# QUALITY PROFESSIONAL SERVICES COMMITTEE MEETING

**Wednesday, June 25, 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=88957139875**

Meeting ID: 936 145 7125
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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**
*Lilavati Indulkar, MD, Chair*

**B. ACTION: Consent Agenda**

**B1.** **Approval of the Minutes of the May 28, 2025 Quality Professional Services Committee Meeting**

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

- Medication Drug Recall
- Outpatient Pharmacy Dispensing

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

**AHS and AH Medical Staff:**
- Identifying and Credentialing HIV/AIDS Specialists

**AHS Medical Staff:**
- Medical Staff Department Structure and Division Leadership
- Introduction of a New Privilege or New Privilege for a Specific Department or Specialty

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

**Revised Application Forms for AHS & AH:**
- HIV AIDS Specialist Designation Letter and Form

**Revised Privilege Forms for AHS:**
- Pediatrics – Developmental Behavioral
- Pain Medicine Advanced Practice Provider

***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: Ambulance Patient Offload Times (APOT)**
*Andrea Wu, MD, Associate Chief Medical Officer Highland*

**F. CLOSED SESSION**

**F1. Consideration of Confidential Medical Staff Credentialing Reports**
*Chief of Staff, AHS Medical Staff*
*Chief of Staff, AH Medical Staff*

**F2. Regulatory Affairs, Risk Management, Patient Safety**
[Health and Safety Code 101850(ai) (1)]

***(Reconvene to Open Session)***

**OPEN SESSION**

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

**ADJOURNMENT**

**ADDENDUMS:**

**Agenda Item D, OKRS**

**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

**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

**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*

## QUALITY PROFESSIONAL SERVICES COMMITTEE MEETING MINUTES

**THE MEETING WAS CALLED TO ORDER AT 5:00 pm**

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

**ABSENT:** None

**PUBLIC COMMENT: None**

**A. DISCUSSION: Clinical Highlights of the OKRs**
*Lilavati Indulkar, MD, Chair*

Trustee Indulkar highlighted several patient stories in an effort to connect the work they were doing qualitatively and quantitatively as living data points that provide the how and the why behind the metrics. Additionally, it humanized the conversations around patient care.

Trustee Linton asked if there was any thought about the most effective treatment for the patient described. Trustee Indulkar they used a multi-pronged approach with many layers of treatment and

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therapies. It wasn't one single thing that made a difference, it was the layers of treatment.

Trustee Garrett said the example spoke to the commitment to high quality care he had witnessed from staff since joining AHS.

Trustee Indulkar said she hoped some of the stories would be taken into consideration when they considered bedside unit operations. Mr. Jackson said the impact of the story was humanizing and demonstrative of what can be done when people really care. The behavioral health safety net was broken. There were many opportunities for improvement. The IOP (Intensive Outpatient Program) was so critical and inadequate. He was excited about the BHCIP (Behavioral Health Continuum Infrastructure Program) work they were starting.

## B. ACTION: Consent Agenda

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

### 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 Forms 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

Trustee Linton moved and Trustee Garrett 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, Indulkar, Linton, and Moss
**NAYS:** None
**ABSTENTION:** None

***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 |

Trustee Garrett asked if they had national or comparative benchmarks for the Stroke Program so he could have a better understanding of how they were doing. Ms. Torres said they were looking at 100% compliance.

Trustee Moss asked if the intercranial hemorrhage mortality was after their initial event and not what they were presenting with. Dr. Lash confirmed that he was correct.

Trustee Indulkar asked if interventional radiology was a must have or did they just need to have a plan in place to keep the trauma certification. Dr. Mahler said it was a must have and they did have it. They included it in the SWOT threats because they had two physicians leaving. They were actively recruiting, but the flag was raised to keep the interventional radiology situation stable. Additionally, they were looking at how to improve the vascular coverage. Trauma surgeons could cover, but there was a need. All of these enhancements were to make the trauma program more stable.

Trustee Linton asked about the cancer center that was listed in the SWOT as an opportunity. Dr. Lash said this was a dream that Dr. Victorino wanted to bring up. There was not a specific plan, but they have made many improvements in their oncology unit in an effort to get patients into care sooner. Trustee Linton said she was curious to see, as the operational plan rolls out, whether or not the cancer center becomes an identified service in the plan and then perhaps the Foundation can begin implementing funding. Mr. Fratzke said that cancer care was a highly advancing form of care, and a cancer center had to be able to keep up with the expense of the advancing technology. It can be done, but that has to be considered.

Trustee Indulkar said that surgical robots were something that needed to be looked at as well because those patients were also going out of our system. It would be helpful to understand what the milestones for a cancer center and for surgical robots look like. Mr. Jackson said it was important to not let their reach exceed their grasp. They would love to have a cancer center, in a perfect world. In his conversations with Dr. Victorino, they were focused on things like the surgical robot in a hybrid room as those were things that would not only benefit our patients now, but also the young providers coming in.

Trustee Indulkar asked Dr. Pyun if she had any updated information regarding the improvement plan for imaging services. Dr. Pyun said they did not have an update yet. It was on the agenda for next month. The MRI went down for maintenance at inconvenient times. The CAT scanner seemed to break regularly. Mr. Fitzgerald Shaw said that the CAT scanner was the only machine in use at Alameda Hospital, increasing the wear on the machine, causing it to break down more often, and require more frequent maintenance. They have attempted to get maintenance done at more opportune times, but the company who services the machine doesn't have anyone available at those times. The equipment for the MRI was owned by Alliance who did most of the maintenance. AHS did not have much control over that.

Trustee Moss said even with a new scanner they would have the same maintenance updates. Mr. Fitzgerald Shaw agreed. Mr. Fratzke said the fleet assessment will be key to determining if they had the budget or needed to raise funds. Also, the room was too small to accommodate a new scanner, so they had a lot to work through. They were trying to understand where they were in the market so they could be competitive.

Trustee Indulkar asked if they could get a timeline of the fleet assessment. Mr. Fratzke said they'd be happy to bring it to the Committee.

Trustee Linton asked if it was also an issue at Highland or San Leandro. Mr. Fratzke said it was not an issue at Highland, and San Leandro just had a brand new scanner installed. It was a long process. Mr. Fitzgerald Shaw said the newer machines took less time to upload patches as well.

Trustee Indulkar said a timeline of what to expect would be helpful.

## D. REPORT/DISCUSSION: Quality Reports

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

Trustee Linton asked why Alameda Hospital tended to lag behind in performance. Ms. Torres said it depended on the metric. For example, readmissions was one area they struggled in. A lot of their work was targeted at improving in that area.

Trustee Moss said part of the equation was that a significant proportion of the population that used Alameda Hospital were more SNF patients. Dr. Mahler agreed and added that Highland often sent patients to Alameda Hospital who were problematic for disposition at Highland.

Trustee Indulkar said Highland ER boarding times were higher and it took longer to see a physician. Patients would often self-select to go to other hospitals to avoid these issues. She asked if it would make sense to look at as a system rather than site specific. Dr. Mahler said they did both; they blended them together and reviewed them by each campus.

Trustee Indulkar asked if it was still the case that when a patient had a complication or adverse outcome for another reason, if sepsis landed on their chart it was reported as sepsis on the mortality data. Dr. Chen said it was still the case. Ms. Johnson said they looked at either primary or secondary diagnosis codes. So, it was being pulled into the Observed to Expected Mortality (O:E) data.

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

Trustee Moss asked for estimates on the short stay Medicare patients. Mr. Espinoza said they may have three at Park Bridge right now, out of 120 patients, and the numbers were lower at the other facilities.

Trustee Indulkar was surprised that the Medicare numbers were so low. Mr. Espinoza said there were over 900 post-acute beds on the island. AHS was not the largest facility; the other facilities were getting a lot of the Medicare patients and the commercial patients from Alameda Hospital. We tended to take the uninsured or lower insured patients. They were currently working on opening the 18 bed short stay skilled facility at Alameda Hospital.

Trustee Indulkar asked if Highland becoming a stroke certified center had anything to do with the increased internal referrals. Mr. Espinoza said they changed their clinical liaisons and how they operated. They also had a stroke certified program through CARF for the acute rehab unit.

## 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*

Trustee Linton asked what the potential 5% revenue increase Ms. Weber spoke of could buy. Ms. Weber said it could buy everything on her needs list.

Trustee Indulkar asked what factors increased efficiency around block utilization. Ms. Weber said the answer was complicated. Trustee Indulkar suggested they come back with a report on that. Ms. Webber said they have a long way to go to work out how they present that data. Mr. Fratzke said when that comes back to the Committee they could include Dr. Victorino and Dr. Lang because they have stepped up in this project.

**G. 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.

**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*

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 May 28, 2025, as approved by the Quality Professional Services Committee on June 25, 2025:

_____
Ronna Jojola Gonsalves
Clerk of the Board

APPROVED AS TO FORM:

Reviewed by: _____

Ahmad Azizi
General Counsel

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

| Alameda Health System | | | CPC Executive Summary to AHS and AH Medical Executive Committee(s) – June 2025 | | | |
|---|---|---|---|---|---|---|
| Policies and Procedures | | | | Chars: Dr. Bullard & Wacheera Davis | | |
| | | | | | | |
| **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** | | | | | | |
| Medication Drug Recall | Priya Patel, PharmD | • Change process of reporting drug recall from Midas to<br>• System P&T approved 5/2025<br>• Consent Item – PolicyTech | | 06/2028 | | • System P&T 5/2025<br>• CPC 6/05/2025<br>• MEC 6/18/2025 |
| Outpatient Pharmacy Dispensing | Nataliya Miller, PharmD | • TJC Triennial review<br>• System P&T approved 5/2025<br>• Consent Item – PolicyTech | | 06/2028 | | • System P&T 5/2025<br>• CPC 6/05/2025<br>• MEC 6/18/2025 |

ALAMEDA HEALTH SYSTEM

# MEDICATION: DRUG RECALL

| | | | |
|---|---|---|---|
| ***Site*** | Alameda Health System | ***Previous Revision Dates*** | 7/2017, 3/2020 |
| ***Effective Date*** | 6/2025 | ***Date Revised*** | 5/2025 |
| ***Document Owner*** | MGR SYS MED SAFETY-CLIN PHARM | ***Next Scheduled Review*** | 5/2028 |
| ***Approvals*** | BOT, QPSC | | |

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

## POLICY

Pharmacy department promotes patient safety by immediate removal of unstable, improperly labeled, or otherwise unsuitable drugs for patient administration. The pharmacy department shall be responsible for the initiation and coordination of removing all medications identified for recall.

DEFINITIONS: Recalls are actions taken by a firm to remove a product from the market. Recalls may be conducted on a firm's own initiative, by FDA request, or by FDA order under statutory authority. Recall may be undertaken voluntarily and at any time by manufacturers and distributors, or at the request of the Food and Drug Administration. A request by the Food and Drug Administration that a firm recall a product is reserved for urgent situations and is to be directed to the firm that has primary responsibility for the manufacture and marketing of the product that is to be recalled.

1. **Class I recall:** a situation in which there is a reasonable probability that the use of or exposure to a violative product will cause serious adverse health consequences or death.
2. **Class II recall:** a situation in which use of or exposure to a violative product may cause temporary or medically reversible adverse health consequences or where the probability of serious adverse health consequences is remote.
3. **Class III recall:** a situation in which use of or exposure to a violative product is not likely to cause adverse health consequences.
4. **Market withdrawal:** occurs when a product has a minor violation that would not be subject to FDA legal action. The firm removes the product from the market or corrects the violation. For example, a product removed from the market due to tampering, without evidence of manufacturing or distribution problems, would be a market withdrawal.
5. **Voluntary Recalls:** Based on 21CFR7 Recall is a voluntary action that takes place because manufacturers and distributors carry out their responsibility to protect the public health and well-being from products that present a risk of injury or gross deception or are otherwise defective.

**PROCEDURE**

1. Upon receipt of "Drug Recall Bulletins" the pharmacy buyer, designated pharmacy technician(s) or pharmacist(s) under direction of pharmacist on duty or management will, within 72 hours. The designee (s) will check pharmacy stock, each nursing station/patient care area and for Class I and Class II agents, the sterile compounding log to identify any current patients who have received the product and take appropriate action as signified by the "Recall Notice" itself
2. Purchase histories are obtained to identify affected product in stock.
3. The buyer, pharmacist on duty or pharmacy staff designee will document "total number in stock" or "none in stock", whichever is applicable on the bulletin or manufacturer's return slip.
    a. For departments that have an automated dispensing machine, the pharmacy technician will remove/return all recalled medications for the pharmacist to sign off.
    b. Upon removal from storage areas, recalled medications will be quarantined in a designated area in the pharmacy until disposition. Documentation will be given to the pharmacy buyer and the Pharmacist-in-Charge (PIC) for verification.
    c. The following documentation will be completed for each recalled items:
        a. Date notified
        b. Date action taken
        c. Action taken: areas inspected, quantities removed, notification of shipment to wholesaler/manufacturer, notifications to prescribers and staff (if necessary),other actions required by the recall notice, law or regulation, and organizational policy
4. The documentation will be completed by the buyer, the Pharmacist-in-Charge (PIC), pharmacist on duty or a pharmacist designee.
5. The buyer, pharmacist on duty or pharmacy technician designee will process all paperwork, and notify the Pharmacist-in-Charge (PIC) or Pharmacy Director in case of any pertinent recalls.
    1. Pertinent recalls will be defined based on FDA classification Class I – III.
6. The pharmacy buyer or pharmacy technician designee is responsible for the proper handling and/or shipping of all recalled items.
7. If deemed appropriate, the medical staff will be informed through the AHS email system orat System P&T meeting,
8. Patients who may have received Class I or II recalled medications will be notified of the recall.
9. After all of the proceeding steps have been taken, pharmacy buyer or pharmacist-in-charge will complete recall documentation into the AHS ECRI Product Recall system in order to track all recalls and notify other potentially affected departments of the recall items.
10. If pharmacy has been advised that a patient has been harmed by using a non-sterile and/or sterile compounded product, pharmacy will report the event to MedWatch within 72 hours, and to AHS specific Midas event reporting immediately.
11. Pharmacy to contact the Board of Pharmacy within 12 hours of the recall notice if the use of or exposure to the recalled drug preparations has caused serious adverse health consequences or death.

**REFERENCES**

TJC MM05.01.17

21 CFR 7.40-59 Title 21 Chapter 7 SubPart C https://www.ecfr.gov/current/title-21/chapter-I/subchapter-A/part-7?toc=1

**APPROVALS**

| | | System | Alameda | AHS/Highland/John George/San Leandro |
|---|---|---|---|---|
| **Department** | **Date:** | 4/2025 | | |
| **Pharmacy and Therapeutics (P&T)** | **Date:** | 5/2025 | | |
| **Clinical Practice Council (CPC)** | **Date:** | 11/2022<br>6/2025 | | |
| **Medical Executive Committee** | **Date:** | 6/2025 | | |
| **Board of Trustees** | **Date:** | 7/2025 | | |

ALAMEDA HEALTH SYSTEM

# OUTPATIENT PHARMACY DISPENSING

| | | | |
|---|---|---|---|
| ***Site*** | Highland/FMT/JGPH/ALH/SLH | ***Previous Revision Dates*** | 3/2017,01/2022 |
| ***Effective Date*** | 8/05 | ***Date Revised*** | 4/2025 |
| ***Document Owner*** | MGR SYS MED SAFETY-CLIN PHARM | ***Next Scheduled Review*** | 4/2028 |



## Purpose

To establish the process for the accurate, safe and compliant processing and filling of outpatient prescriptions at pharmacy locations where take-home medications are prepared.

## Policy

1. Only prescriptions from Alameda Health System (AHS) patients, prescribed by AHS providers, as deemed eligible for 340B (when processed at 340B-sites), will be processed, filled and dispensed.
    a. Prescriptions sent with a corresponding referral documentation may be processed.
    b. For 340B eligible sites, refer to requirements and procedures set forth in the 340B Policy.
2. Proper use of robotic filling devices or automatic delivery device systems (ADDS) and pharmacy software systems, such as Epic-Willow and Willow Ambulatory software equipment and respective bar-coding using National Drug Codes (NDC's) will be used to lessen the risk of dispensing errors.
    a. Examples of automatic delivery devices and storage devices include: ScriptPro, Parata, Pyxis, RxSafe.

## Procedure

1. The pharmacy will ensure the patient is registered within the Epic system.
2. For 340B sites, the pharmacy will ensure the patient is eligible under340B eligible, before proceeding.
3. All prescriptions will be checked for accuracy, drug-drug interactions, allergy, drug-disease interactions, and completeness at clinical review, point of take-in, or order entry.
    a. If clarifications are needed or concerning red flags arise, provider and/or patient will be contacted to facilitate resolution.
4. All pharmacy regulations must be followed, including but not limited to Board of Pharmacy requirements, DEA requirements, HRSA 340B requirements.
5. Receipt of controlled substance prescriptions should be in electronic format via DEA compliant systems, such as Epic software system.

6. Pharmacy may continue to dispense medications from legally valid written, oral, or faxed prescriptions pursuant to Board of Pharmacy- Business and Professions Code Subdivision 688(i).
    a. In the case where a directly printed prescription order is received, only Schedule II-V medications must be on a compliant prescription form with a serialized barcode.
        i. Telephone prescriptions may be accepted for non-control or schedule III-V medications if there is an IT barrier with sending an electronic prescription, or other applicable parameters as listed within Business and Professions Code 688.
            1. Faxed prescriptions are only accepted if sent from a secure number, for non-control or schedule III-V.

7. Medications will be pulled and filled in in a manner that ensures accuracy, package integrity, quality, storage and safe handling.

8. Prescriptions may interface with an automatic delivery device system (ADDS), if the medication is loaded into the device.
    a. Highland Outpatient Pharmacy Only: prescriptions filled via ADDS will be done with ScriptPro.
        i. Routine maintenance of the ScriptPro machine will be performed according to manufacturer's guidelines to ensure the cells are calibrated appropriately and cleaned to reduce dust particles.
        ii. Random audits will be conducted to ensure correct dispensation of medications.
        iii. Pharmacists or Epic-Willow analysts are responsible for updating the NDC that is loaded into the ScriptPro and linking it in Epic.
        iv. Pharmacy personnel are responsible for refilling the ScriptPro cells with the correct medication and updating the expiration date and lot numbers on the cells.
    b.

9. The pharmacist will verify prescriptions at the verification step to ensure proper the medication was accurately filled, ensure proper labeling and printing of medication guides and monographs.

10. All prescription labels will be completed with expiration date and initials of reviewing pharmacist and if applicable, filling technician..

Lot or batch number will be included for compounded medications. -.

11. The Epic-Willow trainer is responsible for systems training; the Epic security team is responsible for assigning user access.

12. If applicable, co-pays or share of cost are collected at the point of dispensation (refer to Cash Control Policy and Medication Discharge Policy).

13. All pharmacy personnel will dispense medications to the patient, nurse, provider, clinic team member, or patient's agent using two patient identifiers (name, social security number and/or date of birth, MRN, address, phone number).
    a. Proof of identification is required when patients are picking up CII-V medications.

14. All of the patient's prescription information will appear within Epic point of sale. The technician or pharmacist will verify the number of prescriptions and medications with the patient or patient's agent.

15. The patient or patient's agent will sign for or notate receipt of the medication.
16. Consultation will be provided for the following:
    a. For new medications
    b. For medications dispensed in a different dosage form, strength, or with new directions
    c. Upon request from the patient or provider
    d. Whenever pharmacist deems it is warranted

    Consultation declinations may only be provided to a pharmacist or intern-pharmacist (under direct pharmacist supervision).
17. If consultation is requested, only a registered pharmacist or intern under the direct supervision of the pharmacist is authorized. The pharmacist will provide the following at a minimum (patient information sheets may also be provided):
    a. Name of medications
    b. Indications if known
    c. Directions for use
    d. Potential Drug-food or drug-drug interactions
    e. Potential side effects
    f. Essential storage information
    g. Any other pertinent information

18. For medications that are delivered to the patient by a healthcare provider or team member, nurse, or through the courier delivery process, patient will be provided a consultation notice with instructions to contact the pharmacy to review their medications.
    a. For medications that are delivered through the meds-to beds- process, to the nurse or nursing unit or emergency room, the provider or nurse will provide the patient teaching and consultation.
19. Prescriptions will be profiled or returned to stock in the following situations:
    a. Prescriptions are received and are too soon based on last filled date, or are not yet due for the patient
    b. Prescriptions that are not picked up or fail courier delivery
    c. Upon request of patient, patient's agent, or provider
20. For Highland Outpatient Pharmacy only: Patients may request refills by doing any of the following:
    a. Coming to the pharmacy during business hours
    b. Accessing MyChart

c. Calling the pharmacy and placing a request with pharmacy personnel
d. Calling the pharmacy and requesting refill automatically via IVR

**Approvals**

| | |
|---|---|
| **Departmental** | **Date: 1/2022, 4/2025** |
| **System Pharmacy and Therapeutics Committee** | **Date: 2/2022, 5/2025** |
| **Clinical Practice Committee** | **Date: 3/2022, 6/2025** |
| **Medical Executive Committee** | **Date: 3/2022, 6/2025** |
| **Board of Trustees** | **Date: 4/2022, 6/2025** |

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

ALAMEDA HEALTH SYSTEM

June 25, 2025

**TO:** Quality Professional Services Committee

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

**SUBJECT:** **Agenda Item:** A3

**Meeting Date:** June 25, 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:**
- Identifying and Credentialing HIV/AIDS Specialists

**AHS Medical Staff:**
- Medical Staff Department Structure and Division Leadership
- Introduction of a New Privilege or New Privilege for a Specific Department or Specialty

# Alameda Health System

## IDENTIFYING AND CREDENTIALING HIV/AIDS SPECIALISTS

| | | | |
|---|---|---|---|
| ***Department*** | Medical Staff | ***Effective Date*** | 3/2018 |
| ***Campus*** | AHS, AH | ***Date Revised*** | 3/2022; 2/2023; 5/2023; 6/2025 |
| ***Unit*** | Medical Staff | ***Next Scheduled Review*** | 6/2029 |
| ***Manual*** | Medical Staff | ***Author*** | Manager, Medical Staff Services |
| ***Replaces the following Policies:*** | | ***Responsible Person*** | Chief of Staff |

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

### Purpose

This policy as an extension of the Medical Staff Bylaws, Rules and Regulations and Policies of the Alameda Health System (AHS) and Alameda Hospital (AH) Medical Staffs, establishes the verification steps for designation of HIV/AIDS physician specialists.

### Policy Statement

This policy of the Medical Staff at Alameda Health System (AHS) and Alameda Hospital (AH) is to ensure that HIV/AIDS specialists wishing to be designated as such are identified and meet the qualifying criteria as defined by the California State Regulations.

### Procedure

1. Annually, the Medical Staff Department verifies the HIV/AIDS credentials of any physician requesting to be so designated based upon the criteria of an HIV/AIDS Specialist according to California State regulations prior to being listed as an HIV/AIDS Specialist.

2. The physician will be required to complete the form which includes attestation of the required qualifications of an HIV / AIDS specialist (Attachment A). This form will be maintained in the physician's credentials file and made available, electronically, to the respective department(s) requiring notification.

3. The Medical Staff Department's Provider Enrollment Services provides a list of identified qualifying physicians to the payors.

4. In accordance with the Alameda Health System Confidentiality Policy and all applicable state and federal laws, any and all information that is required to be kept confidential, shall be kept confidential.

5. The HIV/AIDS specialist may utilize the services of a nurse practitioner or physician assistant if:

a. The nurse practitioner or physician assistant is under the supervision of an HIV/AIDS specialist; and
b. The nurse practitioner or physician assistant meets the qualifications specified in subsection (e)(4); and
c. The nurse practitioner or physician assistant and that provider's supervising HIV/AIDS specialist have the capacity to see an additional patient.

**Definitions / Acronyms**

A. AIDS means Acquired Immunodeficiency Syndrome
B. HIV means Human Immunodeficiency Virus
C. Category 1 continuing medical education means continuing medical education courses recognized as qualifying for category 1 credit by the Medical Board of California
D. HIV/AIDS Specialist means a physician who holds a valid, unrevoked and unsuspended certificate to practice medicine in the state of California who meets any one of the following four criteria:
   1. Is credentialed as an "HIV Specialist" by the American Academy of HIV Medicine; or
   2. Is board certified in HIV Medicine, or has earned a Certificate of Added Qualification in the field of HIV Medicine granted by a member board of the American Board of Medical Specialties; or
   3. Is board certified in the field of Infection Diseases by a member board of the American Board of Medical Specialties and meets the following qualifications:
      a. In the immediately preceding 12 months has clinically managed medical care to a minimum of 25 patients who are infected with HIV; and
      b. In the immediately preceding 12 months has successfully completed a minimum of 15 hours of category 1 continuous medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients, including a minimum of five (5) hours related to antiretroviral therapy per year; or
   4. In the immediately preceding 24 months has clinically managed medical care to a minimum of 20 patients who are infected with HIV; and has completed any of the following:
      a. In the immediately preceding 12 months has obtained board certification or re-certification in the field of Infectious Disease from a member board of the American Board of Medical Specialties; or
      b. In the immediately preceding 12 months has successfully completed a minimum of 30 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients; or
      c. In the immediately preceding 12 months has successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients and has successfully completed the HIV

Medicine Competency Maintenance Examination administered by the American Academy of HIV Medicine.

Resources

- Alameda Health System and Alameda Hospital, Medical Staff Bylaw, Rules & Regulations, Policies and Procedures.
- Cal. Code Regs. Tit. 28, § 1300.74.16
- H&SC, Division 2, Chapter 2.2, § Article 5 1374.16

**Approvals:**

| | | AHS Core | AH |
|---|---|---|---|
| **Credentials Committee** | **Date:** | **6/12/25** | |
| **Medical Executive Committee** | **Date:** | **6/18/25** | **6/20/25** |
| **QPSC** | **Date:** | **6/25/25** | |

ALAMEDA HEALTH SYSTEM

**Letter to Practitioner**
**Screening for Identification of Qualified HIV/AIDS Practitioners**

[Date]

[Insert practitioner's name]
[Insert address]
[Insert City, State Zip]

Dear Doctor [name],

California Health & Safety Code (CA H&SC) 1374.16 requires the establishment of a process for standing referrals to a specialist, to include a process to refer a member with a condition or disease that requires specialist medical care over a prolonged period of time or is life-threatening, degenerative, or disabling to a specialist or specialty care center that has expertise in treating the condition or disease.

California code 28 CCR1300.74.16 (e) establishes the required qualifications of an HIV/AIDS specialist to whom a member is being referred on an extended or standing basis, under the conditions of CA H&SC 1374.16.

In order to comply with this regulation, we need to routinely identify appropriately qualified specialists within the payer networks who meet the definition of an HIV/AIDS specialist. Please complete the attached form indicating:

• Your preference to be listed as a qualifying HIV/AIDS specialist for the purpose of receiving standing referrals for members whose condition requires ongoing treatment by a practitioner with the specified expertise in treating their condition.

• If you state you wish to be listed for purposes of standing referrals, then please indicate the criterion or criteria, as defined by state regulation, under which you qualify. You must meet at least one of these criteria as written in order to qualify.

We will provide your information to the payers for internal referral procedures.
As always, please notify us promptly if information about your clinical practice changes.

Thank you for your cooperation. We appreciate your continued dedication to our patients.
Sincerely,

*Alameda Health System Medical Staff Services*

ALAMEDA HEALTH SYSTEM

**Medical Staff HIV/AIDS Specialist Designation Form**

□ No, I do not wish to be designated as an HIV/AIDS specialist.

□ Yes, I do wish to be designated as an HIV/AIDS specialist based on one of the criteria below:

□ I am credentialed as an "HIV Specialist" by the American Academy of HIV Medicine ***OR***
□ I am board certified in HIV Medicine or have earned a Certificate of Added Qualification in the field of HIV Medicine granted by a member board of the American Board of Medical Specialties. ***OR***
□ I am board certified in Infectious Disease by a member board of the American Board of Medical Specialties and meet the following qualifications:

1. In the immediately preceding 12 months, I have clinically managed medical care to a minimum of 25 patients who are infected with HIV; **AND**
2. In the Immediately preceding 12 months, I have successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV Infection, combined with diagnosis, treatment or both of HIV-infected patients, including a minimum of 5 hours related to antiretroviral therapy per year ***OR***

□ Meet the following qualifications:
In the Immediately preceding 24 months, I have clinically managed medical care to a minimum of 20 patients who are infected with HIV; **AND** Completed any of the following:

1. In the immediately preceding 12 months, I have obtained board certification or re-certification in the field of Infectious Disease from a member board of the American Board of Medical Specialties; ***OR***
2. In the immediately preceding 12 months, I have successfully completed a minimum of 30 hours of category I continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment or both, of HIV-infected patients; ***OR***
3. In the immediately preceding 12 months, I have successfully completed a minimum of 15 hours of category I continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment or both, of HIV-infected patients Medicine and successfully completed the HIV Medicine Competency Maintenance Examination administered by the American Academy of HIV Medicine.

I attest that, to the best of my knowledge, the above information can be supported by documentation (if required).

Physician's Name (print): _____ Date:_____
Physician's Signature: _____ License#:
_____
Physician's NPI: _____Telephone #:
_____

# Alameda Health System

## MEDICAL STAFF DEPARTMENT STRUCTURE AND DIVISION LEADERSHIP

| | | | |
|---|---|---|---|
| ***Department*** | Medical Staff | ***Effective Date*** | 9/2023 |
| ***Campus*** | AHS | ***Date Revised*** | 1/24/24, 1/29/25, 5/21/25, 6/18/25 |
| ***Unit*** | All | ***Next Scheduled Review*** | 6/2028 |
| ***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.

**Site Director Qualifications**

Each Site Director must be an Active Staff member or a Provisional Staff member and a member of the department. The Site Director must be qualified by training, experience, and demonstrated current ability in the clinical area covered by the Department.

**Site Director Appointment and Removal**

A Site Director 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 Site Director's performance shall be periodically reviewed by the Chair of the Department and the appointment shall continue if performance is satisfactory.

A Site Director will immediately cease being the Site Director 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 Site Director role is eliminated.

**Site Director Duties**

a. 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;

b. evaluate the clinical work performed at the site;

c. conduct inquiries and investigations and submit reports and recommendations to the Chair of the Department;

d. 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** |
|---|---|---|
| **Medical Executive Committee** | **Date:** | **6/18/2025** |
| **Quality Professional Services Committee of the Board** | **Date:** | |

# Alameda Health System

## INTRODUCTION OF A NEW PRIVILEGE OR A NEW PRIVILEGE FOR A SPECIFIC DEPARTMENT OR SPECIALTY

| | | | |
|---|---|---|---|
| ***Department*** | Medical Staff | ***Effective Date*** | 4/2003 |
| ***Campus*** | AHS, AH | ***Date Revised*** | 2/2008, 10/2011, 6/2014, 6/2017, 6/2019, 6/2022, 6/2025 |
| ***Unit*** | Medical Staff | ***Next Scheduled Review*** | 6/2028 |
| ***Manual*** | Medical Staff | ***Author*** | Vice President, Physician Services |
| ***Replaces the following Policies:*** | | ***Responsible Person*** | Chief Medical Officer |

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

### Purpose

As medical technology changes, the types of services provided by the Medical Staff also change. As medical technology changes the groups of practitioners within the Medical Staff providing a specific clinical service or procedure may also change. The purpose of this policy is to define the procedure for introducing a new privilege into the Medical Staff or introducing a new privilege into a specific department or specialty.

### Policy

All practitioners who provide clinical services at Alameda Health System (AHS) and Alameda Hospital (AH) must be competent to perform the services they provide. When members of different departments or specialties exercise the same privilege, there must be an equivalent comparable standard for the granting of the same clinical privilege in each department or specialty.

### Procedure

Introducing a new procedure to AHS and AH

1. If a practitioner or group of practitioners (collectively referred to as "Medical Staff Members") wish to exercise a new privilege at AHS and AH , the Medical Staff Members shall submit the request for the new privilege in writing to the Division Chief (if applicable), Site Director, Department Chair, or Chief of Staff.

2. The Medical Staff Members' request for a new privilege should include the following information:
    a. A detailed description of the privilege.
    b. Copies of scientific articles related to the privilege.
    c. Recommendations for specific training and education necessary to be granted the new privilege.
    d. Recommendations for specific experience and current competence necessary to be granted the new privilege.
    e. Recommendations for proctoring requirements to the new privilege.

   f. Recommendations for the number of times the privilege must be exercised or performed during a two- (2) year reappointment cycle in order to maintain current competence.
   g. Other information that is relevant and required in Attachment A

3. If the new privilege is an update or replacement of an existing privilege and no new additional credentialing criteria are required, this information shall also be submitted to the Division Chief/ Site Director.

4. The Division Chief/Site Director shall review the information submitted and make a recommendation to the Department Chair regarding the addition of the new privilege, and if addition of the privilege is recommended, a recommendation also shall be made regarding criteria for the new privilege. The Division Chief's/Site Director's recommendation shall address items A2 (c-f) described above and include a copy of all relevant supporting documents.

5. The recommendation of the Division Chief/Site Director shall also include submission of Attachment A —"Criteria for New Privilege Delineation."

6. The Department Chair shall review the information submitted and make a recommendation to the Credentials Committee regarding the addition of the new privilege, and if addition of the privilege is recommended, a recommendation also shall be made regarding criteria for the new privilege. The Department Chair's recommendation shall address items A2 (c-f) described above and include a copy of all relevant supporting documents.

7. The recommendation of the Department Chair shall also include submission of Attachment A.

8. The Credentials Committee shall review the recommendation of the Department Chair and shall:
   a. Meet with a representative of the Medical Staff Members requesting the new privilege.
   b. Submit a recommendation to the Medical Executive Committee regarding whether the new privilege should be introduced at AHS and, if so, the specific credentialing criteria to be utilized.

9. The Medical Executive Committee shall review the recommendation of the Credentials Committee and may request an interview with a representative of the Medical Staff Members requesting the new privilege. The recommendation of the Medical Executive Committee regarding the new privilege, including the criteria for granting the new privilege, will be forwarded to the Quality Professional Service Committee (QPSC) of the Board of Trustees for action.

10. Once a new privilege has been approved by favorable recommendation of the Medical Executive Committee, practitioners who meet all applicable criteria may begin to apply for the new privilege. No new privileges will be granted, however,

until the new privilege and associated criteria have been reviewed and approved by the QPSC and appropriate organizational and nursing policies and procedures have been developed and implemented as may be necessary to support the safe and effective performance of the new privilege.

Introducing a new privilege in one department which is currently being granted by another department or specialty

1. The Department Chair, upon recommendation by the Division Chief/Site Director, shall recommend to the Medical Executive Committee the addition of the new privilege to the department privilege delineation form.

2. If the Medical Staff is not currently utilizing appropriate criteria for the privilege, the procedure described in Section A shall be followed to develop appropriate criteria. All departments or specialties that will be granting the privilege will be involved in the criteria development process. The recommendations of this interdepartmental group shall be submitted to the Medical Executive Committee for action.

3. If appropriate criteria for the privilege have already been developed, a meeting will be scheduled to include the Division Chief/Site Director, the Department Chair, and specialty representatives from each department in which the privilege is currently granted and those departments who wish to grant the clinical privilege in the future. The interdepartmental group will meet to assure either development of single criteria that are applicable to all departments and specialties **or** development of multiple equivalent comparable criteria sets.

4. If multiple equivalent comparable criteria sets are designed, the interdepartmental group must assure that a single level of care is maintained relevant to granting of the privilege.

5. The interdepartmental group shall submit a recommendation to the Medical Executive Committee for action.

6. If the interdepartmental group is unable to arrive at consensus related to privilege criteria, the issue will be referred to the Medical Executive Committee for evaluation and action.

7. The Medical Executive Committee may recommend privileging criteria to the QPSC with or without the recommendation of the interdepartmental group.

Medical Executive Committee's Considerations

1. In making a recommendation regarding the granting of a new privilege or extending an existing privilege to a new department or specialty, the Medical Executive Committee shall consider the following:

a. Whether the new privilege may be performed safely using the health system's available resources including facilities, equipment, support personnel, and support services.
b. Whether the current composition of the Medical Staff permits its members to appropriately monitor and review the competence of those who perform the new privilege or whether it is feasible to arrange to have other qualified physicians proctor performance of the new privilege.
c. Whether qualified physicians are available to provide continuous care in the event physicians performing the new privileges are unavailable or ill.
d. Whether sufficient research has been conducted to determine the new privilege is safe and clinically efficacious.
e. Whether the performance of the new privilege poses any bioethical concerns.
f. Whether the benefits of the new privilege outweigh the consequences of not exercising the new privilege.

2. The Medical Executive Committee shall also consider information available from other organizations currently performing the new procedure and/or other organizations that have extended the new privilege to additional departments or specialties.

Quality Monitoring

1. When the Medical Staff has added a new privilege, or a new privilege has been added to a particular department or specialty, the VP/Director of Quality Management (or designee) shall be notified.

2. The VP/Director of Quality Management (or designee shall work with appropriate Medical Staff representatives to determine if and how the new privilege shall be included in the organization's performance improvement program.

3. The Medical Executive Committee, prior to granting the privilege to any Medical Staff Member, shall review issues regarding quality management monitoring related to the privilege.

**Approvals**

| | | **AHS** | **Alameda** |
|---|---|---|---|
| **Medical Executive Committee** | **Date:** | **6/18/2025** | **6/20/2025** |
| **QPSC** | **Date:** | | |

**ATTACHMENT A**

## Introduction of a New Privilege or a New Privilege for a Specific Department or Specialty

### CRITERIA FOR NEW PRIVILEGE DELINEATION

**SPECIFIC PROCEDURE:**

**DEPARTMENT/DIVISION:**

**DESCRIPTION:**

**Training & Education**

**Experience & Current Competence**

**Proctoring Requirements**

**Reappointment Requirements**

Recommend ☐ As submitted ☐ With the following modifications

**Approval:**
Department Chair : _____ Date : _____

Division Chief :_____ Date : _____

# B4. Approval of the AHS Medical Staff Revised Application Forms and Revised Privilege Forms listed below:

ALAMEDA HEALTH SYSTEM

June 25, 2025

**TO:** Quality Professional Services Committee

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

**SUBJECT:** **Agenda Item:** B4

**Meeting Date:** June 25, 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:**
- HIV AIDS Specialist Designation Letter and Form

**Revised Privilege Forms for AHS:**
- Pediatrics – Developmental Behavioral
- Pain Medicine Advanced Practice Provider

*Add to physician initial application and reapplication portals*

**Letter to Practitioner**
**Screening for Identification of Qualified HIV/AIDS Practitioners**

California Health & Safety Code (CA H&SC) 1374.16 requires the establishment of a process for standing referrals to a specialist, to include a process to refer a member with a condition or disease that requires specialist medical care over a prolonged period of time or is life-threatening, degenerative, or disabling to a specialist or specialty care center that has expertise in treating the condition or disease.

California code 28 CCR1300.74.16 (e) establishes the required qualifications of an HIV/AIDS specialist to whom a member is being referred on an extended or standing basis, under the conditions of CA H&SC 1374.16.

In order to comply with this regulation, we need to routinely identify appropriately qualified specialists within the payer networks who meet the definition of an HIV/AIDS specialist. Please complete the attached form indicating:

• Your preference to be listed as a qualifying HIV/AIDS specialist for the purpose of receiving standing referrals for members whose condition requires ongoing treatment by a practitioner with the specified expertise in treating their condition.

• If you state you wish to be listed for purposes of standing referrals, then please indicate the criterion or criteria, as defined by state regulation, under which you qualify. You must meet at least one of these criteria as written in order to qualify.

We will provide your information to the payers for internal referral procedures.
As always, please notify us promptly if information about your clinical practice changes.

Thank you for your cooperation. We appreciate your continued dedication to our patients.
Sincerely,

*Alameda Health System Medical Staff Services*

ALAMEDA HEALTH SYSTEM

# Medical Staff HIV/AIDS Specialist Designation Form

**Physician Name:** _____ **License #:** _____

**Department/Division:** _____

☐ No, I do not wish to be designated as an HIV/AIDS specialist.

☐ Yes, I do wish to be designated as an HIV/AIDS specialist based on one of the criteria below:

☐ I am credentialed as an "HIV Specialist" by the American Academy of HIV Medicine

**OR**

☐ I am board certified in HIV Medicine or have earned a Certificate of Added Qualification in the field of HIV Medicine granted by a member board of the American Board of Medical Specialties.

**OR**

☐ I am board certified in Infectious Disease by a member board of the American Board of Medical Specialties and meet the following qualifications:

1. In the immediately preceding 12 months, I have clinically managed medical care to a minimum of 25 patients who are infected with HIV; **AND**

2. In the Immediately preceding 12 months, I have successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV Infection, combined with diagnosis, treatment or both of HIV-infected patients, including a minimum of 5 hours related to antiretroviral therapy per year: **OR**

☐ Meet the following qualifications:

In the Immediately preceding 24 months, I have clinically managed medical care to a minimum of 20 patients who are infected with HIV; **AND**

Completed any of the following:

1. In the immediately preceding 12 months, I have obtained board certification or re-certification in the field of Infectious Disease from a member board of the American Board of Medical Specialties; **OR**

2. In the immediately preceding I 2 months, I have successfully completed a minimum of 30 hours of category I continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment or both, of HIV-infected patients; **OR**

3. In the immediately preceding 12 months, I have successfully completed a minimum of 15 hours of category I continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment or both, of HIV-infected patients Medicine and successfully completed the HIV Medicine Competency Maintenance Examination administered by the American Academy of HIV Medicine.

I attest that, to the best of my knowledge, the above information can be supported by documentation (if required).

Physician's Name (Print): _____ Date: _____

Physician's Signature: _____ Telephone #: _____

Name of Person Submitting Form / Title: _____

Physician's Signature: _____ License#: _____
Physician's NPI: _____Telephone #: _____

# Pediatrics - Developmental-Behavioral -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 or AOA accredited Residency training program in Pediatrics.<br>**AND**<br>Completion of an ACGME accredited Fellowship training program in Developmental Behavioral Pediatrics. |
| **Certification** | Current certification or board eligibility in the examination process leading to certification in Developmental Behavioral Pediatrics by the American Board of Pediatrics. |
| **Clinical Experience (Initial/Reappointment)** | Applicant must provide documentation of provision of 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 BLS 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 | |

## Primary Privileges in Developmental-Behavioral Pediatrics

***Description:*** Developmental-Behavioral pediatrics is the pediatric subspecialty that focuses on the complex developmental processes of infants, children, adolescents, and young adults in the context of their families and communities; understanding the biological, psychological, and social influences in development in emotional, social, motor, language, and cognitive domains; and identification and treatment of disorders of behavior and development throughout childhood and adolescence.

| Request | ***Request all privileges listed below.*** *Uncheck any privileges that you do not want to request.* | Dept Chair Rec |
|---|---|---|
| | **Evaluation and Management** | |
| | Evaluate, diagnose, consult, manage, and provide treatment to patients presenting with cognitive, language, motor, behavioral, or emotional concerns, delays, or disorders. These conditions may be associated with additional psychiatric conditions, medical illnesses, genetic disorders, or neurological conditions. In addition to a thorough physical, neurological, and neurobehavioral examination, the evaluation may include the use of laboratory and genetic testing, as well as the administration of standardized psychological, psycho-educational, or neuropsychological assessments. The evaluation may also include gathering additional information from immediate and/or extended family members; teachers and/or other school- or preschool-based staff; or community-based workers, such as social workers or public health nurses, to obtain information necessary for diagnosis of the child | |
| | Treatment may include individual, family, parenting, and group therapy | |
| | Prescribe psychopharmacological therapy for neurobehavioral and neurodevelopmental disorders and monitor progress of children on therapy | |

| 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

# Alameda Health System

## IDENTIFYING AND CREDENTIALING HIV/AIDS SPECIALISTS

| | | | |
|---|---|---|---|
| ***Department*** | Medical Staff | ***Effective Date*** | 3/2018 |
| ***Campus*** | AHS, AH | ***Date Revised*** | 3/2022; 2/2023; 5/2023; 6/2025 |
| ***Unit*** | Medical Staff | ***Next Scheduled Review*** | 6/2029 |
| ***Manual*** | Medical Staff | ***Author*** | Manager, Medical Staff Services |
| ***Replaces the following Policies:*** | | ***Responsible Person*** | Chief of Staff |

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

### Purpose

This policy as an extension of the Medical Staff Bylaws, Rules and Regulations and Policies of the Alameda Health System (AHS) and Alameda Hospital (AH) Medical Staffs, establishes the verification steps for designation of HIV/AIDS physician specialists.

### Policy Statement

This policy of the Medical Staff at Alameda Health System (AHS) and Alameda Hospital (AH) is to ensure that HIV/AIDS specialists wishing to be designated as such are identified and meet the qualifying criteria as defined by the California State Regulations.

### Procedure

1. Annually, the Medical Staff Department verifies the HIV/AIDS credentials of any physician requesting to be so designated based upon the criteria of an HIV/AIDS Specialist according to California State regulations prior to being listed as an HIV/AIDS Specialist.

2. The physician will be required to complete the form which includes attestation of the required qualifications of an HIV / AIDS specialist (Attachment A). This form will be maintained in the physician's credentials file and made available, electronically, to the respective department(s) requiring notification.

3. The Medical Staff Department's Provider Enrollment Services provides a list of identified qualifying physicians to the payors.

4. In accordance with the Alameda Health System Confidentiality Policy and all applicable state and federal laws, any and all information that is required to be kept confidential, shall be kept confidential.

5. The HIV/AIDS specialist may utilize the services of a nurse practitioner or physician assistant if:

a. The nurse practitioner or physician assistant is under the supervision of an HIV/AIDS specialist; and
b. The nurse practitioner or physician assistant meets the qualifications specified in subsection (e)(4); and
c. The nurse practitioner or physician assistant and that provider's supervising HIV/AIDS specialist have the capacity to see an additional patient.

**Definitions / Acronyms**

A. AIDS means Acquired Immunodeficiency Syndrome
B. HIV means Human Immunodeficiency Virus
C. Category 1 continuing medical education means continuing medical education courses recognized as qualifying for category 1 credit by the Medical Board of California
D. HIV/AIDS Specialist means a physician who holds a valid, unrevoked and unsuspended certificate to practice medicine in the state of California who meets any one of the following four criteria:
   1. Is credentialed as an "HIV Specialist" by the American Academy of HIV Medicine; or
   2. Is board certified in HIV Medicine, or has earned a Certificate of Added Qualification in the field of HIV Medicine granted by a member board of the American Board of Medical Specialties; or
   3. Is board certified in the field of Infection Diseases by a member board of the American Board of Medical Specialties and meets the following qualifications:
      a. In the immediately preceding 12 months has clinically managed medical care to a minimum of 25 patients who are infected with HIV; and
      b. In the immediately preceding 12 months has successfully completed a minimum of 15 hours of category 1 continuous medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients, including a minimum of five (5) hours related to antiretroviral therapy per year; or
   4. In the immediately preceding 24 months has clinically managed medical care to a minimum of 20 patients who are infected with HIV; and has completed any of the following:
      a. In the immediately preceding 12 months has obtained board certification or re-certification in the field of Infectious Disease from a member board of the American Board of Medical Specialties; or
      b. In the immediately preceding 12 months has successfully completed a minimum of 30 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients; or
      c. In the immediately preceding 12 months has successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients and has successfully completed the HIV

Medicine Competency Maintenance Examination administered by the American Academy of HIV Medicine.

Resources

- Alameda Health System and Alameda Hospital, Medical Staff Bylaw, Rules & Regulations, Policies and Procedures.
- Cal. Code Regs. Tit. 28, § 1300.74.16
- H&SC, Division 2, Chapter 2.2, § Article 5 1374.16

**Approvals:**

| | | AHS Core | AH |
|---|---|---|---|
| **Credentials Committee** | **Date:** | **6/12/25** | |
| **Medical Executive Committee** | **Date:** | **6/18/25** | **6/20/25** |
| **QPSC** | **Date:** | **6/25/25** | |

ALAMEDA HEALTH SYSTEM

**Letter to Practitioner**
**Screening for Identification of Qualified HIV/AIDS Practitioners**

[Date]

[Insert practitioner's name]
[Insert address]
[Insert City, State Zip]

Dear Doctor [name],

California Health & Safety Code (CA H&SC) 1374.16 requires the establishment of a process for standing referrals to a specialist, to include a process to refer a member with a condition or disease that requires specialist medical care over a prolonged period of time or is life-threatening, degenerative, or disabling to a specialist or specialty care center that has expertise in treating the condition or disease.

California code 28 CCR1300.74.16 (e) establishes the required qualifications of an HIV/AIDS specialist to whom a member is being referred on an extended or standing basis, under the conditions of CA H&SC 1374.16.

In order to comply with this regulation, we need to routinely identify appropriately qualified specialists within the payer networks who meet the definition of an HIV/AIDS specialist. Please complete the attached form indicating:

• Your preference to be listed as a qualifying HIV/AIDS specialist for the purpose of receiving standing referrals for members whose condition requires ongoing treatment by a practitioner with the specified expertise in treating their condition.

• If you state you wish to be listed for purposes of standing referrals, then please indicate the criterion or criteria, as defined by state regulation, under which you qualify. You must meet at least one of these criteria as written in order to qualify.

We will provide your information to the payers for internal referral procedures.
As always, please notify us promptly if information about your clinical practice changes.

Thank you for your cooperation. We appreciate your continued dedication to our patients.
Sincerely,

*Alameda Health System Medical Staff Services*

ALAMEDA HEALTH SYSTEM

**Medical Staff HIV/AIDS Specialist Designation Form**

□ No, I do not wish to be designated as an HIV/AIDS specialist.

□ Yes, I do wish to be designated as an HIV/AIDS specialist based on one of the criteria below:

□ I am credentialed as an "HIV Specialist" by the American Academy of HIV Medicine ***OR***
□ I am board certified in HIV Medicine or have earned a Certificate of Added Qualification in the field of HIV Medicine granted by a member board of the American Board of Medical Specialties. ***OR***
□ I am board certified in Infectious Disease by a member board of the American Board of Medical Specialties and meet the following qualifications:

1. In the immediately preceding 12 months, I have clinically managed medical care to a minimum of 25 patients who are infected with HIV; **AND**
2. In the Immediately preceding 12 months, I have successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV Infection, combined with diagnosis, treatment or both of HIV-infected patients, including a minimum of 5 hours related to antiretroviral therapy per year ***OR***

□ Meet the following qualifications:
In the Immediately preceding 24 months, I have clinically managed medical care to a minimum of 20 patients who are infected with HIV; **AND** Completed any of the following:

1. In the immediately preceding 12 months, I have obtained board certification or re-certification in the field of Infectious Disease from a member board of the American Board of Medical Specialties; ***OR***
2. In the immediately preceding 12 months, I have successfully completed a minimum of 30 hours of category I continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment or both, of HIV-infected patients; ***OR***
3. In the immediately preceding 12 months, I have successfully completed a minimum of 15 hours of category I continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment or both, of HIV-infected patients Medicine and successfully completed the HIV Medicine Competency Maintenance Examination administered by the American Academy of HIV Medicine.

I attest that, to the best of my knowledge, the above information can be supported by documentation (if required).

Physician's Name (print): _____ Date:_____
Physician's Signature: _____ License#: _____
Physician's NPI: _____Telephone #: _____

# Alameda Health System
# and
# Alameda Hospital
# Medical Executive Committee
# Report to
# Quality Professional Services Committee of the Board

**Berenice Perez, MD, AHS Chief of Staff**

**Cathy Pyun, DO, AH Chief of Staff**

# Medical Staff Leadership & Administrative Leadership Responsibilities


Presentation by Ann Mary Olson, Sr. Assoc General Counsel & Jennifer Jackson, Medical Staff Services Manager


Highlighted the intersection and separation of responsibilities when a physician leader is appointed dual roles from Medical Staff and Administration


Reviewed AHS and AH Medical Staffs reporting in accordance with:
- Governance structure of the Medical Staff Bylaws, Policies and Procedures

# Graduate Medical Education (GMEC) Annual Report for the Academic Year 2024-2025

The Graduate Medical Education Committee (GMEC) at Alameda Health System, Highland Hospital fulfills its Accreditation Council of Graduate Medical Education (ACGME) Accreditation status.

Our sponsoring institution and all of our programs (Accreditation Council for Graduate Medical Education or ACGME and Council of Dental Accreditation or CODA) have continued to maintain full continued accreditation status.

Addiction Medicine Fellowship has inaugural site visit approximately September 1, 2025

Oral Maxillofacial Surgery (OMFS) has a scheduled CODA site visit upcoming in 2026

Our 10-year ACGME institutional virtual site visit was on 6/11/2024 which resulted in Continued Accreditation and 3 areas not in compliance (citations).

Our institution does not have any underperforming programs currently.

ALAMEDA HEALTH SYSTEM

# AHS Medical Staff Patient Safety Committee– April 2025

- Report on causes, contributing factors, and process improvement plans of three Root Cause Analysis.

# AHS Clinical Practice Committee

As of May 2025, the Clinical Practice Council is a Medical Staff Committee

Multidisciplinary membership that includes medical staff, quality, nursing, pharmacy, informatics, infection control, and other members as deemed necessary

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).

At the last meeting, the CPC reviewed and approved multiple policies and physician order sets, which have been included in the consent agenda for Board approval.

# Department of Ambulatory and Preventive Medicine Report

Dr. Puranam presented the annual report was presented in a SWOT (Strengths, Weaknesses, Opportunities, Threats) format to succinctly highlight key insights and strategic considerations.

## Strengths

- Strong clinical operational leaders
- QIP metrics
- Staffing to demand
- QI policy
- Controlled Med prescribing guidelines
- Group classes
- In basket NP at Hayward
- Convenience Care clinic at Eastmont
- Chronic care teams for DM and HTN management
- Retreat

## Weaknesses

- Slow to recruit at Hayward
- Staff burnout
- Lack of Population Health Department
- Quality metrics driven by QIP only

# Department of Ambulatory and Preventive Medicine Report – Cont.

## Opportunities

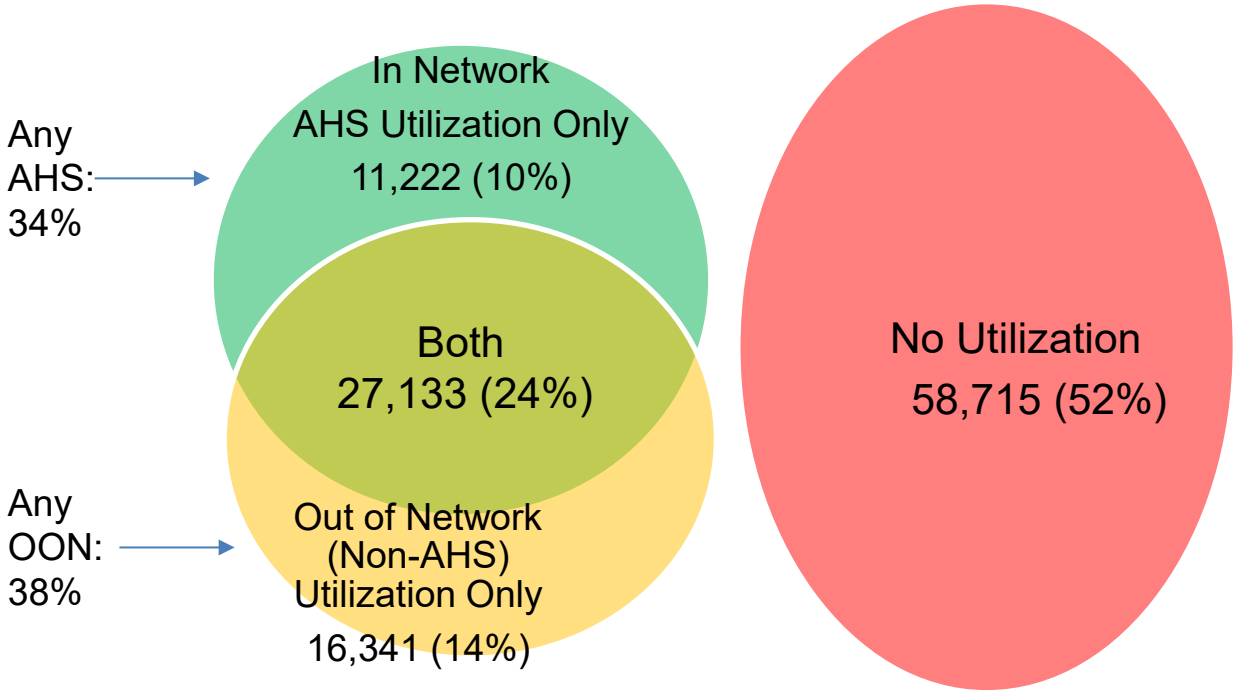
- AI ambient note taking pilot
- In basket management
- Expansion of chronic care team support
- DME referrals
- External Referrals
- SDI processing
- Ambulatory case management and social work support
- Access to outpt services at St Rose
- Collaborate better with Value based care / Health transitions

## Threats

- Assigned but unseen population
- Federal funding cuts
- Refugee clinic

# Department of Ambulatory and Preventive Medicine – Threats


- QIP metrics harder to achieve
  - More metrics now including patients assigned to AHS but not yet seen.
  - Currently approximately 45% of patients with continuous AHS assignment are unseen
- Potential for federal funding cuts
  - Could lead to increase in number of uninsured, reduction in reimbursements and clinic volumes
- Anticipate Refugee clinic volumes to go down




ALAMEDA HEALTH SYSTEM

# Alameda Hospital Transforming Care

- Case Overview/Background
  - One Patient's Journey
- Challenge/Risk
- Intervention
  - Care Coordination
- Outcome
- Strategic Alignment

# D. Quality Reports

**BOT Executive Summary: Quality Report**
**Ana Torres, Vice President of Quality**
**June 25, 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 (HRSN) | | ✓ | |
| Likelihood to Recommend | | ✓ | |

HARMS

Hospital Acquired Pressure Injuries (HAPI) are the most frequently reported harm. The HAPI events peaked in December but have since declined. The improvement strategy centers around early identification of high-risk patients and rapid implementation of prevention measures.

READMISSIONS

Alameda Hospital and San Leandro Hospital are not meeting the readmission goal. The improvement strategy for readmissions is focused on identifying and addressing the challenges of each hospital. Alameda Hospital readmissions are primarily SNF patients admitted for chronic disease management. San Leandro Hospital readmissions are primarily patients with pain management needs and substance use disorder.

LIKELIHOOD TO RECOMMEND:

The Likelihood to Recommend goal for acute care was not met at any of the hospitals. The improvement plan focuses on addressing responsiveness of staff, leader rounding, the discharge communication process which addresses several patient satisfaction areas, reinforcement 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 50$^{th}$ percentile; 20% improvement from baseline (HAPI, Behavior Events); national mean (sepsis mortality); 75$^{th}$ percentile (Patient Experience)

Alameda Hospital

- Metrics meeting benchmark goal: Central line-associated bloodstream infection (CLABSI), MRSA bloodstream infection

- Metrics meeting improvement goal: Catheter associated urinary tract infection (CAUTI), C. difficile infection (CDI), Falls with Injury, and ED Likelihood to Recommend
- Metrics improved over baseline: ED Boarding with a 5% improvement and HRSN with a 13% improvement

Highland

- Metrics meeting benchmark goal: CLABSI, Falls with Injury
- Metrics meeting improvement goal: CAUTI, MRSA, CDI, ED Likelihood to Recommend, and Ambulatory Surgery Likelihood to Recommend
- Metrics improved over baseline: Readmission with a 5% improvement and HRSN with an 18% improvement

San Leandro Hospital

- Metrics meeting benchmark goal: CLABSI, CAUTI, Behavior Events with Injury, HRSN
- Metrics meeting improvement goal: CDI, Falls with Injury, and Ambulatory Surgery Likelihood to Recommend
- Metrics improved over baseline: ED Boarding with a 5% improvement

John George Hospital

- Metrics meeting benchmark goal: Behavior Events with Injury

Ambulatory Care

- Metrics meeting benchmark goal: Behavior Events with Injury
- Metrics meeting improvement goal: Waitlist time for Primary Care

**Key Point 3: Regulatory activity for May 2025 included self-reported events and regulatory visits.**

The following regulatory activities occurred in May 2025:

- Self-reported events: There were three self-reported events. One each from San Leandro Hospital, Highland Hospital, and John George Hospital.
- Surveys:
    - A three-day unannounced survey Joint Commission survey at Alameda Hospital. Corrective action plans are underway.
    - A three-day unannounced CDPH/CMS Validation survey at Highland Hospital.
    - A four-day unannounced CMS EMTALA survey at Highland Hospital.

June
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: combined CMS & CDPH Complaint Validation Survey 05/21/2025 – 05/23/2025
    a. Categories surveyed: Nursing Services, Pt. Rights, Pharmacy Services
    b. Surveyors conducted observations, interviews of staff, medical staff, and visitors, chart review and human resources file review.
    c. One observation cited upon completion of the survey regarding critical lab values missing documentation of the communication from the nurse to the provider. The official CMS 2567 review is pending supervisory review.

2. Update: CMS EMTALA visit Highland Hospital 04/28/2025 – 05/01/2025 – Final CMS 2567 Statement of Deficiencies received Highland Hospital found to be in compliances with CMS CoPs, with no cited deficiencies.

## B. CDPH Self-Reported Events

1. 05/06/25 – Highland Hospital – Allegation of Sexual Assault

2. 05/16/25 – San Leandro Hospital – Hospital Acquired Pressure Injury

3. 05/21/25 – John George Psychiatric Hospital – Assault

## C. Joint Commission Complaints

1. No Joint Commission Complaints in May 2025.

## D. Joint Commission Sentinel Events

1. No Joint Commission Sentinel Events reported in May 2025.

## E. Joint Commission Survey

1. Alameda Hospital: The Joint Commission Triennial Hospital Accreditation Survey 05/13/2025 – 05/15/2025
    b. Two Joint Commission surveyors performed the triennial hospital accreditation survey for Alameda Hospital and Creedon wound Care Clinic.
    c. Opportunities identified during the survey included: Infection Control, Life Safety, Environment of Care, Provision of Care, Human Resources, Waived Testing, Medication Management, and Medical Staff Chapters
    d. Evidence of Standards Compliance are due to Joint Commission July 15, 2025.
    e. CMS Conditions of Participation were met during the accrediting survey.

## 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 | Mar 2025 | FY25 YTD | FY2024 Actual | Improvement | Benchmark | Accountable Leaders |
| Provide safe care | Total Patient Harms* | 41 | 396 | 410 | 353 | 293 | R. Lofton, E. Mahler |
| | Sepsis Mortality O/E Ratio | 0.87 | 1.05 | 1.05 | | 1.04 | R. Lofton, E. Mahler |
| **Timely, Effective, and Efficient Care** | | | | | | | |
| OBJECTIVES | KEY RESULTS | Mar 2025 | FY25 YTD | FY2024 Actual | Improvement | Benchmark | Accountable Leaders |
| Promote wellbeing | All Cause 30-day readmission rate | 12.29% | 12.36% | 12.05% | 11.56% | 11.12% | D. Littlepage, E. Mahler |
| Provide accessible care | Waitlist time - New Primary Care Adult | 61 | 62 | 94 | 71 | 30 | T. Fitzgerald-Shaw, P. Mack |
| | ED Boarding Time for Admitted Patients Community Hospital | 3:10 | 3:00 | 3:10 | 2:20 | 1:30 | R. Lofton, A.Wu |
| | ED Boarding Time for Admitted Patients Highland | 13:35 | 13:13 | 13:05 | 8:30 | 4:00 | R. Lofton, A. Wu |
| **Equitable Care** | | | | | | | |
| OBJECTIVES | KEY RESULTS | Mar 2025 | FY25 YTD | FY2024 Actual | Improvement | Benchmark | Accountable Leaders |
| Serving all: Deliver equitable care | Health-related Social Needs Assessment Completed on Inpatients | 80.34% | 74.50% | 64.58% | 75.00% | 90.00% | R. Lofton |
| **Patient-Centered Care** | | | | | | | |
| OBJECTIVES | KEY RESULTS | Mar 2025 | FY25 YTD | FY2024 Actual | Improvement | Benchmark | Accountable Leaders |
| Be the most welcoming system to receive care | Likelihood to recommend care composite | 76.34% | 77.43% | 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

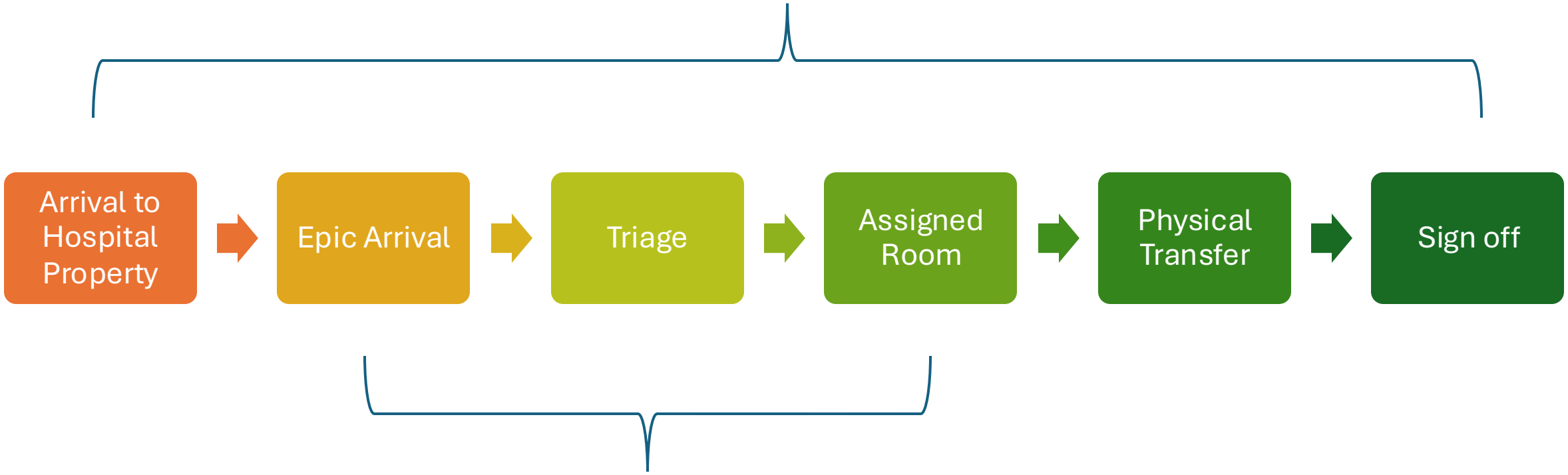
OKR Metric Definitions for QPSC

| Metric | Definition | GOAL | |
|---|---|---|---|
| | | Improvement | Benchmark |
| Patient Harm | The number of potential health-care acquired patient harms<br>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<br>50% gap reduction to the 50th Percentile | 293<br>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<br>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%<br>50% gap reduction to the 50th Percentile CMS Hospital Compare | 11.12%<br>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<br>25% Reduction | 30 Days<br>Eliminates waitlist as most clinics schedule up to 30 days out |
| ED Boarding Time<br>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.<br>Decision to Admit = First Admit Disposition<br>Admit = Time patient admitted to Inpatient Unit | 2:20 Community Hospitals:<br>50% gap closure to pre=pandemic performance<br><br>8:30 Highland:<br>50% gap closure to TJC benchmark | 1:30 Community Hospitals:<br>Pre-pandemic Performance<br><br>4:00 Highland:<br>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%<br>Internal Benchmark: Best Performing Campus rate for FY24 | 90%<br>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%<br>2% Improvement over FY24 Baseline | 79.16%<br>75th Percentile for Inpatient Med Surg<br>50th Percentile for all other areas based on Press Ganey National Database |

# Ambulance Patient Offload Times

Quality Professional Services Committee Report

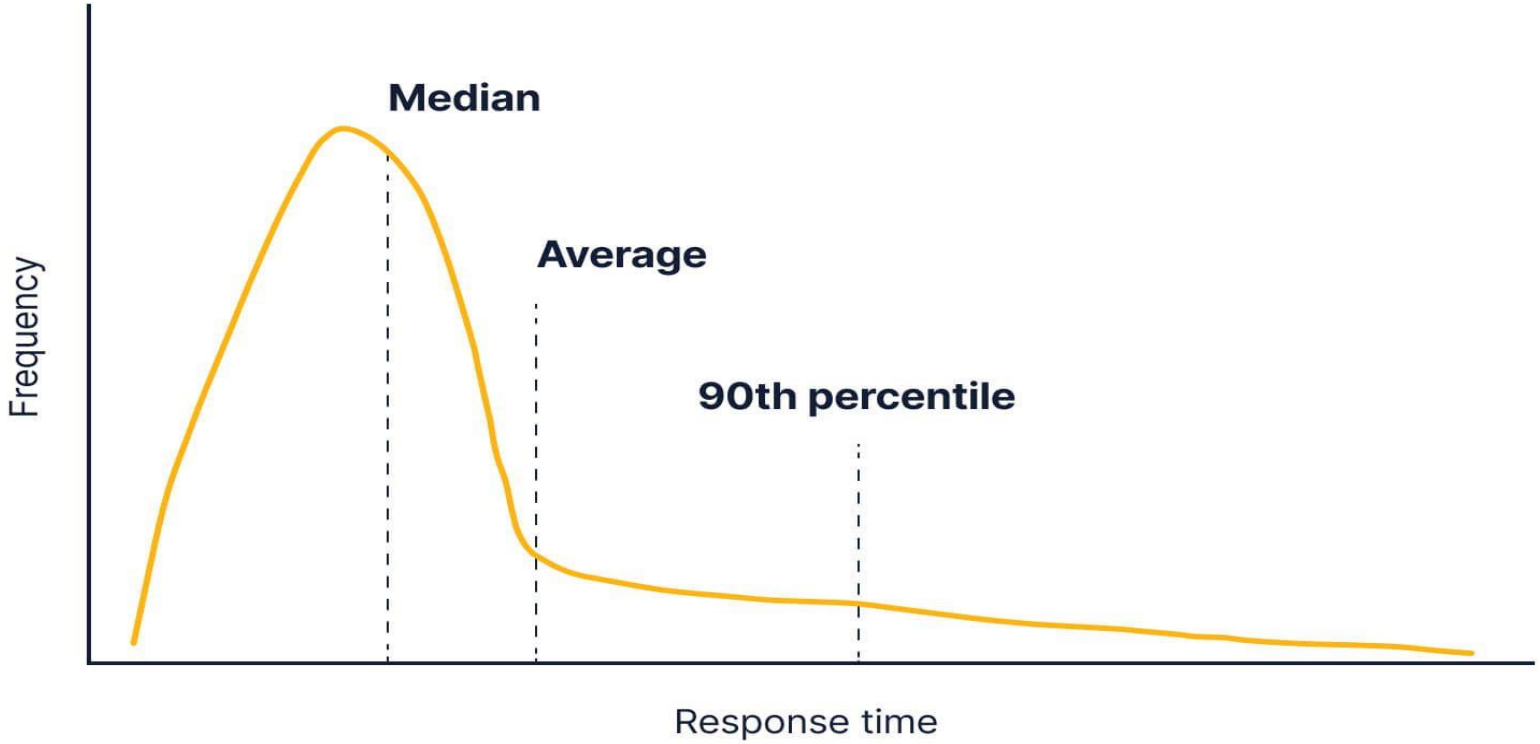
# County APOT Definition




# Available ED Data

- AB 40: Establishes 90% APOT at 30 minutes
- Aims to reduce delays >30 min to less than 10% of ambulances
- 90th percentile captures if a significant portion of ambulances is held for long periods of time
- Reflects stress on a system more than normal operations

## 90th percentile and the long tail



# APOT is an ED measurement that reflects system strain

## EMS

## Emergency Department

## Hospital

- EMS volume
- EMS traffic distribution
- Patient acuity

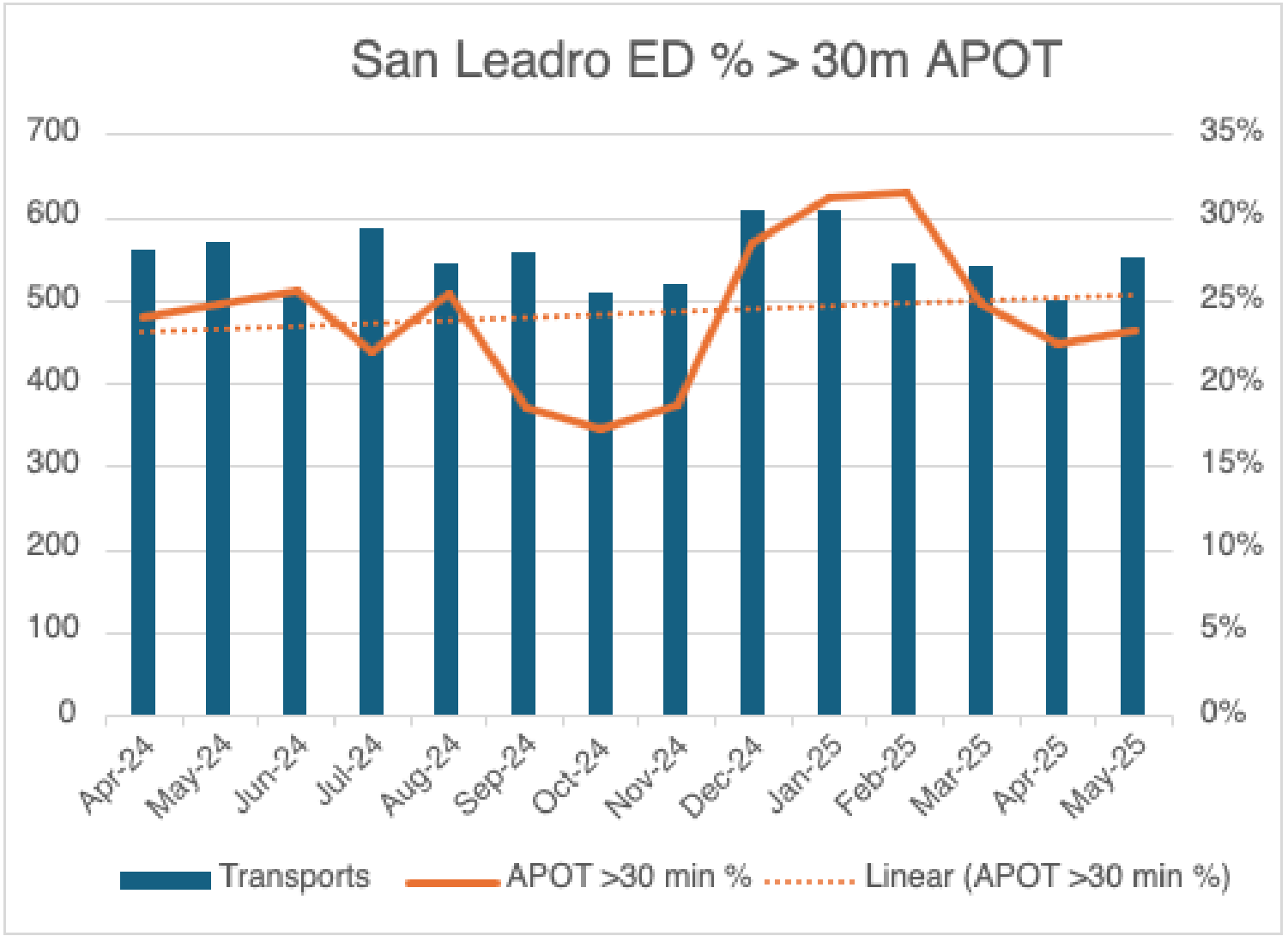
- Staffing
  - Nurse
  - Physician
- Space limitations
- Boarding
- Specialty care

- Staffing
  - Open but unstaffed beds
- Discharge barriers for admitted patients

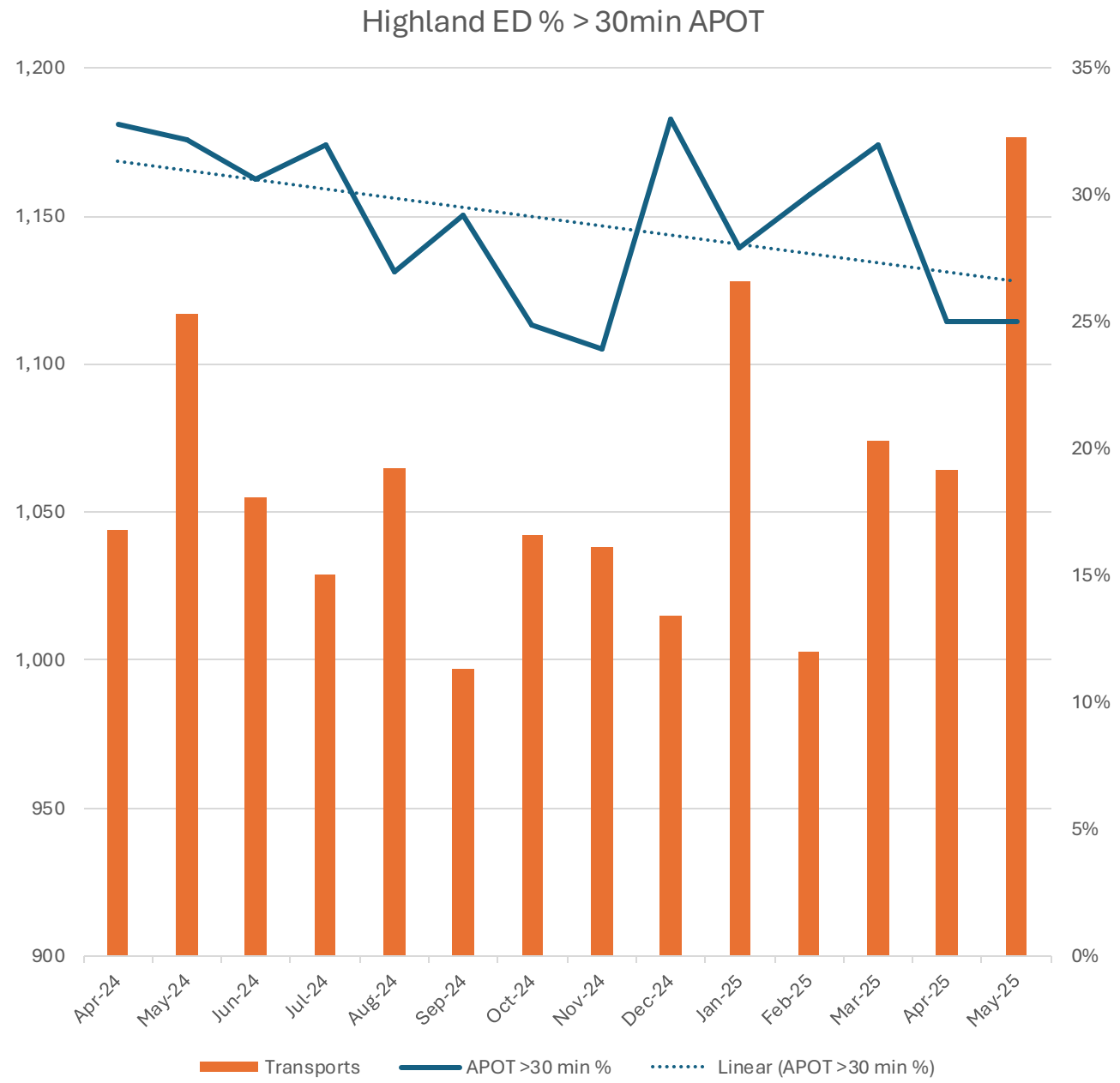
# Current strategies

- Staff Education
  - Rapid room assignment when available
- Provider Rapid Medical Evaluation
  - Directing EMS patients to the waiting room
- Communication with EMS on ED status
- Hospital representation at Receiving Hospital Meetings
- Collaboration with EMS consultant regarding APOT
- Systemwide surge planning
  - Level loading

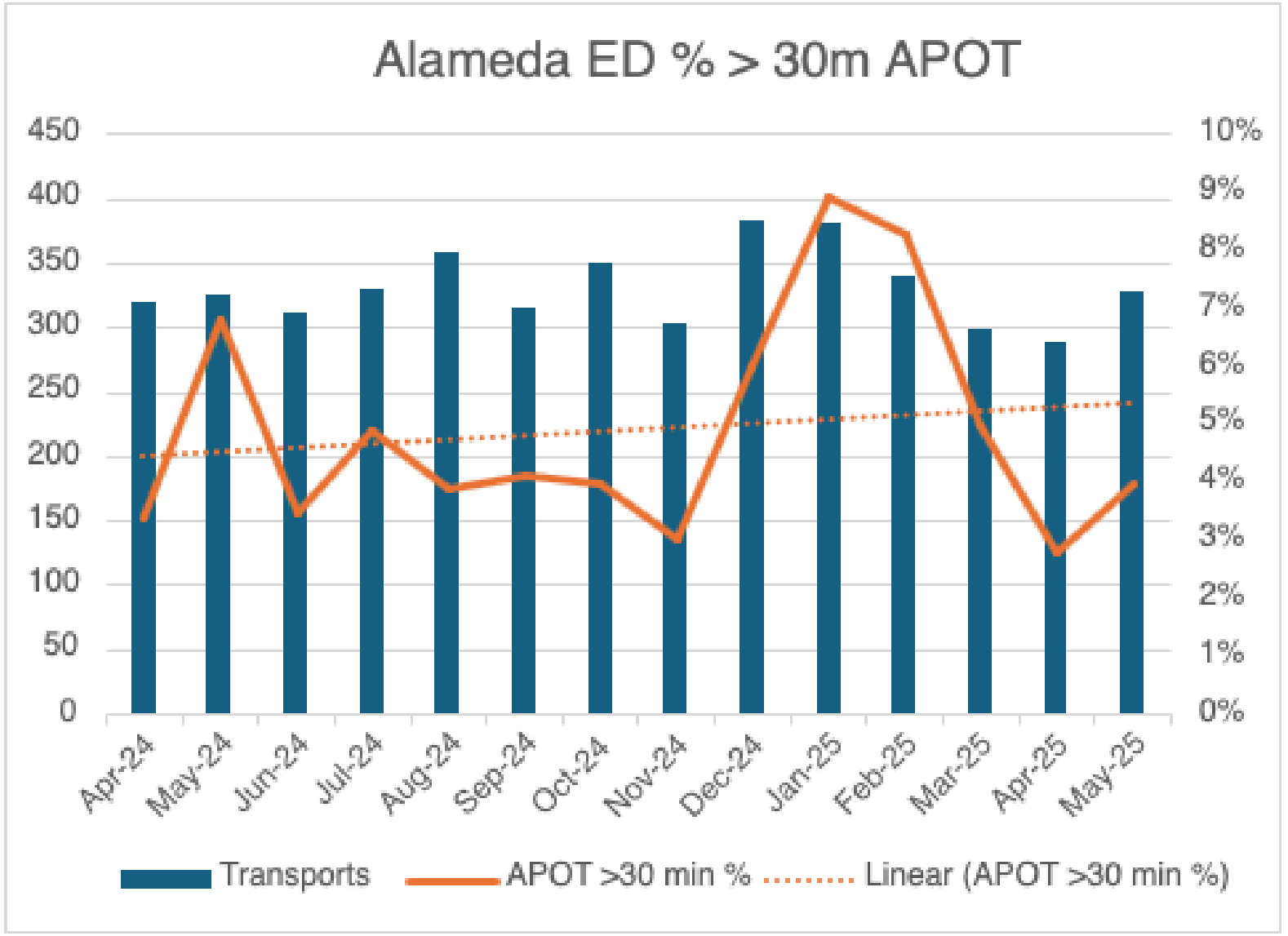
- SLH ED 13 beds, 2 chair (surge up to 5 hall)
- 1-2 Physicians, 0-2 APP
- Correlation between volume and APOT
- Reported APOT Delays
  - No rooms
  - Boarding
  - 5150
  - Non-ambulatory/Fall risk
- 2024 Patient/Treatment space 2,340 (2023 State Median 1500)



- Highland ED- 44 beds, Fast Track (up to 5 halls, 2 chairs)
- 25%-30%  transports >30 minutes
- Overall downtrending
- 2024 Patient/Treatment Space: 1,367



- Alameda ED – 10 rooms, 2 hall
- 1 Physician, 0-1 APP
  - Same provider cohort as San Lenadro
- 2024 Patient/Treatment space: 1,670
- Alameda City Fire primary EMS (vs Falck)



# Opportunities

- Improve hospital throughput
  - Better outpatient and discharge support
- Optimize staffing
- Level loading with EMS

# 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 | Mar 2025 | FY25 YTD | FY24 Actual | Improvement | Benchmark | Accountable Leaders |
| Provide safe care | Eliminate Patient Harms | Total Patient Harms | 8 | 63 | 38 | 28 | 22 | |
| | | CLABSI # Events/SIR | 0/0 | 0/0 | 0/0 | 0/0.378 | 1/0.756 | |
| | | CAUTI # Events/SIR | 0/0 | 1/0.71 | 0/0 | 0/0.323 | 1/0.646 | |
| | | MRSA # Events/SIR | 0/0 | 0/0 | 0/0 | 0/0.397 | 0/0.793 | |
| | | C. Difficile # Events/SIR | 0/0 | 2/0.43 | 8/81.48 | 5/0.944 | 2/0.417 | |
| | | SSI # Events/SIR | 0/0 | 1/1.35 | 0/0 | 0/0.38 | 0/0.756 | |
| | | Falls with Injury/% Per 1000 Days | 2/1.62 | 8/0.49 | 13/0.94 | 9/0.71 | 6/0.49 | |
| | | HAPI #/% per 1000 Discharges | 5/21.097 | 44/21.16 | 15/4.98 | 11/3.89 | 10/3.46 | |
| | | Behavior Events with Physical Injury | 1/0.81 | 7/0.68 | 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 | NA | 1.07 | 1.04 | | 1.04 | |
| | | Bundle Compliance Sepsis Early Management | 87.50% | 74.36% | 51.10% | | | |
| | Embed Critical Behaviors | Hand Hygiene Compliance | 88.10% | 84.46% | 83.30% | | | |

Fiscal Year Starts in July 1 and Ends June 30

FY25 YTD is results from July 2024 to Mar 2025

| Timely, Effective, and Efficient Care | | | Performance | | | FY25 Goals | | |
|---|---|---|---|---|---|---|---|---|
| OBJECTIVES | KEY RESULTS | Detailed KPIs | Mar 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 | 11.22% | 15.82% | 14.42% | 12.46% | 11.12% | |
| Provide accessible care | Minimize Time Spent Waiting for our Patients | ED Boarding Time for Admitted Patients | 3:05 | 3:05 | 3:15 | 2:20 | 1:30 | |
| Equitable Care | | | Performance | | | FY25 Goals | | |
| OBJECTIVES | KEY RESULTS | Detailed KPIs | Mar 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 | 53.30% | 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 | Mar 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 | 57.14% | 59.96% | 64.62% | 65.91% | 77.80% | |
| | | Likelihood to recommend ED | 63.04% | 65.32% | 58.92% | 60.02% | 70.10% | |
| | | Communication with Nurses | 59.52% | 67.90% | 72.89% | 74.35% | 76.41% | |
| | | Communication with Providers | 64.29% | 75.85% | 79.13% | 80.71% | 83.40% | |

Fiscal Year Starts in July 1 and Ends June 30

FY25 YTD is results from July 2024 to Mar 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<br>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<br>NDNQI 50th Percentile |
| CLABSI<br># Events/<br>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 .<br>#: Number of infections that occurred<br>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<br># Events/<br>SIR | an infection of the urinary tract caused by a tube (urinary catheter) that has been placed to drain urine from the bladder.<br>#: Number of infections that occurred<br>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<br># Events/<br>SIR | Potential hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA) staph infection that is difficult to treat because of resistance to some antibiotics.<br>#: Number of infections that occurred<br>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<br># Events/<br>SIR | Potential hospital acquired infection that causes diarrhea and colitis (an inflammation of the colon).<br>#: Number of infections that occurred<br>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<br># Events/<br>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.<br>#: Number of infections that occurred attributed to month procedure performed<br>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/<br>#<br>% Per 1000 Days | Patient Fall reported via Midas Safety Alert.<br># 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<br>#/<br>% per 1000 DCs | Hospital Acquired Pressure Ulcers reported via Midas Safety Alert.<br># 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<br># 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<br>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.<br>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.<br>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:<br>Born at or after 37 weeks gestation<br>Singleton (no twins or more)<br>In the vertex presentation (no breech or transverse positions) | | |
| ED Boarding Time<br>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.<br>Decision to Admit = First Admit Disposition<br>Admit = Time patient admitted to Inpatient Unit | 2:20 Community Hospitals:<br>50% gap closure to pre=pandemic performance<br><br>8:30 Highland:<br>50% gap closure to TJC benchmark | 1:30 Community Hospitals:<br>Pre-pandemic Performance<br><br>4:00 Highland:<br>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%<br>Internal Benchmark: Best Performing Campus rate for FY24 | 90%<br>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.<br>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.<br>Percent of surveyed Inpatient discharges where patient response was highest of the scale | 2% improvement as compared to Fiscal Year 2026 | Per Press Ganey<br>Community Hospitals: 75th Percentile<br>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 | Mar 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 | 80.60% | 80.57% | 80.40% | 88.44% | 90% | |
| **Timely, Effective, and Efficient Care** | | | **Performance** | | | **FY25 Goals** | | |
| OBJECTIVES | KEY RESULTS | Detailed KPIs | Mar 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 | 7.88% | 12.43% | 12.05% | 11.56% | 11.12% | |
| | | MyChart Activation Rate | 33.00% | 30.22% | 27.00% | | | |
| | Find and treat conditions early | Breast Cancer Screening | 59.03% | | 54.88% | 53.99% | 62.67% | |
| | | Cervical Cancer Screening | 44.03% | | 41.94% | 50.85% | 66.48% | |
| | | Colorectal Cancer Screening | 61.01% | | 61.35% | 60.04% | 61.32% | |
| | Achieve the best health outcomes | Glycemic status assessment of patients with diabetes | 31.58% | | 32.00% | 32.83% | 29.44% | |
| | | Controlling High Blood Pressure | 63.80% | | 63.40% | 62.18% | 72.22% | |
| | | Child and Adolescent Well-Care Visits | 49.59% | | 43.96% | 45.80% | 61.15% | |

Fiscal Year Starts in July 1 and Ends June 30

FY25 YTD is results from July 2024 to Mar 2025

| Timely, Effective, and Efficient Care (continued) | | | Performance | | | FY25 Goals | | |
|---|---|---|---|---|---|---|---|---|
| OBJECTIVES | KEY RESULTS | Detailed KPIs | Mar 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 | 4 | 4 | 7 | 15 | 2 | |
| | | Waitlist time - Primary Care Review | 61 | 61 | 94 | 71 | 30 | |
| | | Waitlist time - Specialty Care | 18 | 17 | 36 | 30 | N/A | |

| Equitable Care | | | Performance | | | FY25 Goals | | |
|---|---|---|---|---|---|---|---|---|
| OBJECTIVES | KEY RESULTS | Detailed KPIs | Mar 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 | Mar 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) | 48.75% | 62.20% | 61.05% | 62.27% | 63.49% | |
| | | Likelihood to recommend (Primary/Specialty) | 74.80% | 72.88% | 75.93% | 75.16% | 94.40% | |
| | | Communication with Care Provider (Primary/Specialty) | 74.57% | 73.58% | 76.48% | 76.28% | 78.01% | |

Fiscal Year Starts in July 1 and Ends June 30

FY25 YTD is results from July 2024 to Mar 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 | Mar 2025 | FY25 YTD | FY24 Actual | Improvement | Benchmark | Accountable Leaders |
| Provide safe care | Eliminate Patient Harms | Total Patient Harms | 12 | 163 | 173 | 145 | 119 | |
| | | CLABSI # Events/SIR | 0/0 | 0/0 | 7/0.775 | 6/0.766 | 6/0.756 | |
| | | CAUTI # Events/SIR | 0/0 | 6/1.1 | 13/1.54 | 9/1.093 | 5/0.646 | |
| | | MRSA # Events/SIR | 0/0 | 2/0.97 | 3/1.01 | 2/1.034 | 1/0.793 | |
| | | C. Difficile # Events/SIR | 3/1.31 | 13/0.65 | 20/0.77 | 15/0.599 | 10/0.417 | |
| | | SSI # Events/SIR | 0/0 | 31/2.87 | 24/1.68 | 18/1.13 | 12/0.756 | |
| | | Falls with Injury/% Per 1000 Days | 4/0.43 | 26/0.4 | 35/0.6 | 32/0.56 | 30/0.52 | |
| | | HAPI #/% per 1000 Discharges | 3/3.158 | 63/7.48 | 46/3.95 | 41/3.55 | 36/3.16 | |
| | | Behavior Events with Physical Injury | 2/0.43 | 24/0.56 | 27/0.51 | 22/0.39 | 19/0.34 | |
| | | Serious Safety Events (F or Greater) | 0 | 8 | 6 | | | |
| | Reduce Mortality from Sepsis | Sepsis Mortality Observed:Expected & Total Deaths | NA | 1.18 | 1.07 | | 1.04 | |
| | | Bundle Compliance Sepsis Early Management | 63.64% | 58.42% | 46.30% | | | |
| | Embed Critical Behaviors | Hand Hygiene Compliance | 91.80% | 88.63% | 91.05% | | | |
| Fiscal Year Starts in July 1 and Ends June 30 | | | | | FY25 YTD is results from July 2024 to Mar 2025 | | | |

| Timely, Effective, and Efficient Care | | | Performance | | | FY25 Goals | | |
|---|---|---|---|---|---|---|---|---|
| OBJECTIVES | KEY RESULTS | Detailed KPIs | Mar 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 | 11.05% | 11.38% | 12.14% | 11.36% | 11.12% | |
| | Achieve the best health outcomes | NTSV Cesarean Section Rate | NA | 23.00% | 22.60% | | | |
| Provide accessible care | Minimize Time Spent Waiting for our Patients | ED Boarding Time for Admitted Patients | 13:35 | 13:03 | 13:05 | 8:32 | 4:00 | |
| Equitable Care | | | Performance | | | FY25 Goals | | |
| OBJECTIVES | KEY RESULTS | Detailed KPIs | Mar 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 | 87.88% | 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 | Mar 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 | 83.21% | 73.45% | 74.75% | 76.25% | 77.80% | |
| | | Likelihood to recommend ED | 57.47% | 56.36% | 52.97% | 54.03% | 70.10% | |
| | | Likelihood to recommend Amb Surg | 87.80% | 81.44% | 77.82% | 79.43% | 86.00% | |
| | | Communication with Nurses | 76.28% | 72.87% | 74.53% | 76.02% | 76.41% | |
| | | Communication with Providers | 87.17% | 82.44% | 83.40% | 85.07% | 85.93% | |
| Fiscal Year Starts in July 1 and Ends June 30 | | | FY25 YTD is results from July 2024 to Mar 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<br>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<br>NDNQI 50th Percentile |
| CLABSI<br># Events/<br>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 .<br>#: Number of infections that occurred<br>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<br># Events/<br>SIR | an infection of the urinary tract caused by a tube (urinary catheter) that has been placed to drain urine from the bladder.<br>#: Number of infections that occurred<br>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<br># Events/<br>SIR | Potential hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA) staph infection that is difficult to treat because of resistance to some antibiotics.<br>#: Number of infections that occurred<br>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<br># Events/<br>SIR | Potential hospital acquired infection that causes diarrhea and colitis (an inflammation of the colon).<br>#: Number of infections that occurred<br>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<br># Events/<br>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.<br>#: Number of infections that occurred attributed to month procedure performed<br>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/<br>#<br>% Per 1000 Days | Patient Fall reported via Midas Safety Alert.<br># 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<br>#/<br>% per 1000 DCs | Hospital Acquired Pressure Ulcers reported via Midas Safety Alert.<br># 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<br># 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<br>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.<br>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.<br>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:<br>Born at or after 37 weeks gestation<br>Singleton (no twins or more)<br>In the vertex presentation (no breech or transverse positions) | | |
| ED Boarding Time<br>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.<br>Decision to Admit = First Admit Disposition<br>Admit = Time patient admitted to Inpatient Unit | 2:20 Community Hospitals:<br>50% gap closure to pre=pandemic performance<br><br>8:30 Highland:<br>50% gap closure to TJC benchmark | 1:30 Community Hospitals:<br>Pre-pandemic Performance<br><br>4:00 Highland:<br>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%<br>Internal Benchmark: Best Performing Campus rate for FY24 | 90%<br>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.<br>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.<br>Percent of surveyed Inpatient discharges where patient response was highest of the scale | 2% improvement as compared to Fiscal Year 2026 | Per Press Ganey<br>Community Hospitals: 75th Percentile<br>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 | Mar 2025 | FY25 YTD | FY24 Actual | Improvement | Benchmark | Accountable Leaders |
| Provide safe care | Eliminate Patient Harms | Total Patient Harms | 13 | 55 | 68 | 61 | 54 | P. Espeseth<br>R. Delaney |
| | | Falls with Injury/% Per 1000 Days | 0/0 | 13/0.66 | 9/0.68 | 8 | 7 | R. Delaney |
| | | Behavior Events with Physical Injury | 13/6.31 | 42/2.12 | 59/2.15 | 53 | 47 | P. Espeseth<br>R. Delaney |
| | | Serious Safety Events (F or Greater) | 0 | 0 | 0 | 0 | 0 | P. Espeseth<br>R. Delaney |
| **Patient-Centered Care** | | | **Performance** | | | **FY25 Goals** | | |
| OBJECTIVES | KEY RESULTS | Detailed KPIs | Mar 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 | 51.22% | 57.33% | 61.60% | 62.83% | 68.50% | P. Espeseth<br>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<br>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/%<br>Per 1000 Days | Patient Fall reported via Midas Safety Alert.<br># 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<br>with Physical Injury | Behavior events that resulted in physicial injury via Midas Safety Alerts<br># 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<br>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 | Mar 2025 | FY25 YTD | FY24 Actual | Improvement | Benchmark | Accountable Leaders |
| Provide safe care | Eliminate Patient Harms | Total Patient Harms | 8 | 75 | 83 | 67 | 54 | |
| | | CLABSI # Events/SIR | 0/0 | 0/0 | 2/1.69 | 1/1.224 | 0/0.756 | |
| | | CAUTI # Events/SIR | 0/0 | 0/0 | 2/1.75 | 1/1.199 | 0/0.646 | |
| | | MRSA # Events/SIR | 1/26.32 | 2/5.21 | 2/3.41 | 1/2.361 | 0/0.793 | |
| | | C. Difficile # Events/SIR | 0/0 | 4/0.84 | 8/1.56 | 5/0.985 | 2/0.417 | |
| | | SSI # Events/SIR | 0/0 | 2/1.55 | 0/0 | 0/0.38 | 1/0.756 | |
| | | Falls with Injury/% Per 1000 Days | 1/0.88 | 8/0.58 | 11/0.78 | 8/0.64 | 6/0.49 | |
| | | HAPI #/% per 1000 Discharges | 6/22.556 | 52/21.78 | 35/9.54 | 31/8.59 | 27/7.63 | |
| | | Behavior Events with Physical Injury | 0/0 | 7/0.67 | 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 | NA | 1.11 | 1.01 | | 1.04 | |
| | | Bundle Compliance Sepsis Early Management | 66.67% | 61.77% | 68.90% | | | |
| | Embed Critical Behaviors | Hand Hygiene Compliance | 89.60% | 95.40% | 95.02% | | | |

Fiscal Year Starts in July 1 and Ends June 30

FY25 YTD is results from July 2024 to Mar 2025

| Timely, Effective, and Efficient Care | | | Performance | | | FY25 Goals | | |
|---|---|---|---|---|---|---|---|---|
| OBJECTIVES | KEY RESULTS | Detailed KPIs | Mar 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 | 10.57% | 13.46% | 8.80% | 9.96% | 11.12% | |
| Provide accessible care | Minimize Time Spent Waiting for our Patients | ED Boarding Time for Admitted Patients | 3:19 | 2:58 | 3:07 | 2:20 | 1:30 | |
| Equitable Care | | | Performance | | | FY25 Goals | | |
| OBJECTIVES | KEY RESULTS | Detailed KPIs | Mar 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 | 85.41% | 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 | Mar 2025 | FY25 YTD | FY24 Actual | Improvement | Benchmark | Accountable Leaders |
| | Optimize performance regarding patient experience | Likelihood to recommend Acute | 73.59% | 65.45% | 68.92% | 70.30% | 77.80% | |
| | | Likelihood to recommend ED | 49.09% | 59.02% | 58.67% | 59.84% | 70.10% | |
| | | Likelihood to recommend Amb Surg | 100.00% | 85.44% | 76.92% | 78.46% | 86.00% | |
| | | Communication with Nurses | 80.55% | 72.33% | 73.75% | 75.23% | 76.41% | |
| | | Communication with Providers | 81.70% | 78.46% | 79.41% | 81.00% | 83.40% | |

Fiscal Year Starts in July 1 and Ends June 30

FY25 YTD is results from July 2024 to Mar 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<br>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<br>NDNQI 50th Percentile |
| CLABSI<br># Events/<br>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 .<br>#: Number of infections that occurred<br>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<br># Events/<br>SIR | an infection of the urinary tract caused by a tube (urinary catheter) that has been placed to drain urine from the bladder.<br>#: Number of infections that occurred<br>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<br># Events/<br>SIR | Potential hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA) staph infection that is difficult to treat because of resistance to some antibiotics.<br>#: Number of infections that occurred<br>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<br># Events/<br>SIR | Potential hospital acquired infection that causes diarrhea and colitis (an inflammation of the colon).<br>#: Number of infections that occurred<br>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<br># Events/<br>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.<br>#: Number of infections that occurred attributed to month procedure performed<br>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/<br>#<br>% Per 1000 Days | Patient Fall reported via Midas Safety Alert.<br># 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<br>#/<br>% per 1000 DCs | Hospital Acquired Pressure Ulcers reported via Midas Safety Alert.<br># 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<br># 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<br>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.<br>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.<br>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:<br>Born at or after 37 weeks gestation<br>Singleton (no twins or more)<br>In the vertex presentation (no breech or transverse positions) | | |
| ED Boarding Time<br>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.<br>Decision to Admit = First Admit Disposition<br>Admit = Time patient admitted to Inpatient Unit | 2:20 Community Hospitals:<br>50% gap closure to pre=pandemic performance<br><br>8:30 Highland:<br>50% gap closure to TJC benchmark | 1:30 Community Hospitals:<br>Pre-pandemic Performance<br><br>4:00 Highland:<br>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%<br>Internal Benchmark: Best Performing Campus rate for FY24 | 90%<br>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.<br>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.<br>Percent of surveyed Inpatient discharges where patient response was highest of the scale | 2% improvement as compared to Fiscal Year 2026 | Per Press Ganey<br>Community Hospitals: 75th Percentile<br>Highland Hospital: 90th Percentile |