	1/5.21	2/3.41	1/2.361	0/0.793	
		C. Difficile # Events/SIR	NA/0	4/1.23	8/1.56	5/0.985	2/0.417	
		SSI # Events/SIR	NA/0	2/1.94	0/0	0/0.38	1/0.756	
		Falls with Injury/% Per 1000 Days	2/0.93	7/0.54	11/0.78	8/0.64	6/0.49	
		HAPI #/% per 1000 Discharges	11/45.082	46/21.68	35/9.54	31/859	27/7.63	
		Behavior Events with Physical Injury	1/0.93	7/0.76	33/1.61	20/1.48	18/1.21	
		Serious Safety Events (F or Greater)	0	1	2			
	Reduce Mortality from Sepsis	Sepsis Mortality Observed:Expected	Pending	1.11	1.01		1.04	
		Bundle Compliance Sepsis Early Management	60.00%	61.29%	68.90%			
	Embed Critical Behaviors	Hand Hygiene Compliance	91.33%	95.40%	94.75%			

Fiscal Year Starts in July 1 and Ends June 30

FY25 YTD is results from July 2024 to Feb 2025

Timely, Effective, and Efficient Care			Performance			FY25 Goals		
OBJECTIVES	KEY RESULTS	Detailed KPIs	Feb 2025	FY25 YTD	FY24 Actual	Improvement	Benchmark	Accountable Leaders
Promote wellbeing	Provide the right care at the right time	All Cause 30-Day Readmission Rate	13.13%	13.34%	8.80%	9.96%	11.12%	
Provide accessible care	Minimize Time Spent Waiting for our Patients	ED Boarding Time for Admitted Patients	3:20	2:57	3:07	2:20	1:30	
Equitable Care			Performance			FY25 Goals		
OBJECTIVES	KEY RESULTS	Detailed KPIs	Feb 2025	FY25 YTD	FY24 Actual	Improvement	Benchmark	Accountable Leaders
Serving all: Deliver equitable care	Health-related social needs recognized and addressed	Health-related social needs assessment completed on inpatients	92.90%	90.50%	94.23%	75%	90%	
		Health-related social needs referrals placed	NA	NA	NA	Pending	Pending	
Patient-Centered Care			Performance			FY25 Goals		
OBJECTIVES	KEY RESULTS	Detailed KPIs	Feb 2025	FY25 YTD	FY24 Actual	Improvement	Benchmark	Accountable Leaders
	Optimize performance regarding patient experience	Likelihood to recommend Acute	66.67%	66.19%	68.92%	70.30%	77.80%	
		Likelihood to recommend ED	60.00%	60.00%	58.67%	59.84%	70.10%	
		Likelihood to recommend Amb Surg	82.35%	84.21%	76.92%	78.46%	86.00%	
		Communication with Nurses	70.37%	71.92%	73.75%	75.23%	76.41%	
		Communication with Providers	85.19%	78.31%	79.41%	81.00%	83.40%	

Fiscal Year Starts in July 1 and Ends June 30

FY25 YTD is results from July 2024 to Feb 2025

Fiscal Year 2025

OKR Metric Definitions for QPSC

Metric	Definition	GOAL	
		Improvement	Benchmark
Patient Harm	The number of potential health-care acquired patient harms Includes: CLABSI, CAUTI, MRSA BSI, C-Diff, SSI for Acute Med-Surg/Critical Care, and Patient Falls with injuries, Hospital Acquired Pressure Injuries and Behavior Events that result in Injury for all areas (practically, not inclusive of ambulatory)	50% gap reduction to the 50th Percentile	NHSN 2022 50th Percentile NDNQI 50th Percentile
CLABSI # Events/ SIR	A primary bloodstream infection (that is, there is no apparent infection at another site) that develops in a patient with a central line in place . #: Number of infections that occurred SIR: Standardized Infection Ratio compares the actual number of infections to the predicted number of infections. The predicted number is risk adjusted. Results less 1 are desirable	50% gap reduction to the 50th Percentile	NHSN 2022 50th Percentile
CAUTI # Events/ SIR	an infection of the urinary tract caused by a tube (urinary catheter) that has been placed to drain urine from the bladder. #: Number of infections that occurred SIR: Standardized Infection Ratio compares the actual number of infections to the predicted number of infections. The predicted number is risk adjusted. Results less 1 are desirable	50% gap reduction to the 50th Percentile	NHSN 2022 50th Percentile
MRSA # Events/ SIR	Potential hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA) staph infection that is difficult to treat because of resistance to some antibiotics. #: Number of infections that occurred SIR: Standardized Infection Ratio compares the actual number of infections to the predicted number of infections. The predicted number is risk adjusted. Results less 1 are desirable	50% gap reduction to the 50th Percentile	NHSN 2022 50th Percentile
C. Difficile # Events/ SIR	Potential hospital acquired infection that causes diarrhea and colitis (an inflammation of the colon). #: Number of infections that occurred SIR: Standardized Infection Ratio compares the actual number of infections to the predicted number of infections. The predicted number is risk adjusted. Results less 1 are desirable	50% gap reduction to the 50th Percentile	NHSN 2022 50th Percentile
SSI # Events/ SIR	an infection that occurs after surgery in the part of the body where the surgery took place. Excludes superficial infections. Attributed to date of procedure. #: Number of infections that occurred attributed to month procedure performed SIR: Standardized Infection Ratio compares the actual number of infections to the predicted number of infections. The predicted number is risk adjusted. Results less 1 are desirable	50% gap reduction to the 50th Percentile	NHSN 2022 50th Percentile
Falls with Injury/ # % Per 1000 Days	Patient Fall reported via Midas Safety Alert. # of Events / Rate: Number of events divided by number of patient days times 1000	50% gap reduction to the 50th Percentile	NDNQI 50th Percentile
HAPI #/ % per 1000 DCs	Hospital Acquired Pressure Ulcers reported via Midas Safety Alert. # of Events / Rate: Number of events divided by number of patient discharges times 1000	10% improvement as compared to Fiscal Year 2024	20% improvement as compared to Fiscal Year 2024
Behavior Events with Physical Injury	Behavior events that resulted in physicial injury via Midas Safety Alerts # of Events/Rate: Number of events divided by number of patient days times 1000	10% improvement as compared to Fiscal Year 2024	20% improvement as compared to Fiscal Year 2024
Serious Safety Events (F or Greater)			

Fiscal Year 2025

OKR Metric Definitions for QPSC

Metric	Definition	GOAL	
		Improvement	Benchmark
Sepsis Mortality O/E Ratio	The observed to expected (O:E) sepsis mortality ratio is a comparison of the actual number of sepsis-related deaths in a hospital (observed) to the predicted number of deaths (expected). Performance is considered better than expected if the O:E ratio is less than 1, and worse than expected if the ratio is greater than 1. A lower O:E ratio indicates that more people are surviving conditions that would otherwise be fatal.	NA	1.04 National Mean per Vizient
Bundle Compliance Sepsis Early Management	A set of guidelines that hospitals use to manage patients with severe sepsis or septic shock. The guidelines focus on early recognition and intervention to save lives and limbs. This is an "all-or-nothing" measure, meaning that hospitals must adhere to all elements of the bundle to receive credit. Follows CMS/TJC SEP 1 Definition		
Hand Hygiene Compliance	Hand hygiene is a leading way to reduce the spread of pathogens in healthcare settings. It includes: Washing hands with soap and water and Using an antiseptic handrub. Hand hygiene compliance is the percentage of times that a person performs hand hygiene when an opportunity arises. It's calculated by dividing the number of hand hygiene actions performed by the total number of opportunities.		
All-cause 30 day Readmissions Rate	Percentage of inpatient acute med-surg encounters, regardless of payer type, with an unplanned readmission to any AHS facility within 30 days for any cause among encounters for acute care inpatients with a principal discharge diagnosis/procedure for a clinical classification category in the Cardiorespiratory, Cardiovascular, Medicine, Neurology, or Surgery/Gynecology cohort. *Note:* This measure approximates, but likely does not match, the value of the corresponding CMS readmission measure.	50% gap reduction to the 50th Percentile CMS Hospital Compare	50th Percentile CMS Hospital Compare
NTSV Cesarean Section Rate	he NTSV C-section rate is the percentage of live babies born to women in their first pregnancy who meet the following criteria: Born at or after 37 weeks gestation Singleton (no twins or more) In the vertex presentation (no breech or transverse positions)		
ED Boarding Time Time in ED from Decision to Admit to Inpatient Bed	Median time from Decision to Admit to departure from the emergency department for admitted patients. Decision to Admit = First Admit Disposition Admit = Time patient admitted to Inpatient Unit	2:20 Community Hospitals: 50% gap closure to pre=pandemic performance 8:30 Highland: 50% gap closure to TJC benchmark	1:30 Community Hospitals: Pre-pandemic Performance 4:00 Highland: TJC guidance for max boarding time
Rate of Inpatients screened for health-related social needs (food, housing, transportation, safety, utilities) ↑	The percentage of inpatient acute medical/surgical admissions where the patient is screened for social determinents of health: food insecurity, housing, transportation, safety and utilites	75% Internal Benchmark: Best Performing Campus rate for FY24	90% Internal Benchmark: Monthly Rate achieve by Best Performing Campus
Health-related social needs referrals placed	A "health-related social needs referral" means directing a patient to a community service or organization that can address social issues impacting their health, such as food insecurity, housing instability, lack of transportation, or financial hardship, identified through a screening process within a healthcare setting; essentially, referring a patient to support that can help address social factors that could be affecting their health outcomes.	TBD	TBD
Acute: Rate of patients who reported they would “definitely” recommend AHS	Percentage of discharged inpatients who would recommend AHS	2% improvement as compared to Fiscal Year 2024	75th Percentile per Press Ganey
Same Day Surgery:Rate of patients who reported they would “definitely” recommend AHS	Percentage of same day surgery patients who would recommend AHS	2% improvement as compared to Fiscal Year 2024	50th Percentile per Press Ganey

Fiscal Year 2025

OKR Metric Definitions for QPSC

Metric	Definition	GOAL	
		Improvement	Benchmark
Emergency: Rate of patients who reported they would “definitely” recommend AHS	Percentage of Emergency patients who would recommend AHS	2% improvement as compared to Fiscal Year 2024	50th Percentile per Press Ganey
Communication with Nurses	A domain of HCAHPS which measures patients' perceptions of how well patients feel that their nurses: explained things clearly, listened carefully, and treated the patient with courtesy and respect. Percent of surveyed Inpatient discharges where patient response was highest of the scale	2% improvement as compared to Fiscal Year 2025	50h Percentile per Press Ganey
Communication with Providers	A domain of HCAHPS which measures patients' perceptions of how well patients feel that their provider(s): explained things clearly, listened carefully, and treated the patient with courtesy and respect. Percent of surveyed Inpatient discharges where patient response was highest of the scale	2% improvement as compared to Fiscal Year 2026	Per Press Ganey Community Hospitals: 75th Percentile Highland Hospital: 90th Percentile

Addendum Item D Post Acute Presentation

ALAMEDA HEALTH SYSTEM

Post-Acute Quality Report 5/28/25

Richard Espinoza, NHA, CAO Post-Acute Services

CMS Quality Star Rating

All AHS Post-Acute SNF/SA sites:

April 2025
5-star Overall Quality Rated

The top 10% of skilled nursing facilities in the United States receive a 5-star rating from the Centers for Medicare and Medicaid Services (CMS)

Fairmont continues with 5 stars in every CMS category

Alameda SNFs/SA CMS Report

Care Compare Five-Star Ratings of Nursing Homes

Provider Rating Report for April 2025

Ratings for Alameda Hospital D/P SNF (555381) Alameda, California			
Overall Quality	**Health Inspection**	**Quality Measures**	**Staffing**
★★★★★	★★★★★	★★★	★★★

Fairmont CMS Report

Care Compare Five-Star Ratings of Nursing Homes

Provider Rating Report for April 2025

Ratings for Alameda County Medical Center D/P SNF (056479) San Leandro, California			
Overall Quality	Health Inspection	Quality Measures	Staffing
★★★★★	★★★★★	★★★★★	★★★★★

New CMS metrics released

Flu & pneumonia prevention measures - Short-stay residents

Percentage of short-stay residents who needed and got a flu shot for the current flu season

Higher percentages are better

49.1%

National average: 79%

California average: 93.4%

Percentage of healthcare personnel who got a flu shot for the current season

Higher percentages are better

94.8%

National average: 45%

Percentage of short-stay residents who needed and got a vaccine to prevent pneumonia

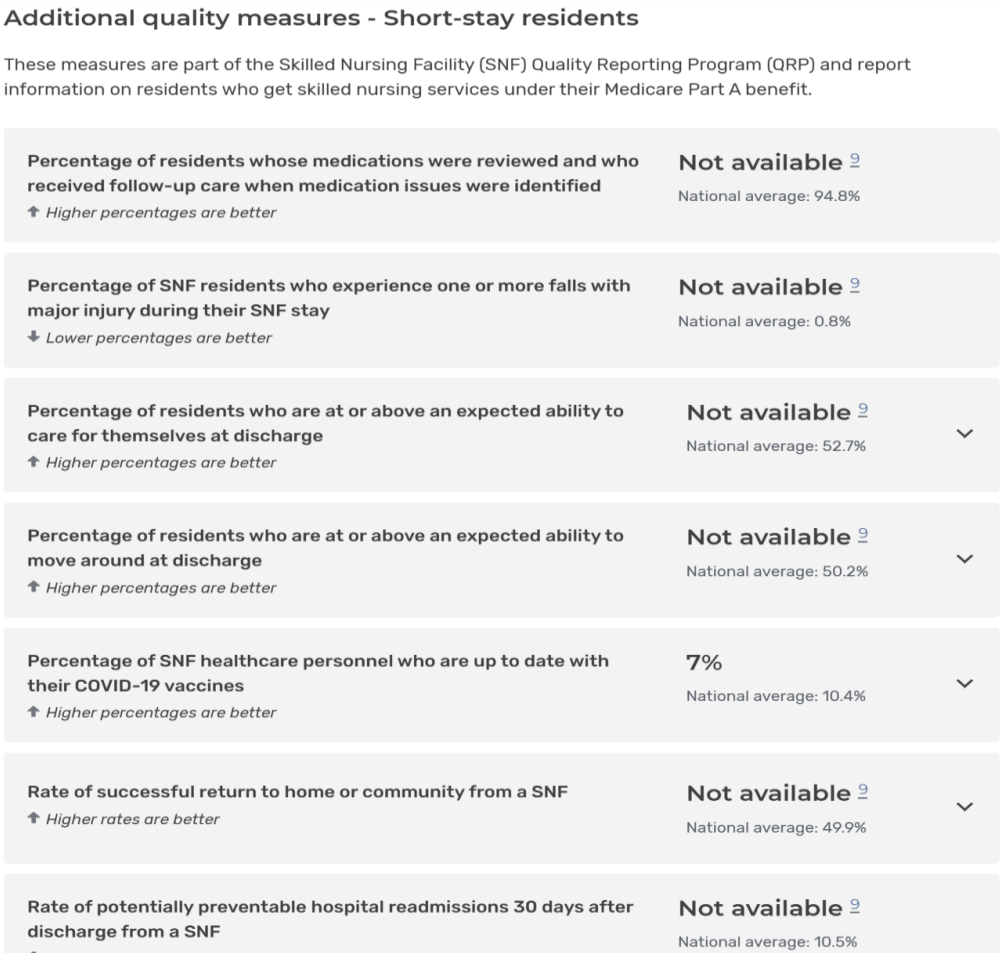
Higher percentages are better

80.9%

National average: 81.6%

California average: 94.2%

Additional CMS metrics



Additional quality measures - Short-stay residents

These measures are part of the Skilled Nursing Facility (SNF) Quality Reporting Program (QRP) and report information on residents who get skilled nursing services under their Medicare Part A benefit.

Percentage of residents whose medications were reviewed and who received follow-up care when medication issues were identified *Higher percentages are better*	**Not available** National average: 94.8%
Percentage of SNF residents who experience one or more falls with major injury during their SNF stay *Lower percentages are better*	**Not available** National average: 0.8%
Percentage of residents who are at or above an expected ability to care for themselves at discharge *Higher percentages are better*	**Not available** National average: 52.7%
Percentage of residents who are at or above an expected ability to move around at discharge *Higher percentages are better*	**Not available** National average: 50.2%
Percentage of SNF healthcare personnel who are up to date with their COVID-19 vaccines *Higher percentages are better*	**7%** National average: 10.4%
Rate of successful return to home or community from a SNF *Higher rates are better*	**Not available** National average: 49.9%
Rate of potentially preventable hospital readmissions 30 days after discharge from a SNF	**Not available** National average: 10.5%

CDPH/DHCS Visits

- CDPH visits:
  - St. Rose:

CDPH Federal Survey: 4/9-4/10
- No findings

CDPH Life Safety Survey: 4/15/25
- 3 findings – state average is 6.9

No visits to our other AHS sites

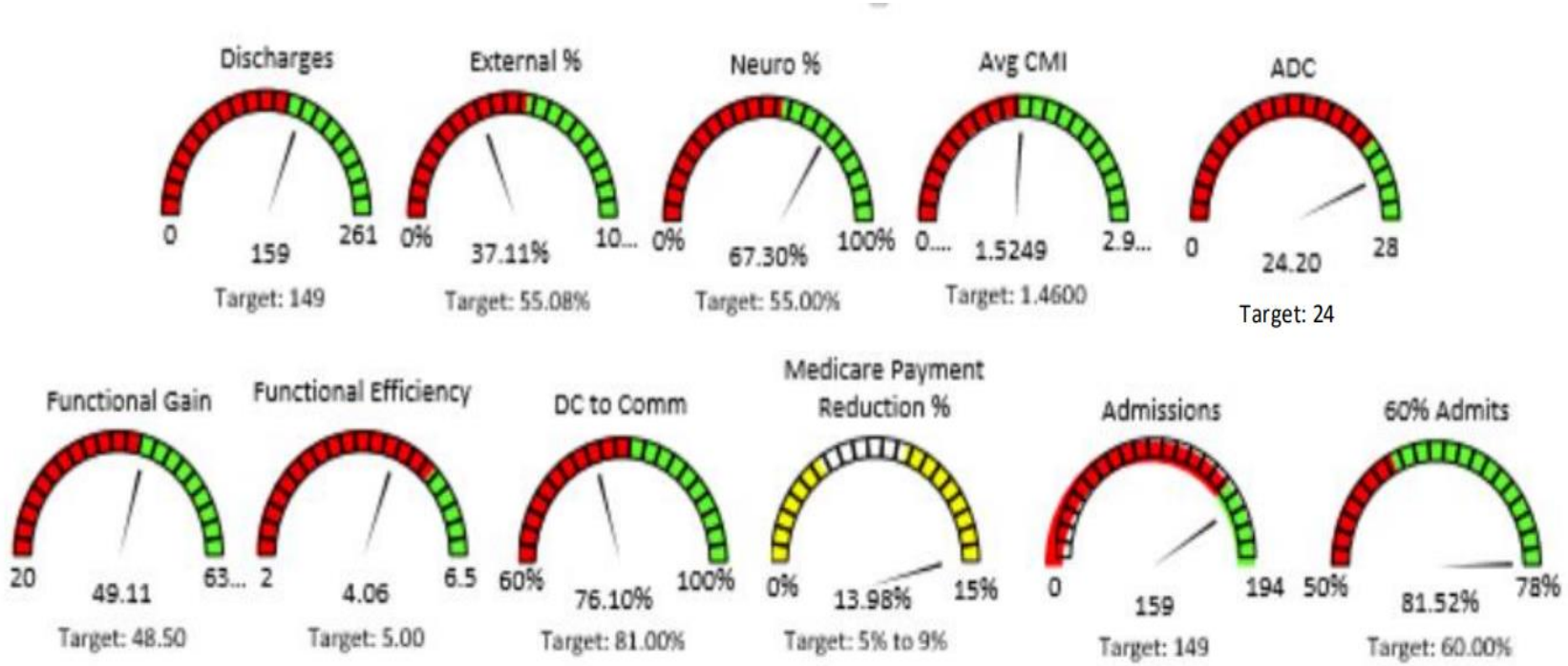
AHS support to St. Rose

- Director of Executive Clinical Operations and CAO of PA recently have gained oversite of St. Rose's Sub-Acute Unit. (currently a SNF).

- St. Rose team has recently accomplished:

  - Passed the CDPH Federal survey on 4/9-4/10/25 with zero findings
  - Passed their life Safety survey with 3 findings – state average is 6.9
  - CDPH has recommended certification to CMS with a date of 4/17/25
    - We wait to hear from CMS now.

ARU Dashboard



ARU admission sources

Patient Throughput Management

Admission Sources

Admission Origin	1/1/2025	2/1/2025	3/1/2025	Grand Total
Alameda Health Highland	25	19	27	71
Alameda Health Alameda	9	3	4	16
Washington Hospital	5	2	4	11
Alameda Health San Leandro	3	2	4	9
Sutter Alta Bates Summit Summit	2	2	3	7
UCSF Medical Center	4		2	6
Sutter Eden	1	5		6
St Rose Hayward	1	1	3	5
Stanford ValleyCare Pleasanton	1	2	1	4
Stanford Medical Center	2	1	2	5
Zuckerberg San Francisco General Hospital		2		2
Sequoia Hospital		2		2
Legacy Post Acute Care			2	2
Kindred San Francisco Bay		1	1	2
MarinHealth Medical Center	1			1
The Fountains Skilled Nursing			1	1
Sutter Mills Peninsula	1			1
Oakland Heights Nursing and Rehabilitation		1		1
Mercy Medical Center Redding		1		1
Mission Valley Post Acute			1	1
Contra Costa Regional Medical Center			1	1
Sutter California Pacific Davies		1		1
Kaiser Oakland		1		1
CPMC Van Ness Campus		1		1
El Camino Mountain View		1		1
Grand Total	**55**	**48**	**56**	**159**

Admission Origin	1/1/2025	2/1/2025	3/1/2025	Grand Total	
Alameda Health Highland	25	19	27	71	
Alameda Health Alameda	9	3	4	16	60.40%
Alameda Health San Leandro	3	2	4	9	
AHS Total	**37**	**24**	**35**	**96**	
St Rose Hayward	1	1	3	5	63.50%
Grand Total	**38**	**25**	**38**	**101**	

Jan-March, Alameda System admissions accounted for ~60% of total admissions. This is a continued sustained improvement: April-June: ~48%; July-Sept ~56%, Oct-Dec ~61%.

Including St Rose as a new affiliation partnership, this increases the system throughput to ~63% of total admission.

ALAMEDA HEALTH SYSTEM | San Leandro Hospital

Lifepoint Rehabilitation

10

Thank you

Questions?

Addendum Item E, OKR Metric Recommendation

Quality OKR Metric Proposal FY2026

QPSC

May 28, 2025

Objectives & Key Results (OKRs)

vs.

Key Performance Indicators (KPIs) & Metrics

Objectives

- Aspirational goals tied to organizational mission and vision
  Who we are, who we serve
- Bring "life" to the organizational strategic plan
  Where we're headed
- Inspiring and memorable

Key Results

- ***Critical milestones*** which measure progress toward objectives
- Generally no more than 3-5KRs per objective

Key Performance Indicator

- Data reflecting how the system is working
- key *domain-specific process and outcome metrics*
- Organizations can have hundreds across domains
- KPIs don't necessarily provide broader context for overall Organizational Objectives

Metric

Any measure of something

The difference between KPIs and OKRs. https://www.whatmatters.com/resources/difference-between-okr-kpi

Quality Care

Pillar Definition:

AHS provides Safe, Timely, Effective, Efficient, Equitable and Patient-Centered care that is accessible to all.

Strategic Objective: Safe place to receive exceptional and compassionate care

Strategic Key Results
Leapfrog Hospital Grades: Target A-B
CMS Hospital STAR Ratings : Shadow Metric Year 1 and 2
CMS Post-Acute STAR Ratings : Maintain 5 STARS
CDPH Quality Incentive Program : Optimal Performance

Fiscal Year 2026 Quality OKR Proposal

OBJECTIVES	KEY RESULTS	Definition	Strategic Key Results Link	Recommendation
Safe Care - Caring, Healing, Teaching All				
Provide safe care	Total Patient Harms	The number of potential health-care acquired patient harms Includes: CLABSI, CAUTI, MRSA BSI, C-Diff, SSI, Patient Falls with injuries, Hospital Acquired Pressure Injuries and Behavior Events that result in Injury	Leapfrog, CMS Star Rating. HAC Penalty, QIP	**Revise** - Reportable HAPIs, Focus 6 Surgical Categories for SSI (Colon, C-Section, Gallbladder, Hysterectomy, Spinal Fusion, Small Bowel)
	Sepsis Mortality O/E Ratio	The observed to expected ratio is a comparison of the actual number of sepsis-related deaths in a hospital (observed) to the predicted number of deaths (expected).	CMS Star Rating	**Keep**
Timely, Effective, and Efficient Care				
Promote wellbeing	All Cause 30-day readmission rate	Percentage of inpatient acute med-surg encounters, regardless of payer type, with an unplanned readmission to any AHS facility within 30 days for any cause for acute care inpatients	CMS Star Rating, Readmission Penalty	**Keep**
Provide accessible care	Waitlist time - New Primary Care Adult & New Specialty Referral	The amount of days between when a new patient to AHS requests an initial primary care appointment or is referred for a new specialty appointment to the day of appointment.	Ambulatory Access	**Revise** % of Specialty Clinics at Goal % of Primary Clinics at Goal
	ED Boarding Time for Admitted Patients Community/HGH	Median time from Decision to Admit to departure from the emergency department for admitted patients.	CMS Star Rating	**Keep**

Fiscal Year 2026 Quality OKR Proposal

OBJECTIVES	KEY RESULTS	Definition	Strategic Key Results Link	Recommendation
Equitable Care				
Serving all: ~~Deliver equitable care~~ Deliver Whole Person Care	Health-related Social Needs Assessment Completed on Hospital Inpatient and Outpatient Encounters	The percentage of hospital inpatient and hospital outpatient encounters where the patient is screened for social determinants of health: food insecurity, housing, transportation, safety and utilities	Process Readmissions Link Stewardship: Grow and optimize resources for the patient care continuum to meet the community need	**Revise** Expand to Hospital Based Outpatient Encounters (ED, Same Day Surgery, Imaging, Testing) **Add** 2nd Metric Screening Positivity Rate
Patient-Centered Care				
Be the most welcoming system to receive care	Likelihood to recommend care composite	Percentage of patients who would recommend AHS (includes rehab, acute, ambulatory, ED, outpatient surgery, dental, radiology)	Leapfrog, Star Rating	**Keep**