BOARD OF TRUSTEES SPECIAL MEETING

WEDNESDAY, SEPTEMBER 17, 2025

5:00pm or immediately following the Audit and Compliance Committee meeting to 9:00pm

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

LOCATION:

Open Session, In Person: HCP Conference Center, see above address
Teleconference Location: 4501 Pleasanton Avenue, Pleasanton, CA 94566

ZOOM Meeting Link:[1]
https://alamedahealthsystem.zoom.us/j/9361457125?pwd=4JnAmhDnBaLqY4GWf4PQBwp3w0Puy2.1&omn=88542066766
Meeting ID: 936 145 7125
Meeting Password: 20200513

One tap mobile
+14086380968,,9361457125# or
+13462487799,,9361457125#

Dial by your location
+1 408 638 0968 US (San Jose)
+1 346 248 7799 US (Houston)
+1 646 518 9805 US (New York)

Find your local number: https://alamedahealthsystem.zoom.us/u/agoA8zDn2

MEMBERS

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

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

BOARD OF TRUSTEES SPECIAL MEETING AGENDA

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

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

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

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

OPEN SESSION / ROLL CALL

PUBLIC COMMENT

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

B. MEDICAL STAFF REPORTS

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

C. COMMITTEE AND TRUSTEE REPORTS

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

C2. Quality Professional Services Committee: July 23, 2025 and August 27, 2025
Lilavati Indulkar, MD, Chair

C3. Finance Committee: September 3, 2025
Alan Fox, Committee Chair

C4. The Governance Institute Leadership Conference Report
David Sayen, Chair

D. CONSENT AGENDA: ACTION

D1. Approval of the July 9, 2025 and August 13, 2025 Board of Trustees Meeting Minutes.

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

- HR Policy 1.90 – Employee Referral Program
- HR Policy 3.24 – Compliance Enforcement and Discipline
- HR Policy 5.12 – Employee Safety and Security
- HR Policy 1.35 – Drug-Free Workplace
- HR: Zero Tolerance to Violence Policy
- HR: AHS Tuition Reimbursement Policy
- HR: Timekeeping Policy
- HR: Bereavement Leave Policy
- HR: Reproductive Loss Leave Policy

Recommendation from the Quality Professional Services Committee on July 23, 2025 to approve the policies listed below.

D3.Approval of the System Wide Policies and Standardized Procedures listed below

- Highland Hospital 340B Policy
- Alameda Hospital 340B Policy
- Alameda Health System-Freestanding Clinics 340B Policy
- AVOIDING DUPLICATE PRN "As Needed" POLICY
- MEDICATIONS SELF-ADMINISTRATION (34361-1)
- MEDICATION KITS TRANSPORT BOXES FOR SPECIFIC DEPARTMENTS AND DIVISIONS (34324-1)
- Highland Hospital Outpatient Pharmacy Quality Assurance and Medication Error Reporting (34359 -1)
- Clinical Practice Council Charter
- AHS Administrative Closure of Incomplete Records 2025

Recommendation from the Quality Professional Services Committee on July 23, 2025 to approve the policies listed below.

D4.Approval of the AHS Medical Staff Policies and Procedures listed below:

AHS and AH Medical Staff:

- Introduction of a New Privilege or New Privilege for a Specific Department or Specialty
- Pain Medicine Anesthesia Standardized Procedure

Recommendation from the Quality Professional Services Committee on August 27, 2025 to approve the policies listed below.

D5.Approval of the System Wide Policies and Standardized Procedures listed below

- Subanesthetic Ketamine Use for Pain or Withdrawal Policy
- Antimicrobial Stewardship Policy
- Meropenem Extended Infusion Policy
- Radiopharmaceuticals Procurement Receiving Storage and Security
- Controlled Substance Drug Diversion Investigation and Reporting Policy

- Clinical Alarm Testing Policy
- Clinical Practice Council Charter

Recommendation from the Quality Professional Services Committee on August 27, 2025 to approve the policies listed below.

D6. Approval of the AHS Medical Staff Policies and Procedures listed below:

AHS and AH Medical Staff:

- Medical Staff Credentialing and Privileging of Providers
- Medical Staff Policy for Credentialing Practitioners in the Event of a Disaster

Recommendation from the Finance Committee on September 3, 2025 to approve the contracts listed below.

D7. Contracts

D7a. New agreement with Entisys Solutions, Inc. dba E360 for provision of the Citrix virtual access platform supporting remote and mobile network access. The term of this agreement is effective September 29, 2025 through September 28, 2028. The estimated impact of this agreement is $1,499,410.
Christine Yang, Chief Information Officer

D7b. Renewal agreement with GuidePoint Security LLC for provision of Arctic Wolf cybersecurity monitoring and recovery services. The term of this agreement is effective September 30, 2025 through June 30, 2028. The estimated impact of this agreement is $1,457,310.
Christine Yang, Chief Information Officer

D7c. Renewal agreement with Xerox, Inc. for provision of printer equipment and services. The term of this agreement is effective November 1, 2025 through October 31, 2030. The estimated impact of this agreement is $3,983,160.
Christine Yang, Chief Information Officer

D7d. New agreement with Anthem Blue Cross Life and Health Insurance Company for the provision of third-party administration services for the Alameda Health System employee health insurance plan. The initial term of this agreement is effective January 1, 2025 through December 31, 2027. The estimated impact of this agreement is $5,930,739.
Arleen Gomez, Chief Human Resources Officer

D7e. Renewal agreement with Cardea Health for provision of respite housing services. The term of this agreement is effective October 1, 2025 through September 30, 2028. The estimated impact of this agreement is $6,394,800.
Romoanetia Lofton, Chief Clinical Officer

D7f. Amendment with Lifepoint Rehabilitation of California, LLC to renew terms for provision of management services for the Alameda Health System inpatient rehabilitation facility. The term of this amendment is effective October 1, 2025 through September 30, 2028. The estimated impact of this amendment is $4,211,233.
Mark Fratzke, Chief Operating Officer

D7g. Renewal agreement with McKesson Corporation for provision of wholesale pharmaceutical supply services. The term of this agreement is effective April 1, 2026 through March 31, 2031. The estimated impact of this agreement is $447,180,000.
Romoanetia Lofton, Chief Clinical Officer

D7h. Amendment with Quest Diagnostics to increase funding for provision of reference laboratory test services. The term of this amendment is March 1, 2022 through February 28, 2026. The estimated impact of this amendment is $13,280,743.
Romoanetia Lofton, Chief Clinical Officer

D8. Recommendation from the Quality Professional Services Committee on July 23, 2025 to approve the QPSC Metric Selection and Goal Setting Approval

E. ACTION/DISCUSSION

E1. DISCUSSION: SCORE Survey Review
Darshan Grewal, Director Patient Safety

F. DISCUSSION: Board Calendar and Tracking

G. STAFF REPORTS (Written)

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

G2. Public Affairs and Community Engagement Report
Jeanette Dong, Chief Public Affairs and Community Engagement Officer

CLOSED SESSION

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

1. **Conference with Labor Negotiators**
   [Government Code Section 54957.6]
   AHS Designated Representatives: Ulysses Madison, Director of People Operations
   Employee Organization: UAPD

2. **Conference with Labor Negotiators**
   [Government Code Section 54957.6]
   AHS Designated Representatives: Ulysses Madison, Director of People Operations
   Employee Organization: SEIU

3. **Public Employee Performance Evaluation**
   [Pursuant to Government Code Sections 54957(b)(1)]
   Title: Chief Executive Officer

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

(Reconvene to Open Session)

General Counsel Report on Action Taken in Closed Session

OPEN SESSION

TRUSTEE COMMENTS

ADJOURNMENT

Our Mission
Caring, Healing, Teaching, Serving All

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

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

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

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

the meeting room. Citizens are encouraged to testify at Committee meetings and to write letters to the Clerk of the Board or to its members, 1411 East 31st Street Oakland, CA 94602.

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

Disability Access

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

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

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

CEO REPORT

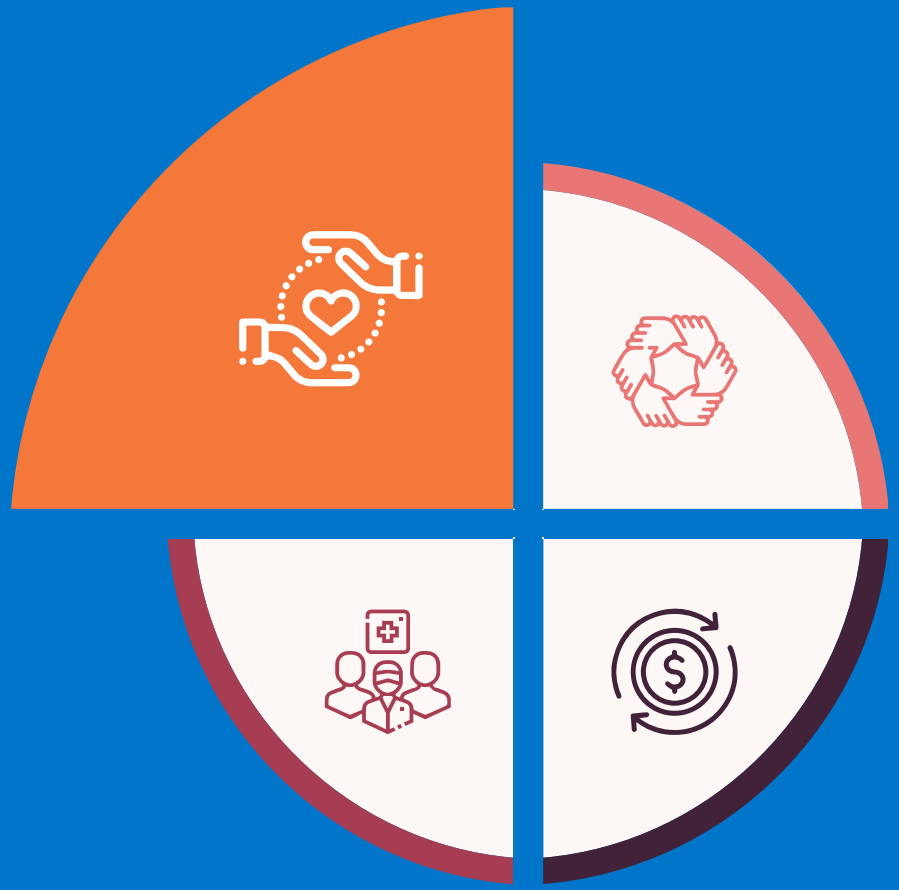
AHS CEO Board Report

James Jackson
9/17/2025
Board of Trustee Meeting

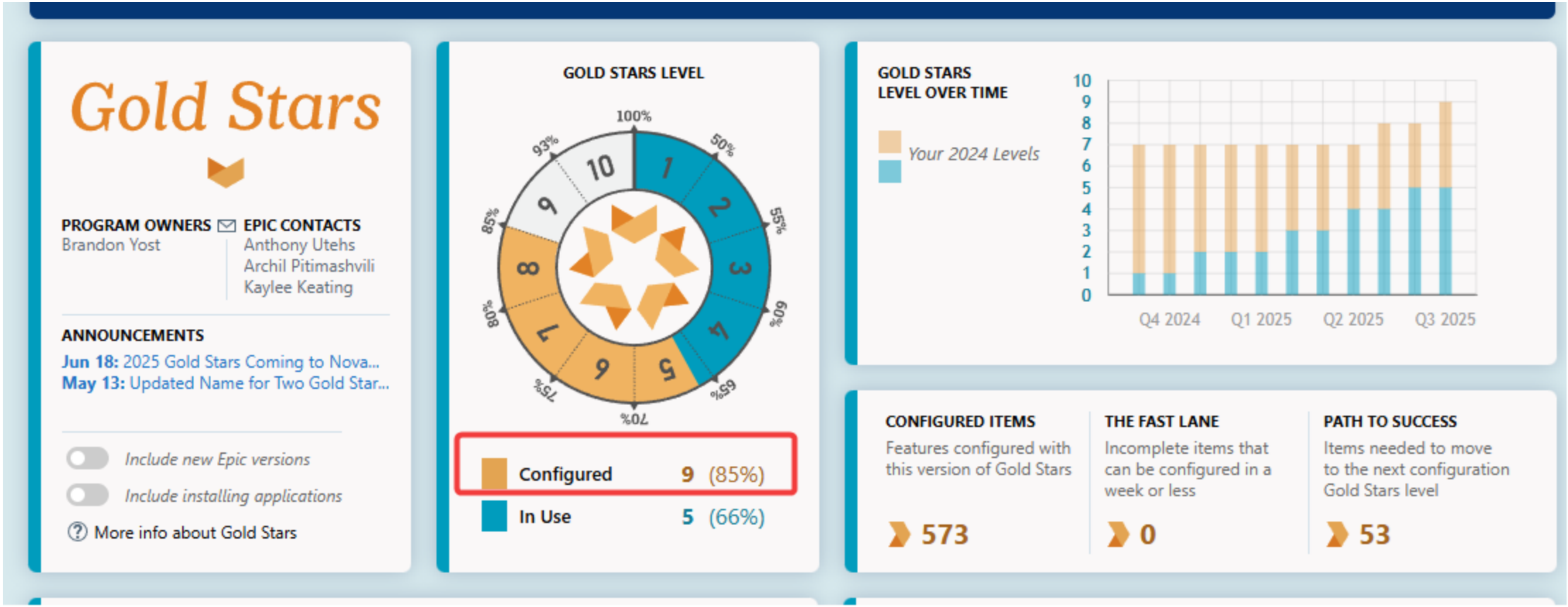
AHS Pillars

Quality Care

AHS provides Safe, Timely, Effective, Efficient, Equitable and Patient-Centered care that is accessible to all.




September 15–19
Celebrating Healthcare Simulation Week
@HcSimWeek
#HcSimWeek25
ssih.org/HcSimWeek
HEALTHCARE SIMULATION WEEK 2025
SEPTEMBER 15–19
SSH
Society for Simulation in Healthcare


Gold Stars
PROGRAM OWNERS
Brandon Yost
EPIC CONTACTS
Anthony Utehs
Archil Pitimashvili
Kaylee Keating
ANNOUNCEMENTS
Jun 18: 2025 Gold Stars Coming to Nova...
May 13: Updated Name for Two Gold Star...
Include new Epic versions
Include installing applications
More info about Gold Stars
GOLD STARS LEVEL
100%
50%
55%
60%
65%
70%
75%
80%
85%
93%
Configured 9 (85%)
In Use 5 (66%)
GOLD STARS LEVEL OVER TIME
Your 2024 Levels
Q4 2024
Q1 2025
Q2 2025
Q3 2025
CONFIGURED ITEMS
Features configured with this version of Gold Stars
573
THE FAST LANE
Incomplete items that can be configured in a week or less
0
PATH TO SUCCESS
Items needed to move to the next configuration Gold Stars level
53

ALAMEDA HEALTH SYSTEM

MEMORANDUM

TO: All AHS Staff and All Medical Staff

FROM: Mark Fratzke, Chief Operating Officer

DATE: September 3, 2025

SUBJECT: Dr. Damon Francis Announcement

Dr. Damon Francis, our current Medical Director for the Homeless Health Center has accepted the position of Community Health Officer for AHS. Dr. Francis will begin in his new role on Monday September 15 and will report directly to the Chief Operating Officer.

In his role as Community Health Officer (CHO), Dr. Francis will have a more expansive role bridging FQHC strategy with our AHS strategy related to all the upcoming growth and development of our AHS Wellness Centers. He will continue to work with the Co-Applicant Board to support consumer-led governance of outpatient homeless services and FQHC compliance.

Dr. Francis will supervise the Director of Community Health, supporting the department's work to address community health needs by strengthening partnerships with community organizations. He will serve as the primary AHS interface with Alameda County Public Health Department leadership, assisting with the integration of public health policy and programs into AHS operations.

I'm excited about the work Dr. Francis will be doing in these areas on behalf of AHS. Please join me in congratulating Dr. Francis on his new role!

Good morning, everyone,

Please find the detailed outcome for the most recent donor case and forward to your teams as you find appropriate.

On 8/20/2025 a 26-year-old gentleman was admitted after suffering from a GSW to the head.
On 8/20/2025 RN Izeezee H from the ED made a timely organ referral. Please thank RN Izeezee!

While all intervention and support were provided, he was sadly declared brain dead.
We met with his family to provide additional grief support and provide them with the option of donation, which they graciously authorized.

Overnight on 8/25/2025 he was transferred to the OR for organ recovery as hospital staff and the patient's friends & family lined the halls for an Honor Walk.

The following organs were recovered and transplanted, which resulted in 3 lives saved:

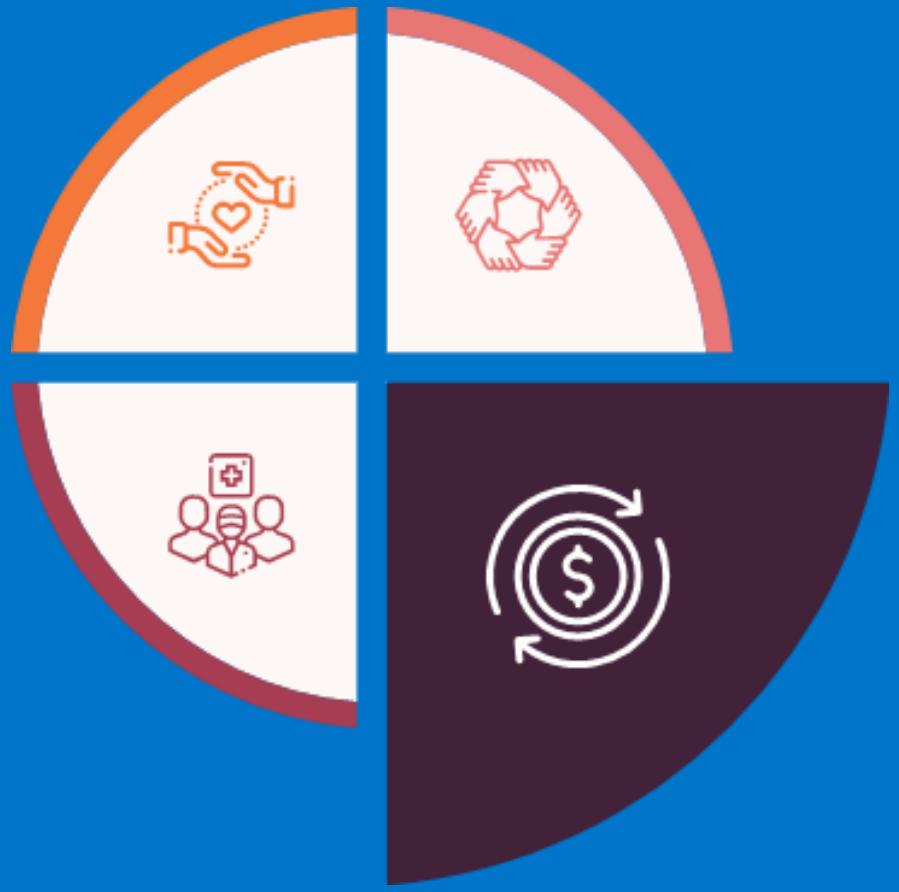
1. **Heart**
2. **Lungs**
3. **Both Kidneys**
4. **Liver**

There has been a lot of donor activity in the last 3 months, with 3 donors in June and 2 this month. I want to thank everyone for your selfless service to our community, your collaboration with Donor Network West, and your commitment to helping heal and save lives through organ donation.

As always, your teams are much appreciated. If you have any questions or feedback please let me, Nakia, Tyler or Kayla know. Thank you!

AHS Pillars

Sustainability



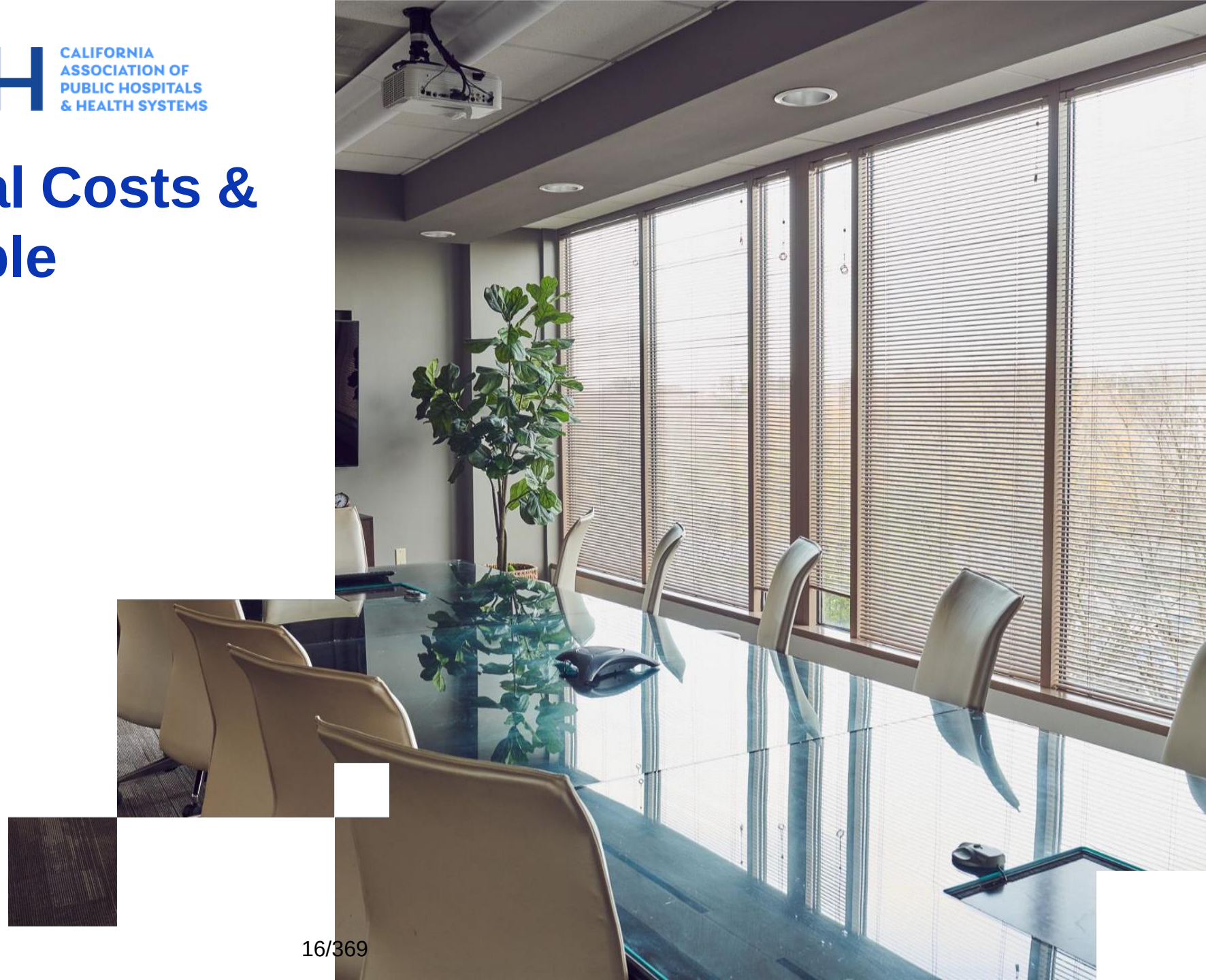
AHS will pursue innovative approaches to invest in new programs while managing targeted investments in infrastructure to support the delivery of high-quality care.

CONFIDENTIAL

CAPH CALIFORNIA ASSOCIATION OF PUBLIC HOSPITALS & HEALTH SYSTEMS

Reducing Hospital Costs & Driving Sustainable Efficiency

September 2025



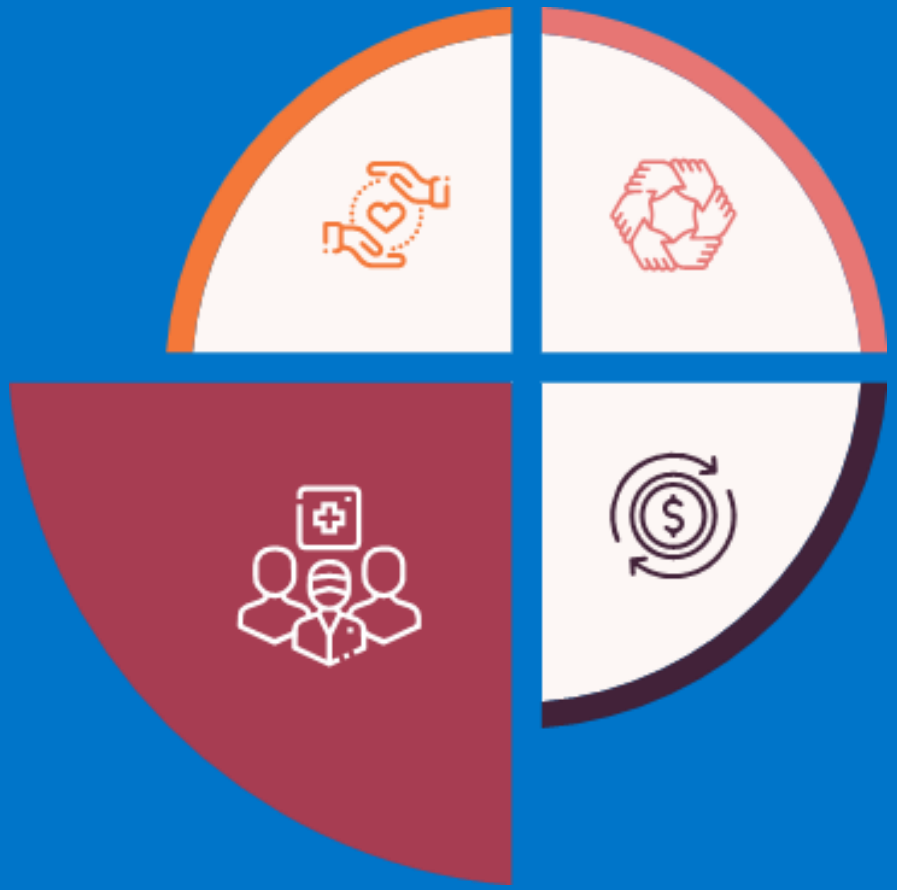
Coker

CAPH Learning Day Agenda

Time: 8:00 AM – 4:00 PM | Includes Breaks & Lunch	Date: 9/9/25	
Learning Day Agenda		**Speaker**
8:00 – 8:15 AM	**Introductions and Rules of Engagement**	Rich Rubinstein; Daniel DeBehnke, MD, MBA
8:15 – 9:00 AM	**Opening Plenary: Benchmarking California's Public Hospitals**	Daniel DeBehnke, MD, MBA
9:00 – 11:30 AM	**Non-Labor Cost Reduction Deep Dive (includes 15-minute break at 10:00 AM)** 1. Supply Chain Optimization 2. Purchased and Shared Services/Managed Services 3Pharmacy Cost Containment 4. Revenue Cycle Optimization 5Information Technology Efficiency	 Paul Weintraub, MBA; Carolyn Howard Paul Weintraub, MBA; Carolyn Howard Kathleen Pawlicki, MS, RPh, FASHP Pat Wulf, MBA Scott Leavell, JM
11:30 –12:15 PM	**Networking Lunch and Table Discussion of Morning Topics**	
12:15 – 1:00 PM	**Physician Enterprise & Ambulatory Cost Management**	Brandt Jewell; Alex Kirkland, MBA
1:00 – 1:45 PM	**Labor Efficiency & Workforce Optimization**	Brandt Jewell
1:45 – 2:30 PM	**Facility and Service Optimization**	Stephen Ross, MHA, FHFMA, CMPE
2:30 – 2:45 PM	**Break**	
2:45 – 3:30 PM	**Individual Table Discussions of Afternoon Topics**	
3:30 – 4:00 PM	**Wrap-Up: Integrated Cost Transformation Roadmap & Next Steps**	Daniel DeBehnke, MD, MBA

AHS Pillars

Staff & Physician Experience



AHS values its physicians, clinicians, and staff and seeks to grow, engage, retain, and empower them to serve all.

CONGRATULATIONS
TO OUR NEW

CHIEF INFORMATION OFFICER

CHRISTINE YANG

ALAMEDA HEALTH SYSTEM

ALAMEDA HEALTH SYSTEM

Congratulations to Christine Yang on her promotion to Chief Information Officer (CIO)!

Christine joined AHS in 2022 as vice president and chief technology officer, and most recently served as interim CIO. With more than 30 years of experience in health care IT, she brings exceptional leadership, deep technical expertise and a strong track record of driving transformation.

Christine was also recently honored with the Modern Healthcare Leading Women 2025 award, recognizing her outstanding contributions to the industry.

WELCOME OUR NEW

CHIEF MEDICAL OFFICER

DR. LISA LAURENT

ALAMEDA HEALTH SYSTEM

ALAMEDA HEALTH SYSTEM

This is a great day for the Alameda Health System!
I am honored to welcome Lisa Laurent, MD MBA MS FAAPL to the AHS leadership team as our Chief Medical Officer (CMO).
Dr. Laurent is a proven positive change agent and her passion, enthusiasm and talent will be critical as AHS progresses on our journey to excellence.
Onward and upward!

TO: AHS All Staff & Medical Staff

FROM: Jeanette Dong, Chief Public Affairs and Community Engagement

DATE: September 8, 2025

SUBJECT: Using social media responsibly

Recent news coverage has shown how quickly workplace actions shared online can draw public attention and impact the trust patients place in health care providers.

This is a timely reminder of our collective responsibility to uphold professionalism, safeguard patient privacy and use social media responsibly.

Professionalism and respect for patient privacy are central to the trust our community places in us. Whether on site, working remotely, or engaging in the broader community, each of us represents Alameda Health System (AHS) and is expected to act with maturity, respect and accountability.

AHS policy prohibits posting work-related social media, photos, videos, or commentary, even with good intentions, without authorization and coordination with the Public Affairs and Community Engagement (PACE) department.

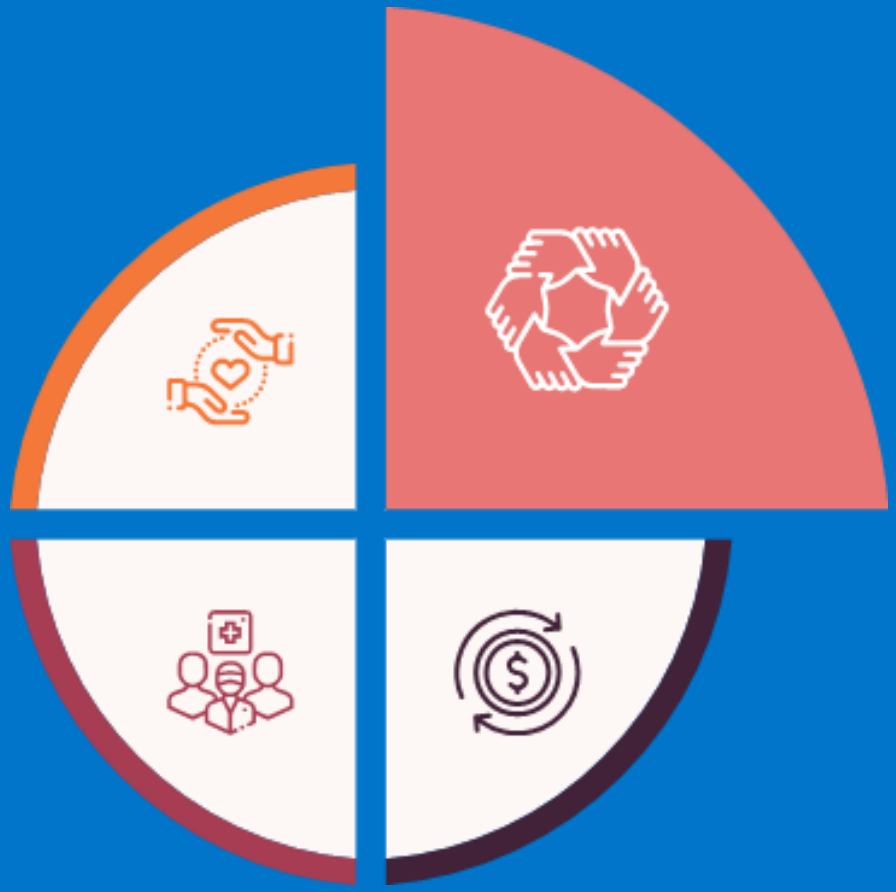
Patient information, including images or details that could directly or indirectly identify an individual, is strictly protected under federal and state privacy laws such as HIPAA and California regulations. Sharing this information without proper authorization can breach trust and may carry legal or regulatory consequences.

Protecting patient privacy is a responsibility we all share both online and offline.

Thank you for your continued commitment to professionalism and for ensuring that our patients, colleagues, and community can place their trust in us.

Community Connection

AHS is an anchor in its community and aligns its services to deliver a comprehensive continuum of care by providing needed services and being a trusted partner in its community at large.




CELEBRATING
HISPANIC
HERITAGE MONTH


14TH STREET SB
ALAMEDA
HEALTH SYSTEM
Teaching, ...ving All


ALAMEDA
HEALTH SYSTEM


ALAMEDA
HEALTH SYSTEM


Crayola
Crayola


Be
Brilliant
HEALTH ADVOCATE
JANSPORT
Crayola

Questions

James Jackson
9/17/2025
Board of Trustee Meeting

MEDICAL STAFF REPORTS

Alameda Health System
and
Alameda Hospital
Medical Executive Committee
Report to
Board of Trustees

September 17, 2025

Berenice Perez, MD, AHS Chief of Staff

Cathy Pyun, DO, AH Chief of Staff

Guiding Principles

Responsible for the "***quality of medical care to patients and for the ethical and professional practices of its members***" --Board of Trustees Bylaws.

Overview

- Credentialing and Privileging
- Peer Review
- Quality and Patient Safety
- Committee and Department Reports
  - Operating Room
  - Psychiatry
- Committee Reports

Committee and Department Reports

- **Credentials Committee**— Routine Credentialing & Privileging and Telemedicine Credentialing by Proxy
- **Patient Safety Committee** (July 11)—RCAs, operational issues that affect quality and patient safety
- **Quality Steering Committee** (Aug 12)—OKRs and KPI dashboards
- **Clinical Practice Council** (Aug 7) —Forwarded 25+ policies/order sets for approval
- **Operating Room Committee** — Efficiency initiative due to underutilization of OR time at SL and AH (74% and 50%). Block time decreased (18% HGH, 50% SL) starting August 1st. Utilization increased to 80% HGH and 81% SL. Unclear impact on patient access.
- **Psychiatry Department Annual Report** — Active Committee on Patient Safety, fully staffed PES physicians, stable nurse staffing, assault with injury is down, Changes to Writ Hearing procedure, Expansion of 5150/5250 to include substance use

Negligent Credentialing- Importance

Failure to protect patients by allowing unfit providers to practice.

- Negligent credentialing is a separate legal claim from medical malpractice, though it often arises from the same set of facts.
- The hospital may be responsible for failure to verify information falsely submitted on an application. It must verify the information and ensure the competency of a provider before credentialing their practice at the medical center.
- The prevention is by developing and adhering to the credentialing process.

Patient safety depends on competent providers

Hospitals are legally liable for credentialing failures

Physician leaders must lead with diligence and objectivity and promote culture of accountability and safety

Medical Staff Peer Review

Current State Peer Review

Each Medical Staff Department has its own QRC (12)

MEC delegates oversight of the Department QRCs to IPPC

Lacks standardization

Enlisted the help of a consultant to evaluate our current processes

Peer Review Redesign

October start redesign of the peer review process

One primary multi-disciplinary QRC Committee

Cases reviewed based on pre-determined performance indicators

Create Standard Work

A new Peer Review Policy by Jan/Feb 2026

Ongoing Professional Practice Evaluation (OPPE)

Continuous Process to assess clinical performance and factored into reappointment decisions.

Performance indicators used for case peer review

Peer Review Process Overview

Concerns

Initial Review

Review Committee

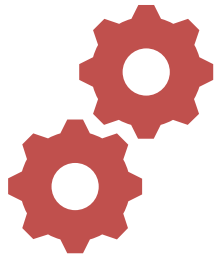
Peer Review & Case Adjudication

Improvement Opportunities

Aggregate Reporting

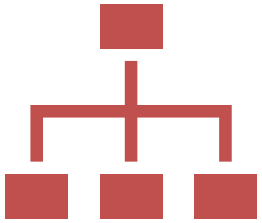
Peer Review Outcomes & Quality Improvement

Driving Quality Through Peer Review



System-level improvements come from identified trends

Promotes accountability, learning, and patient safety culture



Integration with quality programs including M&M, CME, MIDAS Incident reporting

AHS and AH Medical Staff
Voluntary Resignations January – June 2025

95 Voluntary Resignations by Medical Staff

Excludes Telemedicine provider resignations

AHS Core	68
Administrative Staff	1
Advanced Eye Physicians	1
AHS - Employed	26
Alameda Health Medical Group (AHMG)	13
Bass Medical Group	1
California Sports and Orthopaedic Institute Inc	1
Diablo Valley Oncology & Hematology Medical Group, Inc.	1
Emeritus	2
Eye Physicians of the East Bay	1
Honorary	2
Island Medical Group	1
Locum Tenens - CompHealth	1
Locum Tenens - Vaya	3
No Group	1
Traditions Behavioral Health	9
UCSF	3
West Coast Kidney Institute	1

AH	26
Advanced Eye Physicians	1
AHS - Employed	12
Alameda Eye Physicians	1
Alameda Health Medical Group (AHMG)	4
Alameda Inpatient Medical	1
California Sports and Orthopaedic Institute Inc	1
Independent Contractor	1
Island Medical Group	1
Locum Tenens - Vaya	1
No Group	2
UCSF	1

Of the 95 provider resignations 14 providers resigned from both AHS and AH

(independent Medical Staffs therefore included on both reports)

**Facility resignations also include providers who may have only resigned from Medical Staff.*

ALAMEDA HEALTH SYSTEM

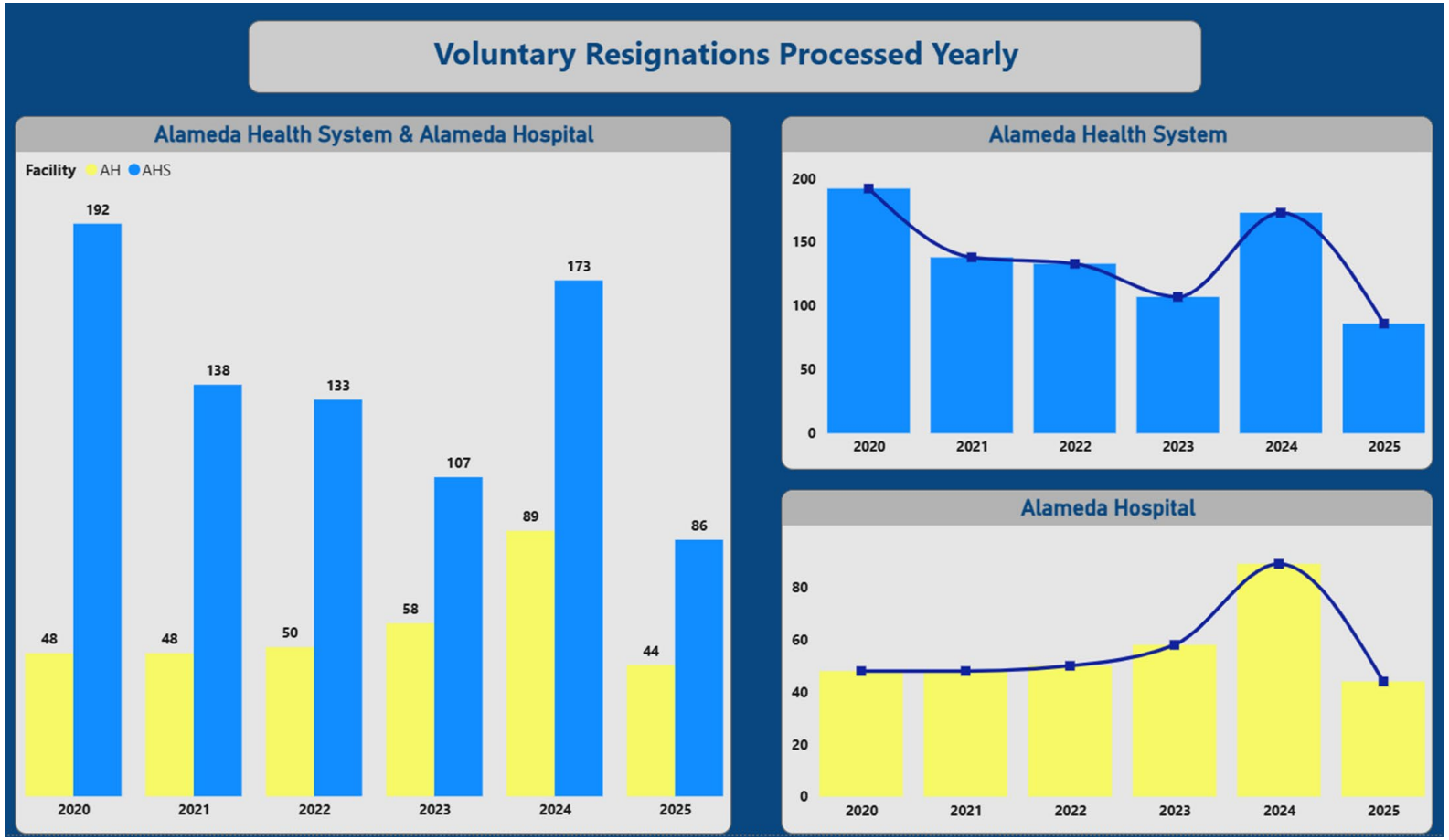
Voluntary Resignations 2020-2025

43% of providers have privileges on the AHS & AH Medical Staffs

For CY 2024 a deeper dive of the data reflects:

- 13 resignations – Contracted group cancelled contract with AHS (East Bay Nephrology)

- 22 resignations – Locum Tenens across specialties



Note: Yearly Voluntary Resignation Charts include Telemedicine providers in totals.

ALAMEDA HEALTH SYSTEM

ALAMEDA HEALTH SYSTEM

Medical Staff Voluntary Resignation Form

I am formally submitting my voluntary resignation from the Medical Staff(s) listed below.

☐ *Alameda Health System ☐ Alameda Hospital

Requested Voluntary Resignation Date (must be a date after this form is submitted to the Medical Staff Office):

Date: _____

I attest that my charting and medical records and any care I provided will be completed on or before my voluntary resignation as above (H&Ps, procedure notes, orders, discharge summaries)

I acknowledge and agree that I continue to be bound by the Medical Staff Bylaws until my voluntary resignation date, including but not limited to assuring that I maintain professional liability coverage through that date.

I acknowledge that my AHS network logon and all application access will be automatically deactivated on the date of my voluntary resignation documented above.

Any request to change my voluntary resignation date or a desire to rescind this resignation **MUST** be communicated verbally and in writing to the Medial Staff Office and your Department Chair prior to the date specified above for my voluntary resignation and you must request a date after the requested change is submitted in writing to the Medical Staff Office.

Failure to communicate any changes in dates will result in the resignation being effective as of the date above and all systems access will cease as outlined on this form.

Reason(s) *(please select all that apply)*:

- ☐ Layoff / Reduction in Workforce
- ☐ Resignation / Termination of Employment
- ☐ No longer with contracted group
- ☐ No longer utilize AHS Facilities
- ☐ Moved out of state
- ☐ Retired from practice
- ☐ Other _____

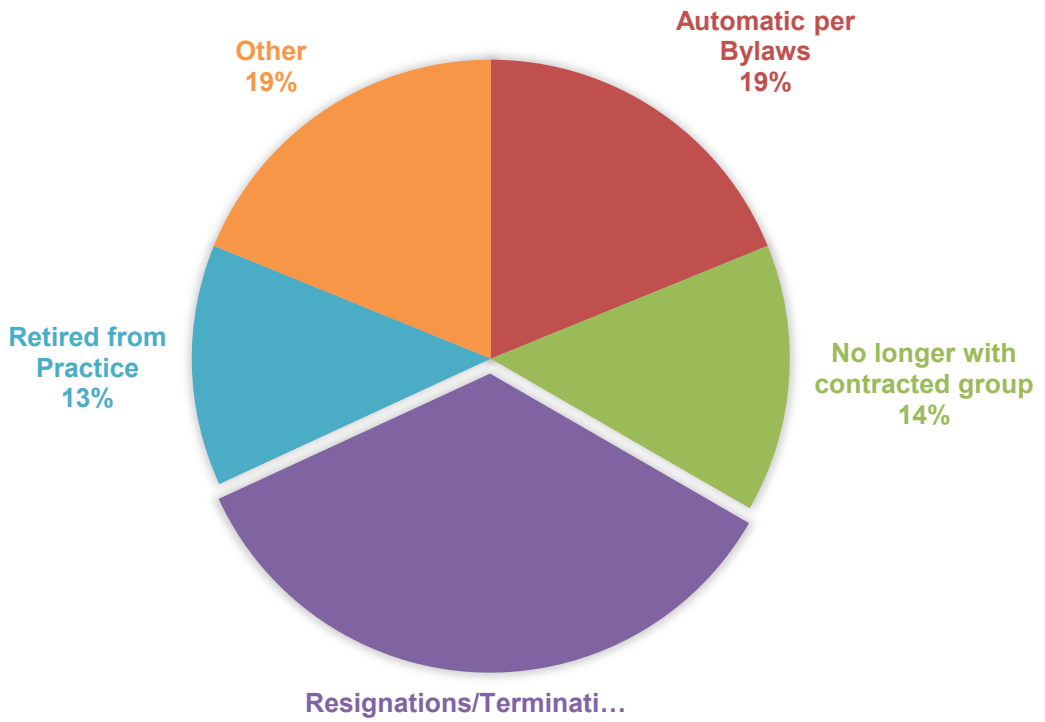
Practitioner's Printed Name	Department / Specialty	Medical Group Name *(if applicable)*
Practitioners Signature	Date	

Please submit your completed form via email or fax:
medicalstaff@alamedahealthsystem.org Fax: (510) 379-7440

You will receive a letter that confirms your voluntary resignation of membership and/or privileges after the resignation has been accepted by the Board. For any questions, please contact Medical Staff Services at Alameda Health System (510) 437-4292 or Alameda Hospital (510) 813-4035.

**Highland Hospital, San Leandro Hospital, John George Psychiatric Hospital, Fairmont Hospital, Wellness Clinics*

AHS MEDICAL STAFF VOLUNTARY RESIGNATIONS JANUARY - JUNE 2025



AHS Medical Staff—Next 6 months to 1 year

1. **Solidify the culture of Interdepartmental Professional Practice Committee as a safe space to work through peer review**
2. **Scope of the Patient Safety Committee—RCAs, operational factors that affect quality and safety**
3. **Procedural Innovation Committee - Align with strategic goals. Operational and clinical alignment**
4. **Peer Review Redesign—Timeline for development of new peer review policy**
5. **Department OPPE indicators - continuous assessment of clinical competence**
6. **Operating Room Committee Focus on access to patient care**

Alameda Hospital Medical Staff

- The Medical Executive Committee met in August for the purpose of credentialing and privileging which was reported at the QPSC meeting in closed session.

Submitted by the AHS and AH Medical Executive Committees

THANK YOU

COMMITTEE AND TRUSTEE REPORTS

No Written Materials

Agenda Item C Committee and Trustee Reports

No written materials were submitted for this agenda item. If materials become available, the item will be updated in Boardvantage and on the internet. A verbal discussion of the item may take place at the meeting.

CONSENT AGENDA: ACTION

BOARD OF TRUSTEES SPECIAL MEETING

WEDNESDAY, AUGUST 13, 2025
5:00pm to 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, In Person: HCP Conference Center, see above address

MEMBERS

Alan E. Fox	Greg Garrett
Lilavati Indulkar, MD	Donna Linton
Nicholas Moss, MD	Nely Obligacion
Rachel Richman	David Sayen

Sblend A. Sblendorio

BOARD OF TRUSTEES SPECIAL MEETING MINUTES

THE MEETING WAS CALLED TO ORDER AT 5:05 pm

ROLL CALL WAS TAKEN AND THE FOLLOWING TRUSTEES WERE PRESENT: Greg Garrett, Lilavati Indulkar, MD, Donna Linton, Nely Obligacion, David Sayen and Sblend Sblendorio

ABSENT: Alan Fox, Nicholas Moss, MD, and Rachel Richman

PUBLIC COMMENT: None

A. CONSENT AGENDA: ACTION

A1. Approve the Resolution to authorize Mark Fratzke to submit the Behavioral Health Community Infrastructure Program grant application for San Leandro Hospital and authorize Mark Fratzke to enter into and execute and deliver all other documentation necessary to secure the grant funds

A2. Approve the Resolution to authorize Mark Fratzke to submit the Behavioral Health Community Infrastructure Program grant application for Saint Rose Hospital authorize Mark Fratzke to enter into and execute and deliver all other documentation necessary to secure the grant funds

Moved by Trustee Sblendorio and seconded by Trustee Indulkar 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, Obligacion, Sayen, Sblendorio
NAYS: None
ABSTENTION: None

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

CLOSED SESSION

1. **Public Employee Performance Evaluation; Conference with Labor Negotiator Pursuant to Government**
   Code Sections 54957(b)(1) and 54957.6
   Title: Chief Executive Officer
   Agency Designated Representative: David Sayen, President Board of Trustees

(Reconvene to Open Session)

General Counsel Report on Action Taken in Closed Session

Trustee Sayen said the Board met in closed session and there was no reportable action.

OPEN SESSION

TRUSTEE COMMENTS

ADJOURNMENT 7:37PM

BOARD OF TRUSTEES MEETING

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5:00pm to 9:00pm

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Rachel Richman	David Sayen
Sblend A. Sblendorio	

THE MEETING WAS CALLED TO ORDER AT 5:03 pm

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

ABSENT: None

PUBLIC COMMENT:

Matthew spoke regarding his manager, Rose Zhang, who gave everyone in the department the opportunity to triage.

Danica spoke regarding Rose Zhang, who was terminated for the third time in the last few years. This caused concerns about patient care as staff felt the turmoil. This could lead to serious injuries.

Armida Paraiso spoke regarding Rose Zhang, who was an amazing manager. Under her leadership the department became organized and streamlined. Rose lead by example with clear and respectful communication.

Lucky appreciated Rose Zhang's leadership. Something wrong was happening. Over 130 people signed a petition on her behalf and delivered it to the CEO. He asked the Board to look into the situation.

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Jackie Moran read a letter on behalf of Mawata Kamara, stating that she was a target because she advocated for her patients. Management has continued a campaign against her that was unjust. She requested the Board appoint an independent investigator.

Bernadett Carline said the Board's attempt to change what was agreed to in the recent contract by stretching the nursing staff too thin was wrong. It was their obligation to find and demand the needed resources, while honoring the agreement.

Ilka George spoke regarding AHS's attempts to target union nurse leaders. AHS has been consistently notified about patient safety concerns, and they have only focused on budget goals rather than resolving the concerns.

Angela Marie said the management was not honoring the union contract and was targeting a member of the bargaining team. They will not allow harassment of nurses who are caring for the patients.

Lisa Lafave said they had a sacred contract with the patients to provide care at the highest standard. No one exemplified that better than Mawata Kamara. To work with her confirmed respect in her. This organization should be proud to have her.

Linda Strack said she was on the bargaining team. She said nurses stayed in their job for decades, unlike management. Nurses were the ones treating the patients. Mawata Kamara was cut from that cloth and was the backbone of the hospitals.

Dmolola said when Mr. Delaney came he had no experience in a union environment. Instead of collaborating with the union, he treated staff like enemies, disregarded the MOU, and made destabilizing decisions.

Barbara said Rose was an exceptional leader who had been targeted. They were asking the Board to look into what was happening.

Celestine Thomas said it was unacceptable to use the good faith of nurses then betray them after signing the contract. Charge nurses were vital. AHS sent notice to the union that they were going back on their word and cutting nurses.

John Lindsay Poland, American Friends Service Committee, spoke regarding health care at Santa Rita Jail. Healthcare at the jail had been deficient for a long time. The current contract was up in 2027, and they thought AHS should work to address this.

A. CEO REPORT

James E.T. Jackson, Chief Executive Officer

B. MEDICAL STAFF REPORTS

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

Trustee Fox said the report indicated that 96 physicians have resigned in the first half of the year, he asked for information about why the resignations were so high and what areas they were from. Dr. Perez agreed it was a lot, the numbers were consistent with previous years. She said they could do a deeper dive to discover if there are patterns. Ms. Dalton said they reported out on this in QPSC closed session. She'd be happy to report to the full Board as well, if they wished.

Trustee Indulkar said they noticed two things this year. Because of the ongoing work toward providing more governance and structure, some folks who were not working here for extended amounts of time were contacted to see if they wanted to voluntarily resign. There has been a lot of effort from the physician leaders to clean up their roster, so to speak. Under Dr. Akileswaran's leadership there has been a push to have more FTE positions and minimize the SAN use to have physicians be held accountable for the work they were hired to do.

Trustee Fox asked if physician turnover was monitored at QPSC in closed. Trustee Indulkar said they did not monitor it at a detailed level. Though the resignations were brought to the committee, they could add more details. Trustee Fox said he didn't want to add more work for people, but the Board needed to be aware if we were losing positions that have been recently recruited because of dissatisfaction.

Trustee Linton said perhaps there could be analysis of the 96 who resigned to review if they were FTE or SAN workers. The system had an outside vendor for separation interviews, perhaps they could also look to see if the doctors were using that and if there was any information there that could help. Mr. Jackson said they would work to ensure people know this exit interview system is in place.

Trustee Garrett asked how many physicians they had. Dr. Perez said they had just over 1000. Trustee Garrett asked if staff could bring a comparative analysis that compares our rate of turnover to other systems.

C. COMMITTEE AND TRUSTEE REPORTS

C1. Audit and Compliance Committee: June 18, 2025
Sblend Sblendorio, Chair

C2. Quality Professional Services Committee: June 26, 2025
Lilavati Indulkar, MD, Chair

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

Trustee Linton spoke regarding the operating cost being above what is budgeted. The biggest factor was the cost of labor. This will be an important and ongoing issue in the upcoming fiscal year. We could expect to have more public comment as changes were implemented.

Trustee Garrett said as a Board they believed in the need to reel in labor costs. But they also understood the tremendous pressure it put on the CEO and his team. When we hear about reductions in the labor force, it creates tremendous pressure questioning those decisions. He acknowledged the conflict that created for the leadership team. On one hand the Board was telling them they must reel in labor, but on the other hand they brought pressure to the team when they took actions on that. The Board needed to support the team when they made those decisions. Mr. Jackson appreciated the comments.

Trustee Linton said the pressure was only going to grow given what was happening at the Federal and State levels.

Trustee Obligacion said they needed to be proactive in talking with the unions. If there were engagement and the labor groups understood through collaboration and transparency it would help everyone move forward. The Trustees needed to be a part of the engagement with labor. Mr. Jackson said he and Mr. Fratzke met with Dr. Mahler and Dr. Perez to plan and develop an informational curriculum where we will be transparent about the ramifications of what was happening at the Federal level. Additionally, this curriculum will focus on how to engage in a multidisciplinary way with labor to start talking about the tools that were available for us to do this work and honor our mission.

D. CONSENT AGENDA: ACTION

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

D1. Approval of the May 14 and June 11 Board of Trustees Meeting Minutes.

D2. Recommendation to the Board of Trustees for approval of the System Wide Policies and Standardized Procedures listed below:

- Medication Drug Recall
- Outpatient Pharmacy Dispensing

D3. 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

D4. Contracts

D4a. Renewal agreement with Alliance HealthCare Services, Inc. dba Alliance HealthCare Radiology for provision of mobile imaging services. The term of

this renewal agreement is effective April 23, 2025 through April 22, 2028. The estimated impact of this renewal is $3,333,044.
Mark Fratzke, Chief Operating Officer

D4b. Renewal agreement with CareFusion Solutions, LLC for provision of infusion pumps and supplies. The term of this renewal agreement is effective August 19, 2025 through August 18, 2030. The estimated impact of this renewal agreement is $7,206,000.
Romoanetia Lofton, Chief Nursing Executive

D4c. Renewal agreement with East Oakland Community Project for provision of respite care services. The term of this renewal agreement is effective August 1, 2025 through July 31, 2028. The estimated impact of this agreement is $1,593,600.
Romoanetia Lofton, Chief Nursing Executive

D4d. Renewal agreement with The Regents of the University of California on behalf of the University of California, San Franciso, Department of Neurological Surgery for provision of professional neurosurgery services. The term of this renewal agreement is August 1, 2025 through July 31, 2027. The estimated impact of this renewal agreement is $7,594,371.
Elizabeth Mahler MD, Chief Medical Officer

Moved by Trustee Sblendorio and seconded by Trustee Linton to approve the consent agenda.

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

E. ACTION/DISCUSSION

E1. ACTION / DISCUSSION: Resolution Accepting Grant Funds From the California Health Facilities Financing Authority and Authorize the Chief Executive Officer to Execute the Grant Agreement and Related Documents
Mark Fratzke, Chief Operating Officer

Trustee Sayen asked if there was any public comment on agenda Item E1. Ms. Jojola Gonsalves said there was not.

Moved by Trustee Linton and seconded by Trustee Moss to approve agenda Item E1.

ACTION: A motion was made and seconded to approve Agenda Item E1. A roll call was taken, and the motion passed.
AYES: Trustees Fox, Garrett, Indulkar, Linton, Moss, Obligacion, Richman, Sayen, Sblendorio
NAYS: None
ABSTENTION: None

E2. ACTION / DISCUSSION: Resolution Approving 401(h) Account, Pursuant to Section 31592
Arleen Gomez, Interim Chief Human Resources Officer
Ahmad Azizi, General Counsel

Trustee Sayen asked if there was any public comment on agenda Item E2. Ms. Jojola Gonsalves said there was not.

Moved by Trustee Indulkar and seconded by Trustee Linton to approve agenda Item E2.

ACTION: A motion was made and seconded to approve Agenda Item E2. A roll call was taken, and the motion passed.
AYES: Trustees Fox, Garrett, Indulkar, Linton, Moss, Obligacion, Richman, Sayen, Sblendorio
NAYS: None
ABSTENTION: None

E3. DISCUSSION: Operating Plan
Mark Fratzke, Chief Operating Officer
Christy Roberg, Vice President, Business Planning

Trustee Linton asked if they had capacity to manage the projected growth trends. Mr. Fratzke said the projected growth was not going to be AHS taking patients out of the market. It was us seeing the patients they were not seeing who called us directly.

Trustee Garrett said the cause of physician leakage has been a topic of discussion. Ms. Roberg said there were several reasons for the leakage. One was there was a lot of managed care business with Kaiser and Sutter, and the insurance will direct the care. They've also heard from some AHS providers that it could be patient preference, as they did not want to wait for service. And at times it was simply services AHS did not offer. She suggested they focus on the areas that were core services for AHS and drill into those to figure it out.

Trustee Fox asked if it was because so much of the first point of care was in the ED and then the patient would go back to their regular provider. Ms. Roberg said the goal for patients who were insured by Sutter or Kaiser was always to stabilize them then transfer them to their insured facility.

Trustee Garrett asked where else Medicaid patients were going. Ms. Roberg said they were going to places like Washington Hospital and then the Alliance had to pay out of network costs for the patients to go there.

Trustee Linton asked about relocating the PES to Highland. Mr. Fratzke said it's not going to be Highland. They were working on how to make the Highland ED more accommodating. But they were considering moving the PES at John George to San Leandro to create an integrated model of medicine and mental health. They had until October to submit for BHCIP.

Trustee Indulkar said currently all the 5150 and 5250 patients came to Highland due to the certification requirements. She asked if they were suggesting the County authorize them to stay at San Leandro instead. Mr. Fratzke said that was correct. The ambulances would still come to Highland, but there will be other options.

Trustee Garrett asked about relocating Highland primary and specialty care. Mr. Fratzke said it would probably be primary care. Specialty care was usually co-located within acute care. They've been focusing more on how to move primary care into a primary setting and then put urgent care next to it.

Trustee Linton said they had a Strategic plan, and this was now operationalizing these focus areas. Some priorities won't come online for 3-5 years. She asked if they would then create an annual implementation plan that prioritized what was being worked on. Mr. Fratzke said that was the next step. Ms. Roberg was starting to develop a process in terms of how they prioritize these. Ms. Roberg said that they wanted to standardize these processes. The strategic planning, operational planning, budgeting and financial planning should all be integrated.

Trustee Indulkar said the physicians were grateful for the work put into this plan to allow them to see what they need to be working toward. They had an opportunity to see this firsthand and had a chance to have some input. She asked that they spend time with physician leaders to understand what physician leakage was, where the gaps were, and what did they needed to take away. This was a new language for them. Ms. Roberg said that was their goal. As they built out the initiatives they would work with the physicians.

Trustee Sblendorio asked when this would begin to be actualized. Mr. Fratzke said the end of August.

Trustee Sblendorio asked how the reprioritization will be sold throughout the system. Mr. Fratzke said they had a lot of work to do. His experience was that it helped get an idea of directionality, but everyone would have their own ideas about what should be first.

Trustee Sblendorio said the message was that they were all getting older and sicker, so we needed to provide services for those patients. They all knew that. It was a tough message for people to accept. Mr. Fratzke said both sides were difficult as on one side they needed to focus on improvement and growth, but on the other side they needed to eliminate services that may not be part of the core. To him this was transformative. It was a resizing and rethinking about who they were and where they wanted to go.

Trustee Obligacion was not sure how the stakeholders were going to be involved because that was important. Change was always hard. They were going to hear public comments over and over. She was concerned. She hoped there would be lots of conversation.

F. DISCUSSION: Board Calendar and Tracking

G. STAFF REPORTS (Written)

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

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

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

CLOSED SESSION

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

1. **Conference with Labor Negotiators**
   [Government Code Section 54957.6]
   AHS Designated Representatives: Ulysses Madison, Director of People Operations
   Employee Organization: UAPD

2. **Public Employee Performance Evaluation**
   [Pursuant to Government Code Sections 54957(b)(1)]
   Title: Chief Executive Officer

3. **Public Employee Performance Evaluation; Conference with Labor Negotiator Pursuant to Government**
   Code Sections 54957(b)(1) and 54957.6
   Title: Chief Executive Officer
   Agency Designated
   Representative: David Sayen, President Board of Trustees

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

(Reconvene to Open Session)

General Counsel Report on Action Taken in Closed Session

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

OPEN SESSION

H. Discussion and Possible Action to Amend the Employment Agreement with the Chief Executive Officer

Trustee Sayen asked if there was any public comment on agenda Item H. Mr. Azizi said there

was no public comment and there were no reportable actions taken in closed session.

Trustee Sayen said that the Board concluded their review of the Chief Executive Officer's performance. They were a lot of great results this year. He noted the significance of the financial results being much better than they thought they would be. The Board was mindful of the need to keep compensation close to the median in the market. As such, Trustee Sayen said he would like to make a motion that we amend the CEO's Employment Agreement to increase his salary to $852,000.

Moved by Trustee Sayen and seconded by Trustee Sblendorio to amend the CEO employment agreement to increase his salary to $852,000.

ACTION: A motion was made and seconded to amend the CEO employment agreement to increase his salary to $852,000. A roll call was taken, and the motion passed.
AYES: Trustees Garrett, Indulkar, Linton, Moss, Obligacion, Richman, Sayen, Sblendorio
NAYS: None
ABSTENTION: None

ADJOURNMENT: 10:28pm

BOARD OF TRUSTEES SPECIAL MEETING

WEDNESDAY, AUGUST 13, 2025
5:00pm to 7:00pm

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1411 East 31st Street Oakland, CA 94602
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Alan E. Fox	Greg Garrett
Lilavati Indulkar, MD	Donna Linton
Nicholas Moss, MD	Nely Obligacion
Rachel Richman	David Sayen
Sblend A. Sblendorio	

BOARD OF TRUSTEES SPECIAL MEETING MINUTES

THE MEETING WAS CALLED TO ORDER AT 5:05 pm

ROLL CALL WAS TAKEN AND THE FOLLOWING TRUSTEES WERE PRESENT: Greg Garrett, Lilavati Indulkar, MD, Donna Linton, Nely Obligacion, David Sayen and Sblend Sblendorio

ABSENT: Alan Fox, Nicholas Moss, MD, and Rachel Richman

PUBLIC COMMENT: None

A. CONSENT AGENDA: ACTION

A1. Approve the Resolution to authorize Mark Fratzke to submit the Behavioral Health Community Infrastructure Program grant application for San Leandro Hospital and authorize Mark Fratzke to enter into and execute and deliver all other documentation necessary to secure the grant funds

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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, Obligacion, Sayen, Sblendorio
NAYS: None
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   Code Sections 54957(b)(1) and 54957.6
   Title: Chief Executive Officer
   Agency Designated Representative: David Sayen, President Board of Trustees

(Reconvene to Open Session)

General Counsel Report on Action Taken in Closed Session

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PUBLIC COMMENT:

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A. CEO REPORT

James E.T. Jackson, Chief Executive Officer

B. MEDICAL STAFF REPORTS

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AH Medical: Catherine Pyun, DO, Chief of Medical Staff

Trustee Fox said the report indicated that 96 physicians have resigned in the first half of the year, he asked for information about why the resignations were so high and what areas they were from. Dr. Perez agreed it was a lot, the numbers were consistent with previous years. She said they could do a deeper dive to discover if there are patterns. Ms. Dalton said they reported out on this in QPSC closed session. She'd be happy to report to the full Board as well, if they wished.

Trustee Indulkar said they noticed two things this year. Because of the ongoing work toward providing more governance and structure, some folks who were not working here for extended amounts of time were contacted to see if they wanted to voluntarily resign. There has been a lot of effort from the physician leaders to clean up their roster, so to speak. Under Dr. Akileswaran's leadership there has been a push to have more FTE positions and minimize the SAN use to have physicians be held accountable for the work they were hired to do.

Trustee Fox asked if physician turnover was monitored at QPSC in closed. Trustee Indulkar said they did not monitor it at a detailed level. Though the resignations were brought to the committee, they could add more details. Trustee Fox said he didn't want to add more work for people, but the Board needed to be aware if we were losing positions that have been recently recruited because of dissatisfaction.

Trustee Linton said perhaps there could be analysis of the 96 who resigned to review if they were FTE or SAN workers. The system had an outside vendor for separation interviews, perhaps they could also look to see if the doctors were using that and if there was any information there that could help. Mr. Jackson said they would work to ensure people know this exit interview system is in place.

Trustee Garrett asked how many physicians they had. Dr. Perez said they had just over 1000. Trustee Garrett asked if staff could bring a comparative analysis that compares our rate of turnover to other systems.

C. COMMITTEE AND TRUSTEE REPORTS

C1. Audit and Compliance Committee: June 18, 2025
Sblend Sblendorio, Chair

C2. Quality Professional Services Committee: June 26, 2025
Lilavati Indulkar, MD, Chair

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

Trustee Linton spoke regarding the operating cost being above what is budgeted. The biggest factor was the cost of labor. This will be an important and ongoing issue in the upcoming fiscal year. We could expect to have more public comment as changes were implemented.

Trustee Garrett said as a Board they believed in the need to reel in labor costs. But they also understood the tremendous pressure it put on the CEO and his team. When we hear about reductions in the labor force, it creates tremendous pressure questioning those decisions. He acknowledged the conflict that created for the leadership team. On one hand the Board was telling them they must reel in labor, but on the other hand they brought pressure to the team when they took actions on that. The Board needed to support the team when they made those decisions. Mr. Jackson appreciated the comments.

Trustee Linton said the pressure was only going to grow given what was happening at the Federal and State levels.

Trustee Obligacion said they needed to be proactive in talking with the unions. If there were engagement and the labor groups understood through collaboration and transparency it would help everyone move forward. The Trustees needed to be a part of the engagement with labor. Mr. Jackson said he and Mr. Fratzke met with Dr. Mahler and Dr. Perez to plan and develop an informational curriculum where we will be transparent about the ramifications of what was happening at the Federal level. Additionally, this curriculum will focus on how to engage in a multidisciplinary way with labor to start talking about the tools that were available for us to do this work and honor our mission.

D. CONSENT AGENDA: ACTION

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

D1. Approval of the May 14 and June 11 Board of Trustees Meeting Minutes.

D2. Recommendation to the Board of Trustees for approval of the System Wide Policies and Standardized Procedures listed below:

- Medication Drug Recall
- Outpatient Pharmacy Dispensing

D3. 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

D4. Contracts

D4a. Renewal agreement with Alliance HealthCare Services, Inc. dba Alliance HealthCare Radiology for provision of mobile imaging services. The term of

this renewal agreement is effective April 23, 2025 through April 22, 2028. The estimated impact of this renewal is $3,333,044.
Mark Fratzke, Chief Operating Officer

D4b. Renewal agreement with CareFusion Solutions, LLC for provision of infusion pumps and supplies. The term of this renewal agreement is effective August 19, 2025 through August 18, 2030. The estimated impact of this renewal agreement is $7,206,000.
Romoanetia Lofton, Chief Nursing Executive

D4c. Renewal agreement with East Oakland Community Project for provision of respite care services. The term of this renewal agreement is effective August 1, 2025 through July 31, 2028. The estimated impact of this agreement is $1,593,600.
Romoanetia Lofton, Chief Nursing Executive

D4d. Renewal agreement with The Regents of the University of California on behalf of the University of California, San Franciso, Department of Neurological Surgery for provision of professional neurosurgery services. The term of this renewal agreement is August 1, 2025 through July 31, 2027. The estimated impact of this renewal agreement is $7,594,371.
Elizabeth Mahler MD, Chief Medical Officer

Moved by Trustee Sblendorio and seconded by Trustee Linton to approve the consent agenda.

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

E. ACTION/DISCUSSION

E1. ACTION / DISCUSSION: Resolution Accepting Grant Funds From the California Health Facilities Financing Authority and Authorize the Chief Executive Officer to Execute the Grant Agreement and Related Documents
Mark Fratzke, Chief Operating Officer

Trustee Sayen asked if there was any public comment on agenda Item E1. Ms. Jojola Gonsalves said there was not.

Moved by Trustee Linton and seconded by Trustee Moss to approve agenda Item E1.

ACTION: A motion was made and seconded to approve Agenda Item E1. A roll call was taken, and the motion passed.
AYES: Trustees Fox, Garrett, Indulkar, Linton, Moss, Obligacion, Richman, Sayen, Sblendorio
NAYS: None
ABSTENTION: None

E2. ACTION / DISCUSSION: Resolution Approving 401(h) Account, Pursuant to Section 31592
Arleen Gomez, Interim Chief Human Resources Officer
Ahmad Azizi, General Counsel

Trustee Sayen asked if there was any public comment on agenda Item E2. Ms. Jojola Gonsalves said there was not.

Moved by Trustee Indulkar and seconded by Trustee Linton to approve agenda Item E2.

ACTION: A motion was made and seconded to approve Agenda Item E2. A roll call was taken, and the motion passed.
AYES: Trustees Fox, Garrett, Indulkar, Linton, Moss, Obligacion, Richman, Sayen, Sblendorio
NAYS: None
ABSTENTION: None

E3. DISCUSSION: Operating Plan
Mark Fratzke, Chief Operating Officer
Christy Roberg, Vice President, Business Planning

Trustee Linton asked if they had capacity to manage the projected growth trends. Mr. Fratzke said the projected growth was not going to be AHS taking patients out of the market. It was us seeing the patients they were not seeing who called us directly.

Trustee Garrett said the cause of physician leakage has been a topic of discussion. Ms. Roberg said there were several reasons for the leakage. One was there was a lot of managed care business with Kaiser and Sutter, and the insurance will direct the care. They've also heard from some AHS providers that it could be patient preference, as they did not want to wait for service. And at times it was simply services AHS did not offer. She suggested they focus on the areas that were core services for AHS and drill into those to figure it out.

Trustee Fox asked if it was because so much of the first point of care was in the ED and then the patient would go back to their regular provider. Ms. Roberg said the goal for patients who were insured by Sutter or Kaiser was always to stabilize them then transfer them to their insured facility.

Trustee Garrett asked where else Medicaid patients were going. Ms. Roberg said they were going to places like Washington Hospital and then the Alliance had to pay out of network costs for the patients to go there.

Trustee Linton asked about relocating the PES to Highland. Mr. Fratzke said it's not going to be Highland. They were working on how to make the Highland ED more accommodating. But they were considering moving the PES at John George to San Leandro to create an integrated model of medicine and mental health. They had until October to submit for BHCIP.

Trustee Indulkar said currently all the 5150 and 5250 patients came to Highland due to the certification requirements. She asked if they were suggesting the County authorize them to stay at San Leandro instead. Mr. Fratzke said that was correct. The ambulances would still come to Highland, but there will be other options.

Trustee Garrett asked about relocating Highland primary and specialty care. Mr. Fratzke said it would probably be primary care. Specialty care was usually co-located within acute care. They've been focusing more on how to move primary care into a primary setting and then put urgent care next to it.

Trustee Linton said they had a Strategic plan, and this was now operationalizing these focus areas. Some priorities won't come online for 3-5 years. She asked if they would then create an annual implementation plan that prioritized what was being worked on. Mr. Fratzke said that was the next step. Ms. Roberg was starting to develop a process in terms of how they prioritize these. Ms. Roberg said that they wanted to standardize these processes. The strategic planning, operational planning, budgeting and financial planning should all be integrated.

Trustee Indulkar said the physicians were grateful for the work put into this plan to allow them to see what they need to be working toward. They had an opportunity to see this firsthand and had a chance to have some input. She asked that they spend time with physician leaders to understand what physician leakage was, where the gaps were, and what did they needed to take away. This was a new language for them. Ms. Roberg said that was their goal. As they built out the initiatives they would work with the physicians.

Trustee Sblendorio asked when this would begin to be actualized. Mr. Fratzke said the end of August.

Trustee Sblendorio asked how the reprioritization will be sold throughout the system. Mr. Fratzke said they had a lot of work to do. His experience was that it helped get an idea of directionality, but everyone would have their own ideas about what should be first.

Trustee Sblendorio said the message was that they were all getting older and sicker, so we needed to provide services for those patients. They all knew that. It was a tough message for people to accept. Mr. Fratzke said both sides were difficult as on one side they needed to focus on improvement and growth, but on the other side they needed to eliminate services that may not be part of the core. To him this was transformative. It was a resizing and rethinking about who they were and where they wanted to go.

Trustee Obligacion was not sure how the stakeholders were going to be involved because that was important. Change was always hard. They were going to hear public comments over and over. She was concerned. She hoped there would be lots of conversation.

F. DISCUSSION: Board Calendar and Tracking

G. STAFF REPORTS (Written)

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

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

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

CLOSED SESSION

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

1. **Conference with Labor Negotiators**
   [Government Code Section 54957.6]
   AHS Designated Representatives: Ulysses Madison, Director of People Operations
   Employee Organization: UAPD

2. **Public Employee Performance Evaluation**
   [Pursuant to Government Code Sections 54957(b)(1)]
   Title: Chief Executive Officer

3. **Public Employee Performance Evaluation; Conference with Labor Negotiator Pursuant to Government**
   Code Sections 54957(b)(1) and 54957.6
   Title: Chief Executive Officer
   Agency Designated
   Representative: David Sayen, President Board of Trustees

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

(Reconvene to Open Session)

General Counsel Report on Action Taken in Closed Session

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

OPEN SESSION

H. Discussion and Possible Action to Amend the Employment Agreement with the Chief Executive Officer

Trustee Sayen asked if there was any public comment on agenda Item H. Mr. Azizi said there

was no public comment and there were no reportable actions taken in closed session.

Trustee Sayen said that the Board concluded their review of the Chief Executive Officer's performance. They were a lot of great results this year. He noted the significance of the financial results being much better than they thought they would be. The Board was mindful of the need to keep compensation close to the median in the market. As such, Trustee Sayen said he would like to make a motion that we amend the CEO's Employment Agreement to increase his salary to $852,000.

Moved by Trustee Sayen and seconded by Trustee Sblendorio to amend the CEO employment agreement to increase his salary to $852,000.

ACTION: A motion was made and seconded to amend the CEO employment agreement to increase his salary to $852,000. A roll call was taken, and the motion passed.
AYES: Trustees Garrett, Indulkar, Linton, Moss, Obligacion, Richman, Sayen, Sblendorio
NAYS: None
ABSTENTION: None

ADJOURNMENT: 10:28pm

	Policy	
ALAMEDA HEALTH SYSTEM	**HR Section 1.00 - Policy 1.90 Employee Referral Program**	**Reference # Version**
	LEVEL ☐ System ☐ Site	EFFECTIVE DATE: 9/2025

POLICY STATEMENT

The Alameda Health System (AHS) Employee Referral Program is meant to support our hiring departments in identifying and hiring top talent. To thank our employees for their involvement, employees are eligible to receive a referral bonus for successfully hired referrals. If a referred candidate is hired, the referring employee will receive an incentive (if all eligibility requirements are met—see below) which will vary depending on the level of role that the referral is hired into.

The Talent Acquisition Team may increase bonuses for specific hard-to-fill roles at any given time.

PURPOSE

Our employees are our most important asset, and we know that no one knows our business like our current employees. That's why we developed our Employee Referral Program: to encourage our employees to get involved in helping to build Alameda Health System by referring your talented friends, family and former colleagues to roles here at AHS. To encourage the referral of potential employees of diverse backgrounds that reflect the community that AHS serves.

PROCEDURES

Eligibility

- All permanent employees are eligible to participate in the Employee Referral Program. We welcome interns and contractors to participate in the program, but they are not eligible to receive a referral bonus.
- Any employee can refer a candidate for a role, but they are not eligible to receive a payment for someone referred to a position over which they have any management or hiring responsibility.
- The referring employee must be an active Alameda Health System employee at the time of payout.
- All jobs, excluding internships, are bonus eligible unless otherwise noted.
- Once a candidate is referred by an employee, the first referring employee retains that referral for a period of 365 days, after which time the candidate will become the referral of Alameda Health System. Candidates who are referred by multiple employees will be accredited to the first-referring employee for the entirety of the referral period.
- Final decisions regarding the eligibility for a referral bonus will be decided by the Talent Acquisition Team.

How to Refer

- All employee referrals must be made through the HR Service Center, ServiceNow platform.
- Referral must be submitted through the HR Service Center before the candidate applies for the job position. Referrals submitted afterward will not be eligible for referral bonuses.
- The Talent Acquisition Team will contact you directly:
  - To confirm your referral has been received.
  - If the candidate referred is hired, you will receive information about your referral bonus within a month of hire date.

Payment Process

- Referrals are tracked by the Talent Acquisition team. Payments will be tracked and made on a monthly basis through the payroll system.
- Referral bonuses are paid 90 days after the date of referred candidate's hire. The referred candidate must be an active AHS employee at the time of payout.
- A Referral bonus is paid in one lump sum and is subject to standard payroll and tax withholdings.

Exclusions:

- Individuals assigned to positions of Vice President or above will be exempt from receiving a referral bonus.
- While you may refer candidates to internships and volunteer opportunities (and we encourage you to do so!) referrals to internships and volunteer service are not bonus eligible.
- Candidates referred who are current or previous employees of Alameda Health System are not bonus eligible.

Questions?

For any questions pertaining to the referral bonus program, please send your questions to the HR Service Center HRServiceCenter@alamedahealthsystem.org

Referral Bonus Amounts

Referral bonus amounts are assigned by the HR department in line with budget and operational needs. Amounts are subject to change.

ALAMEDA HEALTH SYSTEM	Policy	
	HR Section 3.00 – Policy 3.24 **Compliance Enforcement and Discipline**	**Reference # tbd**
	LEVEL ☐ System ☐ Site	EFFECTIVE DATE: 9/2025

POLICY STATEMENT

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

PURPOSE

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

GUIDELINES

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

REFERENCES

AHS Code of Conduct
COMPLIANCE HOTLINE POLICY
COMPLIANCE HIPAA WALKTHROUGH ASSESSMENT PROTOCOL
RESPONSIBILITIES FOR COMPLIANCE REPORTING
HR SECTION 3.00 - POLICY 3.20 EXPECTATIONS OF CONDUCT

ALAMEDA HEALTH SYSTEM	Policy	
	HR SECTION 5.00 - POLICY 5.12 **Employee Safety and Security**	**Reference # Version**
	LEVEL ☐ System ☐ Site	EFFECTIVE DATE: 12/1996 LAST REVIEW DATE:

POLICY STATEMENT

Alameda Health System (AHS) prohibits the control, possession, transfer, sale or use of illegal drugs, alcohol, firearms, explosives, or other contraband on the premises of AHS.

AHS reserves the right to conduct investigations into allegations of violation of this policy in any AHS facility. Investigations may involve search of employee's desk, lockers, backpacks/bags, or vehicles, if parked on AHS premises.

When necessary, Law Enforcement could be summoned to assist in conducting an investigation including but not limited to searching and recovering items mentioned in this policy.

PURPOSE

To maintain a work environment free of illegal drugs, alcohol, firearms, explosives, or other contraband. In the context of this policy, tools used for job related duties are allowed to be possessed and used at work to carry out these duties.

DEFINITIONS

Contraband - At AHS, contraband is defined as any instrument, device, or item likely to cause injury, death, harm, or deemed a safety concern. Illegal weapons and unauthorized items include, but are not limited to, all items mentioned in Penal Code sections: 171b, 653(k), 12020, 12025, 12031(a)(1), 12401, 12402 and 12403.7.

Contraband includes but is not limited to:

a. Firearms and ammunition
b. Explosives and/or explosive material
c. Knives/box cutters/razor blades
d. Chemical agents (mace, pepper spray, or other sprays that debilitate a person)
e. Impact weapons (nunchaku, batons)
f. Tasers
g. Screw drivers/ice picks/knitting needles/corkscrews
h. Leatherman or multi-tools
i. Flammable liquids
j. Alcohol based/aerosol canisters
k. Syringe
l. Scissor
m. Metal forks/cutlery
n. Metal nail files/metal comb picks
o. Alcoholic beverages
p. Illegal/illicit controlled substances/drugs
q. Marijuana - while legal in the state of CA, is not permitted in AHS Facilities due to Federal funding.
r. Drug paraphernalia
s. Lighters/matches
t. Hammer(s)
u. Tools such as wrenches, ratchets, etc.

v. Any item which AHS Security, or AHS staff, determine can cause harm to others

RESPONSIBILITIES

All employees are required to actively participate in the administration of this policy.

PROCEDURES

1. Desks, lockers and other storage devices are provided for the convenience of employees but remain the sole property of AHS. Accordingly, they, as well as any articles found within them, can be inspected by a representative of AHS at any time, either with or without prior notice.

2. AHS also reserves the right, without prior notice, to search its premises thoroughly at any time. Additionally, a search can be conducted of any of AHS's equipment used in the scope and course of business.

3. Failure to cooperate in a search may result in disciplinary action up to and including termination.

REFERENCES

- HR SECTION 1.00 - POLICY 1.54 EMPLOYEE LOCKERS
- HR SECTION 3.00 - POLICY 3.20 EXPECTATIONS OF CONDUCT
- WEAPON SCREENING & CONTRABAND POLICY
- SECURITY MANAGEMENT PLAN

	Policy	
ALAMEDA HEALTH SYSTEM	**HR SECTION 1.00 – POLICY 1.35 DRUG-FREE WORKPLACE**	**Reference # tbd**
	LEVEL ☐ System ☐ Site	EFFECTIVE DATE: 9/2025

POLICY STATEMENT

The manufacture, use, sale, purchase, possession, transfer, or transport of illegal or mind-altering drugs or the misuse of prescription or over-the-counter drugs on Alameda Health System (AHS) property by employees, and consumption or being under the influence of any such drugs or of alcoholic beverages while at work is strictly prohibited and will result in immediate disciplinary action. Breaches of this policy may result in disciplinary action up to and including termination of employment.

Federal Grant or contract Employees Special Requirement: The Drug-Free Workplace Act of 1988 requires that an employee directly engaged in the performance of work on a Federal contract or grant shall notify his or her Department manager upon receipt of any criminal drug statute violation occurring in the workplace.

PURPOSE

To state AHS intent to maintain a drug-free workplace in conformity with the Federal Drug-Free Workplace Act of 1988; and to provide guidance for employees of Alameda Health System who may need assistance with drug or alcohol issues.

AHS is committed to providing and maintaining a workplace that is safe and productive. To that end, AHS does not tolerate the possession, sale or use of illegal drugs; the improper possession, sale or use of other controlled substances; or the possession, sale or use of alcohol while at work or engaged in work-related activities. Additionally, employees are required to report to work and be able to perform their job duties competently and safely.

SCOPE

All employees, contractors and travelers.

PROCEDURES

A. When the Department Manager has a reasonable suspicion that an employee is under the influence of drugs or alcohol, the supervisor may refer the employee for a breath or urine, and/or blood test. A checklist for indications that an employee may be under the influence, a reasonable suspicion, is attached to this policy as Appendix "A." Once the checklist is completed, the manager must call Human Resources to set up the test or call the appropriate testing vendor's number for night and weekend testing. The manager must notify the leader and Human Resources of the incident. Employees who refuse to submit to screening or fail to execute consent forms when required by the AHS will be subject to disciplinary action up to and including termination of employment. Any employee's efforts to subvert the testing process can be cause for disciplinary action and or termination.

B. Employees who test positive for the first time will, as a matter of policy, be offered a chance to rehabilitate themselves in an appropriate program after signing an agreement committing themselves to such a program. Employees testing positive thereafter will be dealt with on a case-by-case basis for disciplinary purposes.

C. If an employee believes that they have a substance abuse problem, they should consult with their leader/manager/supervisor, and/or Human Resources and attempts will be made to assist the employee in finding appropriate treatment including references to the Employee Assistance Program (EAP). Employees can also call EAP directly. All contacts will be treated in strict confidence. Requests for time off for treatment will be reasonably accommodated and seeking treatment is encouraged. Subject to applicable laws, including laws protecting persons with disabilities, seeking treatment or other accommodation does not preclude AHS from taking disciplinary action, where appropriate, up to and including termination, for violation of this policy.

Questions and additional clarification of this policy should be directed to Human Resources.

REFERENCES
The Drug-Free Workplace Act of 1988, U.S Department of Labor

ATTACHMENTS
Appendix A – Reasonable Suspicion Checklists

Appendix A

OBSERVATION CHECKLIST

Employee Name: _____

Directions: Check Pertinent Items

1.	Walking	☐ Stumbling ☐ Unable to Walk	☐ Staggering ☐ Swaying	☐ Falling ☐ Unsteady
2.	Standing	☐ Swaying ☐ Staggering	☐ Rigid ☐ Feet wide apart	☐ Unable to stand ☐ Sagging at knees
3.	Speech	☐ Shouting ☐ Slow ☐ Slurred	☐ Silent ☐ Rambling ☐ Slobbering	☐ Whispering ☐ Mute ☐ Incoherent
4.	Demeanor	☐ Cooperative ☐ Sleepy ☐ Talkative ☐ Fighting	☐ Polite ☐ Crying ☐ Excited	☐ Calm ☐ Silent ☐ Sarcastic
5.	Actions	☐ Fighting ☐ Hyperactive ☐ Hostile	☐ Threatening ☐ Drowsy ☐ Erratic	☐ Calm ☐ Using Profanity ☐ Resisting Communication
6.	Eyes	☐ Bloodshot ☐ Glassy	☐ Watery ☐ Droopy	☐ Dilated ☐ Closed
7.	Face	☐ Flushed	☐ Pale	☐ Sweaty
8.	Clothing	☐ Unruly ☐ Neat ☐ Body Excrement Stains on Clothing	☐ Messy ☐ Having Odor	☐ Dirty ☐ Partially Dressed
9.	Breath	☐ Alcoholic Odor ☐ No Alcoholic Odor	☐ Faint Alcoholic Odor	
10.	Movement	☐ Fumbling ☐ Normal	☐ Jerky ☐ Nervous	☐ Slow ☐ Hyperactive
11.	Eating/Chewing	☐ Gum ☐ Other (Identify if possible) _____	☐ Candy	☐ Mints

Employee Signature: _____ Date and Time _____

☐ Employee Refused to Sign

Supervisor Signature: _____ Date and Time _____

Appendix A

COORDINATION EXAMINATION

Employee Name: _____

1. Balance
   - ☐ Fair
   - ☐ Staggering
   - ☐ Falling
   - ☐ Sagging Knees
   - ☐ Swaying

2. Walking
   - ☐ Fair
   - ☐ Falling
   - ☐ Reaching for Support when Turning
   - ☐ Arms Extended for Balance
   - ☐ Sure-Footed
   - ☐ Swaying
   - ☐ Stumbling

3. Speech
   - ☐ Fair
   - ☐ Confused
   - ☐ Slurred
   - ☐ Silent
   - ☐ Incoherent
   - ☐ Whispering

4. Awareness
   - ☐ Fair
   - ☐ Sleepy
   - ☐ Confused
   - ☐ Alert
   - ☐ Bewildered

Employee Signature _____ Date and Time _____

☐ Employee Refused to Sign

Supervisor Signature _____ Date and Time _____

Appendix A

SUPERVISOR'S INTERVIEW AND INVESTIGATION

Employee Name _____

1. Are you feeling ill? ☐ yes ☐ no If yes, what are your symptoms _____

_____

2. Are you under doctor's care? ☐ yes ☐ no If yes, what are you being treated for? _____

What is the Doctor's name and address? _____

When did you last visit the doctor? _____

3. Are you taking any medication? ? ☐ yes ☐ no If yes, what medication? _____

Who prescribed it? _____ Do you have your prescription in your possession? ☐ yes ☐ no Do you have any additional medication in your possession? ☐ yes ☐ no

4. Do you have any pre-existing medical problems? ☐ yes ☐ no Diabetes? ☐ yes ☐ no
Are you taking insulin? ☐ yes ☐ no Do you have low blood sugar? ☐ yes ☐ no
Are you epileptic? ☐ yes ☐ no

5. Do you have a cold? ☐ yes ☐ no If yes, are you taking any cold pills ☐ yes ☐ no
Cough medicine? ☐ yes ☐ no Antihistamines? ☐ yes ☐ no

6. Are you using any type of drug? ☐ yes ☐ no If yes, what? _____

When? _____ Where? _____

With Whom? _____ How Much _____

7. Would you submit to a physical examination to include a blood test and/or urinalysis by a medical doctor or hospital so we can be sure that you are in good health and able to safely perform your job?
☐ yes ☐ no If no, what are your reasons for refusal? _____

_____

Would you submit to a basic coordination test? ☐ yes ☐ no

8. Did you drink alcohol or an alcoholic beverage today? ☐ yes ☐ no What did you drink? _____
How much? _____ When did you start? _____ When did you stop? _____
Where did you drink? _____ With whom did you drink? _____

_____

Supervisor Signature _____ Date and Time _____

Appendix A

EMPLOYEE CONSENT AND RELEASE FORM

I, _____, do hereby give my consent to Alameda Health System
(Employee Name)

and _____to perform appropriate test or examinations on me
(Testing Facility)

for the presence of drugs. I further give permission _____
(Testing Facility)

to release the results of the test or examinations to my employer.

I currently am taking the following medications or have taken them within the past thirty days:

Name of Drug: _____ Condition for which taken: _____

Name of Physician/Over the Counter: _____

Employee Signature _____ Date and Time _____

☐ Employee Refused to Sign

Supervisor Signature _____ Date and Time _____

Appendix A

VOLUNTARY SUBMISSION FOR
PHYSICAL EXAMINATION, BLOOD AND URINE ANALYSIS
AND
RELEASE OF FINDINGS AND INFORMATION

I, _____, voluntary agree to take a physical examination to include a blood and
(Employee Name)
urine analysis by a doctor, medical center, hospital, or medically qualified personnel.

Furthermore, I authorize release of the results of all tests and examinations to Alameda Health System (AHS) or any of its representatives.

Employee Signature _____ Date and Time _____

☐ Employee Refused to Sign

Supervisor Signature _____ Date and Time _____

	Policy	
ALAMEDA HEALTH SYSTEM	**Zero Tolerance to Violence**	**Reference # Version**
	LEVEL ☐ System ☐ Site	EFFECTIVE DATE: Effective Date LAST REVIEW DATE: Last Periodic Review Date

POLICY STATEMENT

This establishes an anti-violence policy that prohibits actual or direct or implied threatened violence by employees and agents against co-workers, residents, patients, medical staff, volunteers, students, visitors, or any other persons who either are on our premises or have contact with employees in the course of their duties.

Alameda Health System (AHS) is firmly committed to providing a violence-free workplace. The safety and security of AHS personnel, residents, patients, medical staff, and visitors are of vital importance. In keeping with this commitment, we have established this *Zero Tolerance Violence* policy that prohibits acts or threats of violence made by an employee against another person's life, health, well-being, family, or property.

Acts or threats of violence, whether made directly or indirectly, by words, gestures, or symbols, infringe upon AHS' right and obligation to provide a safe workplace for its employees, residents, patients, volunteers, visitors, medical staff, and students.

Additionally, this policy is intended to promote workplace security by addressing situations in which outsiders enter the workplace and engage in violent acts or threaten employees, or others with violence. Weapons are not permitted on the premises except for those carried by law enforcement officers. Employees play a crucial role in the implementation and use of this workplace security and violence prevention policy.

Alameda Health System refuses to tolerate violence in the workplace and will make every effort to prevent violent incidents from occurring by implementing this policy. This organization has a *Zero Tolerance Policy* to all forms of violence on its premises. All AHS employees have the right to work in a violence-free workplace, and our patients and visitors have the right to visit, receive healthcare, in a therapeutic environment free from risk to their personnel safety. Physical and/or non-physical assault will not be tolerated, and decisive action will be taken to protect staff. This organization will not tolerate any form of violence and will ensure that appropriate and consistent action is taken up to and including pursuing criminal charges.

It is not the intent of this policy that inappropriate action be taken against patients whose violent behavior is a direct result of a medical or psychiatric condition. In these circumstances, the emphasis is on prompt, effective clinical management and compassionate care of the patient, while at the same time, protecting the safety of the patient, as well as the safety of staff and others who may be affected by their behavior. To achieve this end, we will provide adequate authority and budgetary resources to responsible parties so that our goals and responsibilities can be met. In addition, all managers and supervisors are responsible for implementing and maintaining this organization's *Zero Tolerance Policy*.

Employee participation in designing and implementing this policy is encouraged. Prompt and accurate reporting of all violent incidents is required.

Victims of violence in Alameda Health System will not be discriminated against and bringing violent incidents to the attention of appropriate leadership will not result in retaliation. Finally, all employees,

including managers and supervisors, are responsible for using safe work practices, following all directives, policies, and procedures, and for assisting in maintaining a safe and secure work environment.

PURPOSE
To provide a safe and secure environment, free of violence, for patients, staff, and visitors.

SCOPE
This policy applies to the Alameda Health System (AHS) workforce. The AHS workforce, in this context includes employees, contractors, providers, travelers, students, residents, interns, and volunteers.

DEFINITIONS
AHS Workforce: Alameda Health System employees, contractors, providers, travelers, students, residents, interns, and volunteers.

Commented [SM1]: This includes interns, residents, volunteers… do we want to include/specify all of these?

Commented [SC2R1]: I see no harm in calling out interns, residents, volunteers, etc.

Intimidation: in the context of this policy includes behavior which has the purpose or effect of inspiring fear in a reasonable person and/or has the purpose or effect of inhibiting speech or actions by an act or threat of violence.

Remedial action: Corrective measures include, but is not limited to, discipline up to and including termination of employment and criminal prosecution.

Violence: Acts or threats of violence include physical assaults and actions or statements which, either directly or indirectly, by words, gestures, symbols, intimidation, or coercion give a reasonable person cause to believe that the personal safety of the affected individual or others may be at risk.

RESPONSIBILITIES
This policy applies to the Alameda Health System (AHS) workforce.

All employees and members of management are obligated to report any incident where they:

1. Believe they have been the subject of actual or threatened violence, or

2. Have observed or otherwise learned of such conduct by any person employed by AHS. These incidents should be reported to the Department Manager, Security, and Human Resources/Labor Relations immediately. Incidents to be reported include acts or threats of violence which manifest themselves in the workplace; acts or threats of violence stemming from work-related issues which manifest themselves either within or outside the workplace environment; and acts or threats of violence which may be unrelated to the workplace, but which manifest themselves within the workplace.

Retaliation against anyone who reports acts or threats of violence or participates in any procedures or investigations related to such complaints, will not be tolerated and will be subject to investigation and possible discipline up to and including termination.

Document Owner: Director, Security; Executive Responsible: Chief Human Resources Officer

PROCEDURES

Imminent Threat of Harm or Risk of Violence

If an employee becomes aware of any actual violence, or threat of imminent violence, obtaining emergency assistance must be a matter of first priority.

Staff should call security at their respective campuses; when appropriate staff should call 9-911 to reach the local law enforcement authorities for emergency assistance. The employee must report the incident to his/her supervisor.

The supervisor must notify Human Resource Business Partner /Labor Relations Consultant immediately. If the supervisor is not immediately available, the employee should contact Human Resource Business Partner /Labor Relations Consultant or supervisor immediately after contacting the law enforcement authorities.

Employees may report any incidents of violence or threats of violence without fear of reprisal of any kind. Employees are required to report according to the procedure which follows, any behavior of any employee, resident, patient, medical staff, or visitor that appears to compromise AHS' ability to maintain a safe work environment. There will not be any retaliation by management or co-workers for reporting any acts or threats of violence. However, the willful filing of a false report is strictly prohibited and will subject the employee to disciplinary action, see policy violations section below.

Manager's Roles and Responsibilities:

1. Ensure the staff understand that tolerating violence in the workplace IS NOT acceptable and not part of their job.
2. Lead by example and take violence, and threats of violence seriously.
3. Make sure staff know their options when confronted with violence and encourage and support staff in using them. This includes supporting a staff decision to pursue criminal charges when appropriate.
4. Know and exercise their responsibilities as a manager in dealing with violence.
5. Ensure that all violent incidents are reported and encourage a culture of reporting.
6. Investigate all violent incidents and respond promptly to all reports of bullying.
7. Ensure the policy is enforced and that staff are educated and/or re-educated on an ongoing basis; notify the Risk Management Department of any identified policy issues which may require updating, based on staff feedback and/or risk management input.
8. Prompt a culture of zero tolerance by:
    a. Including zero tolerance to violence as a topic in staff meetings.
    b. Debriefings after violent incidents
    c. Encourage and promote staff feedback.

d. Communicating incident investigation result and actions.

e. Posting the Alameda Health System Zero Tolerance to Violence poster throughout pertinent areas of respective departments (see Appendix A).

Employee Responsibilities

1. Understanding that tolerating violence IS NOT an acceptable part of their job.
2. Read this policy and understand how it will be implemented in the event of a security incident.
3. Know their options when confronted with violence and exercise options consistently. These options include, but are not limited to:
    a. Requesting a second staff member's presence if a patient is known to have a history of violence and/or if staff members feel additional caution is necessary.
    b. De-Escalation and Redirection techniques
    c. Activation of Panic Alarm Buttons (Code Grey)
    d. Discuss the application of restraints when clinically appropriate.
    e. Pursuit of criminal charges.
    f. Understanding management will support them in utilizing these options.
4. Promptly report all violent incidents.
5. Understand the potential for violence but know it can be avoided or mitigated through preparation.

Prevention and Management of Violence and Aggression

Prevention must be the primary objective of all staff. It is recognized, however, that on occasion, prevention will not be possible, but every attempt should be made to diffuse the situation. When a patient or aggressor begins to behave in an aggressive or violent manner, the staff member should attempt to:

1. Adopt an open position.
2. Remain calm; be objective and as non-threatening as possible.
3. Place themselves in a position which allows them to escape if need be.
4. Continue to talk to and listen to the patient or aggressor, being as reassuring as possible, unless the patient finds it aggravating.
5. Make no false promises and tell no lies to the patient/aggressor.
6. Determine if the individual is becoming aggressive due to a patient/customer experience matter, remove yourself from the scene when possible, and escalate to your supervisor for service recovery.

7. If the matter cannot be resolved by de-escalation techniques and redirection, summon help if this can be done without antagonizing the patient.
8. Prevent others from threatening the patient/aggressor.
9. Follow your facility's Code Activation procedures, i.e., Code Silver or Code Gray.

Staff assisting staff managing a potentially violent patient/aggressor should:

1. Without delay, approach the situation calmly and without rushing and threatening the patient/aggressor.
2. Remove items likely to cause injury (bedside tables, IV pumps/poles, rolling blood pressure cuffs, sharps, etc.) out of sight of the patient/aggressor.
3. Observe the situation they find and decide whether it is best to wait out of sight, in sight of the staff member or patient/aggressor or both, or takeover.
4. If time allows, remove other patients, visitors, etc. from the scene. Staff must be patient in attempting to resolve such situations. They should attempt to negotiate a resolution rather than force it upon others.

Action to be taken when PHYSICAL ASSAULT has taken place:

1. Follow your facility's Code Activation procedures, i.e., Code Silver or Code Gray.
2. Immediately contact local law enforcement. Although any staff member can call law enforcement, the complainant must be identified as the staff member who was assaulted.
3. Seek medical care if an injury occurs.
4. File an Occurrence Report (either written in the Midas Care Management system, or via voicemail – (510) 437-8484, ext. 48484)
5. Pursuit criminal charges against assailant.

Action to be taken when NON-PHYSICAL ASSAULT (Verbal Abuse) has taken place:

1. Determine if the patient/visitor is verbally assaultive due to a patient/customer experience matter, remove yourself from the scene when possible, and escalate to your supervisor for service recovery.
2. If the matter cannot be resolved by de-escalation techniques and redirection, follow your facility's Code Activation procedures, i.e., Code Silver or Code Gray.
3. When appropriate, law enforcement should be contacted as soon as possible by the person subjected to the verbal abuse, or by a relevant colleague. The seriousness of the incident should be taken into consideration when deciding whether law enforcement should be involved, but

where the incident is racially or religiously aggravated the matter should always be reported to the law enforcement.

4. Determine if the aggressor is a visitor/family member, follow the aforementioned steps above to Prevent and Manage Violent and/or Aggressive persons, ask them to stop their aggressive action, if they do not, follow your facility's Code Activation procedures. When the security team or law enforcement arrives, inform them of the individual's behavior and request the security team or law enforcement to remove the individual from the premises.
5. File an Occurrence Report (either written via the Midas Care Management system, or via voicemail – (510) 437-8484 ext. 48484).
6. If the aggressor is a patient with a non-emergent complaint (med refill, etc.) follow the steps above to Prevent and Manage Violent and/or Aggressive persons, ask them to stop their aggressive action. If the patient refuses to comply:
    a. Immediately contact a physician for a medical exam (MSE) and a prompt disposition.
    b. If they do not, follow your facility's Code Activation procedures.
    c. When the security team or law enforcement arrives, inform them of the individual's behavior and request the security team or law enforcement to remove the individual from the premises.
7. If the aggress\or is a patient with a legitimate medical complaint, ask them to stop their aggressive action. If they do not, inform them of the AHS Zero Tolerance to Violence policy, that they could potentially be placed under a "Citizen's Arrest" by the staff and criminal charges will be filed against them when they are discharged from the hospital
    a. a. The staff member must verbalize to the aggressor, "I am placing you under a Citizen's Arrest". Contact Law Enforcement for immediate assistance and follow-up of appropriate paperwork.
8. If the aggressor is a patient with a legitimate medical complaint but can be released with a MSE by the physician, facilitate their discharge and have them removed from the premises or placed them under "Citizen's Arrest."
9. File an Occurrence Report (either written via the Midas Care Management system, or via voicemail – (510) 437-8484 ext. 48484)

POLICY VIOLATIONS

Employee violations of this policy are subject to employees being placed on Paid administrative leave pending completion of an investigation and disciplinary action up to and including immediate termination of employment.

REFERENCES

- SECURITY MANAGEMENT PLAN
- WORKPLACE VIOLENCE PREVENTION AND RESPONSE PLAN IN THE WORKPLACE

APPENDIX A


Welcome to Alameda Health System, a place of mutual respect and healing. Where we safely serve all.
Bienvenido a Alameda Health System, un lugar de sanación y respeto mutuo. Donde servimos a todos con seguridad.
歡迎來到阿拉米達健康系統, 這是一個互相尊重和得到治癒的地方。
在這裡我們安全地為所有人服務。
Aggressive behavior will not be tolerated.
No se tolerará el comportamiento agresivo.
攻擊性行為是不會被容忍的。
No physical assault (hitting, use of force)
No asalto físico (golpear, uso de la fuerza)
禁止身體攻擊 (毆打、使用武力)
No weapons or firearms No threatening or aggressive behavior
No posesión de armas o armas de fuego No comportamiento amenazante o agresivo
禁止任何武器或槍械
禁止威脅或攻擊性行為
No verbal harassment (inappropriate words)
No acoso verbal (palabras inapropiadas)
禁止語言騷擾 (不當語言)
No sexual language or unwanted touching
No lenguaje sexual o tocamientos no deseados
禁止有性意味的語言或不必要的觸摸
No interfering with the delivery of patient care
No interferir en la prestación de cuidados al paciente
不可干擾病人的護理
No recording or photographing without consent
Prohibido grabar o fotografiar sin consentimiento
未經同意不得錄音或拍照
ALAMEDA HEALTH SYSTEM

ALAMEDA HEALTH SYSTEM	Policy	
	Tuition Reimbursement Policy	**Reference # TBD**
	LEVEL ☐ System ☐ Site	EFFECTIVE DATE: 9/2025

POLICY STATEMENT

Alameda Health System has established a tuition reimbursement program to help eligible employees improve job skills and enhance opportunities for advancement within the organization. This program is open to eligible employees, unrepresented or full-time eligible ACMEA members, who wish to voluntarily pursue educational courses or training from an accredited college or university for both credit and extended education courses. It does not apply to courses or training that are required by the employee's department or the organization, nor does it cover membership fees or courses required for maintaining certification or licenses. The tuition reimbursement program is administered by the Human Resources department.

PURPOSE

We value the professional and personal development of our employees, Alameda Health System (AHS) has adopted the following policy pertaining to reimbursement of certain educational expenses.

SCOPE

Under this policy, educational assistance is provided to:

- All full-time AHS employees who are not eligible for the SEIU-UHW Education Fund. Full-time is defined as 0.8 and above for the purposes of this policy.
- Who have worked at Alameda Health System for twelve months without interruption before enrolling in a course/course that are included in a degree program,
- And who are on the payroll upon completion of the course.

However, educational assistance will not or will no longer be provided to any qualified employee who:

- Has received a formal warning within three months prior to seeking approval; or
- Has received formal warning at any time after approval has been granted and before the course is completed.

DEFINITIONS

Certification – A credential awarded by an educational institution based on completion of all requirements for a program of study, including coursework and test or other performance evaluations. In the context of this policy, certification is a certificate of any level, undergraduate or post-graduate.

Degree program - An academic program of study leading to a bachelor's, master's, Ph. D. or professional degree.

Professional degree – a graduate-level degree that provides specialized training and knowledge for a specific career or profession. It often prepares individuals for licensure or certification in their field and is considered a terminal degree, meaning it's typically the highest degree needed to enter a particular profession.

Post-graduate studies – In the context of this policy, post-graduate studies are master's degrees, Doctorates, and professional degrees.

Registration fee - Payments required to officially enroll in a program or courses.

Student loan – A loan taken out to finance a student's education, typically for college or other post-secondary studies, and it must be repaid with interest after graduation or when the student leaves school.

PROCEDURES

Reimbursement Requirements

Employees who want to take advantage of this program must make a formal request for educational assistance by completing applicable paperwork provided by the Human Resources Department. This must be done before starting any coursework for which he or she wants to be reimbursed.

The appropriate manager/supervisor/department head must authorize any reimbursement, and reimbursement is only permitted for approved degree programs. Reimbursement is also contingent upon the successful completion of the approved course/courses.

Employees must complete any approved coursework on their own time. If that is not possible, accommodation may be made (in our sole discretion), as long as there is no substantial disruption in the routine operations of the employing department.

Approved Degree Programs/Coursework

Approved degree programs and coursework are defined as: Associates, Bachelors, Masters, and Doctorate degree programs that are business or job-related.

Reimbursement will be provided for any required or elective course that is related to an employee's work; or that leads to a business-related or job-related degree. Within this context, AHS reserves the exclusive right to decide whether a degree program or course is business or job related. Approval of tuition reimbursement for certifications or fellowships is at the discretion of management and Human Resources.

Reimbursement Amount

AHS will provide reimbursement for tuition, including required course fees, for all passing grades up to $3000 per calendar year for undergraduate studies and $5000 per calendar year for graduate and post-graduate studies.

AHS will reimburse the employee directly as long as the employee/student earns the minimum passing grade or better. This is also referred to as Satisfactory Course Completion.

For the purposes of this policy, a passing grade is defined as an "A," "B," or "C" for undergraduate classes, and at least a "B" for graduate classes. If the course is a "Pass/Fail," a "Pass" is acceptable.

For the purposes of this policy, AHS will also recognize the numerical equivalents of a letter grade may be accepted instead of a letter grade. However, Alameda Health System will only do so as long as the college/university provides official verification that any such grade is equivalent to a letter grade.

AHS will not provide any reimbursement if an employee withdraws from an approved course or if the approved course is canceled. Furthermore, the employee must promptly inform the appropriate manager/supervisor/department head and Human Resources if they withdraw from an approved course or if the course is canceled.

If the employee receives an Incomplete in a course, the employee will have until the end of the following semester to remedy the matter by meeting any and all requirements. Failure to do so will preclude the employee from participating in the tuition reimbursement plan.

Application for Approval

To secure approval for the educational assistance provided per this policy, prior to the start of the program or course the employee must complete and return the completed Tuition Reimbursement Application form with required documentation and signatures to the Human Resources Department via the Human Resources Service Center. Incomplete applications will not be processed.

After submission of an application, the employee will receive an acceptance or denial letter through the HR Service Center ticketing system. Submission of an application does not guarantee reimbursement. Applications will not be accepted after the start of the program or course. Reimbursement is never issued in advance or retroactively.

Applications are approved for the calendar year in which course(s) applied for will be completed. Applications do not carry over beyond the year of approval, nor does it cover courses not included in the approved application.

How to Request Reimbursement

After completing the application process, prior to the start of the program, upon successful completion of an approved course(s), the employee should submit a copy of the required documents with the Tuition Reimbursement Request Form to the Human Resources Department via the Human Resources Service Center. The employee should also provide an official transcript of grades received and proof of payment. Examples of the latter include either a bursar's receipt or proof of electronic payment.

Professional Training and Development

From time to time, it may be necessary for one or more employees to take work-related training courses, such as certification programs, that are separate from a degree program. Because this benefits both the employee/employees and Alameda Health System, approval of tuition reimbursement for certifications is at the discretion of management and Human Resources.

Eligibility:

- The recipient(s) must work at Alameda Health System.
- The employee(s) must have prior written approval from their supervisor/manager/department head.
- The employee(s) must be required to attend classes and seminars paid for by Alameda Health System.

Reimbursement will be provided for:

- Any tuition and/or applicable registration fees.
- Books and supplies, stipulated by the course syllabus.
- Parking.

Reimbursement will not be provided for:

- Prerequisite associated fees/costs
- Other college/university fees, such as health, ID, campus fees
- Student loans or repayment of any type of loan or loan forgiveness
- Courses started and/or completed at the time of application
- Certification renewal fees
- Certifying organizational membership costs or dues

REFERENCES
IRS Publication 970, Tax Benefits for Education

ATTACHMENTS
Tuition Reimbursement Application Forms

Tuition Reimbursement Application Form

How To Apply

Applications for Tuition Reimbursement must be submitted to ALAMEDA HEALTH SYSTEM Human Resources no earlier than two months prior to the start of class, but no later than fifteen (15) days before the start of the class/program. Approval is subject to the terms of the ALAMEDA HEALTH SYSTEM Employee Tuition Reimbursement Program.

- ☐ Complete Tuition Reimbursement Application Form (Supervisor's signature required) and Tuition Reimbursement Program Terms of Agreement
- ☐ Attach an official course description from the school website/brochure/catalog
- ☐ Attach official verification of the tuition cost (per credit hour or per course) from the school website/ brochure/catalog (fees not covered)
- ☐ Submit application, terms of agreement, and required documents by opening a ticket in: ALAMEDA HEALTH SYSTEM Human Resources/Payroll Service Center: https://alamedahealthsystemprd.service-now.com/esc?id=ec_pro_home

How to Get Reimbursed

Once you have completed the course(s) in your approved application, you must submit the following to ALAMEDA HEALTH SYSTEM Human Resources Service Center within 45 days of the completion of your course.

- ☐ Complete Tuition Reimbursement Request Form
- ☐ Attach Proof of payment of tuition charges (i.e. student account statement of tuition charges and payments to the institution, credit card receipt) and any other approved expenses (i.e. Books).
- ☐ Attach Proof of Satisfactory Course Completion. Satisfactory Course Completion means that the employee has achieved a passing grade or course certificate. (See Policy for passing grade requirements)
- ☐ Submit form and all required documents by opening a ticket in: ALAMEDA HEALTH SYSTEM Human Resources/Payroll Service Center: : https://alamedahealthsystemprd.service-now.com/esc?id=ec_pro_home
- ☐ Requests for reimbursement will be processed and returned to the employee within a reasonable processing time. After processing is complete, reimbursement will be issued on the following paycheck cycle. ALAMEDA HEALTH SYSTEM will provide reimbursement for tuition, including required course fees, for all passing grades up to $3000 per calendar year for undergraduate studies and $5000 per calendar year for graduate and post-graduate studies.

TUITION REIMBURSEMENT POLICY

Tuition Reimbursement Application Form

Please review the Tuition Reimbursement Policy and instructions prior to completion of this form.

All fields must be completed. All required documents/documentation must be submitted along with complete application. Incomplete applications will be returned with a request for all required information and documentation. It must be returned with all required information and documentation a minimum of 15 days prior to the start of the course(s).

Employee Number	Last Name	First Name	MI

Date of Hire	Daytime Phone Number	Work Email Address

Department Name & Number	Job Title	Manager/Director

Degree pursuing:		**Major:** (if applicable)	
School Attending		**Type of Course**	☐ **In-Person** ☐ **Online**

Course Title	Start Date	End Date	Credit Hours	Cost per credit hour	Tuition Cost (do not include any additional fees)	Required Textbook (provide syllabus and receipt)	Cost of Books (do not include shipping or tax)
				$	$		$
				$	$		$
				$	$		$
				$	$		$
Totals Credits				**Total Tuition**	$	**Book Total:**	$

Amount of aid (grant or scholarship) money received: (Loans which must be paid back are not aid)	**$**
Total Amount Requested for Tuition and Books (Not to exceed $3000 for undergraduate courses, $5000 for graduate courses per calendar year):	**$**

Please explain why this course and/or degree is job-related to your current position at Alameda Health System:

Employee Signature _____ **Date** _____

Supervisor Signature _____ **Date** _____ **Supervisor Name - Printed** _____

Tuition Reimbursement Application Form

Terms of Agreement

1. **I am submitting my completed *Tuition Reimbursement Application* with all required documentation to ALAMEDA HEALTH SYSTEM Human Resources/Payroll Service Center, by opening a ticket, prior to the beginning of class. I understand that applications submitted after the course start date will be denied.**
2. I understand ALAMEDA HEALTH SYSTEM does not provide reimbursement in advance for books. I will only be reimbursed for books after they have been purchased, and I have completed my course with a satisfactory score (per Tuition Reimbursement Policy). To receive book reimbursement, I will submit a paid receipt with textbook title and a copy of the syllabus to show that the books are required for my courses with the *Tuition Reimbursement Request Form*.
3. My *Tuition Reimbursement Request Form* is for tuition, books, and approved costs only. I have included all fields on the form. Approval of tuition reimbursement for certifications is at the discretion of management and Human Resources.
4. My *Tuition Reimbursement Request Form* is **not** for expenses for which additional educational benefits are available such as Veterans Administration, grants, scholarships, etc. I have disclosed all additional educational benefits I will be receiving in my *Tuition Reimbursement Application*.
5. I understand I must receive a C or better (B or better for graduate courses) or a P grade for Pass/Fail courses.
6. I will maintain an active 0.8 to 1.0 FTE status through completion of the course to qualify.
7. I understand the reimbursement will be credited to the calendar year in which the class ends, up to $3000 per year for undergraduate studies/programs and certifications (undergraduate or post-graduate), and $5000 per calendar year for graduate and post-graduate studies per calendar year.
8. My status is active and at least 0.8 FTE
9. I have not received any written disciplinary actions within three months prior to seeking approval.

I have read the Terms of Agreement and agree to abide by all of the terms listed above.

Signature Date

Print Name

TUITION REIMBURSEMENT POLICY

Tuition Reimbursement Request Form

<u>Please Note</u>: This form can only be used by eligible staff with an approved Tuition Reimbursement Application on file with Human Resources prior to the start of the course/program for which the form is being submitted. This form cannot be used for any other purposes.

Reimbursement can be made after successful completion of course(s) - B for graduate, C for undergraduate.

Instructions: Please fill out this form and attach all required documentation.

FIRST NAME	LAST NAME	EMPLOYEE NUMBER	QIC CODE
DEPARTMENT NAME		DIRECTOR	WORK PHONE

Course Title		**Tuition Cost** (do not include any additional fees)	**Required Textbook** (provide syllabus and receipt)	**Cost of Books** (do not include shipping or tax)
		$		$
		$		$
		$		$
		$		$
	Total Tuition:	$	**Book Total:**	$
			Total Reimbursement Request Amount:	$

Required Documentation:

Documentation of program/certificate/class syllabus: [ ] Yes [ ] No

Proof of payment of tuition and approved expenses attached: [ ] Yes [ ] No

Documentation of satisfactory completion of course: [ ] Yes [ ] No

I certify that I have an approved Tuition Reimbursement Application on file with Human Resources and I incurred the local expenses detailed herein in accordance with Alameda Health System Tuition Reimbursement Policy, and that this information is true and correct to the best of my knowledge.

Employee Signature: _____

Date: _____

Employee Full Name Printed: _____

HUMAN RESOURCES APPROVAL

I certify that the above claim complies with the relevant provisions of the Terms of Agreement and the Alameda Health System Tuition Reimbursement Policy and that the claimant's application for reimbursement was approved for the costs incurred.

HR Vice President Signature: _____ Date: _____

ALAMEDA HEALTH SYSTEM	Policy	
	HR SECTION 3.00 – Policy 3.26 TIMEKEEPING POLICY	**29806 1**
	LEVEL ☐ System ☐ Site	EFFECTIVE DATE: 9/2025

POLICY STATEMENT
All Alameda Health System employees are required to use the automated Time and Attendance System (UKG Dimensions / Kronos) to record all paid hours and scheduled workdays. While requirements may vary based on exemption classification, recordkeeping obligations include, but are not limited to, tracking days and hours actually worked; tracking other time eligible under compensation or the benefit programs, and tracking unpaid time or time scheduled but not worked.

PURPOSE
The purpose of this policy is to provide guidelines for accurate timekeeping to support payroll and benefit calculations in accordance with federal and state laws and regulations. Any Employee found to not have accurately documented time away from work is subject to disciplinary action up to and including termination of employment.

And, to establish uniform and consistent time recording expectations for all employees.

SCOPE
This policy applies to all Alameda Health System facilities and clinics and replaces any other timekeeping policies.

DEFINITIONS
Work week: The Alameda Health System "workweek" commences at midnight Sunday morning and consists of seven consecutive 24-hour days, ending at 11:59PM on Saturday.

Pay periods are bi-weekly

Timekeeping System: The timekeeping system (aka UKG Dimensions / Kronos) tracks and records employee hours worked for payroll processing. Data recorded in timekeeping systems is the official record of time worked.

Punch In: Is the start time at beginning of a shift and return from a meal or return to work. Employees may also be required to punch in and out to account for in-service or training time during work hours. This is also referred to as 'Clock In' within this document. (in-service and training hours are entered as edits, not punches)

Punch out: Is the end of each workday, start time for beginning of a meal period, or when leaving work for a non-work-related reason. This is also referred to as 'Clock Out' within this document. (in-service and training hours are entered as edits, not punches).

Exception: Is generated when time is reported and either an element about the time is incorrect, or the time does not comply with a rule that has been defined in the system. For example: if someone forgets to punch in or out for the beginning of their shift or break, this creates an exception in UKG. (See Attachments Section for Exception Log).

Time Clock: Refers to the time clock or computer employees in a particular area or department use for all time entries.

Time Record: An electronic or manual history of an employee's timecard and/or attendance data.

Exempt Employee: Employees who are paid on a fixed salary basis and exempt from federal and state overtime laws. Exempt employees are responsible for using UKG Dimensions / Kronos to document all hours worked per applicable MOU, pay practices, federal and state regulations and/or AHS policy, this includes the accurate recording of paid time **off.**

Non-Exempt Employee: Hourly employees who are responsible for using UKG Dimensions / Kronos to document all hours worked per applicable MOU, pay practices, federal and state regulations and/or AHS policy. Non-exempt employees are eligible for overtime. Non-exempt employees are required to punch in and out on physical timeclocks, using their ID Badge, or by logging into UKG Dimensions/Kronos on a workstation to punch in and out using the timestamp tile, if approved by management.

Primary Approver: The department chair, division chief, medical director, lead physician, supervisor, manager, or director of a department, group, project, or cost center who is responsible for validating that the time submitted for their employee group(s) is accurate and timely and is accountable for financial results. The Primary Approver has overall responsibility for the review and approval of employee time each pay period.

Timekeeper: The individual to whom a Primary Approver may delegate time record related data entry and editing tasks. Timekeepers may not approve time records. The Primary Approver is responsible for final approval of employee time at the end of each pay period. Timekeepers may not adjust or approve their own timecard.

Daily Attestation: The process of an employee confirming the accuracy of their work hours, including whether meal and rest breaks have been taken.

RESPONSIBILITIES

Employees are responsible for recording their worked hours and paid time off (PTO) hours accurately in UKG Dimensions / Kronos. Employees are accountable for the hours they enter and approve. If an error is discovered, the employee is accountable for the accuracy of the time reported.

Timekeepers: Each pay period and daily, timekeepers should confirm that employee's worked hours are appropriate by reviewing and updating non-exempt and exempt employee time records before and by the processing deadline.

- Timekeeper duties:
  - Ensures that all non-worked hours are entered into the timekeeping system with the appropriate pay code.

- Assists employees and managers with payroll inquiries, timekeeping questions, and system issues.
- Enters exception time and edits time records in assigned approval cost centers designated by approvers.

Primary Approvers: Primary Approvers are responsible for approval of the timecards for their direct reports. Approvers are department chair, division chief, medical director, lead physician, supervisor, manager, director, and other leaders with direct reports. Each pay period, Primary or Alternate Approvers confirm that the hours entered in UKG Dimensions / Kronos system are appropriate by reviewing and approving hourly and exempt employee time records by the established processing deadlines. Approvers confirm that all information is accurate and in compliance with applicable MOU, pay practices, federal and state regulations, and/or AHS procedures.

- Permanent Record: Approval of a time record indicates the approver has checked and agrees with the hours and leave time reported by the employee and is confident the time record is correct. Electronic and/or manual signature approval is a permanent record of authorization and is subject to periodic audit. When corrections are made, the approver should enter a comment stating the reason for the change.
- Knowledge of Attendance and Punctuality: Employee time must be approved by a person with knowledge of the employee's time and attendance (work schedule).

  - Alternate Approver: A Primary Approver may assign timekeeping approver responsibilities to an already designated / preapproved Alternate Approver who, in the Primary Approver's professional judgment, possesses the requisite knowledge, and trustworthiness to perform the function.
  - Delegation: Primary Approvers can select an alternate approver by using UKG Dimensions / Kronos Delegate process.
  - Accountability: In all cases, Primary Approvers retain accountability for the accuracy of the approved time records. Once an employee's time record has been approved, the Primary Approver is accountable for time record errors and omissions, except in cases where the Primary Approver would have prior documentation of the error or omission.
  - Approving Inaccurate Time Prohibited: Approvers may not intentionally or knowingly approve false time and attendance records.
  - Employee Profile Changes: Approvers submit all changes to employee's profile by completing a PAR form and sending to pars@alamedahealthsystem.org.

Payroll Processing Deadline: **Timecards are to be approved by Primary or Alternate Approver by 12:00 noon on the Monday following the end of each pay period**. If Monday falls on a holiday the deadline will move to 12:00 noon on Tuesday.

- Unapproved Time Records: Time records without proper approval are considered unapproved time records and will be approved and processed by the Payroll Department for payment to the employee based on what the timecard shows at the time of the payroll processing deadline.
    - Accountability: Primary Approvers are held accountable for unapproved time records of their employees.
    - Failure to Meet Approval Deadlines: If a timecard is not approved before the established processing deadline, AHS Payroll will escalate to Primary Approver's manager/director. Any corrections needed after the payroll processing deadline will need to be communicated to the Primary Approver who will then communicate to the Payroll Department for correction.
    - **Continuation in failing to meet Payroll's established processing deadline will be reported to the Executive Leader for counseling.**

The information provided in this policy is intended to serve as a guideline. Managers are expected to consistently apply the guidelines equitably amongst their employee groups.

PROCEDURES

All employees: Exempt and Non-exempt:

a. One timecard is required for each pay period of two consecutive work weeks. Time is recorded in the UKG Dimensions / Kronos system. Employees assigned a time clock or computer to record their worked time must punch in and punch out if required. Employees using other time and attendance methods (paper timecards) are also required to adapt to this procedure.

b. All Employees are required to review and approve their timecards at the end of each pay period by clicking the "approve" button in the UKG Dimensions / Kronos system. Approving the timecard confirms the employee has viewed all information and certifies their timecard is complete and accurate, including corrections made during the pay period. Employees called in to work after "approving" the timecard should click the approve button and click remove approval before signing into the added work shift. Reapprove the timecard after the last shift worked in the pay period.

c. Employees not scheduled to work on the last day of the pay period must approve the time on the last day of work within the current pay period. Timecards can be approved at the time clock or by accessing UKG Dimensions / Kronos on any local network computer if designated to use a computer for time recording.

d. Employees must correct timecard errors in the UKG Dimensions / Kronos system on their next active workday. An employee must enter any missed punches which will be sent to their manager to approve through the system. Exception logs should be used only if the UKG Dimensions / Kronos system is down.

e. Timecards are subject to review by Payroll to ensure hours captured on the timecard are paid in accordance with state and federal regulations, and applicable MOU and AHS policy.

f. **Failure to comply with timekeeping procedures may result in disciplinary action up to and including termination.**

Badge Requirements: For employees using a timeclock, the employee's badge is required to punch in and out and must always be in working condition. Employees using a workstation to clock in and out will need to follow standard procedure.

Entries on the non-exempt time record must reflect actual hours worked, arrival and departure times on a daily basis, meal period start and end times, distribution of time worked to the correct cost center and any PTO or other benefit time used.

Employees punch in and out at the time clock closest to their work assignment at the beginning of their scheduled shift unless an earlier start time has been authorized in advance by a manager or designee. At the end of each pay period, non-exempt employees must attest to the accuracy of the hours recorded on their timecard. If an adjustment is required, the employee is expected to make the correction in the UKG Dimensions / Kronos system and submit to the manager/timekeeper for correction. Accurate accounting of work hours is the responsibility of the employee.

Clocking Outside of scheduled hours: Hourly employees may not clock **in or out** prior to their scheduled start or end times without prior supervisor or manager's approval.

Reporting Time for Other Employees: Employees are prohibited from clocking In and Out on behalf of other employees for any reason. An employee who clocks In and Out for another employee or permits another employee to clock in and out on their behalf, will be considered to have falsified /misrepresented a time record, thus being subject to disciplinary action up to and including termination.

Leaving Department or Worksite: Hourly employees who leave their department or worksite for any personal reason during scheduled working hours (except while on a designated rest periods) are required to **clock Out and clock In** when leaving and returning to the department or worksite during work hours. This does not apply to employees required to leave their worksite for official AHS business. Employees leaving their work area for personal reasons must have manager/supervisor approval. An employee who leaves the work area unit and does not **clock Out and In** as required; and/or without manager/supervisor authorization, the employee will be considered to have abandoned the work site and subject to

disciplinary action (this includes leaving the unit on non-break time to move their car, etc) up to and including termination of employment.

Overtime: Supervisor or manager's prior approval is required before an employee can work overtime. Employees who work unauthorized overtime will be paid for all time worked but may be subject to disciplinary action.

Working off the clock: Hourly employees may not work before they punch in or continue to work after they have punched out for the day.

Exempt employees: Must confirm all time away from work in accurately recorded on their timecard. The regular work schedule entered in the UKG Dimensions / Kronos system determines payment unless edits or exceptions are entered. Time scheduled for PTO/ESL, Bereavement, Jury Duty, and other bases for paid leave must be accurately recorded in the electronic timekeeping system.

Attestation & Approval:

- Non-Exempt: At the end of each pay period non-exempt employees must attest to the accuracy of the hours recorded in their timecard. If an adjustment is required, the employee is expected to make the correction in the UKG Dimensions / Kronos system and submit to the manager/timekeeper for correction. Non-exempt employees are required to attest to daily attendance, i.e. were meal and rest breaks taken. This attestation occurs on the timeclock every shift worked; this is referred to as Daily Attestation.
- Exempt: Exempt level employees must approve the accuracy of the hours recorded on their timecard on the last day worked of each pay period.

Any Employee found to not have accurately documented time away from work is subject to disciplinary action up to and including termination of employment. The following are some examples: falsified time punches, adding or removing time punches in UKG Dimensions / Kronos, recording incorrect information on exception reports.

REFERENCES

HR Section 3.00 - Policy 3.19 Attendance and Punctuality
HR Section 1.00 – Policy 1.31 Conditions of Employment – Identification Badges
AHS PHOTO ID OF WORKFORCE POLICY
HR Section 3.00 Policy 3.20 Expectations of Conduct
HR Section 2.00 Policy 2.10 Wage and Hour Terms and Definitions
HR SECTION 2.00 - POLICY 2.30 OVERTIME

ATTACHMENTS

- Exception Log

ALAMEDA HEALTH SYSTEM	Policy	
	HR SECTION 2.00 - POLICY 2.55 Bereavement Leave	**Reference # tbd**
	LEVEL ☐ System ☐ Site	EFFECTIVE DATE: 12/1996 NEXT REVIEW DATE: **9/2028**

POLICY STATEMENT
Eligible employees of Alameda Health System (AHS) will be granted paid time off for working time lost while on leave due to the death of an immediate family member or others as described below.

Purpose

To establish guidelines for granting paid time off to qualified employees for the purpose of bereavement.

ELIGIBILITY

1. All Employees who have worked for AHS for 30 days or more, whether full time, part time or Services as Needed, will be eligible for bereavement leave with pay for working time lost. Employees are to contact AHS' current leave management vendor to apply for this leave.

2. An employee will be granted bereavement leave with pay upon the death of an immediate family member which is defined as a: spouse, child, parent, parent-in-law, grandparent, grandchild, brother, sister, domestic partner, court appointed legal guardian, stepmother, stepfather, stepson, stepdaughter or any other person sharing the relationship of in loco parentis and, when living in the same household, brother or sister-in-law.

3. **Represented Employees:** The applicable Memorandum of Understanding (MOU) shall control if it provides for bereavement leave. If a represented employee's corresponding MOU does not speak to bereavement leave, then this policy shall apply to represented employee.

DEFINITIONS
in loco parentis – 'in the place of a parent' or 'instead of the parent.'

PROCEDURES

1. The employee's immediate supervisor will grant up to five (5) regularly scheduled working days for bereavement. Employees must complete their leave during the three months after the death of the person for whom they are taking leave.

2. Proof of death and relationship are required upon request from leave vendor and/or employee Manager. This documentation must be provided within 30 days of the first day of your bereavement leave. This documentation may be in the form of a death certificate, obituary, or written verification of death, burial, or memorial service from a mortuary, funeral home, burial society, crematorium, religious institution, or government agency.

   AHS will keep this documentation confidential and not disclose it except as necessary to internal personnel or counsel, or if required by law.

3. Bereavement leave is job protected leave. It is unlawful to discriminate or retaliate against an employee who requests or uses bereavement leave.

Failure to Return to Work

An employee who fails to return to work within three days after the expiration of a leave of absence will be referred to Human Resources by their Manager which may result in discipline up to and including termination.

REFERENCES

Assembly Bill 1949 (AB-1949) Employees: Bereavement Leave

ATTACHMENTS

Bereavement-Leave_AB-1949_FAQ_ENG.pdf

Bereavement Leave

FAQ

California law guarantees most employees up to five days of bereavement leave from work following the death of a family member.[1] The Civil Rights Department (CRD), which enforces this right to bereavement leave, created this Frequently Asked Questions (FAQ) document to help employers and employees understand this right, which became effective on January 1, 2023.

1 Is bereavement leave available to me?

If you work for an employer with five or more employees, you may be entitled to bereavement leave following the death of certain family members. Beginning January 1, 2023, private employers with five or more employees are required to grant an eligible employee's request for up to five days of bereavement leave from work following the death of the employee's family member. To be eligible for bereavement leave, an employee must have been employed for at least 30 days before taking the leave. Bereavement leave is also available to employees who work for the State of California[2] and for local governments.

2 For which family members can I take bereavement leave?

An employer is only required to permit the use of bereavement leave for the death of certain family members. Covered employers must allow you to take bereavement leave upon the death of your spouse, child, parent, sibling, grandparent, grandchild, or parent-in-law. However, an employer may voluntarily allow bereavement leave to be taken upon the death of another person with whom you have a relationship.

3 What if my employer already has a bereavement leave policy?

You must follow your employer's existing bereavement leave policy. For example, if your employer's policy requires you to inform human resources that you are taking bereavement leave, you must continue to do so under the new law. However, if the employer's policy does not grant at least five days of bereavement leave following the death of a family member (as defined in question 2), you are still entitled to five days of bereavement leave under the law.

1 Government Code section 12945.7.
2 State employees who are eligible for bereavement leave under Government Code section 19859.3 are not covered under the new bereavement law. However, section 19859.3 creates a bereavement leave entitlement for state employees who are excluded from collective bargaining. For state employees who are covered under collective bargaining agreements, those agreements must include a bereavement leave entitlement that is at least as protective as the leave required under Government Code section 12945.7.

CRD-E17P-ENG / March 2023

4 | Do I have to take my bereavement leave all at once?

No, but you must complete your leave during the three months after the death of the person for whom you are taking leave. For example, following the death of a parent, you could take three days of leave immediately and then take two days off from work two months later.

5 | Does my employer have to let me return to work after bereavement leave?

Yes. It is unlawful for your employer to discriminate or retaliate against you because you requested or used bereavement leave. An employer is prohibited from terminating, demoting, suspending, or taking other adverse actions toward you because you requested or used bereavement leave. Employers also cannot take negative action against you if you provide information or make a complaint to CRD about you or your coworker's request for bereavement leave.

6 | Am I limited to taking bereavement leave for only one death per year?

No. You are entitled to take up to five days of bereavement leave upon the death of each family member (as defined in question 2). For example, an employee who loses a parent, child, and grandparent within the same year can take three five-day periods of bereavement leave during that year.

7 | If I take bereavement leave, will that reduce the amount of time that I can take for other types of protected leave from work?

No. Bereavement leave is separate from, and in addition to, your right to take other types of protected leave from work. In addition to bereavement leave, eligible California employees are entitled to up to 12 weeks of leave from work to care for their own serious heath condition, a family member with a serious health condition, or to bond with a new child (commonly known as California Family Rights Act Leave or CFRA Leave). Additionally, eligible California employees are entitled to up to four months of leave when they are disabled by pregnancy, childbirth, or a related medical condition (commonly known as Pregnancy Disability Leave). For more information about these types of leave, visit: https://calcivilrights.ca.gov/family-medical-pregnancy-leave.

8 | Does my employer have to pay me during bereavement leave?

Not unless you use other paid leave available. Although covered employers are required to grant up to five days of bereavement leave, the law does not require that employers pay you for this leave time. However, many employers have paid bereavement leave policies, so be sure to check with your employer about any existing policy that they may have in place. Also, if your employer does not provide paid bereavement leave but you have available sick leave, vacation, personal leave, or other types of paid leave, your employer is required to allow you to use that leave so you can receive pay during your bereavement leave.

9 | Do I have to provide my employer any documentation in order to take bereavement leave?

Yes, if requested. If your employer requests documentation of the death, you are required to provide it. However, you are not required to provide such documentation before you begin your leave. Instead, you must provide this documentation within 30 days of the first day of your bereavement leave. This documentation may be in the form of a death certificate, obituary, or written verification of death, burial, or memorial service from a mortuary, funeral home, burial society, crematorium, religious institution, or government agency.

Your employer must keep this documentation confidential and not disclose it except as necessary to internal personnel or counsel, or if required by law.

10 | I am in a union and under a collective bargaining agreement – am I entitled to bereavement leave?

Yes. Collective bargaining agreements must provide for at least five days of unpaid, job-protected bereavement leave.

11 | I think my right to bereavement leave was violated. What do I do?

File a complaint with CRD. If you have been denied bereavement leave, or if you have been subjected to discrimination, harassment, or retaliation at work for requesting or using bereavement leave, you may file a complaint with CRD (see "To File a Complaint," below).

The right to take bereavement leave is subject to CRD's small employer family leave mediation program. This program gives small employers (of 5 to 19 employees) and their current or former employees the right to mediate certain disputes, including disputes regarding bereavement leave, through CRD's Dispute Resolution Division. For more information, you can review CRD's fact sheet on the small employer family leave mediation program.

If you think you have been a victim of discrimination, please contact CRD.

TO FILE A COMPLAINT

Civil Rights Department
calcivilrights.ca.gov / Toll Free: 800.884.1684 / TTY: 800.700.2320

Have a disability that requires a reasonable accommodation?
CRD can assist you with your complaint.

For translations of this guidance, visit: calcivilrights.ca.gov/posters/employment

ALAMEDA HEALTH SYSTEM	Policy	
	HR SECTION 2.00 - POLICY 2.55.5 Reproductive Loss Leave	**Reference # tbd**
	LEVEL ☐ System ☐ Site	EFFECTIVE DATE: 9/2025

PURPOSE

The purpose of this policy is to provide support and compassion to employees who experience reproductive loss events, such as miscarriage, stillbirth, failed assisted reproduction, failed adoption, or failed surrogacy, so long as the employee would have been the parent of the child born or adopted. This policy aims to acknowledge the emotional and physical toll these events may have on our employees and their families and to ensure that they have the necessary time and resources to cope and recover. This policy acknowledges Alameda Health System's commitment to its staff and adherence to Senate Bill No. 848 Leave for Reproductive Loss.

ELIGIBILITY

All employees who have been employed by the company for at least 30 days prior to the commencement of leave are eligible for reproductive loss leave. Leave must be completed within three months of the reproductive loss event unless the employee is already on or chooses to go on leave from work for other reasons. In such circumstances, the leave must be completed within three months of the end date of their other approved leave.

LENGTH OF LEAVE

Employees are entitled to up to five days of reproductive loss leave following a reproductive loss event. If an employee experiences more than one reproductive loss event within a 12-month period, they may be granted a total of up to 20 days of reproductive loss leave within that period.

DOCUMENTATION

Employees are not required to provide medical documentation for reproductive loss leave. However, they may be asked to provide a brief explanation of the reproductive loss event to their supervisor or HR for record-keeping purposes. All information will be kept confidential, except as necessary to internal personnel or counsel, or if required by law.

RETURN TO WORK

Employees are expected to return to work promptly following the conclusion of their reproductive loss leave. If additional time is needed beyond the allotted leave period, employees may request additional leave through our standard leave of absence procedures.

PAY

Reproductive loss leave is unpaid, except that employees may use accrued and available sick leave, vacation, personal leave, or compensatory time off to receive pay during their leave period. Reproductive Loss leave is separate and distinct from our Bereavement Leave policy.

INTEGRATION

Reproductive loss leave will not run concurrently with any other applicable leave policies, including but not limited to family medical leave, or any other leave required by state or federal law.

REFERENCES

Senate Bill No. 848 Leave for Reproductive Loss
HR SECTION 2.00 - POLICY 2.55 BEREAVEMENT LEAVE

ALAMEDA HEALTH SYSTEM

Highland Hospital 340B DRUG PRICING PROGRAM

Site	Alameda Health System	***Previous Revision Dates***	
Effective Date	9/2023	***Date Revised***	Not Approved Yet
Document Owner	MGR SYS MED SAFETY-CLIN PHARM	***Next Scheduled Review***	6/2028

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

Purpose

The purpose of this policy is to establish guidance regarding Highland Hospital (HGH) and all child sites' compliance with the rules and regulations set forth by the Health Resources and Services Administration's Office of Pharmacy Affairs ("OPA") pertaining to the Section 340B Drug Discount Program

Background

Section 340B of the Public Health Service Act (1992) requires drug manufacturers participating in the Medicaid Drug Rebate Program to sign a pharmaceutical pricing agreement (PPA) with the Secretary of Health and Human Services.

a. This agreement limits the price that manufacturers may charge certain covered entities for covered outpatient drugs.

The 340B Program is administered by the federal Health Resources and Services Administration (HRSA) in the Department of Health and Human Services (DHHS).

Upon registration on 340B OPAIS (Office of Pharmacy Affairs Information System), Alameda Health System:

a. Agrees to abide by specific statutory requirements and prohibitions.
b. May access 340B drugs.

340B Policy Statements

HGH develops and maintains policies and procedures to ensure compliance with the guidelines and regulations of the 340B Drug Pricing Program for outpatients as outlined by Health Resources and Services Administration (HRSA)/Office of Pharmacy Affairs (OPA).

It is the policy of HGH to participate in the 340B Program, to comply with all rules and regulations of the 340B Program, and to implement procedures and safeguards to protect the integrity of the 340B Program including but not limited to the prevention of Duplicate Discounts/rebates under Medicaid, and the prohibition against transferring drugs purchased under 340B to anyone other than a patient of the entity, as well as adherence to the 340B Eligible Patient criteria.

The 340B Program savings will support HGH's mission to serve all and stretch federal resources and by providing more comprehensive services to patients.

HGH maintains auditable records demonstrating compliance with the 340B Program. These reports are reviewed by HGH biannually as part of its 340B Oversight Committee and compliance program.

Scope:

This policy applies to the 340B Programs Covered Entities/Child Sites identified below. All employees, contract employees, or agents providing services under 340B Program at HGH or a child site must adhere to this policy.

a. DSH050320: Alameda Health System – Highland General Hospital
b. DSH050320A: Alameda Health System –JGP Emergency PES (Psych Emergency Services)

Procedure:

I. Eligibility:

HGH ensures that 340B drugs are dispensed/administrated/prescribed only to eligible patients. HGH will also ensure that the following 340B eligibility determination filters are implemented:

1. Validates site eligibility. Care site must be within the four walls of the covered entity or listed as a child site on the HRSA OPAIS database as the point of service.
2. Determines patient status at the point of service.
   a. Patient must be in outpatient status at the time the medication is dispensed or administered based on medication type received.
3. HGH must maintain records of individual's health care. If the patient only receives prescriptions from the pharmacy, the patient is not considered as 340B eligible.
4. HGH deems patient care delivered via telehealth to constitute the provision of health care services by a health care professional that has a documented arrangement with HGH such that responsibility for care provided remains with HGH.
5. HGH must determine provider eligibility.
   a. Provider is either employed by the covered entity or provider health care on a contractual or other arrangement (e.g., referral for consultation), or granted privileges by covered entities.

b. Pharmacists and dieticians who are employed by Alameda Health System, practicing under a collaborative practice agreement within a clinic, may at times prescribe medications.

6. Ambulatory pharmacists, retail pharmacy pharmacists and dieticians are considered eligible providers under these terms. Encounter/prescription eligibility for Disease State management and/or MTM:
    a. The responsibility for the health care service that result in the use of, or prescription for, 340B drugs must remain with covered entity.
    b. Prescriptions will be deemed eligible if they meet one of the following criteria:
    c. A prescription is derived from a qualifying outpatient health care service documented within the previous 36 months from the date of fill.
    d. A qualifying outpatient health care service occurs within 30 days after the date of fill where the prescription is documented in the service summary.
7. HGH determines patients' Medicaid status at the point of service to prevent duplicate discounts. [1]
    a. GPO prohibition – Highland Hospital and child site John George Hospital are registered on the OPAIS 340B database as participating in the 340B Program are subject to the GPO prohibition and cannot obtain covered outpatient drugs through a GPO or other group purchasing arrangement.
    b. HGH may not purchase covered outpatient drugs through a GPO for any of its clinics/departments within the four walls of the hospital at any point in time. If HGH is unable to purchase a covered outpatient drug at the 340B price, written notification should be sent to OPA immediately.

    c. HGH will purchase using a non-GPO account and only replenish with 340B drugs once 340B patient eligibility is confirmed and can be documented through auditable records. Monthly audits are completed to ensure program integrity and report any violations.

II. II. Definitions:

1. 340B Eligible Patient – An individual is considered a "340B Eligible Patient" only if:
    a. HGH has an established relationship with the individual such that HGH maintains records of the individual's health care; and,
    b. The individual receives health care services from a health care professional who is either employed by HGH or who provides health care under contractual or other arrangements (e.g., referral or consultation) such that the responsibility for the individual's care remains with HGH. If health care is provided under referral for consultation, HRSA-recommended documentation is accessible:
        i. Request for referral

[1] Statutory Prohibition on Group Purchasing Organization Participation, *340B Drug Pricing Program Notice. Release No. 2013-1*; (February 3rd,2013). Health Resources and Services Administration Healthcare System Bureau Office of Pharmacy Affairs. https://www.hrsa.gov/sites/default/files/opa/programrequirements/policyreleases/prohibitionongpoparticipation020713.pdf

c. The entity maintains responsibility for the patient's health care services
d. An individual shall not be considered an "340B Eligible Patient" if the only health care service received by the individual from HGH is the dispensing of a drug or drugs for subsequent self-administration in a home setting or other institutional settings.
    - ***Referral Exception****: Though not a common practice, prescriptions written outside the Hospital may be filled with 340B drugs if they are written pursuant to a referral and (1) the referral and outcome of the referral are documented in the patient's medical record or (2) the patient obtained subsequent services from the Hospital for the same condition after the referral.*
e. The window for establishing 340B eligibility through care provided by Highland Hospital is based on a 36 month look back period form the date the prescription is filled.
f. Eligible encounter: Any encounter that support a continuing patient-provider relationship may include, but are not limited to office visit, telehealth appointments, refill requests, lab orders, imaging requests, and medication management consults. Any documented interaction that reasonably demonstrates the patient remains under the ongoing care of Highland Hospital maybe considered valid to support 340B eligibility.

2. Covered Drug–HGH does not purchase covered outpatient drugs for its outpatient registered facilities using a Group Purchasing Organization (GPO)
    a. HGH interprets the definition of covered outpatient drugs to include – 'An FDA-approved prescription drug, an over the counter (OTC) drug that is written on a prescription and a biological product that can be dispensed only by a prescription (other than a vaccine) or FDA-approved insulin.
    b. The following drugs and drug categories are excluded from 340B and are GPO exclusion exempt: vaccines, normal saline & water for injection, gases, contrast media/diagnostic agents, large volume fluids without additives, topicals, romiplostim, hyaluronan and hyaluronate derivatives, 503B purchased drugs, cellulose oxidized, state supplied emergency medication (e.g., Covid medications under emergency use approval) manufacturers/labelers that do not participate in 340B program, and bundled items. A detailed list of items and categories can be available through EHR.
    c. Controlled Substance Ordering System (CSOS): HGH is enrolled in the CSOS program which allows for secure electronic transmission of controlled substance orders without the paper DEA 222 Form. All pharmacists are enrolled with DEA to acquire a CSOS digital signing certificate in order to place control substance orders.

3. Covered Entity – covered entities include six categories of hospitals: disproportionate share hospitals (DSHs), children's hospitals, and cancer hospitals exempt from the Medicare perspective payment system, sole community hospitals, rural referral centers, and critical access hospitals (CAHs). Hospitals in each of these categories must be (1) non-profit, (2) be owned and operated by or under contract with state or local governments, and (3) except for CAHs, meet the payer-mix criteria related to the Medicare DSH program. [2]

[2] (Safety Net Hospitals for Pharmaceutical Access (SNPHA). "An Overview of The Section 340B Drug Discount Program.www.safetynetrx.org,2012)

4. Diversion – Pursuant to the 340B Program rules and regulations, 340B participating entities are prohibited from reselling or otherwise transferring outpatient drugs purchased at the statutory discount to an individual who is not a 340B Eligible Patient of HGH. Any such practice qualifies as "Diversion."

5. Duplicate Discount – A "Duplicate Discount," which is prohibited by the 340B statute, occurs when manufacturers provide both a 340B discount on a drug and pay a Medicaid rebate to the State on the same drug.

Contract Pharmacy Operations: [3]

HGH uses contract pharmacy services in accordance with HRSA requirements and guidelines.

HGH has obtained sufficient information from the contract pharmacy contractor to ensure compliance with applicable policy and legal requirements.

1. HGH registers each contract pharmacy location on the HRSA 340B Database prior to the use of 340B drugs at that site.
2. HGH uses a replenishment model using an 11-digit to 11-digit NDC match.
    a. Non-replenishment 340B inventory is never stored at the contract pharmacies, as all 340B stock is supplied through the replenishment model.
3. 340B-eligible prescriptions are presented to contract pharmacies via e-prescribing, hard copy, fax, or phone
    a. HGH Pharmacy staff verify patient, prescriber, and outpatient clinic eligibility via the electronic health record system.
    b. Updates are made to this mechanism by the HGH staff annually or on demand based on patient, provider, or contract pharmacy requests.
4. Contract Pharmacies dispense prescriptions to 340B eligible patients using non-340B drugs.
5. HGH implements bill-to, ship-to arrangement with the contract pharmacies.
    a. Contract Pharmacies order 340B drugs on behalf of HGH, based on eligible accumulation, as determined by HGH staff, through the drug wholesaler.
        i. Orders are triggered by the usage of package size of covered drugs determined by 11-digit NDC.
        ii. Replenishment orders through the wholesaler.
        iii. The wholesaler notifies HGH staff of medication shipped to contract pharmacies.
6. Contract Pharmacies receive 340B drug shipments. Orders are received by authorized pharmacy staff at the contract pharmacies.
7. Contract Pharmacy staff verify quantity received with the quantity ordered.
    a. Identifies inaccuracies.
    b. Resolves inaccuracies with the wholesaler.
    c. Document resolution of inaccuracies.
8. Contract Pharmacies notify HGH if they do not receive 11-digit NDC replenishment order within 90 days (about 3 months) or original order fulfillment request.
9. HGH reimburses contract pharmacies at a pre-negotiated rate per fill for such drugs.

10. HGH can review the invoice for drugs shipped to its contract pharmacies on demand.
11. HGH pays the invoice to wholesaler for all 340B drugs.
12. Contract Pharmacies provider HGH access to all pertinent reimbursement accounts and dispensing records. HGH staff retrieve and review 340B purchases every month.
13. Contract Pharmacies adjust claims when variance or discrepancy has occurred.
    a. Contract Pharmacies uses approved method regarding reconciliation between inventory and invoices with adjustment as necessary to match NDC or cost changes.
    b. Claim adjustments may occur only within 30 days of original billing and not without prior notice and approval of HGH.
14. Contract Pharmacies will not use 340B drugs for Medicaid patients (carve-out):
    a. Contract pharmacies will only dispense 340B drugs to patients who are eligible per HGH Electronic Health Record.
    b. Highland Hospital does not count 340B drug accumulation for Medicaid patients and therefore prevent(s) duplicate discounts for outpatient prescriptions.
15. HGH will audit all adjudicated claims at the contract pharmacies monthly and communicate any errors or inaccuracies to contract pharmacy staff within 5 business days of findings.
16. Independent external audits will be conducted annually to ensure program integrity. All audit results will be communicated to HGH within 90 days from the date of the audit.
    a. HGH will document and make corrections based on audit findings.
    b. All progress made will be documented and communicated to key stakeholders at the 340B Oversight Committee.

III. Responsibilities

This section includes stakeholders and determines their roles and responsibilities in maintaining 340B program integrity and compliance. The following staff members are key stakeholders in the 340B program, including governance and compliance, and should be standing members of the 340B Oversight Committee. HGH will identify who serves as the entity's authorizing official and primary contact for the 340B Program. These individuals are the sponsors of the 340B Oversight Committees.

1. Chief Financial Officer and/or VP of Finance
    a. Must account for savings and use of funds to provide care for the indigent under the indigent care agreement.
    b. Responsible for communication of all changes to the Medicare Cost report regarding clinics or revenue centers of the cost report.
    c. Responsible for communication of all changes to Medi-Cal/Medi-Cal Managed Care reimbursement for pharmacy services/products that impact 340B status (i.e., 340B AAC, modifiers).
    d. Accountable for savings and use of funds to provide care for the indigent under the indigent care agreement.

2. Chief Operations Officer (COO)

a. Responsible for attesting to the compliance of the program in the form of recertification.
b. Responsible as the principal officer in charge of the compliance and administration of the program.
c. Accountable agent for 340B compliance.
d. Responsible as the Authorizing Official for the 340B program.

3. System Director of Pharmacy
   a. Agent of the COO responsible to administer the 340B program to fully implement and optimize appropriate savings and ensure current policy statements and procedures are in place to maintain program compliance.
   b. Must maintain knowledge of the policy changes that impact the 340B program which includes, but is not limited to, HRSA/OPA rules and Medicaid changes
   c. Must coordinate constant knowledge of any change in clinic eligibility/information
   d. Responsible as the primary contact for the 340B program.

4. System 340B Manager
   b. Day to day management of the 340B program.
   d. Responsible for documentation of policies and procedures.
   g. Ensures appropriate safeguards and system integrity.
   h. Ensure compliance with 340B program requirements for qualified patients, drugs, providers, vendors, payers, and locations.
   i. Review and refine 340B cost saving report, detailing purchasing, and replacement practices, as well as dispensing patterns.
   j. Monitors ordering processes, integrating most current pricing from wholesalers, and analyzes invoices, shipping, and inventory processes.
   k. Design and maintain an internal audit plan of the compliance of the 340B program.
   l. Responsible for annual or semiannual physical inventory of pharmacy items.
   m. Designs the annual plan to cover all changes in the 340B program from the preceding year.

5. VP of Compliance and Internal Audit
   a. Design and maintain an internal audit plan of the compliance of the 340B program.

   b. Designs the annual plan to cover all changes in the 340B program from the preceding year.

6. Director of Finance/ Reimbursement
   a. Responsible for communication of all changes to the Medicare Cost Report regarding clinics or revenue centers.
   b. Responsible for communication of all changes to Medicaid reimbursement for pharmacy services/products that affect 340B status.
   c. Engage pharmacy in conversations that affect reimbursement.
   d. Responsible for modeling all managed care contracts (with/without 340B).

7. Revenue Cycle (Billing and Revenue Integrity) and Revenue IS:

a. Correct any findings identified through internal self-audits, independent external audits, or other methods.
b. IS team will conduct systematic correction in the electronic operating system.
c. IS team defines process and access to data for compliant identification of outpatient utilization for eligible patients.
d. Achieves the data to make them available to auditors when audited.

8. Office of the General Counsel ("OGC")

The OGC will provide legal counsel on an as-needed basis.

9. Pharmacy Buyer

Responsible for maintaining three distribution accounts, i.e., non-GPO account, 340B account, and GPO account. Responsible for maintaining direct accounts for GPO ("own use") class of trade as well as direct 340B accounts.

a. Responsible for ordering all medications from the specific accounts as appropriate.
b. Manage purchasing, receiving and inventory control processes.
c. Responsible for segregation, removal, and/or return of 340B drugs, including reverse distributor transactions.
d. Continuously monitor product min/max levels to effectively balance product availability and cost-efficient inventory control
e. Manage purchasing, receiving and inventory control processes.
f. Coordinate annual inventory cycle counts.
g. Monitor ordering processes, integrating most current pricing from wholesaler, analyze invoices, shipping, and inventory processes.

10. System 340B Analyst

a. Defines process and access to data for compliant identification of outpatient utilization for eligible patients.
c. Archives the data to make them available to auditors when audited.
d. Responsible for maintenance and testing of 340B management software.
e. In conjunction with any split-billing software vendor, develop and implement standard data interface controls which, at a minimum, shall perform necessary and reasonable checksum and duplicate record verifications.

IV. Program Integrity Procedures

1. As a participant in the 340B Drug Pricing Program, HGH shall meet all 340B Program eligibility requirements.

2. HGH OPA Database covered entity listing is complete, accurate, and correct.
   a. HGH, a member of AHS (Alameda Health System), a public Hospital Authority organized and existing under the laws of the State of California, provides health care services to low-income individuals.

i. For the most recent cost reporting period that ended before the calendar quarter involved, HGH had a disproportionate share adjustment percentage greater than or equal to 11.75 percent.

1. Reference Medicare Cost Report -Worksheet E Part A, line 33

3. HGH complies with all requirements and restrictions of Section 340B of the Public Health Service Act and any accompanying regulations or guidelines including, but not limited to, the prohibition against duplicate discounts/rebates under Medicaid, and the prohibition against transferring drugs purchased under 340B to anyone other than a patient of the entity. [REFERENCE: Public Law 102-585, Section 602, 340B Guidelines, 340B Policy Releases]
    a. HGH maintains auditable records demonstrating compliance with the 340B requirement
    b. Prescriber has participated in credentialing process therefore obtaining prescribing privileges and agrees to the rules and regulations established by HGH Medical Staff and is under contractual or other arrangements with the entity, and the patient receives a health care service from this professional such that the responsibility for care remains with the entity.
        i. The eligible prescriber listing is managed using credentialing software maintained by the Medical Staff Office & Credentialing and information from this database is imported into the HGH electronic health record system
    c. 340B drugs are used in outpatient facilities that appear as reimbursable on the most recently filed CMS cost report.
    d. Hospitals maintain records of the individual's health care.
    e. Patient is an outpatient at the time medication is administered or dispensed.
    f. HGH has systems/mechanisms and internal controls in place to ensure ongoing compliance with all 340B requirements.
    g. HGH has mechanisms in place to prevent diversion (see V. 340B Procurement, Inventory Management and Dispensing)
    h. HGH has mechanisms in place to prevent duplicate discounts (see VI. Safeguards to Prevent Duplicate Discounts). "UD" modifier and "08" modifier components will be audited quarterly internally. Any discrepancies will be communicated to the appropriate team for correction and resubmission. Discrepancies above self-disclosure thresholds will be reported based on self-disclosure guidelines.
    i. HGH has an internal audit plan and conducted quarterly (see Section VII).
    j. HGH may use contract pharmacy services (if applicable), and the contract pharmacy arrangement is performed in accordance with OPA requirements and guidelines.
4. HGH obtains sufficient information from the contract pharmacy to ensure compliance with applicable policy and legal requirements, and HGH has utilized an appropriate methodology to ensure compliance.
5. HGH has identified locations where it dispenses or prescribes 340B drugs:
    a. Within the four walls of the parent entity.
    b. With off-site outpatient locations that are fully integrated into the hospital, reimbursable on the most recently filed Medicare Cost Report, and registered on 340B OPAIS; and
    c. HGH owned and operated in house outpatient pharmacy.

6. Signed Contract Pharmacy Services Agreement(s) complies with the contract pharmacy essential compliance elements (https://www.govinfo.gov/content/pkg/FR-2010-03-05/pdf/2010-4755.pdf)

7. Material Breach:

A breach of 340B compliance requirements includes any adverse event that results in diversion and/or duplicate discounts.
The material breach threshold is defined as:

a. A violation(s) that exceed 5% of hospital 340B purchases, program savings, or impact to any manufacturer, and
b. Remains non-correctable within 30 days.

HGH acknowledges its responsibility to contact OPA as soon as reasonably possible if there is any change in 340B eligibility or material breach by the hospital of any of the foregoing policies.

Violations identified through internal self-audits, independent external audits, or other methods that exceed the 5% threshold and remain non-correctable within the entity -defined period timeframe of review, will be immediately reported to HRSA and applicable manufacturers.

HGH elects to receive information about the 340B Program from trusted sources, including, but not limited to:

i. The Office of Pharmacy Affairs;
ii. The 340B Prime Vendor Program, managed by Apexus;
iii. Any OPA contractors.

8. 340B Program Education and Competency:

Program integrity and compliance are the responsibility of all 340B key stakeholders. Ongoing education and training are needed to ensure that these 340B key stakeholders have the knowledge to guarantee compliant 340B operations.

1. Alameda Health System Compliance department determines the knowledge and educational requirements for each 340B Program role (refer to "Responsibilities" section of this policy)
2. 340B key stakeholders complete initial basic training upon hire.
    a. Watch "introduction to the 340B Drug Pricing Program" on PVP website.
    b. Complete OnDemand modules on the PVP website.
3. 340B key stakeholders complete additional training as identified and pertaining to their responsibilities.
4. HGH provides educational updates and training, as needed to all staff.
5. HGH conducts annual verification of 340B program competency.
6. Training and education records are maintained per organizational policy and available for review.

9. 340B Enrollment, Recertification, Change Requests:

1. OPA requires entities to recertify their information as listed in the OPA database annually. HGH's Authorizing Official annually recertifies HGH's information by following the directions in the recertification email sent from the OPA to HGH's Authorizing Official by the requested deadline. Specific recertification questions will be sent to: 340b.recertification@hrsa.gov
2. HGH has available the requirement documents:
   a. Medicare Cost Report:
   i. Worksheet S, S-2, S-3
   ii. Worksheet E, Part. A
   iii. For outpatient facilities:
      a) Worksheet C
      b) Worksheet A
      c) Working trial balance.

b. Certification of ownership status.

3. On an annual basis, review Medicare Cost Report and confirm program status as outpatient

4. On a quarterly basis, review Medicaid Exclusion File for accuracy as a curve in the program

5. On a quarterly basis, review OPA 340b-database to confirm or revise listed NPI (National Provider Identifier) numbers

6. Enrollment Procedure: New Clinic Sites:
   a. The HGH Director of Pharmacy evaluates a new service area or facility to determine if the location is eligible for participation in the 340B Program. The criteria used include service area must be fully integrated into DSH, appear as a reimbursable clinic on the most recently filed cost report, have outpatient drug use, and care for patients that meet the 340B patient definition.

   b. If a new clinic meets these criteria, the Director of Pharmacy under the guidance of the Authorizing Official completes the online registration process during the registration window:
      - January 1–January 15 for an effective start date of April 1
      - April 1– April 15 for an effective start date of July 1
      - July 1–July 15 for an effective start date of October 1
      - October 1– October 15 for an effective start date of January 1

   This includes submitting cost report information, as required by OPA.
   http://www.hrsa.gov/opa/eligibilityandregistration/index.html

7. Changes to the Hospital's Information in the OPA Database:

It is HGH's ongoing responsibility to inform OPA of any changes to its information or eligibility. As soon as HGH is aware of its eligibility change, it will notify OPA immediately and stop purchasing of the 340B drugs as soon as HGH files its cost report with a disproportional share percentage < 11.75%. Change form will be submitted to OPA as soon as HGH is aware of the need to make a change to its database entry. HGH will expect changes to be reflected within 2 weeks of submission of the changes/requests.

V.340B Procurement, Inventory Management and Dispensing

340B inventory is procured and managed in the following settings:

1. **Highland Hospital Outpatient Retail Pharmacy**
    a. Prescription eligibility – HGH uses a physical inventory model for its outpatient retail pharmacy operations. The in-house pharmacy is closed door (processing only prescriptions that meet eligibility) and identifies as a Medicaid "carve-in" operation. Patient eligibility status is confirmed using one of the following mechanisms:
        i. Receipt of an electronic prescription from the hospital electronic health record
        ii. Receipt of a faxed prescription
        iii. Receipt of telephone orders which are reduced to writing
        iv. Receipt of a paper prescription that is either electronically generated from the hospital electronic health record or written by an eligible provider. If applicable, the paper prescription form will contain the appropriate watermarks and barcodes associated with either EHR (Electronic Health Record) generated prescriptions or those security requirements by CA Board of Pharmacy and Department of Justice Office of the Attorney General
    b. Medication replenishment - HGH Staff places orders from Wholesaler through daily inventory reviews and shelf inspections of PAR levels.
    c. Medication Storage – Upon receipt of inventory, HGH Staff examine the wholesaler invoice against the order, and reports inaccuracies to the wholesaler.
    d. Records - HGH Staff maintains records of 340B related transactions in accordance with California State Board of Pharmacy Rules and Regulations.
    e. Security - All inventories are stored in the pharmacy. Only pharmacy employees have access to the pharmacy using proximity badges.
    f. HGH Staff (and/or external vendor) conduct an annual physical inventory.

2. **Facility Administered Medications (Mixed Use Areas):**

a. HGH uses a 340B-replenishment inventory within the mixed encounter settings of the facility.

b. Inventory of medications in the mixed encounter setting is maintained using virtual inventory rather than maintenance of physical segregation. Virtual inventory requires initial purchase of unique 11-digit NDCs at a non-340B/non-GPO acquisition cost. As inventory is consumed, discrete units of the depleted inventory are tracked to ascertain whether the inventory was dispensed to outpatients (340B eligible) or inpatients (not eligible for 340B).

c. HGH Staff places inventory replenishment orders from Wholesaler through daily inventory reviews and shelf inspections

d. HGH Staff checks in inventory by examining the wholesaler invoice against the order, and reports inaccuracies to the wholesaler.

e. HGH Staff maintains auditable records of 340B related transactions in accordance with the California State board of Pharmacy Rules and Regulations.

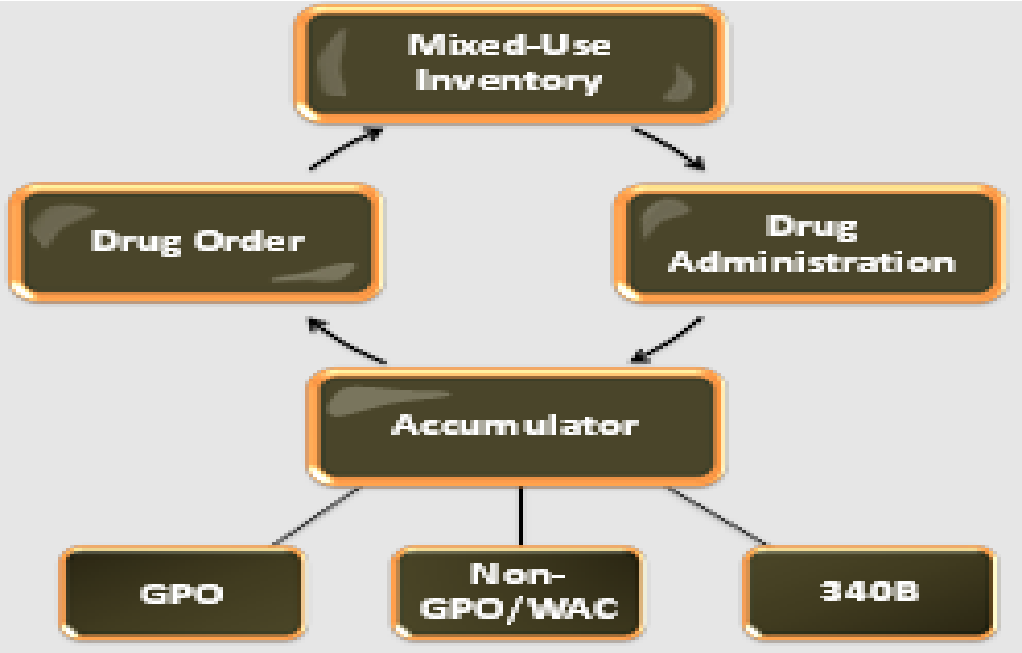
f. All inventory is stored either in the pharmacy maintained with a security system or in the ADS machines throughout the inpatient hospital and outpatient areas. Only pharmacy employees have access to the pharmacy using proximity badges. Only approved personnel have access to the ADS using fingerprint identification.

g. Mixed-use inventory replenishment is monitored by using split-billing software. Key points to address appropriate access to wholesaler accounts and split billing software include:

    a. HGH identifies all pharmacy purchasing accounts.
    b. HGH identifies which accounts are used for each 340B eligible location to purchase 340B drugs
    c. HGH places 340B, GPO, and WAC drug orders, based on orders created from the split-billing system.
        a. 340B drugs are ordered at an 11-digit NDC level.
        b. Appropriate processes are in place to ensure proper ordering, tracking, and adjusting of accumulators for controlled substances
    d. HGH receives shipments.
    e. HGH verifies quantity received with the quantity ordered.
        a. Identifies inaccuracies.
        b. Resolves inaccuracies
        c. Documents resolution of inaccuracies
    f. HGH documents manual manipulations to the 340B split-billing accumulator, including reason for manual manipulations.
    g. HGH reviews purchasing records with dispensing records biannually to ensure that covered outpatient drugs purchased through the 340B program are used only for 340B eligible patients.
    h. HGH staff reports significant discrepancies to HGH management within one business day.
    i. HGH maintains records of 340B – related transactions for a period of 3 years in a readily retrievable format.
        a. These reports are reviewed by Highland Hospital as part of its 340B oversight and compliance program.
    j. The infusion center data tracked by split-billing software is not used for inventory tracking purposes. Data is used only as a secondary reference tool.

h. Wasted/Expired 340B medication:
    a. HGH pharmacy staff documents destroyed or wasted drugs.
    b. System 340B analyst adjust the 340B accumulators based on reported waste.

i. HGH Staff (and/or external vendor) conduct an annual physical inventory.



0. Purchase mixed-use inventory (according to eligible accumulations).
1. Administered and dispensed drugs to patients.
2. Accumulator accumulates drug on an 11-digit NDC match until the unit of use is met, prepares order, uses patient/clinic/prescriber information to determine the appropriate contract for ordering.

GPO	Non-GPO (Non-340B WAC)	340B
GPO/Inpatient class of trade: Inpatient status determined by the hospital at the date/time of administration GPO/Outpatient class of trade: Offsite/unregistered outpatient clinics	Products that do not have an 11-digit NDC match on the 340B contract but are otherwise eligible for 340B purchase Non-340B eligible outpatients, i.e.: Administration or dispensing occurred at a clinic within 4 walls of covered entity, but not 340B eligible Medicaid carve-out outpatients Lost charges or wasted product	Patients met 340B patient definition and received services on an outpatient basis in a 340B registered/participating hospital clinic

- Replenishment drug order(s) are placed according to eligible accumulations.

3.Outpatient Clinic Administered Medications (Highland Wellness Center Clinics)

a. HGH uses 340B medications in all the outpatient ambulatory care clinics.

b. All medications ordered for immediate administration must be documented in the EHR (Electronic Health Record) or medical record

c. Most medications are stored in ADS Machines located in the clinic. Any unavailable medications prescribed for immediate administration must be requested via a patient-specific requisition form and brought to the main K-3 Pharmacy for filling and charging through the EHR.

d. If there are no ADS available, approved medications can be requested through a requisition form, and securely stored in the medication area of the clinic. When administered, these medications must be documented using the EHR to include administration date, patient identifiers and the medication administered.

e. Medication replenishment - HGH Staff places orders from Wholesaler through daily inventory reviews and shelf inspections of PAR levels daily.

f. Medication Storage – Upon receipt of inventory, HGH Staff examines the wholesaler invoice against the order, and reports inaccuracies to the wholesaler.

g. Records - HGH Staff maintains records of 340B related transactions in accordance with California State Board of Pharmacy Rules and Regulations.

h. All inventory is stored either in the pharmacy maintained with a security system or in the ADS machines throughout outpatient clinics. Only pharmacy employees have access to the pharmacy using proximity badges needed to access the department. Only approved personnel have access to the ADS using fingerprint identification.

i. All patients treated in the outpatient infusion center meet the criteria for 340B eligibility. Inventory of medications for the Outpatient Infusion Center is physically segregated from all other medications in the pharmacy and is purchased on a separate and dedicated 340B account. Drug utilization data for these patients will not accumulate on our “virtual inventory” management system.

j. HGH Staff (and/or external vendor) conducts an annual physical inventory.

3. Drug Shortage/340B Price not available

a. Highland Hospital will purchase covered outpatient drugs at 340B price. During times of Drug Shortages or when 340B price is not available, HGH will contact the drug manufacturer.
b. Covered outpatient drug will be purchased on a non-GPO account if the 340B price is not available. If the drug cannot be purchased on a non-GPO account, HGH may use GPO

alternative only if Highland Hospital documents and maintains records that all other options have been exhausted.

c. Highland Hospital must attempt to purchase drug at 340B price every time an order is made.

4. Contract Pharmacy:

a. Separate 340B and non-340B purchased inventory is used for Contract Pharmacies.
b. Pharmacy staff dispense 340B drugs only to patients meeting all the criteria in the "Patient Eligibility/Definition" policy.

Inventory Replenishment system (340B/non-340B) is maintained at Contract Pharmacies.

1. Highland Hospital Pharmacy staff identifies all accounts used for purchasing drugs at contract pharmacies for 340B and non-340B

1. Highland Hospital purchases inventory according to eligible accumulations recorded for 340B replenishment at contract pharmacies.
2. Contract Pharmacies dispense drugs to patients.
3. HGH staff track drug utilizations based on patient eligibility including service location and provider information. This accumulation occurs at the 11-digit NDC level and a full package size will be accumulated before replenishing inventory.

VI.. Safeguards to Prevent Duplicate Discounts

a. HGH is a CA Medi-Cal "Carve in" facility and bills Medicaid per reimbursement requirements, and as reflected its information on the OPA website as Carve in. HGH bills Medicaid per Medi-Cal reimbursement requirements, and as such HGH has reflected its information on the OPA website/Medicaid Exclusion (http://opanet.hrsa.gov/340B/Views/CoveredEntity/SearchDirectory)
    a. HGH informs OPA immediately of any changes to its information on the OPA website/Medicaid Exclusion File
        i. HGH is responsible for the accuracy of the information in Medicaid Exclusion File (MEF) The MEF (Medicaid Exclusion File) lists covered entities that have decided to use 340B drugs for their Medicaid patients and to bill Medicaid for those drugs (carve-in). Having this information in the MEF (Medicaid Exclusion File) indicates to the states and manufacturers which drugs are not subject to Medicaid rebates, and helps ensure the prevention of duplicate discounts, as prohibited by statute.
        ii. Covered entities are required to ensure that information in the MEF is accurate each quarter and at the time of annual recertification.

b. To identify 340B-eligible claims submitted to Medicaid by the Highland Hospital Outpatient Pharmacy, the MISC 1/MSC 1 field has the qualifier titled "08 – 340B/Share Pricing/Public Health".
c. Highland Hospital does not in the course of regular business bill Out of State Medicaid and Managed Medicaid for 340B drugs in the hospital mixed-use and retail pharmacy.

d. A UD Modifier is used for physician-administered claims to identify a 340B purchased drug by using the reporting modifier "UD" in conjunction with the procedures code on the state or federal billing form. When a claim is filed with Medicaid for administering drugs purchased under the 340B drug discount program, a modifier "UD" along with the 11-digit National Drug Code (NDC).
e. John George Psychiatric Hospital, child site, does not bill Medi-Cal and is paid at an hourly/per diem rate for all patient care services by the County of Alameda.

VII.. Emergency and Disaster Medication

Bioterrorism/ FEMA process:

HGH has an agreement with FEMA, Oakland Urban Search and Rescue Task Force (US&R TF), and Alameda County to supply (sell) certain medications during a declared emergency. The purpose of emergency medication is to respond to a disaster in the United States, which overwhelms the resources of local or state authorities. The Emergency medications will not be used for HGH's patients. All emergency meds are physically separated from the mixed-use inventory and purchased on GPO exclusively upon disaster activation.

Flexibility During Emergency:
In the event of a State of Emergency providers may work past term date if necessary due to hospital occupancy.

VIII. Loan/Borrow Processes:

The borrowing and lending process is evaluated based on different criteria, such as 340B status, emergent need, or inventory availability at each pharmacy. See policy: "Borrowing and Loaning Medications Between AHS Inpatient Pharmacies."

IX.. Monitoring and Reporting:

1. Monitoring
    a. The entity uses the process outlined in: 340B Compliance Self-Assessment: Self-Audit Process to Ensure 340B Compliance. Additional monitoring or reporting includes:
        i. Daily monitoring of accrual file upload to wholesaler
        ii. Ongoing monitoring of unreconciled dispenses and wastes
        iii. Ongoing collaboration with Pharmacy IT (Information Technology) to ensure products, units, quantities, prices are up-to-date and correctly represented.
    b. Review of outpatient retail pharmacy prescriptions to ensure eligibility

2. 340B Compliance Overview

a. The 340B Compliance Review summarizes all activities necessary to ensure comprehensive review of 340B compliance at HGH. HGH staff is responsible and accountable for overseeing this review process, as well as taking corrective actions based upon findings.

		Area of Focus			
Activity	Frequency	HGH Eligibility	No Diversion	No Duplicate Discount	GPO Prohibition
Review of all OPA database information for HGH, indigent care agreement with state/local government, and Medicare Cost Report (Worksheet E, Part A and Worksheet A), prior to recertification Internal Compliance *Staff responsible: Director of Pharmacy, System 340B Manager & CFO*	Annual	√			
Review of 340B Self-Audit Reports (mixed-use & outpatient pharmacy) *Staff responsible: System 340B Manager, Director of Pharmacy, CFO, COO*	Quarterly		√	√	√
Review of quarterly contract price load *Staff responsible: Director of Pharmacy, System 340B Manager, System 340B Analyst*	Quarterly		√		
Update of prescriber eligibility files with outpatient patient management processing system *Staff responsible: Provider Service Director and EHR IT manager, system 340B manager*	Monthly		√		
Split-Billing software maintenance (CDM-NDC mapping, updates, etc.) *Staff responsible: System 340B Analyst, System 340B Manager*	Daily or Weekly		√		√

b. Quarterly internal audits will be performed by designated pharmacy staff and reviewed by the Director of Pharmacy. HGH staff are responsible and accountable for overseeing this review process, as well as taking corrective actions based upon findings.
i. Infusion Center audit:
Audits will include, but not limited to, ensuring the patient meets 340B eligibility, the medications were purchased from the 340B account specific for infusion center and that the medications are dispensed from our physically segregated inventory for the infusion center.
ii. Mixed- use area/hospital audits:

Audits will include, but not limited to, ensuring the patients meeting 340B eligibility, the charge on dispense data is accurate, patient status is outpatient, patient had an order for the medication and was written by an eligible provider and the medication accumulated in the correct account in our virtual inventory records.

2. Reporting Non-Compliance
    a. HGH acknowledges that if there is a breach of the 340B requirements, HGH may be liable to the manufacturer of the covered outpatient drug that is the subject of the violation, and depending upon the circumstances, may be subject to the repayment of interest and/or removal from the list of eligible 340B entities.
    b. As HGH identifies areas/types of non-compliance related to entity eligibility, diversion, or duplicate discount, HGH will notify OPA, and any associated drug manufacturers complete with appropriate documentation/records along with a plan for corrective action.
    c. Threshold to self-report:
    Violations identified through internal self-audits, independent external audits, or other methods that exceed the 5% threshold and remain non-correctable within the entity - defined period timeframe of review, as defined as Material Breach under this Policy, will be immediately reported to HRSA and applicable manufacturers. The Self-Disclosure Tool included in this Policy may be utilized to assist Covered Entity in self-reporting a Material Breach.

References

1. Section 340B of the Public Health Service Act.
2. Apexus 340B University
3. Apexus 340B Tools https://www.apexus.com/solutions/education/340b-tools
4. HRSA Entity Self-Disclosures: https://www.hrsa.gov/opa/self-disclosures/self-disclosure.html
5. Apexus 340B Self disclosure tool: https://www.340bpvp.com/resource-center/340b-tools
6. Apexus 340B Material Breaching threshold: https://www.340bpvp.com/resource-center/340b-tools

APPROVALS

		System	AHS Core	Alameda
Compliance Dept.	**Date:**	**11/2021**		
Legal Dept.	**Date:**	**11/2021**		
Pharmacy Dept.	**Date:**	**6/2025**		
System P&T	**Date:**	**6/2025**		
Clinical Practice Committee	**Date:**	**7/2025**		

Medical Executive Committee	**Date:**	**7/2025**		
Board of Trustees	**Date:**	**8/2025**		

Alameda Hospital

A Member of Alameda Health System

340B DRUG PRICING PROGRAM (ALAMEDA HOSPITAL)

Department	AHD AHD PHARMACY, PHARMACY	***Effective Date***	2/2016
Campus	Alameda Hospital	***Date Revised***	9/2015, 6/2016, 8/2017, 12/2018, 7/2019, 12/2022, 6/2025
Unit	All	***Next Scheduled Review***	6//2028
Manual	Pharmacy	***Author***	Director, Pharmacy
Replaces the following Policies:		***Responsible Person***	Chief Operating Officer

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

Purpose

The purpose of this policy is to establish guidance regarding Alameda Hospital (AH) and all child sites' compliance with the rules and regulations set forth by the Health Resources and Services Administration's Office of Pharmacy Affairs ("OPA") pertaining to the Section 340B Drug Discount Program

Background

Section 340B of the Public Health Service Act (1992) requires drug manufacturers participating in the Medicaid Drug Rebate Program to sign a pharmaceutical pricing agreement (PPA) with the Secretary of Health and Human Services.

a. This agreement limits the price that manufacturers may charge certain covered entities for covered outpatient drugs.

The 340B Program is administered by the federal Health Resources and Services Administration (HRSA) in the Department of Health and Human Services (DHHS).

Upon registration on 340B OPAIS (Office of Pharmacy Affairs Information System), Alameda Health System:

a. Agrees to abide by specific statutory requirements and prohibitions.
b. May access 340B drugs.

340B Policy Statements

Alameda Hospital (AH) develops and maintains policies and procedures to ensure compliance with the guidelines and regulations of the 340B Drug Pricing Program for outpatients as outlined by Health Resources and Services Administration (HRSA)/Office of Pharmacy Affairs (OPA).

It is the policy of AH to participate in the 340B Program, to comply with all rules and regulations of the 340B Program, and to implement procedures and safeguards to protect the integrity of the 340B Program including but not limited to the prevention of Duplicate Discounts/rebates under Medicaid, and the prohibition against transferring drugs purchased under 340B to anyone other than a patient of the entity, as well as adherence to the 340B Eligible Patient criteria.

The 340B Program savings will support AH's mission to serve all and stretch federal resources and by providing more comprehensive services to patients.

AH maintains auditable records demonstrating compliance with the 340B Program. These reports are reviewed by AH biannually as part of its 340B Oversight Committee and compliance program.

Scope:

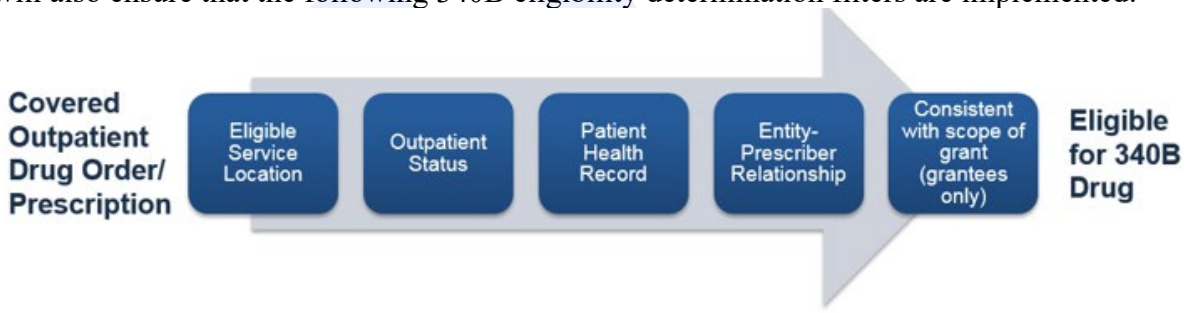
This policy applies to the 340B Programs Covered Entities/Child Sites identified below. All employees, contract employees, or agents providing services under the 340B Program at AH or a child site must adhere to this policy.

a. DSH050211: Alameda Health System –Alameda Hospital
b. DSH050211A: Alameda Health System –AH Wound Care Clinic

Procedure:

I. Eligibility:

AH ensures that 340B drugs are dispensed/administrated/prescribed only to eligible patients. AH will also ensure that the following 340B eligibility determination filters are implemented:



1. Validates site eligibility. Care site must be within the four walls of the covered entity or listed as a child site on the HRSA OPAIS database as the point of service.
2. Determines patient status at the point of service.
   a. Patient must be in outpatient status at the time the medication is dispensed or administered based on medication type received.
3. AH must maintain records of individual's health care. If the patient only receives prescriptions from the pharmacy, the patient is not considered as 340B eligible.

4. AH deems patient care delivered via telehealth to constitute the provision of health care services by a health care professional that has a documented arrangement with AH such that responsibility for care provided remains with AH.
5. AH must determine provider eligibility.
    a. Provider is either employed by the covered entity or provider health care on a contractual or other arrangement (e.g., referral for consultation) or granted privileges by covered entities.
    b. Pharmacists and dieticians who are employed by Alameda Health System, practicing under a collaborative practice agreement within a clinic, may at times prescribe medications.
        a. Ambulatory pharmacists and dieticians are considered eligible providers under these terms.

6. Encounter/prescription eligibility for Disease State management and/or MTM:
    a. The responsibility for the health care service that result in the use of, or prescription for, 340B drugs must remain with covered entity.
    b. Prescriptions will be deemed eligible if they meet one of the following criteria:
        a. A prescription is derived from a qualifying outpatient health care service documented within the previous 36 months from the date of fill.
        b. A qualifying outpatient health care service occurs within 30 days after the date of fill where the prescription is documented in the service summary.

7. AH determines patient's Medicaid status at the point of service to prevent duplicate discounts.[1]

    a. GPO prohibition – Alameda Hospital and child site AH Wound Care Clinics are registered on the OPAIS 340B database as participating in the 340B Program are subject to the GPO prohibition and cannot obtain covered outpatient drugs through a GPO or other group purchasing arrangement.
    b. AH may not purchase covered outpatient drugs through a GPO for any of its clinics/departments within the four walls of the hospital at any point in time. If AH is unable to purchase a covered outpatient drug at the 340B price, written notification should be sent to OPA immediately.

    c. AH will purchase using a non-GPO account and only replenish with 340B drugs once 340B patient eligibility is confirmed and can be documented through auditable records. Monthly audits are completed to ensure program integrity and report any violations.

II. <u>Definitions:</u>

1. 340B Eligible Patient – An individual is considered a "340B Eligible Patient" only if:

[1] Statutory Prohibition on Group Purchasing Organization Participation, *340B Drug Pricing Program Notice. Release No. 2013-1*; (February 3rd,2013). Health Resources and Services Administration Healthcare System Bureau Office of Pharmacy Affairs. https://www.hrsa.gov/sites/default/files/opa/programrequirements/policyreleases/prohibitionongpoparticipation020713.pdf

a. AH has an established relationship with the individual such that AH maintains records of the individual's health care; and,
b. The individual receives health care services from a health care professional who is either employed by AH or who provides health care under contractual or other arrangements (e.g., referral or consultation) such that the responsibility for the individual's care remains with AH. If health care is provided under referral for consultation, HRSA-recommended documentation is accessible:
    i. Request for referral
c. The entity maintains responsibility for the patient's health care services
d. An individual shall not be considered an "340B Eligible Patient" if the only health care service received by the individual from AH is the dispensing of a drug or drugs for subsequent self-administration in a home setting or other institutional settings.
    - ***Referral Exception**: Though not a common practice, prescriptions written outside the Hospital may be filled with 340B drugs if they are written pursuant to a referral and (1) the referral and outcome of the referral are documented in the patient's medical record or (2) the patient obtained subsequent services from the Hospital for the same condition after the referral.*
e. The window for establishing 340B eligibility through care provided by Alameda Hospital is based on a 36 month look back period form the date the prescription is filled.
f. Eligible encounter: Any encounter that support a continuing patient-provider relationship may include, but are not limited to office visit, telehealth appointments, refill requests, lab orders, imaging requests, and medication management consults. Any documented interaction that reasonably demonstrates the patient remains under the ongoing care of Alameda Hospital maybe considered valid to support 340B eligibility.

2. Covered Drug–AH does not purchase covered outpatient drugs for its outpatient registered facilities using a Group Purchasing Organization (GPO)
    a. AH interprets the definition of covered outpatient drugs to include – 'An FDA-approved prescription drug, an over the counter (OTC) drug that is written on a prescription and a biological product that can be dispensed only by a prescription (other than a vaccine) or FDA-approved insulin.
    b. The following drugs and drug categories are excluded from 340B and are GPO exclusion exempt: vaccines, normal saline & water for injection, gases, contrast media/diagnostic agents, large volume fluids without additives, topicals, romiplostim, hyaluronan and hyaluronate derivatives, 503B purchased drugs, cellulose oxidized, state supplied emergency medication (e.g., Covid medications under emergency use approval) manufacturers/labelers that do not participate in 340B program, and bundled items. A detailed list of items and categories can be available through EHR.
    c. Controlled Substance Ordering System (CSOS): AH is enrolled in the CSOS program which allows for secure electronic transmission of controlled substance orders without the paper DEA 222 Form. Pharmacists are enrolled with DEA to acquire a CSOS digital signing certificate in order to place control substance orders.

3. Covered Entity – covered entities include six categories of hospitals: disproportionate share hospitals (DSHs), children's hospitals, and cancer hospitals exempt from the Medicare perspective payment system, sole community hospitals, rural referral centers, and critical access hospitals (CAHs). Hospitals in each of these categories must be (1) non-profit, (2) be owned and operated by or under contract with state or local governments, and (3) except for CAHs, meet the payer-mix criteria related to the Medicare DSH program. [2]

4. Diversion – Pursuant to the 340B Program rules and regulations, 340B participating entities are prohibited from reselling or otherwise transferring outpatient drugs purchased at the statutory discount to an individual who is not a 340B Eligible Patient of AH. Any such practice qualifies as "Diversion."

5. Duplicate Discount – A "Duplicate Discount," which is prohibited by the 340B statute, occurs when manufacturers provide both a 340B discount on a drug and pay a Medicaid rebate to the State on the same drug.

III. Responsibilities

This section includes stakeholders and determines their roles and responsibilities in maintaining 340B program integrity and compliance. The following staff members are key stakeholders in the 340B program, including governance and compliance, and should be standing members of the 340B Oversight Committee. AH will identify who serves as the entity's authorizing official and primary contact for the 340B Program. These individuals are the sponsors of the 340B Oversight Committees.

1. Chief Financial Officer and/or VP of Finance
    a. Must account for savings and use of funds to provide care for the indigent under the indigent care agreement.
    b. Responsible for communication of all changes to the Medicare Cost report regarding clinics or revenue centers of the cost report.
    c. Responsible for communication of all changes to Medi-Cal/Medi-Cal Managed Care reimbursement for pharmacy services/products that impact 340B status (i.e., 340B AAC, modifiers).
    d. Accountable for savings and use of funds to provide care for the indigent under the indigent care agreement.

2. Chief Operations Officer (COO)
    a. Responsible for attesting to the compliance of the program in the form of recertification.
    b. Responsible as the principal officer in charge of the compliance and administration of the program.
    c. Accountable agent for 340B compliance.

[2] (Safety Net Hospitals for Pharmaceutical Access (SNPHA). "An Overview of The Section 340B Drug Discount Program.www.safetynetrx.org,2012)

d. Responsible as the Authorizing Official for the 340B program.

3. Director of Pharmacy
   a. Agent of the COO responsible to administer the 340B program to fully implement and optimize appropriate savings and ensure current policy statements and procedures are in place to maintain program compliance.
   b. Must maintain knowledge of the policy changes that impact the 340B program which includes, but is not limited to, HRSA/OPA rules and Medicaid changes
   c. Must coordinate constant knowledge of any change in clinic eligibility/information

4. System 340B Manager
   b. Day to day management of the 340B program.
   d. Responsible for documentation of policies and procedures.
   g. Ensures appropriate safeguards and system integrity.
   h. Ensure compliance with 340B program requirements for qualified patients, drugs, providers, vendors, payers, and locations.
   i. Review and refine 340B cost saving report, detailing purchasing, and replacement practices, as well as dispensing patterns.
   j. Monitors ordering processes, integrating most current pricing from wholesalers, and analyzes invoices, shipping, and inventory processes.
   k. Design and maintain an internal audit plan of the compliance of the 340B program.
   l. Responsible for annual or semiannual physical inventory of pharmacy items.
   m. Designs the annual plan to cover all changes in the 340B program from the preceding year.
   n. Responsible as the primary contact for the 340B program.

5. VP of Compliance and Internal Audit
   a. Design and maintain an internal audit plan of the compliance of the 340B program.

   b. Designs the annual plan to cover all changes in the 340B program from the preceding year.

6. Director of Finance/ Reimbursement
   a. Responsible for communication of all changes to the Medicare Cost Report regarding clinics or revenue centers.
   b. Responsible for communication of all changes to Medicaid reimbursement for pharmacy services/products that affect 340B status.
   c. Engage pharmacy in conversations that affect reimbursement.
   d. Responsible for modeling all managed care contracts (with/without 340B).

7. Revenue Cycle (Billing and Revenue Integrity) and Revenue IS:
   a. Correct any findings identified through internal self-audits, independent external audits, or other methods.
   b. IS team will conduct systematic correction in the electronic operating system.

c. IS team defines process and access to data for compliant identification of outpatient utilization for eligible patients.
d. Achieves the data to make them available to auditors when audited.

8. Office of the General Counsel ("OGC")

The OGC will provide legal counsel on an as-needed basis.

9. Pharmacy Buyer

Responsible for maintaining three distribution accounts, i.e., non-GPO account, 340B account, and GPO account. Responsible for maintaining direct accounts for GPO ("own use") class of trade as well as direct 340B accounts.

a. Responsible for ordering all medications from the specific accounts as appropriate.
b. Manage purchasing, receiving and inventory control processes.
c. Responsible for segregation, removal, and/or return of 340B drugs, including reverse distributor transactions.
d. Continuously monitor product min/max levels to effectively balance product availability and cost-efficient inventory control
e. Manage purchasing, receiving and inventory control processes.
f. Coordinate annual inventory cycle counts.
g. Monitor ordering processes, integrating most current pricing from wholesaler, analyze invoices, shipping, and inventory processes.

10. IT Pharmacist

a. Defines process and access to data for compliant identification of outpatient utilization for eligible patients.
c. Archives the data to make them available to auditors when audited.
d. Responsible for maintenance and testing of 340B management software.
e. In conjunction with any split-billing software vendor, develop and implement standard data interface controls which, at a minimum, shall perform necessary and reasonable checksum and duplicate record verifications.

IV. Program Integrity Procedures

1. As a participant in the 340B Drug Pricing Program, AH shall meet all 340B Program eligibility requirements.

2. AH OPA Database covered entity listing is complete, accurate, and correct.
   a. AH, a member of AHS (Alameda Health System), a public Hospital Authority organized and existing under the laws of the State of California, provides health care services to low-income individuals.

      i. For the most recent cost reporting period that ended before the calendar quarter involved, AH had a disproportionate share adjustment percentage greater than or equal to 11.75 percent.

         1. Reference Medicare Cost Report -Worksheet E Part A, line 33

3. AH complies with all requirements and restrictions of Section 340B of the Public Health Service Act and any accompanying regulations or guidelines including, but not limited to, the prohibition against duplicate discounts/rebates under Medicaid, and the prohibition against transferring drugs purchased under 340B to anyone other than a patient of the entity. [REFERENCE: Public Law 102-585, Section 602, 340B Guidelines, 340B Policy Releases]
    a. AH maintains auditable records demonstrating compliance with the 340B requirement
    b. Prescriber has participated in credentialing process therefore obtaining prescribing privileges and agrees to the rules and regulations established by AH Medical Staff and is under contractual or other arrangements with the entity, and the patient receives a health care service from this professional such that the responsibility for care remains with the entity.
        i. The eligible prescriber listing is managed using credentialing software maintained by the Medical Staff Office & Credentialing and information from this database is imported into the AH electronic health record system
    c. 340B drugs are used in outpatient facilities that appear as reimbursable on the most recently filed CMS cost report.
    d. Hospitals maintain records of the individual's health care.
    e. Patient is an outpatient at the time medication is administered or dispensed.
    f. AH has systems/mechanisms and internal controls in place to ensure ongoing compliance with all 340B requirements.
    g. AH has mechanisms in place to prevent diversion (see V. 340B Procurement, Inventory Management and Dispensing)
    h. AH has mechanisms in place to prevent duplicate discounts (see VI. Safeguards to Prevent Duplicate Discounts). "UD" modifier components will be audited quarterly internally. Any discrepancies will be communicated to the appropriate team for correction and resubmission. Discrepancies above self-disclosure thresholds will be reported based on self-disclosure guidelines.
    i. AH has an internal audit plan and conducts quarterly (see Section VII).
4. AH has identified locations where it dispenses or prescribes 340B drugs:
    a. Within the four walls of the parent entity.
    b. With off-site outpatient locations that are fully integrated into the hospital, reimbursable on the most recently filed Medicare Cost Report, and registered on 340B OPAIS; and

5. Material Breach:

A breach of 340B compliance requirements includes any adverse event that results in diversion and/or duplicate discounts.
The material breach threshold is defined as:

a. A violation(s) that exceed 5% of hospital 340B purchases, program savings, or impact to any manufacturer, and
b. Remains non-correctable within 30 days.

AH acknowledges its responsibility to contact OPA as soon as reasonably possible if there is any change in 340B eligibility or material breach by the hospital of any of the foregoing policies.

Violations identified through internal self-audits, independent external audits, or other methods that exceed the 5% threshold and remain non-correctable within the entity -defined period timeframe of review, will be immediately reported to HRSA and applicable manufacturers.

AH elects to receive information about the 340B Program from trusted sources, including, but not limited to:

i. The Office of Pharmacy Affairs;
ii. The 340B Prime Vendor Program, managed by Apexus;
iii. Any OPA contractors.

6. 340B Program Education and Competency:

Program integrity and compliance are the responsibility of all 340B key stakeholders. Ongoing education and training are needed to ensure that these 340B key stakeholders have the knowledge to guarantee compliant 340B operations.

1. Alameda Health System Compliance department determines the knowledge and educational requirements for each 340B Program role (refer to "Responsibilities" section of this policy)
2. 340B key stakeholders complete initial basic training upon hire.
    a. Watch "introduction to the 340B Drug Pricing Program" on PVP website.
    b. Complete OnDemand modules on the PVP website.
3. 340B key stakeholders complete additional training as identified and pertaining to their responsibilities.
4. AH provides educational updates and training, as needed to all staff.
5. AH conducts annual verification of 340B program competency.
6. Training and education records are maintained per organizational policy and available for review.

7. <u>340B Enrollment, Recertification, Change Requests:</u>

1. OPA requires entities to recertify their information as listed in the OPA database annually. AH's Authorizing Official annually recertifies AH's information by following the directions in the recertification email sent from the OPA to AH's Authorizing Official by the requested deadline. Specific recertification questions will be sent to: <u>340b.recertification@hrsa.gov</u>
2. AH has available the requirement documents:
    a. Medicare Cost Report:
    i. Worksheet S, S-2, S-3
    ii. Worksheet E, Part. A
    iii. For outpatient facilities:
        a) Worksheet C
        b) Worksheet A
        c) Working trial balance.

b. Certification of ownership status.

3. On an annual basis, review Medicare Cost Report and confirm program status as outpatient

4. On a quarterly basis, review Medicaid Exclusion File for accuracy as a curve in the program

5. On a quarterly basis, review OPA 340b-database to confirm or revise listed NPI (National Provider Identifier) numbers

6. Enrollment Procedure: New Clinic Sites:
    a. The AH Director of Pharmacy evaluates a new service area or facility to determine if the location is eligible for participation in the 340B Program. The criteria used include service area must be fully integrated into DSH, appear as a reimbursable clinic on the most recently filed cost report, have outpatient drug use, and care for patients that meet the 340B patient definition.

    b. If a new clinic meets these criteria, the Director of Pharmacy under the guidance of the Authorizing Official completes the online registration process during the registration window:
        - January 1–January 15 for an effective start date of April 1
        - April 1– April 15 for an effective start date of July 1
        - July 1–July 15 for an effective start date of October 1
        - October 1– October 15 for an effective start date of January 1

    This includes submitting cost report information, as required by OPA.
    http://www.hrsa.gov/opa/eligibilityandregistration/index.html

7. Changes to the Hospital's Information in the OPA Database:

It is AH's ongoing responsibility to inform OPA of any changes to its information or eligibility. As soon as AH is aware of its eligibility change, it will notify OPA immediately and stop purchasing of the 340B drugs as soon as AH files its cost report with a disproportional share percentage < 11.75%. Change form will be submitted to OPA as soon as AH is aware of the need to make a change to its database entry. AH will expect changes to be reflected within 2 weeks of submission of the changes/requests.

V.340B Procurement, Inventory Management and Dispensing

340B inventory is procured and managed in the following settings:

1. **Facility Administered Medications (Mixed Use Areas):**

a. AH uses a 340B-replenishment inventory within the mixed encounter settings of the facility.

b. Inventory of medications in the mixed encounter setting is maintained using virtual inventory rather than maintenance of physical segregation. Virtual inventory requires initial purchase of unique 11-digit NDCs at a non-340B/non-GPO acquisition cost. As inventory is consumed, discrete units of the depleted inventory are tracked to ascertain whether the inventory was dispensed to outpatients (340B eligible) or inpatients (not eligible for 340B).

c. AH Staff places inventory replenishment orders from Wholesaler through daily inventory reviews and shelf inspections

d. AH Staff checks in inventory by examining the wholesaler invoice against the order, and reports inaccuracies to the wholesaler.

e. AH Staff maintains auditable records of 340B related transactions in accordance with the California State board of Pharmacy Rules and Regulations.

f. All inventory is stored either in the pharmacy maintained with a security system or in the ADS machines throughout the inpatient hospital and outpatient areas. Only pharmacy employees have access to the pharmacy using proximity badges. Only approved personnel have access to the ADS using fingerprint identification.

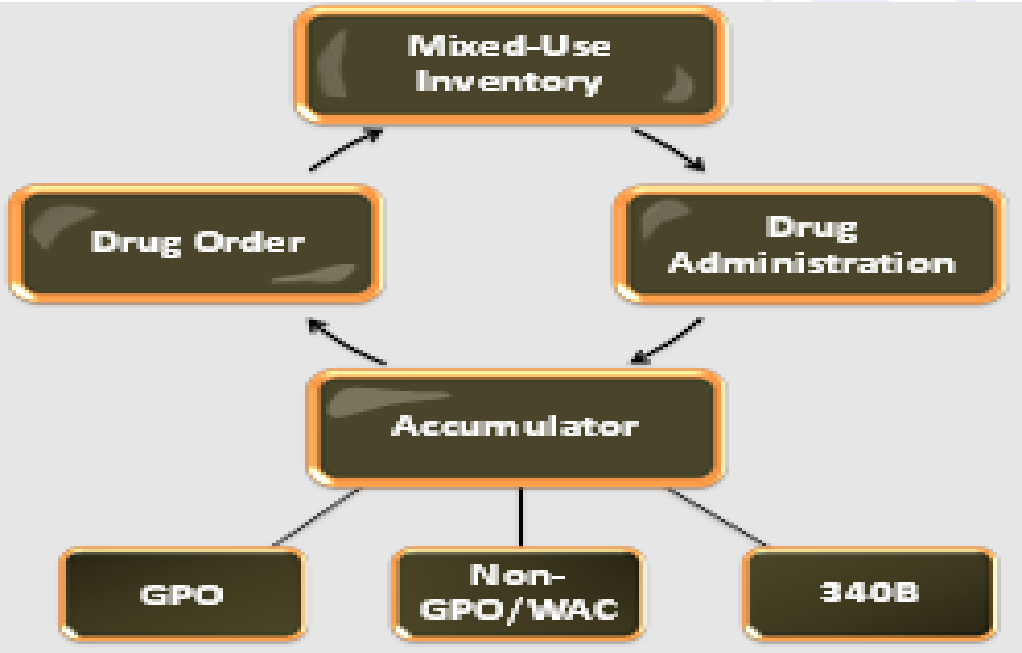
g. Mixed-use inventory replenishment is monitored by using split-billing software. Key points to address appropriate access to wholesaler accounts and split billing software include:

    a. AH identifies all pharmacy purchasing accounts.
    b. AH identifies which accounts are used for each 340B eligible location to purchase 340B drugs
    c. AH places 340B, GPO, and WAC drug orders, based on orders created from the split-billing system.
        a. 340B drugs are ordered at an 11-digit NDC level.
        b. Appropriate processes are in place to ensure proper ordering, tracking, and adjusting of accumulators for controlled substances
    d. AH receives shipments.
    e. AH verifies quantity received with the quantity ordered.
        a. Identifies inaccuracies.
        b. Resolves inaccuracies
        c. Documents resolution of inaccuracies
    f. AH documents manual manipulations to the 340B split-billing accumulator, including reason for manual manipulations.
    g. AH reviews purchasing records with dispensing records biannually to ensure that covered outpatient drugs purchased through the 340B program are used only for 340B eligible patients.
    h. AH staff reports significant discrepancies to AH management within one business day.

i. AH maintains records of 340B – related transactions for a period of 3 years in a readily retrievable format.
    a. These reports are reviewed by Alameda Hospital as part of its 340B oversight and compliance program.

h. Wasted/Expired 340B medication:
    a. AH pharmacy staff documents destroyed or wasted drugs.
    b. AH Pharmacist adjust the 340B accumulators based on reported waste.

i. AH Staff (and/or external vendor) conduct an annual physical inventory.



0. Purchase mixed-use inventory (according to eligible accumulations).
1. Administered and dispensed drugs to patients.
2. Accumulator accumulates drug on an 11-digit NDC match until the unit of use is met, prepares order, uses patient/clinic/prescriber information to determine the appropriate contract for ordering.

GPO	Non-GPO (Non-340B WAC)	340B

GPO/Inpatient class of trade: Inpatient status determined by the hospital at the date/time of administration GPO/Outpatient class of trade: Offsite/unregistered outpatient clinics	Products that do not have an 11-digit NDC match on the 340B contract but are otherwise eligible for 340B purchase Non-340B eligible outpatients, i.e.: Administration or dispensing occurred at a clinic within 4 walls of covered entity, but not 340B eligible Medicaid carve-out outpatients Lost charges or wasted product	Patients met 340B patient definition and received services on an outpatient basis in a 340B registered/participating hospital clinic

- Replenishment drug order(s) are placed according to eligible accumulations.

j. -AH Staff (and/or external vendor) conducts an annual physical inventory.

3. Drug Shortage/340B Price not available

a. Alameda Hospital will purchase covered outpatient drugs at 340B price. During times of Drug Shortages or when 340B price is not available, AH will contact the drug manufacturer.
b. Covered outpatient drug will be purchased on a non-GPO account if the 340B price is not available. If the drug cannot be purchased on a non-GPO account, AH may use GPO alternative only if Alameda Hospital documents and maintains records that all other options have been exhausted.
c. Alameda Hospital must attempt to purchase drug at 340B price every time an order is made.

VI.. Safeguards to Prevent Duplicate Discounts

a. AH is a CA Medi-Cal "Carve in" facility and bills Medicaid per reimbursement requirements, and as reflected its information on the OPA website as Carve in. AH bills Medicaid per Medi-Cal reimbursement requirements, and as such AH has reflected its information on the OPA website/Medicaid Exclusion (http://opanet.hrsa.gov/340B/Views/CoveredEntity/SearchDirectory)
    a. AH informs OPA immediately of any changes to its information on the OPA website/Medicaid Exclusion File
        i. AH is responsible for the accuracy of the information in Medicaid Exclusion File (MEF) The MEF (Medicaid Exclusion File) lists covered entities that have decided to use 340B drugs for their Medicaid patients and to bill Medicaid for those drugs (carve-in). Having this information in the MEF (Medicaid Exclusion File) indicates to the states and manufacturers which drugs are not subject to Medicaid rebates, and helps ensure the prevention of duplicate discounts, as prohibited by statute.

ii. Covered entities are required to ensure that information in the MEF is accurate each quarter and at the time of annual recertification.

b. Alameda Hospital does not in the course of regular business bill Out of State Medicaid and Managed Medicaid for 340B drugs in the hospital mixed-use and retail pharmacy.

c. A UD Modifier is used for physician-administered claims to identify a 340B purchased drug by using the reporting modifier "UD" in conjunction with the procedures code on the state or federal billing form. When a claim is filed with Medicaid for administering drugs purchased under the 340B drug discount program, a modifier "UD" along with the 11-digit National Drug Code (NDC).

VII.. Emergency and Disaster Medication

Flexibility During Emergency:
In the event of a State of Emergency providers may work past term date if necessary due to hospital occupancy.

VIII. Loan/Borrow Processes:

The borrowing and lending process is evaluated based on different criteria, such as 340B status, emergent need, or inventory availability at each pharmacy. See policy: "Borrowing and Loaning Medications Between AHS Inpatient Pharmacies."

IX.. Monitoring and Reporting:

1. Monitoring
    a. The entity uses the process outlined in: 340B Compliance Self-Assessment: Self-Audit Process to Ensure 340B Compliance. Additional monitoring or reporting includes:
        i. Daily monitoring of accrual file upload to wholesaler
        ii. Ongoing monitoring of unreconciled dispenses and wastes
        iii. Ongoing collaboration with Pharmacy IT (Information Technology) to ensure products, units, quantities, prices are up-to-date and correctly represented.

2. 340B Compliance Overview
    a. The 340B Compliance Review summarizes all activities necessary to ensure comprehensive review of 340B compliance at AH. AH staff is responsible and accountable for overseeing this review process, as well as taking corrective actions based upon findings.

		Area of Focus			
Activity	Frequency	AH Eligibility	No Diversion	No Duplicate Discount	GPO Prohibition
Review of all OPA database information for AH, indigent care agreement with state/local government, and Medicare Cost Report (Worksheet E, Part A and Worksheet A), prior to recertification Internal Compliance *Staff responsible: Director of Pharmacy, System 340B Manager & CFO*	Annual	√			
Review of 340B Self-Audit Reports (mixed-use & outpatient pharmacy) *Staff responsible: System 340B Manager, Director of Pharmacy, CFO, COO*	Quarterly		√	√	√
Review of quarterly contract price load *Staff responsible: Director of Pharmacy, System 340B Manager, System 340B Analyst*	Quarterly		√		
Update of prescriber eligibility files with outpatient patient management processing system *Staff responsible: Provider Service Director and EHR IT manager, system 340B manager*	Monthly		√		
Split-Billing software maintenance (CDM-NDC mapping, updates, etc.) *Staff responsible: System 340B Analyst, System 340B Manager*	Daily or Weekly		√		√

b. Quarterly internal audits will be performed by designated pharmacy staff and reviewed by the Director of Pharmacy. AH staff are responsible and accountable for overseeing this review process, as well as taking corrective actions based upon findings.
ii. Mixed- use area/hospital audits:
Audits will include, but not limited to, ensuring the patients meeting 340B eligibility, the charge on administration data is accurate, patient status is outpatient, patient had an order for the medication and was written by an eligible provider and the medication accumulated in the correct account in our virtual inventory records.

2. Reporting Non-Compliance
   a. AH acknowledges that if there is a breach of the 340B requirements, AH may be liable to the manufacturer of the covered outpatient drug that is the subject of the violation, and depending upon the circumstances, may be subject to the repayment of interest and/or removal from the list of eligible 340B entities.
   b. As AH identifies areas/types of non-compliance related to entity eligibility, diversion, or duplicate discount, AH will notify OPA, and any associated drug manufacturers complete with appropriate documentation/records along with a plan for corrective action.

c. Threshold to self-report:
Violations identified through internal self-audits, independent external audits, or other methods that exceed the 5% threshold and remain non-correctable within the entity - defined period timeframe of review, as defined as Material Breach under this Policy, will be immediately reported to HRSA and applicable manufacturers. The Self-Disclosure Tool included in this Policy may be utilized to assist Covered Entity in self-reporting a Material Breach.

References

1. Section 340B of the Public Health Service Act.
2. Apexus 340B University
3. Apexus 340B Tools https://www.apexus.com/solutions/education/340b-tools
4. HRSA Entity Self-Disclosures: https://www.hrsa.gov/opa/self-disclosures/self-disclosure.html
5. Apexus 340B Self disclosure tool: https://www.340bpvp.com/resource-center/340b-tools
6. Apexus 340B Material Breaching threshold: https://www.340bpvp.com/resource-center/340b-tools

Approvals

		System	HH/SLH/JG/FM	Alameda
Departmental	**Date:**	**6/2025**		
Pharmacy and Therapeutics Committee	**Date:**	**6/2025**		
Clinical Practice Council	**Date:**	**7/2025**		
Medical Executive Committee	**Date:**	**7/2025**		
Board of Trustees	**Date:**	**8/2025**		

ALAMEDA HEALTH SYSTEM	Policy	
	340B DRUG PRICING PROGRAM POLICY MANUAL – FREESTANDING CLINICS	**29942 1**
	LEVEL ☐ System ☐ Site	EFFECTIVE DATE: 7/2025 NEXT REVIEW DATE: 7/2028

Table of Contents

Purpose

This Policy Manual contains the written policies and procedures that Alameda Health System uses to oversee 340B Program operations, provide oversight of contract pharmacies, and maintain a compliant 340B Program.

Background

Section 340B of the Public Health Service Act (1992) requires drug manufacturers participating in the Medicaid Drug Rebate Program to sign a pharmaceutical pricing agreement (PPA) with the Secretary of Health and Human Services.

a. This agreement limits the price that manufacturers may charge certain covered entities for covered outpatient drugs.

The 340B Program is administered by the federal Health Resources and Services Administration (HRSA) in the Department of Health and Human Services (DHHS).

Upon registration on the HRSA 340B Database as a participant in the 340B Program, Alameda Health System:

a. Agrees to abide by specific statutory requirements and prohibitions.
b. May access 340B drugs.

340B Policy Statements

Alameda Health System complies with all requirements and restrictions of Section 340B of the Public Health Service Act and any accompanying regulations or guidelines including, but not limited to, the prohibition against duplicate discounts/rebates under Medicaid, and the prohibition against transferring drugs purchased under 340B to anyone other than a patient of the entity. [REFERENCE: Public Law 102-585, Section 602, 340B Guidelines, 340B Policy Releases].

Alameda Health System uses any savings generated from 340B to provide medical services directly to the underserved population of Alameda County.

Alameda Health System has systems/mechanisms and internal controls in place to reasonably ensure ongoing compliance with all 340B requirements.

Alameda Health System maintains auditable records demonstrating compliance with the 340B Program.

a. These reports are reviewed by Alameda Health System every month as part of its 340B oversight and compliance program.

Definitions

Definitions of terms may be found in **340B Glossary of Terms** (https://docs.340bpvp.com/documents/public/resourcecenter/glossary.pdf)

Covered Drug- Wellness clinics do not purchase covered outpatient drugs for its outpatient registered facilities using a Group Purchasing Organization (GPO)

a. The Wellness Clinics interpret the definition of covered outpatient drugs to include – 'An FDA approved prescription drug, an over the counter (OTC) drug that is written on a prescription and a biological product that can be dispensed only by a prescription (other than a vaccine) or FDA-approved insulin.

b. The following drugs and drug categories are excluded from 340B and are GPO exclusion exempt: vaccines, normal saline & water for injection, gases, contrast media/diagnostic agents, large volume fluids without additives, topicals, romiplostim, hyaluronan and hyaluronate derivatives, 503B purchased drugs, cellulose oxidized, state supplied emergency medication (e.g., Covid medications under emergency use approval) manufacturers/labelers that do not participate in 340B program, and bundled items. A detailed list of items and categories can be available through EHR.

References

Each section includes other references to P&Ps, 340B Glossary of Terms, HRSA website, etc. as applicable.

Policy Review, Updates, and Approval

These written policies and procedures will be updated and approved by Alameda Health System staff/committee whenever there is a clarification, or change, in the rules, regulations, or guidelines to the 340B Program requirements. Otherwise, the policy will be reviewed and approved annually.

COVERED ENTITY ELIGIBILITY

Policy: Alameda Health System must meet the requirements of 42 USC §256b(a)(4)(A) to be eligible for enrollment in, and the purchase of drugs through, the 340B Program.

Purpose: To ensure Alameda Health System eligibility to participate in the 340B Program.

Procedure:

1. Alameda Health System basis for 340B eligibility is determined by the following:
    a. Alameda Health System – Eastmont Wellness Center, Hayward Wellness Center, and Newark Wellness Center have a designation as a Federally Qualified Health Center (FQHC) which is consistent with conferring 340B eligibility
        i. The defining legislation for Federally Qualified Health Centers (under the Consolidated Health Center Program) is Section 1905(l)(2)(B) of the Social Security Act.
        ii. Alameda Health System additionally qualifies each Wellness Center through inclusion in our HRSA Scope of Project Form 5A: Services Provided and Form 5B: Service Sites
        iii. AHS reviews Form 5A and 5B on a yearly basis, and as needed, to ensure that each site and service provided at the Wellness Centers is reflected
2. Alameda Health System has identified locations where 340B drugs are dispensed or prescribed:

Within the four walls of the child entities (Eastmont, Hayward, and Newark Wellness Centers)

- Eastmont Wellness Clinic: CH09087B
- Newark Wellness Clinic: CH09087C
- Hayward Wellness Clinic: CH09087W

3. Alameda Health System ensures that the HRSA 340B Database is complete, accurate, and correct for all 340B eligible locations including the parent entity, service sites, and contract pharmacies. [Refer to Alameda Health System Policy and Procedure "340B Program Enrollment, Recertification, and Change Request"].
    a. All service sites that use 340B drugs (as identified in #2 above) are registered on Alameda Health System's HRSA 340B Database.
    b. All main addresses, billing and shipping addresses, the authorizing official, and the primary contact information are correct and up to date.
    c. Alameda Health System regularly reviews its 340B Database records [Refer to Alameda Health System Policy and Procedure "340B Program Compliance Monitoring and Reporting"].
    d. Alameda Health System informs HRSA immediately of any changes to its information by updating the HRSA 340B Database quarterly.

i. See Appendix [1] – HRSA Database Screenshot

https://340bopais.hrsa.gov/

4. Alameda Health System annually recertifies information on HRSA's 340B Database. [Refer to Alameda Health System Policy and Procedure "340B Program Enrollment, Recertification, and Change Request"].

340B PROGRAM ENROLLMENT, RECERTIFICATION, AND CHANGE REQUESTS

Policy: Eligible Federally Qualified Health Centers must be registered on, and maintain the accuracy of, the HRSA 340B Database to participate in the 340B Program.

Purpose: To ensure Alameda Health System registration on, and accuracy of, the HRSA 340B Database.

References:

340B Drug Pricing Program: On-line registration instructions at https://opanet.hrsa.gov/OPA/CERegister.aspx?isnew=true

Registration dates:

- January 1–January 15 for an effective start date of April 1
- April 1–April 15 for an effective start date of July 1
- July 1–July 15 for an effective start date of October 1
- October 1–October 15 for an effective start date of January 1

340B Contract Pharmacy Guidelines https://www.gpo.gov/fdsys/pkg/FR-2010-03-05/pdf/2010-4755.pdf

Procedures:

Enrollment

1. Alameda Health System is eligible to participate in the 340B Program [Refer to Alameda Health System Policy and Procedure "Covered Entity Eligibility"].
2. Alameda Health System has identified upcoming registration dates and deadlines.
3. Alameda Health System has identified authorizing official and primary contact.
4. Alameda Health System has available the required document:
    a. The grant conferring 340B eligibility
5. Alameda Health System has completed registration on the HRSA 340B Database

Recertification Procedure

1. Alameda Health System annually recertifies information on the HRSA 340B Database.
    a. Chief Administrative Officer for Ambulatory completes the annual recertification by following the directions in the recertification email sent from HRSA prior to the stated deadline.

i. Alameda Health System submits specific recertification questions to 340b.recertification@hrsa.gov.

Enrollment Procedure: New Outpatient Facilities

1. Alameda Health System determines that a new service site or facility is eligible to participate in the 340B Program.
    a. The criteria used include that the service site must be identified in the grant, have outpatient drug use, and have patients who meet the 340B patient definition.

Enrollment Procedure: New Contract Pharmacy(ies)

1. Alameda Health System has a signed contract pharmacy services agreement, containing the 12 essential compliance elements in the Contract Pharmacy Guidance, in place between the entity and contract pharmacy prior to registration on the HRSA 340B Database. https://www.gpo.gov/fdsys/pkg/FR-2010-03-05/pdf/2010-4755.pdf
    a. Alameda Health System's legal counsel has reviewed the contract and verified that all federal, state, and local requirements have been met.

2. Alameda Health System has contract pharmacy oversight and monitoring policy and procedure developed, approved, and implemented. [Refer to Alameda Health System Policy and Procedure "Contract Pharmacy Oversight Management"].

3. Alameda Health System's authorizing official or designee completes the online registration during one of four registration windows.
    a. Within 15 days from the date of the online registration, the authorizing official certifies online that the contract pharmacy registration request was completed.
        ii. Contract pharmacy's responsible representative may be the owner, president, CEO, COO, or CFO.

4. Alameda Health System begins using the contract pharmacy services arrangement only on or after the effective date shown on the HRSA 340B Database.

Changes to Alameda Health System's Information in HRSA 340B Database Procedure

1. Alameda Health System notifies HRSA immediately of any changes to Alameda Health System's eligibility to participate in the 340B Drug Program (such as termination of grant or change in designation).
    a. Alameda Health System will stop the purchase of 340B drugs as soon as the change in 340B eligibility is identified. [Refer to Alameda Health System Policy and Procedure "Covered Entity Eligibility"].
    b. Alameda Health System's authorizing official will complete the online change request as soon as a change in eligibility is identified.
        i. Alameda Health System will expect changes to be reflected within two weeks of submission of the changes/requests.

2. Alameda Health System will notify HRSA immediately of any changes to Alameda Health System's information on its HRSA 340B Database. [Refer to Alameda Health System Policy and Procedure "Covered Entity Eligibility"].

3. Alameda Health System's authorizing official will complete the online change request as soon as a change in eligibility is identified.
    a. Alameda Health System will expect changes to be reflected within about 4 weeks of submission of the changes/requests.

PATIENT ELIGIBILITY/DEFINITION

Policy: Per the Final Notice Regarding Section 602 of the Veterans Health Care Act of 1992 Patient and Entity Eligibility, 340B drugs are to be provided only to individuals eligible to receive 340B drugs from covered entities.

Purpose: Alameda Health System ensures that 340B drugs are dispensed/administered/prescribed only to eligible patients.

Definitions:

Administer: Give a medication to an individual, typically in a hospital or a clinic, based on a health care provider's order.

Dispense: Provide a medication, typically in a hospital or a clinic, based on a health care provider's order to be administered to a patient.

Prescribe: Provide a prescription for a medication to an individual to be filled at an outpatient pharmacy.

Procedure:

1. Alameda Health System validates site eligibility.
    a. Refer to Alameda Health System's Policy and Procedure "Covered Entity Eligibility".
    b. All eligibility is verified by HRSA Scope of Services Form 5B

2. Alameda Health System determines patient status.
    a. Patient must be in outpatient status at the time the medication is dispensed/administered at Alameda Health System or a contract pharmacy listed on the HRSA 340B Database.

3. Alameda Health System maintains records of individual's health care.
   a. Freestanding Clinic (Eastmont Wellness, Hayward Wellness, and Newark Wellness) medical records consist of EPIC electronic health records, which are maintained by Alameda Health System.

4. Alameda Health System determines provider eligibility.
   a. Provider is employed by the entity, under contractual or other arrangements with the entity, and the individual receives a health care service (within the scope of grant/designation for which 340B status was conferred) from this professional such that the responsibility for care remains with the entity.
      i. All providers prescribing for 340B eligible patients are employees of Alameda Health System or are contracted through East Bay Medical Group
      ii. Alameda Health System maintains an active eligible provider list through Wellpartner 340B contract pharmacy management system.
         a. Weekly eligibility obtained from current Provider Enrollment Roster search and updated in Wellpartner.
      iii. Wellpartner provider list is part a shared online database with contracted pharmacies listed.
      iv. Eligible provider lists are updated at least monthly and upon notification of provider status changes from the provider or clinic leadership.
      v. Contract Pharmacies have real time online access to eligible provider list through Wellpartner.
      vi. Refer to online Wellpartner 340B contract pharmacy management portal for the location of current eligible provider list.
      vii. Pharmacists and dieticians who are employed by Alameda Health System practice a collaborative practice agreement within an eligible clinic are considered eligible providers.

5. Encounter/prescription eligibility for Disease State management and/or MTM:
   a. The responsibility for the health care service that result in the use of, or prescription for, 340B drugs must remain with covered entity.
   b. Prescriptions will be deemed eligible if they meet one of the following criteria:
      i. A prescription is derived from a qualifying outpatient health care service documented within the previous 36 months from the date of fill.
      ii. A qualifying outpatient health care service occurs within 30 days after the date of fill where the prescription is documented in the service summary.
      iii. The window for establishing 340B eligibility through care provided by The Wellness Clinics is based on a 36 month look back period form the date the prescription is filled.
      iv. Eligible encounter: Any encounter that support a continuing patient-provider relationship may include, but are not limited to office visit, telehealth appointments, refill requests, lab orders, imaging requests, and medication management consults. Any documented interaction that reasonably

demonstrates the patient remains under the ongoing care of the Wellness Clinics maybe considered valid to support 340B eligibility.

6. Alameda Health System determines patient's Medicaid status prior to administration/dispensing [Refer to Alameda Health System's Policy and Procedure "Prevention of Duplicate Discounts"].

PREVENTION OF DUPLICATE DISCOUNTS

Policy: 42 USC §256b(a)(5)(A)(i) prohibits duplicate discounts; that is, manufacturers are not required to provide a discounted 340B price and a Medicaid drug rebate for the same drug. Covered entities must have mechanisms in place to prevent duplicate discounts.

Purpose: To ensure that Alameda Health System is preventing duplicate discounts.

Procedure: ***Alameda Health System has elected to administer 340B drugs to its Medicaid patients (carve-in).***

Medicaid Carve-In

1. Alameda Health System administers 340B purchased drugs to Medicaid patients (carve-in).
    a. Alameda Health System – Eastmont Wellness Center, Hayward Wellness Center, and Newark Wellness Center has answered "yes" to the question, "Will the covered entity dispense 340B purchased drugs to Medicaid patients?" on 340B OPAIS.
2. Alameda Health System – Eastmont Wellness Center, Hayward Wellness Center, and Newark Wellness Center bills Medicaid per state Medicaid reimbursement requirements for all physician-administered medications:
    a. Medicaid Provider Numbers for all state Medicaid agencies billed and applicable National Provider Identifiers (NPIs) for the child sites are listed on the 340B OPAIS Medicaid Exclusion File.
        i. Eastmont Wellness Center:
            1. FQHC – NPI#: 1104959089 MPN: FHC11783G
            2. Family PACT – NPI#: 1750582557 MPN: HAP11783G
            3. Cancer Detection – NPI#: 1841491644 MPN: BCP11783G
            4. Medicare – NPI#: 1932300738 MPN: ZZZ77815Z
        ii. Hayward Wellness Center:
            1. FQHC – NPI#: 1033241633 MPN: FHC11797G
            2. Family PACT – NPI#: 1306047196 MPN: HAP11797G
            3. Cancer Detection – NPI#: 1114128915 MPN: BCP11797G
            4. Meidcare – NPI#: 1023219821 MPN: ZZZ77817Z

iii. Newark Wellness Center:
   1. FQHC – NPI#: 1922131804 MPN: FHC11799G
   2. Family PACT – NPI#: 1689875478 MPN: HAP11799G
   3. Cancer Detection – NPI#: 1770784563 MPN: BCP11799G
   4. Medicare – NPI#: 1497956288 MPN: ZZZ77818Z

b. All billing claims from Alameda Health System containing line items for medications purchased through 340B accounts that are administered to patients during an office visit have a UD modifier added prior to submission
   i. An internal collaborative process, which utilizes both automated and manual practices, ensures that the UD is correctly placed.

c. Alameda Health System maintains a Charge Drug Master (CDM) which contains the 340B purchasing status for all medications available for physician administration at Eastmont Wellness, Hayward Wellness, and Newark Wellness.

3. Alameda Health System informs HRSA immediately of any changes in its MEF information by updating 340B OPAIS before the 15th of the month prior to the quarter when the change take effect (note that this is a different timeframe than quarterly registration).

For example, changes made to 340B OPAIS before March 15 would become effective on April 1.

4. Alameda Health System regularly reviews its 340B OPAIS Medicaid Exclusion File records [Refer to Alameda Health System's Policy and Procedure "340B Program Compliance Monitoring and Reporting."
5. Medicaid reimburses Alameda Health System for 340B drugs per state policy and does not seek rebates on drug claims submitted by Alameda Health System.
6. Wellness clinics do not in the course of regular business bill Out of State Medicaid and Managed Medicaid for 340B drugs for clinic and pharmacy services.

Contract Pharmacies

1. Alameda Health System's contract pharmacies carve-out.

340B PROGRAM ROLES AND RESPONSIBILITIES

Policy: Covered entities participating in the 340B Program must ensure program integrity and compliance with 340B Program requirements.

Purpose: To identify key stakeholders and determine their roles and responsibilities in maintaining 340B Program integrity and compliance.

Procedure:

1. Alameda Health System's key stakeholders' roles and responsibilities with the 340B Program:
    a. Chief Financial Officer and/or VP of Finance:
        i. Responsible as the principal officer in charge for the compliance and administration of the program
        ii. Must account for savings and use of funds to provide care for the indigent under the indigent care agreement
        iii. Responsible for communication of all changes to the Medicare Cost report regarding clinics or revenue centers of the cost report
        iv. Responsible for communication of all changes to Medicaid reimbursement for pharmacy services/products that impact 340B status
    b. Chief Administrative Officer – Ambulatory:
        i. Responsible for attesting to the compliance of the program in form of recertification
        ii. Accountable agent for 340B compliance
    c. System Director of Pharmacy:
        i. Agent of the CFO responsible to administer the 340B program to fully implement and optimize appropriate savings and ensure current policy statements and procedures are in place to maintain program compliance
        ii. Must maintain knowledge of the policy changes that impact the 340B program which includes, but not limited to, HRSA/OPA rules and Medicaid changes
    d. System Ambulatory Care Pharmacy Manager:
        i. Must coordinate constant knowledge of any change in clinic eligibility/information
        ii. Day to day manager of the program
        iii. Responsible for documentation of policy and procedures
        iv. Assure appropriate safeguards and system integrity
        v. Assure compliance with 340B program requirements of qualified patients, medications, providers, vendors, payors, and locations.
        vi. Review and refine 340B cost savings report detailing purchasing, and replacement practices, as well as dispensing patterns
    e. Pharmacy Technician
        i. Responsible for ordering all medications from the specific wholesaler accounts as appropriate
        ii. Manage purchasing, receiving and inventory control processes
        iii. Continuously monitor product min/max levels to effectively balance product availability and cost efficient inventory control
        iv. Monitor ordering processes, integrating most current pricing from wholesaler, analyze invoices, shipping, and inventory processes
        v. Maintain system databases to reflect changes in the drug formulary or product specification
        vi. Responsible for maintenance and testing of Wellpartner 340B management portal

2. Alameda Health System has established a 340B Oversight Committee that is responsible for the oversight of the 340B Program, or other similar oversight process, including that the committee:
    a. Executive Sponsor: COO
    b. Authorizing Officials: CAO Ambulatory, COO AHS
    c. Pharmacy Leaders: System Director of Pharmacy, System Ambulatory Care Pharmacy Operations Mangaer
    d. 340B Pharmacy Technician Support Staff: Freestanding Clinic Pharmacy Technicians
    e. Finance
    f. Compliance
    g. General Counsel

3. Alameda Health System's 340B Oversight Committee:
    a. Meets on a quarterly basis.
    b. Reviews 340B rules/regulations/guidelines to ensure consistent policies/procedures/oversight throughout the entity.
    c. Identifies activities necessary to conduct comprehensive reviews of 340B compliance.

i. Ensure that the organization meets compliance requirements of program eligibility, patient definition, 340B drug diversion, and duplicate discounts via ongoing multidisciplinary teamwork.

ii. Integrate departments such as information technology, legal, pharmacy, compliance, and patient financial services to develop standard processes for contract/data review to ensure program compliance.

    d. Oversees the review process of compliance activities, as well as taking corrective actions based on findings.
        i. 340B Oversight Committee assesses if the results are indicative of a material breach (Refer to Alameda Health System's Policy and Procedure "340B Non-Compliance/Material Breach"].
    e. Reviews and approves work group recommendations (process changes, self-monitoring outcomes and resolutions).

340B PROGRAM EDUCATION AND COMPETENCY

Policy: Program integrity and compliance are the responsibility of all 340B key stakeholders. Ongoing education and training are needed to ensure that these 340B key stakeholders have the knowledge to guarantee compliant 340B operations.

Purpose: To establish 340B education and competency requirements for Alameda Health System's 340B key stakeholders based on their roles and responsibilities in the 340B Program.

Procedure:

1. Alameda Health System determines the knowledge and educational requirements for each 340B Program role [Refer to Alameda Health System's Policy and Procedure "340B Program Roles and Responsibilities"].

2. 340B key stakeholders complete initial basic training upon hire.
    a. Via the link below https://www.brainshark.com/apexus/TopFive340BBasics
    b. Expected to attend 340B University or view the 340B University OnDemand modules on the Apexus website within one year of establishment of 340B role

3. 340B key stakeholders complete additional training as identified in #1 above.

4. Alameda Health System provides educational updates and training, as needed based upon 340B policy and procedure changes, updates in HRSA guidance, changes of roles and responsibilities.

5. Alameda Health System conducts annual verification of 340B Program competency. See Appendix [2]

6. Training and education records are maintained per organizational policy and available for review.

INVENTORY MANAGEMENT

Policy: Alameda Health System must be able to track and account for all 340B drugs to ensure the prevention of diversion.

Purpose: Ensure the proper procurement and inventory management of 340B drugs.

Background:
340B inventory is procured and managed in the following settings:

- Clinic site administration
- Contract pharmacies

Inventory methods for each of the above areas within the entity shall be described within the inventory management policy and procedure.

Alameda Health System uses one of the following inventory methods at each of the above named settings:

a. Stocks only 340B inventory – Clinic site.
b. Electronically (virtual) separates 340B and non-340B purchased inventory – Contract Pharmacies

c. In extraordinary circumstances, if a non-340B purchased drug is procured in the clinic sites, AHS will maintain physically separated inventory.

Pharmacists and technicians dispense 340B drugs only to patients meeting all the criteria in [Refer to Alameda Health System's Policy and Procedure "Patient Eligibility/Definition"].

References:
Apexus Tool: 340B Compliance and the Controlled Substance Ordering System (CSOS) may be used to articulate compliance solutions in this area:
https://docs.340bpvp.com/documents/public/resourcecenter/340B_Compliance_CSOS.pdf

Procedure:

Physical inventory (340B only) is maintained at Alameda Health System Freestanding Clinics (Eastmont Wellness, Hayward Wellness, Newark Wellness)

1. Alameda Health System identifies all Wholesaler accounts used for purchasing drugs for clinic administration.

2. Alameda Health System maintains only 340B inventory in its floor stock/clinic medication rooms at each clinic site. Vaccine products are excluded from 340B drug purchasing and inventory at each clinic site.

3. Alameda Health System Pharmacists or Pharmacy Technicians perform regular inventory reviews and shelf inspections of periodic automatic replenishment (PAR) levels to determine daily purchase order. Nursing staff will notify appropriate pharmacy staff when floor stock medication is out or below PAR levels to assist in timely ordering of medication for clinic administration.

4. Alameda Health System Pharmacy Technician support staff place 340B inventory replenishment orders from Cardinal Wholesaler as needed based on inventory reviews and shelf inspections.

5. A pharmacist, pharmacy technician, registered nurse, physician, or Advanced Practice Provider will sign in for the medication received. Documentation of receipt will include the following:
   a. The date and time delivery was received
   b. Description of medication /supplies received
   c. Quantity of delivered items
   d. Signature and title of person receiving and logging in delivery.

6. Alameda Health System verifies quantity received with quantity ordered.

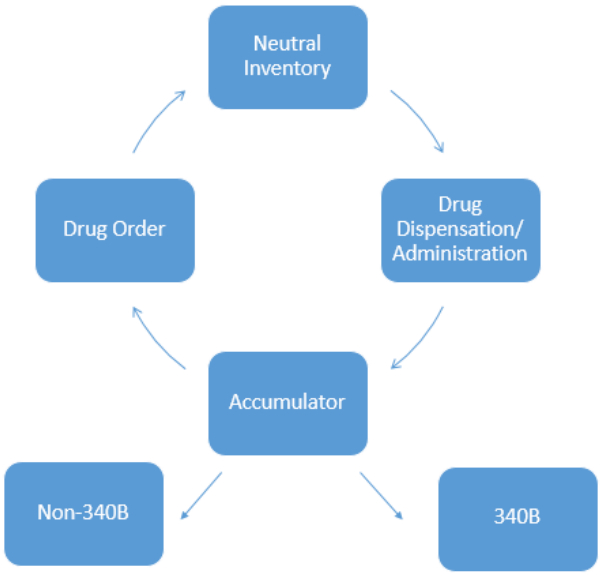
a. Identifies inaccuracies between online Wholesaler order and received invoice upon delivery.
b. Reports and resolves inaccuracies with the Wholesaler.
c. Documents resolution of inaccuracies on the invoice or through other written or electronic communication with the Wholesaler.

7. Alameda Health System maintains records of 340B-related transactions for a period of 5 years in a readily retrievable and auditable format. Online Wholesaler orders are kept electronically through the Cardinal Health account. Receipt/invoice physically stored on site for a period of 5 years.
   a. Random audits of these records are reviewed by Alameda Health System monthly as part of its 340B oversight and compliance program.

8 Wasted/Expired 340B medication:

a. Wellness Clinic pharmacy staff documents destroyed or wasted drugs.
b. Wellness Clinic pharmacy staff monitors unreconciled dispenses and wastes on a monthly basis.

Inventory replenishment system (340B/non-340B) is maintained at Contract Pharmacies



1. Wellpartner – 340B Management 3rd party vendor identifies all accounts used for purchasing drugs at contract pharmacies for 340B and non-340B.
2. Alameda Health System purchases inventory according to eligible accumulations for 340B replenishment at contract pharmacies.
3. Contract Pharmacies dispense drugs to patients.

4. 340B Management Software (Wellpartner) accumulates drug utilization based upon patient eligibility including service location and provider information. This accumulation occurs at the 11-digit NDC level and a full package size will be accumulated before replenishment by the 340B administrator at each site.

340B	Non-340B
Patients met 340B patient definition and received services on an outpatient basis in a 340B registered/participating hospital clinic	-Products that do not have an 11-digit NDC match on the 340B contract but are otherwise eligible for 340B purchase -Products that currently are not available (e.g., drug shortages) such that an 11-digit NDC match is not available -Products for Medicaid eligible patients

CONTRACT PHARMACY OPERATIONS

Policy: Alameda Health System remains responsible for ensuring that its contract pharmacies operations comply with all 340B Program requirements, such that the covered entity remains responsible for the 340B drugs it purchases and dispenses through a contract pharmacy.

Purpose: To ensure that Alameda Health System remains responsible for all 340B drugs used by its contract pharmacies.

Reference:

Federal Register / Vol. 61, No. 165 / Friday, August 23, 1996 / Notices
https://www.gpo.gov/fdsys/pkg/FR-2010-03-05/pdf/2010-4755.pdf

Background:

Alameda Health System uses contract pharmacy services in accordance with HRSA requirements and guidelines.

Alameda Health System has obtained sufficient information from the contract pharmacy contractor to ensure compliance with applicable policy and legal requirements.

The signed contract pharmacy services agreements comply with 12 contract pharmacy essential compliance elements.

Procedure:

1. Alameda Health System contracts with Wellpartner to facilitate both the design and implementation of the 340B contract pharmacy program.

2. Alameda Health System has a written contract in place for each contract pharmacy location:
    a. Garfield Beach CVS, L.L.C. DBA: CVS Pharmacy # 8431 – 7200 Bancroft Ave, Oakland, CA 94605
    b. Longs Drug Stores California, L.L.C. DBA: CVS Pharmacy # 9635 – 1550 E 14th St, San Leandro, CA 94577
    c. Longs Drug Stores California, L.L.C. DBA: CVS Pharmacy # 9622 – 243 W Jackson St, Hayward, CA 94544
    d. Longs Drug Stores California, L.L.C. DBA: CVS Pharmacy # 9494 – 35080 Newark Blvd, Newark, CA 94560

3. Alameda Health System registers each contract pharmacy location on the HRSA 340B Database prior to the use of 340B drugs at that site.

4. Alameda Health System uses a replenishment model using an 11-digit to 11-digit NDC match.
    a. Non-replenishment 340B inventory is never stored at CVS contract pharmacies, as all 340B stock is supplied through the replenishment model.
5. 340B-eligible prescriptions are presented to CVS contract pharmacies via (e-prescribing, hard copy, fax, or phone).
    a. CVS staff verify patient, prescriber, and outpatient clinic eligibility via the Wellpartner online portal.
    b. Updates are made to this mechanism by Alameda Health System Pharmacy Technician 340B support staff yearly or on demand based on patient, provider, or contract pharmacy request.

6. CVS contract pharmacies dispense prescriptions to 340B eligible patients using CVS non-340B drugs.

7. Alameda Health System implements a bill-to, ship-to arrangement with the contract pharmacies.
    a. CVS contract pharmacies order 340B drugs on behalf of AHS, based on eligible accumulation, as determined by the Wellpartner portal, through Cardinal Health Wholesaler.
        i. Orders are triggered by the usage of package size of covered drugs determined by 11-digit NDC
        ii. Replenishment orders through Cardinal Wholesaler Order Express occur daily (Monday through Friday)

iii. Wholesaler notifies Alameda Health System Staff of medications shipped to CVS contract pharmacies.

b. Invoices are billed to Alameda Health System.

8. CVS contract pharmacies receive 340B drug shipment. Orders are received by a Pharmacist, Pharmacy Technician, or other CVS authorized pharmacy staff.

9. CVS contract pharmacies verify quantity received with quantity ordered.
   a. Identifies inaccuracies.
   b. Resolves inaccuracies with Wholesaler.
   c. Documents resolution of inaccuracies.

10. CVS contract pharmacies/Wellpartner notifies Alameda Health System if CVS doesn't receive 11-digit NDC replenishment order within 90 days of original order fulfillment request.
    a. AHS will reimburse CVS Contract Pharmacies for the cost of such drugs (true-up)

11. Alameda Health System reimburses CVS contract pharmacies at a pre-negotiated rate per fill for such drugs.

12. Alameda Health System is able to review the invoice for drugs shipped to its contract pharmacies through Wellpartner 340B management online portal.

13. Alameda Health System pays invoice to Cardinal for all 340B drugs.

14. CVS contract pharmacies (through Wellpartner online portal) provide Alameda Health System access to all pertinent reimbursement accounts and dispensing records.
    a. Pharmacy Technician 340B support staff retrieve and review 340B purchases twice monthly (1st and the 15th of each month)

15. CVS contract pharmacies adjust claims when variance or discrepancy has occurred.
    a. CVS uses approved methods with knowledge and agreement of Alameda Health System regarding reconciliation between inventory and invoices with adjustments as necessary to match NDC or cost changes.
    b. Claim adjustments may occur only within 30 days of original billing and not without prior notice and approval of Alameda Health System.

16. CVS contract pharmacies will not use 340B drugs for Medicaid patients (carve-out):
    a. CVS contract pharmacies will only dispense 340B drugs to patients who are eligible in the Wellpartner 340B management online portal.
    b. Eligible patients include only those who have active HealthPAC coverage. This is a Health Program of Alameda County that provides medical and prescription coverage to those who:

i. Are residents of Alameda County
ii. Have a gross monthly income at or below the 200% Federal Poverty Level
iii. Not be enrolled or eligible for full-scope Medicaid coverage
iv. Not be enrolled in a private or employer-based insurance

c. Wellpartner does not count 340B drug accumulation for Medicaid patients and therefore prevent(s) duplicate discounts for outpatient prescriptions, including those that are billed to the AIDS Drug Assistance Program (ADAP).

340B NONCOMPLIANCE/ MATERIAL BREACH

Policy: Alameda Health System is responsible for contacting HRSA as soon as reasonably possible if there is any material breach or any instance of noncompliance with any of the 340B Program requirements.

Purpose: To define Alameda Health System's material breach of 340B compliance and self-disclosure process.

Definitions:

Materiality: A convention within auditing/accounting pertaining to the importance/significance of an amount, transaction, and/or discrepancy.

Threshold: The point that must be exceeded, as defined by the covered entity, resulting in a material breach.

Reference:
340B University: Defining Material Breach Documentation Tool
https://docs.340bpvp.com/documents/public/resourcecenter/Establishing_Material_Breach_Threshold.pdf

Procedure:

1. AHS defines a material breach of compliance that would require self-disclosure as (1) a violation(s) that exceeds 5% of total clinic drug purchases or contract pharmacy spend and (2) remain non-correctable within 30 days.
    a. Alameda Health System ensures that identification of any threshold variations occurs among all its 340B settings, including the Freestanding Clinics (Eastmont Wellness, Hayward Wellness, Newark Wellness) and CVS contract pharmacies.

2. Alameda Health System assesses materiality:
    a. Violations identified through internal self-audits, independent external audits, or other methods that exceed the 5% threshold and remain non-correctable within the entity-defined period timeframe of review, will be immediately reported to HRSA and applicable manufacturers.

b. Pharmacy Technician 340B support staff will coordinate assessment with necessary parties (including but not limited to Wellpartner, CVS Contract Pharmacies, AHS 340B Financial Department representatives, clinic staff, and the 340B oversight committee)
a. Alameda Health System maintains records of materiality assessments for a minimum of 5 years.

3. Alameda Health System reports identified material breach immediately to HRSA and applicable manufacturers.
    a. Alameda Health System acknowledges that if there is a breach of the 340B requirements, it may be liable to the manufacturer of the covered outpatient drug that is the subject of the violation, and depending upon the circumstances, may be subject to the payment of interest and/or removal from the list of eligible 340B entities.
    b. As Alameda Health System identifies areas of non-compliance or material breach it will notify OPA and any associated drug manufacturers complete with appropriate documentation/records along with a plan for corrective action.
    c. Maintain records of material breach violations, including manufacturer resolution correspondence, as determined by organization policy.

340B PROGRAM COMPLIANCE MONITORING AND REPORTING

Policy: Alameda Health System is required to maintain auditable records demonstrating compliance with 340B Program requirements.

Purpose: To provide an internal monitoring program to ensure comprehensive compliance with the 340B Program.

Procedure:

1. Alameda Health System has developed an internal audit plan approved by the internal compliance officer or as determined by organizational policy.
2. Alameda Health System and the 340B Oversight Committee annually reviews the following items to ensure the accuracy of the information for the parent site and contract pharmacies:
    a. HRSA 340B Database
    b. HRSA Scope of Services Form 5A and 5B
    c. 340B Policies and Procedures
    d. Contracts with outside pharmacies
    e. Employee education compliance

3. Alameda Health System audits purchasing records, dispensing records, and patients' health care records monthly to ensure that covered outpatient drugs purchased through the 340B Program are prescribed by eligible providers, dispensed or administered only to patients eligible to receive 340B drugs and that any variances are not the result of diversion

a. Pharmacy Technician 340B support staff performs a monthly random audit of 10-20 high cost/random prescriptions using the Wellpartner 340B management online portal self-audit tool and clinic records for each site, which includes Cardinal purchasing records.

4. Alameda reconciles dispensing records and Medicaid billing practices to demonstrate that Alameda Health System practice is following the Medicaid billing question on the HRSA 340B Database (carve-out)

5. Alameda Health System 340B Oversight Committee reviews the internal audit results quarterly.
   a. Committee to assess if audit results are indicative of a material breach [Refer to Alameda Health System's Policy and Procedure "340B Noncompliance/Material Breach"].

6. Alameda Health System maintains records of 340B-related transactions for a period of 5 years in a readily retrievable and electronic auditable format located on the Alameda Health System shared drive.

CONTRACT PHARMACY OVERSIGHT AND MONITORING

Policy: Alameda Health System is required to provide oversight of their contract pharmacy arrangements to ensure ongoing compliance. The covered entity has full accountability for compliance with all requirements to ensure eligibility and to prevent diversion and duplicate discounts. Auditable records must be maintained to demonstrate compliance with those requirements.

Purpose: To ensure that Alameda Health System maintains 340B Program integrity and compliance at its CVS contract pharmacies.

Reference:
Federal Register / Vol. 75, No. 43 / Friday, March 5, 2010 / Notices
https://www.gpo.gov/fdsys/pkg/FR-2010-03-05/pdf/2010-4755.pdf

Procedure:

1. Alameda Health System conducts monthly internal reviews of each registered contract pharmacy for compliance with 340B Program requirements. The following elements will be included when conducting self-audits of contract pharmacies to ensure program compliance:
   a. Prescription is written from a site of care that is registered on the HRSA 340B Database
   b. Patient eligibility: The episode of care that resulted in the 340B prescription is supported in the patient's medical record.

c. Provider eligibility: The prescribing provider is employed, contracted, or under another arrangement with the Alameda Health System at the time of writing the prescription so that the entity maintains responsibility for the care.
d. An 11-digit NDC match can be documented for accumulation and/or replenishment of a 340B dispensation (virtual inventory).
e. Alameda Health System can document that no prescriptions processed had Medicaid listed as the primary payer.

2. Alameda Health System conducts independent audits of each registered contract pharmacy for compliance with the 340B Program requirements.
   a. Independent audits will include reviews of:
      i. 340B eligibility.
      ii. 340B registration.
      iii. Documented policies and procedures.
      iv. Inventory, ordering, and recordkeeping practices for all 340B accounts.
      v. Testing of claims sample to determine any instance of diversion or duplicate discounts in a set period of time.

3. Alameda Health System has mechanisms in place to demonstrate compliance with all state Medicaid billing requirements to prevent duplicate discounts at all sites. All clinic sites and Contract Pharmacies are Medicaid Carve-out.

4. Alameda Health System 340B Oversight Committee reviews independent audit results at quarterly committee meetings.
   a. Assess if audit results are indicative of a material breach [Refer to Alameda Health System's Policy and Procedure "340B Noncompliance/Material Breach"].

5. Alameda Health System maintains records of 340B-related transactions for a period of 5 years in a readily retrievable and auditable format located on the Alameda Health System shared drive.

PRIME VENDOR PROGRAM (PVP), ENROLLMENT, AND UPDATES

Policy: The purpose of the Prime Vendor Program (PVP) is to improve access to affordable medications for covered entities and their patients.

Purpose: Assist Alameda Health System's participation in the PVP to receive the best 340B product pricing, information, and value-added products.

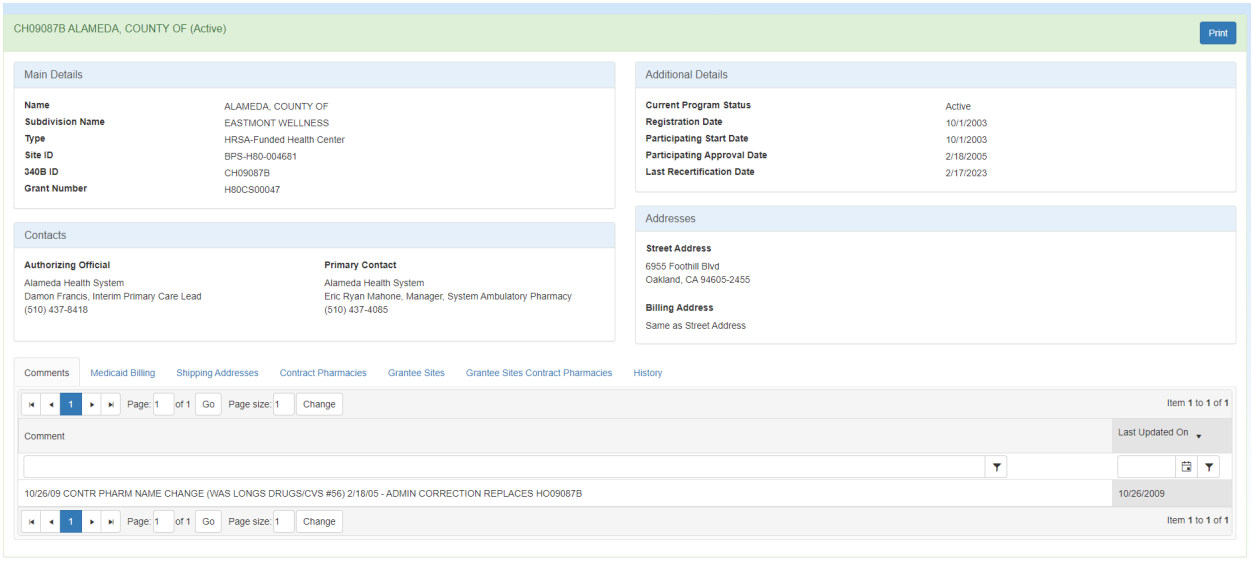
Procedure:

Enrollment in PVP:

1. Alameda Health System has completed online 340B Program registration with HRSA for Eastmont Wellness, Hayward Wellness, and Newark Wellness.

Update PVP Profile:

1. Alameda Health System will update PVP profile yearly through accessing https://members.340bpvp.com/webMemberProfile.aspx.
    a. Find a list of your facilities.
        i. Click on the 340B ID number hyperlink to view or change profile information for that facility.
    b. Update HRSA Information:
        i. Complete the 340B Change Form as detailed above.
            a) After the HRSA 340B Database has been updated, the PVP database will be updated during the nightly synchronization.
2. Alameda Health System updates the 340B Prime Vendor Program (PVP) Participation Information yearly for Eastmont Wellness, Newark Wellness, and Hayward Wellness.



Approvals:

		System
System Pharmacy & Therapeutics	Date:	6/2025
Clinical Practice Committee	Date:	7/2025
Medical Executive	Date:	7/2025
Board of Trustees	Date:	8/2025

AVOIDING DUPLICATE PRN "As Needed" POLICY

Site	Alameda Health System	***Previous Revision Dates***	
Effective Date	7/2025	***Date Revised:***	6/2025
Document Owner	MGR SYS MED SAFETY-CLIN PHARM	**Next Review Date:**	6/2028
Executive Responsible	DIRECTOR, PHARMACY		

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PURPOSE

To identify medications and their PRN indication, to allow timely processing of medication orders, and to reduce the need for order clarifications in order to ensure patient medication safety.

POLICY STATEMENT

PRN, or "As Needed" medication orders are orders which are administered based on the occurrence of a specific indication or symptom. The Alameda Health Systems Pharmacy Services will, with the approval of the Pharmacy & Therapeutics Committee, identify certain medications and their PRN indication. The Department of Pharmacy Services will maintain and update this list as needed.

PROCEDURE

1. All PRN orders shall contain the following information:
   a) Name of medication
   b) Route
   c) Strength
   d) Frequency (if order without frequency is from an orderset, exclude those from this P&P. Submit request to change orderset as needed instead)
   e) Indication (and parameter if appropriate, e.g. SBP, HR, etc.)
   i.e. Mylanta 30ml PO Q4HR PRN Cramping

2. All PRN orders without specific name, strength, and frequency will be clarified by a pharmacist with the physician and reordered in the electronic health record.

3. All PRN medication orders must contain indications for use. If not stated in the original physician's order, the following indications for use will automatically be interpreted for each drug using Table 1.

4. PRN orders without an indication for medications that are not on Table 1 below will be clarified by a pharmacist with the physician and documented in the electronic health record.

5. PRN orders with therapeutic duplication, **overlapping** pain score, or broad indication will be assigned a ranking order (e.g. 1st line, 2nd line, 3rd line) based on route of administration and whether it is a narcotic or non-narcotic in the following sequence:
Exclude PACU/Surgery orders for priority rankings

a) Non-narcotics will have priority ranking over narcotics.

- Example: Orders written for "Tylenol 650mg PO q4h prn mild pain" and "Norco 1 tab PO q4h prn mild pain." Tylenol will be 1st line and Norco will be 2nd line

b) Oral medications will have priority ranking over IV medications regardless of potency. Add a note to the IV medication to use IV when NPO or if failed PO

- Example: Pain medications written for "Norco 1 tab PO q4h prn severe pain" and "Dilaudid 0.2mg IV q2h prn severe pain." Norco will be 1st line and Dilaudid will be 2nd line.
- Example: MD ordered PO and IV prochlorperazine, PO is 1st line and IV is used 2nd line when pt NPO or if failed PO

c) Oral and IV medications will have priority ranking over suppositories; suppositories will have priority ranking over enemas

- Example: Orders written for "Senna 2 tabs PO qhs prn constipation," "Bisacodyl 10mg suppository PR qhs prn constipation," and "Mineral Oil PR qhs prn constipation." Senna will be 1st line , Bisacodyl will be 2nd line, andMineral Oil will be 3rd line.
- Example: MD ordered PO, IV and PR prochlorperazine, PO is 1st line and IV is 2nd line used when pt NPO or if failed PO and PR is 3rd line

d) Over the counter (OTC) medications will have priority ranking over prescription medications.

- Example: Orders written for "Lomotil 1 tab PO TID prn diarrhea" and "Loperamide 2mg QID prn diarrhea." Loperamide will be 1st line and Lomotil will be 2nd line.

e) Assign higher ranking to therapies prescribed first when there is overlapping indications (timing rule)

- Example: Docusate order 09/30/21 2030 vs senna order 10/01/21 0140. Docusate will be 1st line and senna will be 2nd line .

Table 1: Drugs and Indications for use

Drug	Indications for Use	Ranking Orders
Acetaminophen (Tylenol®)	Pain, Headache, Fever	PO> IV > PR
Acetaminophen/Hydrocodone (Norco®), Acetaminophen/Oxycodone (Percocet®), Aspirin/Oxycodone (Percodan®), Hydromorphone (Dilaudid®), Ketorolac (Toradol®), Meperidine (Demerol®), Morphine, Tramadol	Pain	OTC > Non-narcotic > Narcotic Then PO > IV Then Timing
Albuterol, Atrovent, Levalbuterol (Xopenex®), or combination	Wheezing, shortness of breath (SOB)	Call Provider to clarify
Artificial Tears and ointment	Dry Eyes	Call Provider to clarify, should not be ordered together
(Atropine sulfate/diphenoxylate (Lomotil®), loperamide (Imodium®)	Diarrhea, high osteomy output	If indication is for high osteomy output, exclude from this P&P and call Provider to clarify
Aluminum hydroxide/magnesium hydroxide (Maalox®, Mylanta®)	Cramping, indigestion, heartburn	Call Provider to clarify, should not be ordered together
Bisacodyl (Dulcolax®), Docusate, Magnesium hydroxide (MOM), Senna, Senna/Docusate, lactulose, PEG 3350 (Miralax)	Bowel management	PO > PR and timing If those that are equivalent ranking are prescribed at the same time, call Provider to clarify
Guaifenesin (Robitussin®), Oral Antitussive Preparations	Cough	Forms without codeine > those with codeine Then Timing
Lorazepam (Ativan®), midazolam	Anxiety, agitation	PO > IV and timing Call Provider to clarify if both meds prescribed for the same indication at the same time to prioritize
Menthol (Cepacol®), phenol (chloraseptic) spray, lidocaine viscous	Sore throat	Timing
Metoclopramide (Reglan®), Ondansetron (Zofran®),	Nausea/Vomiting	PO > IV > PR And

Prochlorperazine (Compazine®), Promethazine (Phenergan®)		Timing
Nitroglycerin SL or spray	Chest Pain	Call Provider to clarify, should not need both
Oxymetazoline Nasal Spray (Afrin®), Phenylephrine Nasal Spray	Congestion	Timing
Simethicone (Mylicon®, Gaviscon®)	Flatulence	N/A
Temazepam (Restoril®), Triazolam, Zolpidem (Ambien®),1) Melatonin, Diphenhydramine,	Sleep	Melatonin > Diphenhydramine > Zolpidem > Temazepam = Triazolam if prescribed at the same time, otherwise use timing rule

REFERENCES

Title 22 CCR, section 70263 (g)
The Joint Commission 2018, MM.04.01.01

APPROVALS

Pharmacy Department	**Date: 6/2025**
System Pharmacy and Therapeutics	**Date: 6/2025**
CPC	**Date: 7/2025**
Medical Executive Committee	**Date: 7/2025**
Board of Trustees	**Date: 8/2025**

ALAMEDA HEALTH SYSTEM

MEDICATIONS: SELF-ADMINISTRATION POLICY (AHS)

Campus	AHS System	***Effective Date***	03/2018
Document Owner	Medication Safety Officer	***Date Revised***	2/2021, 6/2025
		Next Scheduled Review	6/2028
Executive Responsible	System Director, Pharmacy		

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POLICY

It is the policy of AHS that the self-administration of medications by patients is not allowed **unless** there is an approved protocol or signed order authorizing the self-administration. There are circumstances where it is advantageous for certain patients to self-administer their medications while under the supervision of hospital staff. This policy ensures that those medications are adequately stored between doses and that the self-administration is properly monitored.

This policy excludes self-administration of medications through an Implantable Infusion Pump.

PROCEDURE

1. Self-administration of medications must be approved by the patient's provider or care team and the patient (or caregiver) must demonstrate their competence to do so with nursing.

2. In addition to general evaluation of decision-making capacity, the staff and practitioner will perform a more specific skill assessment, including (but not limited to) the patient's:
   a. Ability to read and understand medication labels;
   b. Comprehension of the purpose, proper dosage and administration time for his or her medications;
   c. Ability to remove medications from a container and to ingest and swallow (or otherwise administer) them; and
   d. Ability to recognize risks and major adverse consequences of his or her medications.
   e. For parenteral medications, the ability to follow appropriate sterile technique in handling the medication, any associated equipment, and the administration point.

3. Any patient considered to be at risk for self-harm, or with a known or suspected history of substance abuse or diversion may be considered inappropriate to self-administer medications.

4. Medications will not be stored within patient's room. All medication must be stored in medication rooms, carts and/or automatic dispensing machines as deemed appropriate by pharmacy and nursing staff. All medications will be provided to the patient by the nurse in accordance with the medication orders. (except Medicinal Cannabis use under SB311)

5. Self-administration of medications must be observed by a nurse to ensure appropriate use.
   a. Nursing will document medication administration in the Medication Administration Record as administered by other after self-administration is observed.
   b. Nursing will correct any inappropriate administration techniques.

6. Effects of medications must be documented in the usual manner.

7. Ongoing appropriateness of self-administration will be assessed on a continual basis. If at any time, nursing staff question the ability of the resident to safely self-administer medications, he or she will convey this concern to the attending physician immediately for re-evaluation.
   a. For SNF, assessment for appropriateness will be at least quarterly during the patient's quarterly care conference and more often if a change in the patient is identified.

REFERENCES

1. 42 CFR483.10 (n)

2. TJC MM 06.01.03 EP 2

APPROVALS

		System	Alameda
Pharmacy Department	**Date:**	6/2025	
Pharmacy and Therapeutics (P&T)	**Date:**	6/2025	
Clinical Practice Council (CPC)	**Date:**	7/2025	
Medical Executive Committee	**Date:**	7/2025	
Board of Trustees	**Date:**	8/2025	

ALAMEDA HEALTH SYSTEM	Policy	
	MEDICATION CARTS, KITS AND TRANSPORT BOXES FOR SPECIFIC DEPTS. AND DIVISIONS	**29923 1**
	LEVEL ☐ System ☐ Site	EFFECTIVE DATE: 6/2025

Policy

To provide access and storage to medications in boxes or kits to specific areas where Automated Dispensing Machines (ADM, e.g. Pyxis) are not accessible and/or certain specific drugs are not included in crash carts. These departments/divisions may include however not limited to Allergy Clinic, Anesthesiology, Cardiology, Diagnostics, Oral Surgery, Operating Room, Emergency Department, and Radiology.
Other medication kits are assembled and put in ADM by pharmacy for the ease of removal under specific situations.

Procedures

A. Preparation

1. Pharmacy staff fills medications listed in the boxes and kits. Non-medicinal supplies in oral surgery boxes are filled by the Oral Surgery division.
2. Pharmacy staff records expiration dates of mediations on the content list.
3. Pharmacy staff who prepares the box or kit will sign and date on the content list.
4. Pharmacist will check all medications against the content list for correct quantity and expiration.
5. Pharmacist will sign and date the content list after checking the box or kit.
6. The signed and dated content list will be put inside the box or kit.
7. A copy of this content list can be put outside the box or kit. Or a sticker with the name of earliest expired drug and expiration date will be put outside the box or kit. This is to identify when to replace the content of the box or kit.
8. Pharmacy will put a tamper resistance lock on the checked box or kit to ensure the box or kit is secured before being dispensed.

B. Dispensing

1. When a box or kit is needed for a procedure by a department/division, the department/division staff will come to pharmacy to pick up the specific box or kit.
2. Pharmacy staff, before dispensing the box or kit, will make sure the lock is secured and medications are not expired.
3. Pharmacy staff fills out the dispensing log to indicate when and where the box/kit is dispensed.

C. Storage

1. Each department/division is responsible for storing the box/kit in an area where direct supervision of its usage is allowed until the procedure is complete.
2. Anesthesia department, oral surgery division and radiology department will store the boxes/kits in their areas until replacement.
3. Such storage areas should be easily monitored by the department or division staff to prevent unauthorized usage.

D. Administering and Returning
   1. When a medication is needed, the department staff will break the lock to open the box or kit.
   2. The department/division staff will put the patient addressograph sticker on the content list for subsequent billing by pharmacy.
   3. The department/division staff will return the used box or kit with the patient stamped content list to pharmacy for replacement.
   4. In the situation where the lock is found broken in the department/division, but medications are not used, the box or kit should be returned to pharmacy for checking.

E. Replacement
   1. Pharmacy will follow the procedures under "Preparation" in this policy to replace and refill any medications used in the box or kit that is returned from the department/division.

F. Medication kits stored in Automated Dispensing Machine (ADM, e.g. Pyxis)
   1. These kits are assembled in pharmacy and checked by pharmacist before putting in ADM.
   2. Kits are removed from ADM according to the ADM procedure.
   3. A refill or stock out report will be printed in the pharmacy to prompt for replacement.
   4. Used kits should be placed in the "return to pharmacy" bin for pick up and return to pharmacy.

APPROVALS

		System	Alameda	AHS/Highland/John George/San Leandro
Pharmacy and Therapeutics (P&T)	**Date:**	6/2025		
Clinical Practice Council (CPC)	**Date:**	7/2025		
Medical Executive Committee	**Date:**	7/2025		
Board of Trustees	**Date:**	8/2025		

ALL Acute Care Medication Carts and Kits

Department/Divisions	Name of Emergency Box/Kit	Page
Radiology	Radiology Contrast Allergic Reaction Kit	3
Critical Care	RSI kit	3
Employee Health Kit	Adult Anaphylaxis Kit	4
Anesthesia	Anesthesia Support Kit	

Radiology Contrast Allergic Reaction Kit

Medication	Quantity	Expiration
Diphenhydramine Inj. 50 mg/ml 1 ml Vial	1	
Epinephrine Inj. 1 mg/ml (1:1000) 1 ml Vial (in light protection bags)	2	
Methylprednisolone Inj.125 mg Vial	1	

Epinephrine Dosing: Hypersensitivity Reaction (e.g. anaphylaxis):
IM administration in the anterolateral aspect of the middle third of the thigh is preferred in the setting of anaphylaxis. Subcutaneous administration results in slower absorption and is less reliable.

IM (preferred anterior thigh): **Adults:** 0.3 to 0.5 mg (0.3 to 0.5 ml) of 1 mg/ml solution every 5 to 15 minutes. **Peds:** 0.01 mg/kg (Max 0.3 mg) of 1 mg/ml solution (AAAAI [Lieberman 2015]; AHA [Vanden Hoek 2010]; WAO [Kemp 2008])

Rapid Sequence Intubation (RSI) Kit

Quantity	Medication	Expiration
1	Etomidate 2 mg/ml vial (total 10 mL)	
1	Rocuronium 10 mg/ml vial (total 10 mL)	
2	Succinylcholine 20 mg/ml inj (total 10 mL)	

Employee Health Adult Anaphylaxis Kit

Quantity	Medication	Expiration date
2	Diphenhydraime 25mg caps	
1	EpiPen 0.3mg/0.3mL prefilled syringe	
1	BD syringe, Leur-lok (1 ml syringe)	
1	BD Eclipse 25G needle	
2	Isopropyl alcohol 70% prep pads	

Anesthesia Support Kit

Quantity	Medication	Expiration
1	Ephedrine 50 mg/ml (1 ml) vial/ampule	
1	Etomidate 2 mg/ml (10 ml) vial	
1	Norepinephrine 1 mg/ml (4 ml) ampule	
1	Propofol 10 mg/ml (20 ml) vial	
1	Rocuronium 10 mg/ml (10 ml) vial	
1	Succinylcholine 20 mg/ml (5 ml) syringe	

Back up medications for situations like power outage and Pyxis failure. The kit is stored in a locked box.

Wilma Chan Highland Hospital Medication Carts and Kits

Anesthesia Intubation Kit (to be put in Anesthesia Airway Backpack)

Drug	Quantity	Expiration
Atropine Inj. 0.1 mg/ml 10 ml syringe	1	
Epinephrine Inj. 0.1 mg/ml (1:10,000) 10 ml syringe	1	
Etomidate Inj. 2 mg/ml 10 ml vial	1	
Phenylephrine Inj. 100 mcg/ml 10 ml syringe	1	
Propofol Inj. 10 mg/ml 20 ml vial	2	
Rocuronium Inj. 10 mg/ml 10 ml vial	1	
Succinylcholine Inj. 20 mg/ml 5 ml syringe	1	
Sugammadex 100 mg/ml 5 ml vials	3	

Cardiac CT Scan/Nuclear Medicine Box

Drug	Quantity	Expiration
Albuterol Inhaler 90 mcg/puff 8 gm inhaler	1	
Aminophylline Inj. 25mg/ml 10 ml vial	2	
Caffeine inj 60mg/3mL	1	

Electrocardiography (EKG) Kit

Medication	Strength	Quantity	Expiration
Atropine inj	1mg/1mL Vial	1	
Diphenhydramine inj.	50 mg/1 ml Vial	1	
Metoprolol inj.	5 mg/5 ml Vial	1	
Nitroglycerin SL tablet	0.4 mg	2 bottles (25 tabs/bottle)	

HEART ALERT (STEMI) Kit

(STEMI = ST-Elevation Myocardial Infarction)

Medication Name	Dose Given	Time	Route	Documented in MAR	Quantity in Kit	Exp. Date	Quantity Used
Atropine Inj 1mg (0.1 mg/ml) 10 ml prefilled syringe				☐	1		
Epinephrine Inj 1mg (1:10,000) 10 ml prefilled syringe				☐	1		
Amiodarone Inj 150mg (50mg/ml) 3 ml vial				☐	2		
Diphenhydramine Inj 50mg/ml 1 ml vial				☐	1		
Nitroglycerin 0.4 mg sublingual tablets				☐	1 bottle		

ADULT TRANSPORT/CODE BOX

Generic drug name	Quantity
Atropine 1mg/10mL syringe	1
Dextrose 50% 25g/50mL syringe	1
Dextrose 10% 100mg/mL (250mL bag)	1
Epinephrine 1:10000 1mg/10mL syringe	1
Oral glucose gel 15g	1
Normal saline 10mL flush	3
Angiocath starter kit*	1
Empty syringe 3mL	1
Empty syringe 10mL	3
18 gauge eclipse needle	4
25 gauge eclipse needle for IM inj	1

Generic drug name	Quantity
RSI meds grouped together	
Etomidate 2mg/mL (10mL)	1
Rocuronium 10mg/mL (10mL)	2
Succinylcholine 20mg/mL (5 ml) syringe	2
Midazolam 10mg/2mL (Versed)	1
Naloxone 2mg/2mL syr	1

*20G 1 ¼" Catheter x2, 18G 1 ¼" catheter x2, IV starter kit with ChloraPrep (DYND74260) x2

*20G 1 ¼" Catheter x2, 18G 1 ¼" catheter x2, IV starter kit with ChloraPrep (DYND74260) x2

Neonatal Transport Box- Pharmacy Section

Pharmacy Section ONLY

Epinephrine 1:10,000 (0.1 mg/mL) 10mL Syringe- 1 ea____ (√)

(Dose of Epinephrine= 0.1 to 0.3 mL/KG of Epinephrine 1:10,000 IV)

Pharmacist Code Stroke Kit

Quantity	Medication	Expiration Date
2	30mL syringe	
2	10mL syringe	
5	5mL syringe	
1	BD Alaris Pump Infusion Set (REF 2426-0500)	
6	18G Eclipse Needles	
6	Saline Flush 10mL	
1	Nicardipine 25mg in 100mL (either NS or D5)	
1	Tenecteplase 50mg kit	
1	Labetalol hydrochloride 100mg / 20mL vial	
N/A	Miscellaneous: labels, tapes, and dosing sheet	

Non-Cytotoxic Vesicant Medication and Fluids Extravasation Kit

Quantity	Medications	Expiration Dates
2	Phentolamine mesylate for injection 5 mg/vial	
2	Hyaluronidase (Amphadase®) 150 units/ml, 1 ml vial (Hyaluronidase is STORED IN PYXIS REFRIGERATOR)	
2	0.9% Sodium chloride for injection, preservative free, 10 ml	
3	Nitroglycerin Ointment USP, 2% (NITRO-BID®) 1 inch (1 gram) foilpac®	

Operation OB – MEDICATION BOX

Quantity	Drug	Expiration Date
2	Oxytocin (Pitocin) 10 units/ml 1 ml vial	
5	Misoprostol (Cytotec) 100 mcg tablet	

OB Procedure Cart

Nursing:
Stamp with patient's name, place in medication box and return to pharmacy

Quantity	Medication	Expiration
2	Calcium gluconate 1g vials	
1	Hydralazine 20mg/mL vial	
1	Labetalol100mg/20mL (5mg/mL) vial	
1	Magnesium sulfate 20g/500mL bag	
2	Magnesium sulfate 50%, 5gm/10mL, 10mL vials	
5	Misoprostol 200mcg tab	
1	Naloxone 2mg/2mL syringe	
1	Nitroglycerin spray 0.4mg/spray	
2	Oxytocin 30 units/500mL bag	
4	Oxytocin 10 units/mL, 1mL vial	
3	Nifedipine 10mg, Immediate Release tabs	
1	Terbutaline1mg/mL vial	
1	Tranexamic Acid 1000mg/10ml	

The following medications are in the **9W** Pyxis Refrigerator under "**OB PPH Emergency Kit**", to access:

- Log in to pyxis
- Hit "remove meds" button
- Hit "kit" button at the bottom of the screen
- Choose the "**OB PPH Emergency Kit**"
- Remove the below meds

Pyxis items in the OB Code Kit	
Quantity	**Medication**
1	Hemabate 250mcg ampule (refrigerator in zip-lock bag)
2	Methergine 0.2mg/mL ampule (refrigerator in zip-lock bag)
5	Misoprostol 200mcg tab

****Diazepam inj** must be **removed separately from Pyxis** when needed

Oral Surgery Box

Supplies	Qty.
Alcohol Pads	8
BD 10ml Syringe w/ Luer Lock Tip Blunt Fill Needles	2
BD 5 ml Syringe	3
BD Eclipse 18G x1½" Needles	4
BD Eclipse 3 ml Syringe w/ 21G x1½" Needle	3
CPR Mask	1
Extension Set w/ y-site	1
IV Catheter 18G x1¼"	2
IV Catheter 20G x1¼"	2
IV Catheter 22G x1"	2
IV Start Kit w/Chloral Prep	2
Oxygen Mask	1
Regular IV Set	1

Drugs	Qty.	Expiration Date
Albuterol Inhaler	1	
Aspirin 325mg	2	
Atropine Inj. 0.4 mg/ml 1 ml Vial	2	
Dextrose 50% Inj. 0.5 gm/ml 50 ml Syringe	1	
Diphenhydramine Inj. 50 mg/ml 1 ml Vial	1	
Ephedrine Inj. 50 mg/ml 1 ml Ampule w/ Filter needle	1	
Epinephrine 1:1000 Inj. 1 mg/ml 1 ml Ampule (For anaphylaxis: Adults: 0.3 to 0.5 mg (0.3 to 0.5 ml) of 1 mg/ml solution given IM, preferred anterior thigh)	1	
Esmolol 100mg/10ml	1	
Flumazenil Inj. 0.1 mg/ml 5 ml Vial	1	
Hydralazine 20mg/mL (1mL) vial	1	
Labetalol Inj. 5 mg/ml 20 ml vial	1	
Lidocaine Gel 2% 5 ml Tube	1	
Methylprednisolone Inj. 125 mg Vial	1	
Naloxone Inj. 0.4 mg/ml 1 ml Vial	2	
Nitroglycerin SL Tablet 0.4 mg/tab #25 tab Bottle	1	
Normal saline 10ml vial	2	
Normal Saline 250 ml Bag	1	
RSI Kit	1	
Sterile Water Inj. 10 ml Vial	1	

Drugs are replaced by pharmacy. Supplies are replaced by dental dept. oral surgery staff

Hypersensitivity Reaction Kit for Infusion Center

Medication	Quantity	Expiration
Diphenhydramine Inj. 50 mg/ml 1 ml Vial	1	
Methylprednisolone Inj.125 mg Vial	1	
Epinephrine 1mg/mL vial (Refer to "MANAGEMENT OF ACUTE ADVERSE REACTIONS (ADR) POLICY: CHEMOTHERAPY/BIOTHERAPY/IMMUNOTHERAPY: policy for dosing)	1	

Famotidine inj. 20 mg/2ml vials are in Pyxis Refrigerator.

- Atropine vial and/or syringe are in the pyxis machine
- Kit will include one 3mL syringe, one 18-gauge needle and one 21-gauge needle.

Chemotherapy/Biotherapy Extravasation Kit

Quantity	Medication	Expiration Date
1	Sodium Thiosulfate 25% (12.5gm/50mL)	
1	Hyaluronidase 150 units/1ml vial **stored in fridge** (Alameda Hospital refrigerator located in the OR/surgery department pyxis)	
1	Topical DMSO 50% - 50 ml vial	
2	Dexrazoxane 500mg vial (Highland Campus Only)	
2	50mL Sterile Water (Highland Campus Only)	

ED Block Cart

Quantity	Medication
Rescue/LAST Treatment	
12	Preferred choice: Intralipid (Fat Emulsion) 20% inj 200 - 250 ml bag with 1.2 micron filter tubing OR 2nd choice: SMOFlipid 20% - 100mL bags x2 with 1.2micron filter tubing + ASRA checklist for treatment of local anesthetic systemic toxicity (LAST) [both original and simplified versions]
2	16 gauge needles
2	50mL syringes

ED Code Bag

Generic drug name	**Quantity**
Atropine 1mg/10mL syringe	1
Dextrose 50% 25g/50mL syringe	1
Dextrose 10% 100mg/mL (250mL bag) **during D50W shortage only**	1
Epinephrine 1:10000 1mg/10mL syringe	1
Etomidate 2mg/mL (10mL)	1
Glucose gel (oral) 15g	1
Midazolam 10mg/2mL (Versed)	1
Naloxone 2mg/2mL syr	1
Rocuronium 10mg/mL (10mL)	2
Succinylcholine 20mg/mL (5 ml) syringe	2
Tenecteplase kit	1
Supplies	**Quantity**
Normal saline 10mL flush	4
Angiocath starter kit*	1
Empty syringe 3mL	2
Empty syringe 10mL	2
18 gauge eclipse needle	4
25 gauge eclipse needle for IM inj	1

Alameda Hospital Only Medication Carts and Kits

Department/Divisions	Name of Emergency Box/Kit	Page
Critical Care	• Anaphylaxis Kit • CCU Difficult Airway Cart	13 14
Critical Care/ED	• Kcentra kit • TNKase kit	15 15
Misc.	• Pain Medication Tray	16

ANAPHYLAXIS KIT

KEEP AT BEDSIDE FOR PACLITAXEL (TAXOL), L-ASPARAGINASE, PEPASPARAGINE INJECTION

PATIENT NAME
RN NAME

Quantity	Generic Name	Trade Name	Strength	Size	Form
1	Diphenhydramine	Benadryl	50mg/ml	1ml	SDV
1	Epinephrine (1:1000) (For anaphylaxis: Adults: 0.3 to 0.5 mg (0.3 to 0.5 ml) of 1 mg/ml solution given IM, preferred anterior thigh)	Adrenalin	1mg/ml	1ml	Ampule
1	Filter Needle			19G	Needle
1	Methylprednisolone	Solu-Medrol	125mg/2ml	2ml	SDV
1	Albuterol Solution	Proventil	2.5mg/3ml	3ml	SDV
3	Syringe			3ml	Syringe
3	Needle 18G			18G	Needle
3	Alcohol Prep Pad			Each	Pad

RETURN TO PHARMACY AFTER INFUSION.

FIRST EXPIRING DRUG:	**EXPIRATION DATE:**

TECH/RPH	**/**

CCU Difficult Airway Cart Drug List

Patient Addressograph

Drugs	Quantity	Quantity Used
Lidocaine 2% Jelly 30ml	2	
Lidocaine 2% 50 ml Multiple Dose Vial	1	
Hurricaine Topical Spray	1	
Phenylephrine Nasal Decongestant Spray	1	

First Drug(s) to Expire:_____ Expiration Date:_____

Filled/Checked By:_____/_____ Date:_____

***Return entire kit to pharmacy for replacement after each use**

Kcentra® Kit Content

(Prothrombin Complex Concentrate, 4 Factor Unactivated)

Item Name	Quantity	Expiration Date
Kcentra Reconstitution Instructions	1	x
Orange "Medication Added" sticker	6	x
60 mL luer lok syringe	2	x
20 mL luer lok syringe	4	x
16 gauge needles	6	x
Empty 100mL IVPB bags	6	
Alcohol swabs	10	x
Kcentra 1000 unit manufacturer box	4	
Kcentra 500 unit manufacturer box	2	

Filled by: _____ Checked by: _____ Date checked: _____

Lock Number: _____

Date Used: _____

PATIENT HOSPITAL LABEL STICKER

***Return entire kit to pharmacy for replacement after each use**

TNKase® Kit Content

Item Name	Quantity	Expiration Date
TNKase 50mg	1	
AIS bag: dose chart, Orange "Medication Added" sticker, 5cc luer lok syringe, AIS flyer	1	
STEMI bag: dose chart, Orange "Medication Added" sticker, STEMI flyer	1	x

Filled by: _____ Checked by: _____ Date checked: _____

Lock Number: _____ Kit #: _____

NURSE: Return to Pharmacy when used

NURSE:

Place Patient Hospital Sticker

Pain Medications Tray List

Drugs	Exp Date	QTY	QTY Used
Lidocaine 1% P.F. (10 mg/mL) – 5 mL		25	
Lidocaine 2% P.F. (20 mg/mL) – 5 mL		10	
Bupivacaine 0.25% P.F. (2.5 mg/mL) – 10 mL		10	
Dexamethasone P.F. 10 mg/mL – 1 mL		25	
Kenalog (Triamcinolone Acetonide) 40 mg/mL – 1 mL		12	
Bupivacaine 0.5% P.F. (5 mg/mL) – 30 mL		9	
MethylPREDNISolone acetatae injectable suspension (Depo-medrol) 80mg		4	

San Leandro Only Medication Carts and Kits

Cardiology Drug Kit

Cardiology Drug Kit	Aminophylline 500mg vial	1
Cardiology Drug Kit	Atropine 1mg/10ml	1
Cardiology Drug Kit	Esmolol 100mg/10ml	1
Cardiology Drug Kit	Nitroglycerin 0.4mg tabs	25
Cardiology Drug Kit	Verapamil 5mg/2ml	1
Cardiology Drug Kit	22ga x1.5” safety needle	1
Cardiology Drug Kit	Diltiazem 5mg/ml 10 ml vial	1

Dobutamine Stress Test Kit (prepared upon order)

Dobutamine stress test kit (prepared upon order)	Dobutamine 250mg/d50w 250ml
Dobutamine stress test kit (prepared upon order)	d5w 500ml
Dobutamine stress test kit (prepared upon order)	esomolol 100mg/10ml
Dobutamine stress test kit (prepared upon order)	atropine 1mg/10ml inj

Rapid Response Kit

Rapid Response Kit	Ipatroprium/Albuterol 0.5mg/3mg amp	1
Rapid Response Kit	Nitroglycerin 0.4mg	1
Rapid Response Kit	Aspirin 325mg tab	1
Rapid Response Kit	Dextrose 50% 50ml	1
Rapid Response Kit	Naloxone 0.4mg	1
Rapid Response Kit	NS 1000ml IV	1

Ancillary ICU Code Box

Ancillary ICU Code Box	Amiodarone 150mg/3ml inj.	3
Ancillary ICU Code Box	Dextrose 5% 100ml bag	1
Ancillary ICU Code Box	Filter - 0.2 Micron	1
Ancillary ICU Code Box	Adenosine 6mg/2ml inj	3
Ancillary ICU Code Box	Atropine 1mg/10ml syringe	3
Ancillary ICU Code Box	Calcium Chloride 10% syringe	1
Ancillary ICU Code Box	Dextrose 50% 50ml syringe	1
Ancillary ICU Code Box	Dopamine 800mg/250ml D5W IV drip	1
Ancillary ICU Code Box	Epinephrine 1mg/10ml syringe	4
Ancillary ICU Code Box	Lidocaine 0.4% 250ml IV drip	1
Ancillary ICU Code Box	Lidocaine 100mg syringe	2
Ancillary ICU Code Box	Magnesium 1gm/2ml vial (Dilute with 9ml NS)	2
Ancillary ICU Code Box	Naloxone 2mg/2ml syringe	2
Ancillary ICU Code Box	Sodium Bicarbonate 8.4% syringe	2
Ancillary ICU Code Box	Sodium chloride flush 10ml syringe	4
Ancillary ICU Code Box	Sterile water 10ml	2
Ancillary ICU Code Box	Vasopressin 20 units/1 ml inj.	2

Kcentra® Kit Content

(Prothrombin Complex Concentrate, 4 Factor Unactivated)

Item Name	Quantity	Expiration Date
Kcentra Reconstitution Instructions	1	x
Orange "Medication Added" sticker	6	x
60 mL luer lok syringe	2	x
20 mL luer lok syringe	4	x
16 gauge needles	6	x
Empty 100mL IVPB bags	6	
Alcohol swabs	10	x
Kcentra 1000 unit manufacturer box	4	
Kcentra 500 unit manufacturer box	2	

Filled by: _____ Checked by: _____ Date checked: _____

Lock Number: _____

Date Used: _____

PATIENT HOSPITAL LABEL STICKER

TNKase® Kit Content

Item Name	Quantity	Expiration Date
TNKase 50mg	1	
AIS bag: dose chart, Orange "Medication Added" sticker, 5cc luer lok syringe, AIS flyer	1	
STEMI bag: dose chart, Orange "Medication Added" sticker, STEMI flyer	1	x

Filled by: _____ Checked by: _____ Date checked: _____

Lock Number: _____ Kit #: _____

NURSE: Return to Pharmacy when used

NURSE:

Place Patient Hospital Sticker

SLH OR Eye Medication Tray 1 Drug List

Drugs	Exp Date	QTY	QTY Used
Cyclopentolate (Cyclogyl) Soln 2% - 2 mL		1	
Cyclopentolate (Cyclogyl) Soln 1% - 2 mL		1	
Tropicamide 1% - 3 mL		1	
Phenylephrine (AK-Dilate) Soln 10% - 5 mL		2	
Sulfacet/Pred (Blephamide) Oint 3.5gm		1	
Gentamicin Soln 5 mL		2	
Gentamicin Oint 3.5 gm		1	
Erythromycin Oint 3.5 gm		2	
Ciprofloxacin (Cipro) Soln 0.3% - 2.5 mL		1	
Neo/Poly B/Dex (Maxitrol) Oint 3.5 gm		10	
Atropine Soln 1% - 2 mL		2	
Epinephrine PF Soln amp 1% - 2 mL		2	
Lidocaine PF Injection amp 1% - 2mL		10	
Cefazolin Injection Vial 1 gm		3	
Sterile Water for Injection SDV 10 mL		3	
Atropine Oint 1% - 3.5 gm		2	
Homatropine Soln 5% - 5 mL		2	
Lidocaine PF Injection 4% - 5 mL		6	
Gentamicin Injection SDV 80 mg/2mL		6	
Dexamethasone Injection SDV 4 mg/mL		8	

SLH OR Eye Medication Tray 2 Drug List

Drugs	Exp Date	QTY	QTY Used
Timolol Soln 0.5% - 5 mL		2	
Lidocaine/Epi Injection SDV 2%/1:200K – 20 mL		1	
Tetracaine Sterile Soln 0.5% - 2 mL		2	
Liquifresh PM Oint 3.5 gm		2	
Brinzolamide (Azopt) 1% - 10 mL		6	
Prednisolone (Pred-Forte) Soln 1% - 5 mL		3	
Fluorescein Sodium Ophth Strip 0.6 mg		3	
Lidocaine/Epi Injection SDV 1%/1:100K – 20 mL MDV		1	
Acetylcholine (Miochol-E) Soln – 2mL		3	
Trypan Blue (Vision Blue) Soln Syr 0.06% - 0.5 mL		5	
Pilocarpine Sterile Soln 2% - 15 mL		2	
Tetracaine Soln 0.5% - 15 mL		2	
Bupivacaine 0.75% - 10 mL		6	
Lidocaine Inj MDV 2% - 5 mL		6	
Lidocaine 2% - 50 mL		1	
Tetracaine (TetraVisc) Soln 0.5% - 5 mL		6	
Gatifloxacin (Zymaxid) Soln 0.5% - 2.5 mL		8	

OR Bleeding Kit

OR Bleeding Kit	GELFOAM (SIZE 100)	2
OR Bleeding Kit	Recothrom (5000 units)	4
OR Bleeding Kit	HEPARIN (1,000 UNITS/ ML) 10 ML	3
OR Bleeding Kit	HEPARIN (1,000 UNITS/ ML) 30 ML	1
OR Bleeding Kit	Gentamicin (80 MG/ 2 ML) 2 ML	4
OR Bleeding Kit	PROTAMINE (10 MG/ ML) 5 ML	1
OR Bleeding Kit	Visipaque (320mg/ml) 50ml	3
OR Bleeding Kit	30 ML SYRINGE	1
OR Bleeding Kit	18 GA HYPO NEEDLE	1
OR Bleeding Kit	MED LABELS	2

Radiology Emergency Drug (CT-box)

Radiology Emergency Drug (CT-Box)	Syringe w/ needle 3ml	3
Radiology Emergency Drug (CT-Box)	Atropine 1mg/ml vial	1
Radiology Emergency Drug (CT-Box)	Benadryl 50mg/ml vial	1
Radiology Emergency Drug (CT-Box)	Epinephrine Inj. 1 mg/ml (1:1000) 1 ml Vial (For anaphylaxis: Adults: 0.3 to 0.5 mg (0.3 to 0.5 ml) of 1 mg/ml solution given IM, preferred anterior thigh)	1
Radiology Emergency Drug (CT-Box)	Ammonia Inhalants	4
Radiology Emergency Drug (CT-Box)	Benadryl 25mg cap	4

Procedure Room Drug Box

Procedure Room Drug Box	Fentanyl 100mcg/2ml	8
Procedure Room Drug Box	Midazolam 5mg/5ml	8

ALAMEDA HEALTH SYSTEM

Highland Hospital Outpatient Pharmacy Quality Assurance and Medication Error Reporting

Site	Highland Hospital Outpatient Pharmacy	***Previous Revision Dates***	
Effective Date	9/2023	***Date Revised***	05/2025
Document Owner	MGR SYS MED SAFETY-CLIN PHARM	***Next Scheduled Review***	05/2028
Executive Responsible	Please Fill In		
Approvals	BOT, QPSC		

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

Purpose

To provide guidelines for Outpatient Pharmacy standardized reporting of adverse medication errors and actions taken in response to these events as required by the California Board of Pharmacy (BOP).

Policy

Adverse medication events (ADE's) will be reported regularly to the Midas Safety Alert system, including medication errors, quality assurance events, or adverse events, that have reached the patient or patient's agent. Highland Hospital Outpatient Pharmacy, as part of the Alameda Health System, subscribes to a Just Culture algorithm.

Definitions

1. Just Culture- a system where honest human errors are treated as learning opportunities, rather than as reasons for punishment.

2. Adverse Events – any undesirable experience that is associated with the use of a medical product or medication, in a patient.

3. Serious disability- refers to physical or mental impairment that limits abilities in major life activities, or results in the loss of bodily functions/parts.

4. Medication Error – any preventable event that may cause or lead to inappropriate medication use or patient harm, while the medication is in control of the healthcare professional, patient or consumer and is determined based on the one or more of the following types of criteria:
    a. Types of Medication Error (includes but not limited to) – prescribing errors, transcribing errors, dispensing errors, and medication delivery errors, where the medication has left the pharmacy. The specifics are categorized on the following:
        i. Prescribing
            a) Contraindicated.
            b) Duplicate Drug Order, not corrected by pharmacist.
            c) Illegible/Unclear Order, not clarified by pharmacist.
            d) Drug Order not authorized by prescriber.

e) Inappropriate Order / Altered Order, not corrected by pharmacist.
f) Incomplete Order, not clarified by pharmacist.
g) Miscalculated Order, not clarified by pharmacist.

ii. Transcribing:
a) Transcribing (copying) error.
b) Order typed or entered incorrectly.
c) Verbal Order (V.O.) written incorrectly.
d) Wrong patient.
e) Labeling error.

iii. Dispensing
a) Contraindicated.
b) Incorrect dose.
c) Failed to verify order.
d) Improper preparation/compounding.
e) Miscalculated dose.
f) Mislabeled, packaging and nomenclature.
g) Incorrect drug.
h) Wrong patient.
i) Drug order not authorized by prescriber.
j) Incorrect route of administration.
k) Wrong directions.

Procedure

1. If an adverse medication event (ADE) is identified that has reached the patient or has the significant potential to cause harm, a Quality Assurance-electronic occurrence report must be completed via the Midas- Safety Alert system as soon as discovered.
    a. An investigation of each medication error shall start as soon as is reasonably possible, but no later than 2 business days from the date the medication error is discovered.

2. Midas Safety Alert report should contain:
    a. The date, location, and participants in the quality assurance review.
    b. The pertinent data and other information relating to the medication error(s).
    c. The review and documentation of any patient contacted, as required.
    d. The findings and determinations generated by the quality assurance review.
    e. Recommended changes to pharmacy policy, procedure, systems, or processes, if any.

3. The Pharmacy Director, Manager, PIC, or designee shall review these documents for completeness and accuracy (i.e. ensuring that the parameters of the event completed by the employee are correct).

4. The Pharmacy Director, Manager, PIC, or designee will take appropriate action as applicable and document such actions in the Midas Safety Alert report.

5. The Pharmacy Director, Medication Safety Officer, Pharmacy Manager, and PIC have access to medication errors and adverse drug reactions that have been entered into the Midas Safety Alert system, via a manager's worklist.

6. The record of quality assurance review must be easily retrievable in the pharmacy for at least 3 years from the date the record was created. Records will be retrievable via the Midas Safety Alert reporting system.

7. Data collected via the Midas reporting system shall be reviewed by the Medication Error Reduction Team (MERT). Review of medication events for tracking and trending to assess improvements in errors with mitigation strategies in place. The review shall occur at least quarterly.

8. MERT, Pharmacy Manager or PIC shall determine appropriate follow-up actions that are needed to reduce the likelihood of similar errors in the future. Recommendations may include:

    a. Use of continuous quality improvement principles to improve medication use processes and outcomes.
    b. Referral to appropriate Peer Review Committees.
    c. Staff education efforts.
    d. IT/Epic system improvements and safeguards.

9. Resolutions and methods of prevention will be reviewed with staff (staff huddles, individual review or email) and may be added to the standard operating procedure manual, along with providing individualized trainings, as needed.

10. Errors reported by Pharmacy or Patient
    a. The pharmacy will communicate with the patient or patient's agent and prescriber, when a medication error has occurred, and steps required to avoid or mitigate the error.
    b. When a medication error has occurred (drug was administered to or by the patient or resulted in clinically significant delay in therapy) the pharmacy will communicate to the prescriber that a medication error has occurred.

11. Reporting errors from automated dispensing systems
    a. Highland Outpatient Pharmacy operates an unlicensed automated drug delivery system (ScriptPro) within the premises of the pharmacy.
    b. Any complaint, error, or omission involving the automated dispensing system (ScripPro) shall be reviewed as part of the pharmacy's quality assurance program pursuant to Section 4125.
    c. Quality Assurance events related to the ScriptPro must be reported to the California Board of Pharmacy at the time of annual renewal of the pharmacy license.

12. Reporting errors related to compounds
    a. In the event of an error, not being limited to an instance where there is a negative patient outcome, Midas Safety Alert will be completed using the AHS Standard Midas Reporting tool.
    b. If the error involves a compounded medication, the individual involved will undergo appropriate training or, at minimum, document review of the policies and procedures.
    c. In the event where a negative patient outcome is associated with a compound, pharmacy will also report to MedWatch within 72 hours of being advised.
        i. The prescriber will be notified within 72 hours of the pharmacy being advised.
13. Medication errors under AB 1286, reporting by Pharmacy
    a. In addition to the steps outlined above, Highland Outpatient Pharmacy is required to report medication errors under AB 1286, to California Board of Pharmacy or the Board Approved vendor Institution for Safe Medication Practices (ISMP), within 14 days of discovery.
        i. Reportable medication errors include:

1. Wrong drug
2. Wrong patient
3. Wrong directions
4. Wrong preparations
5. Wrong route of administration
6. Any variation from a prescription drug order not authorized by prescriber. Errors corrected prior to dispensing to patient or patient's agent are not required to be reported to ISMP or CA BOP, unless they meet other requirements noted within this policy.

ii. An outpatient hospital pharmacy shall not be required to report a medication error that meets the requirements of an adverse event that has been reported to the California Department of Public Health pursuant to Section 1279.1 of the Health and Safety Code.
    1. A health facility licensed pursuant to subdivision (a), (b), or (f) of Section 1250 shall report an adverse event to the department no later than five days after the adverse event has been detected, or, if that event is an ongoing urgent or emergent threat to the welfare, health, or safety of patients, personnel, or visitors, not later than 24 hours after the adverse event has been detected.
        a. Product or device events:
            i. Patient death or serious disability associated with the use of a contaminated drug, device, or biologic provided by the health facility when the contamination is the result of generally detectable contaminants in the drug, device, or biologic, regardless of the source of the contamination or the product.
        b. Care management events:
            i. A patient death or serious disability associated with a medication error, including, but not limited to, an error involving the wrong drug, the wrong dose, the wrong patient, the wrong time, the wrong rate, the wrong preparation, or the wrong route of administration, excluding reasonable differences in clinical judgment on drug selection and dose.

b. Business and Professions Code §4113.1 requires that pharmacy maintain records demonstrating compliance with AB1286- error reporting, for 3 years.
c. Records must be immediately available to California Board of Pharmacy inspector(s).

References

1. California Code of Regulations, Article 12, Section 1711
3. California Code, Business and Professional Code - BPC 4125
4. California Code, Business and Professions Code- BPC 4113
5. California Health and Safety Code- HSC 1279.1

APPROVALS

		System	**HH/SLH/JG/FM**

Regulatory Department	**Date:**	**6/2025**	
Pharmacy Departmental	**Date:**		**6/2025**
System Pharmacy and Therapeutics	**Date:**	**6/2025**	
CPC	**Date:**	**7/2025**	
Medical Executive Committee	**Date:**	**7/2025**	
Board of Trustees	**Date:**	**8/2025**	

Alameda Health System
Clinical Practice Council Charter

Purpose of the Clinical Practice Council

The Clinical Practice Council (CPC) is under the governance of the Alameda Health System (AHS) Medical Staff. The primary purpose of the Alameda Health System (AHS) Clinical Practice Council (CPC) is to review and approve all organization or clinical policies, cross-department protocols, and plans that impact or affect the delivery of patient care. In addition, CPC will review department-level procedures and guidelines.

Guiding Principles

- Ensure all policies, procedures, guidelines, protocols, and plans within CPC's scope:
  - are evidence-based and align with the best patient care and highest safety standards;
  - reflect consensus-driven patient care across disciplines and departments; and
  - are easily accessible to all employees.
- Support continuous performance improvement and patient safety throughout the Alameda Health System.

Approval Responsibilities & Reporting Structure

- All policies, procedures, guidelines, cross-department protocols, and plans that impact or affect the delivery of patient care will be reviewed in their respective committee prior to submission to CPC for review.
- CPC will review all submissions based on its guiding principles. Policies, protocols, and plans approved by CPC will be sent to the medical executive committee (MEC) for approval.
  - MEC will approve or reject documents submitted by CPC.
  - All documents approved by MEC will be presented to the BOT for final approval.
- CPC will review and provide guidance on department procedures and guidelines
- CPC oversees PolicyTech, which is supported by the quality department via the Policy Coordinator(s).

Review and Appeals Process

- If the MEC rejects or requests changes to a document, the policy coordinator will notify the author and provide feedback from the MEC.
- The revised document will be submitted for secondary review and approval by the next CPC meeting; if unable to meet deadline, the author will provide updates to the CPC chair(s).
- Unresolved disputes and delays should be escalated to the CPC chair who can coordinate resolution.
- Timely review and needed collaboration are expected.
- Efforts will be made at each meeting to move pending documents forward.

Membership Composition

- The Clinical Practice Council is a multidisciplinary committee consisting of members from the medical staff, quality, nursing, pharmacy, informatics, infection control, and other members as deemed necessary and appropriate to fulfill its function. Please see the table for committee membership.
- Committee members are appointed by the Chief of Staff (COS); co-chairs are appointed in consultation with the Chief Medical Officer (CMO) and the Chief Clinical Officer (CCO).
- Members serve a minimum of four years with staggered end dates.
- Members must attend at least 75% of scheduled meetings annually.
- Inactive members (failing to meet attendance requirements) will be replaced to maintain continuity.
- A proxy may vote only when attending in an official capacity for a designated member.

Clinical Practice Council Meetings

- CPC meets monthly.
- Meeting minutes are recorded, disseminated, and stored per regulatory requirements and AHS policy.
- The meeting agenda and materials are emailed to all active members at least five days before the meeting.
- A quorum consists of at least 30% active committee members. At least 3 physicians and 3 nurses must be present.
- Voting
    - Approval requires a majority of committee members that are present at each meeting.
    - Voting eligibility includes co-chairs, official members, and ad hoc members.
    - Voting may occur in-person or electronically. Electronic voting is permitted only when document approval is time-sensitive for safety or regulatory compliance.
    - Proxy voting is not permitted unless an alternate is officially designated. A proxy will be officially designated by the committee chair(s) following email communication from the appointed committee member. The COS has final approval on the appointment of the proxy voter.

Review & Amendment Process

- This charter will be reviewed every two years or at the request of the COS.
- Amendments to the charter must be approved by voting standards described above and submitted to the MEC for approval.

Table: Committee Membership

Role	Department
Council Co-Chair	Physician of the medical staff
Council Co-Chair	Nursing Leader
Member	VP Quality
Member	CMO or ACMO
Member	CMIO
Member(s)	Chiefs of Staff AHS and AH
Member(s)	Physician representatives from Ambulatory, Anesthesia, Emergency Medicine, Internal Medicine, Obstetrics & Gynecology, Orthopedics, Pediatrics, Psychiatry, Surgery.
Member	Nurse Informatics
Member(s)	RN (1 from each site) - AH, SL, HGH, JGPH, Amb
Member	Nursing Clinical Educator
Member	Pharmacy
Member	Infection Control
Ad Hoc	Specialty nurse
Ad Hoc	Department-based discipline specific rep

ADMINISTRATIVE CLOSURE OF INCOMPLETE RECORDS

Department	Health Information Services	***Effective Date***	04/1993
Campus	All	***Date Revised***	06/2020, 05/2025
Unit	Health Information Services	***Next Scheduled Review***	5/2028
Manual	Health Information Services	***Author***	Director, Health Information Services
Replaces the following Policies:		***Responsible Person***	Chief Information Officer (CIO)

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

PURPOSE

To outline the process of and define guidelines for appropriate uses of administrative closure with incomplete records.

POLICY STATEMENT

A medical record shall ordinarily be considered complete when the required documentation has been filed.

No Medical Staff member is permitted to complete a medical record on a patient unfamiliar to him/her in order to close a medical record that was the responsibility of another staff member unless it meets the requirements set forth by the "Documentation by Proxy Power Signature" policy.

When the Health Information Management Department is unable to obtain signatures and necessary record documentation to complete a medical record, they may utilize administrative closure for the incomplete record.

PROCEDURE

1. The Health Information Management Department will make every possible effort to obtain signatures and necessary record documentation on incomplete medical records while the physician is still working at Alameda Health System.

2. The Health Information Management Department will have all the physician's incomplete medical records available for completion.

3. The Health Information Management Department will submit a list of incomplete medical records to the appropriate Medical Staff after a physician has resigned from the Medical Staff.

4. If recommendation is made to administratively close the medical record, the Director of Health Information Management will sign the Administrative Closure of Incomplete Record Form (attachment).

5. When authorizing signature has been obtained, the Health Information Management Department will scan the form in our electronic medical record.

REFERENCES

APPROVALS

		System	Alameda	AHS/Highland/John George/San Leandro
Department:	**Date:**	05/2025		
Pharmacy and Therapeutics (P&T)	**Date:**	N/A	N/A	N/A
Clinical Practice Council (CPC)	**Date:**	7/2025	N/A	N/A
Medical Executive Committee	**Date:**	7/2025		
Board of Trustees	**Date:**	8/2025		

ATTACHMENT

ADMINISTRATIVE CLOSURE OF INCOMPLETE RECORD FORM

Medical Record Number: _____ Encounter Number: _____

Patient Name: _____ Attending: _____

Date of Service: _____ Responsible Physician: _____

Several attempts have been made to complete this medical record. The original author is unable to authenticate. Attempts to obtain proxy signature have been unsuccessful. The Department Chief has been notified.

The Health Information Services Department is requesting that this medical record be administratively closed for the following document:

- ☐ History and Physical
- ☐ Discharge Summary
- ☐ Physician's Order
- ☐ Operative Report
- ☐ Other _____

_____ _____

Director, Medical Records Date

CC: HIM Committee

ALAMEDA HEALTH SYSTEM

July 23, 2025

TO: Quality Professional Services Committee

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

SUBJECT: **Agenda Item:** B3

Meeting Date: July 23, 2025

Item Description: Medical Staff Policies and Procedures

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

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

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

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

Board Action Requested: Approval

AHS & AH Medical Staff:

- *Introduction of a New Privilege or New Privilege for a Specific Department or Specialty

AHS Medical Staff:

- Pain Medicine Anesthesia Standardized Procedure

**Item was agendized in June, resubmitting for approval*

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 : _____

Alameda Health System

STANDARDIZED PROCEDURES FOR ADVANCED PRACTICE PROVIDERS IN THE DEPARTMENT OF ANESTHESIA, PAIN MEDICINE DIVISION

Department	Anesthesia, Pain Medicine Division	***Effective Date***	7/2025
Campus	Highland Hospital	***Date Revised***	
Unit	Inpatient/Outpatient	***Next Scheduled Review***	7/2028
Manual	Interdisciplinary Practice	***Author***	Pain Medicine Division Chief
Replaces the following Policies:		***Responsible Person***	Chief of Staff

Procedure Statement

This standardized procedure fulfils Alameda Health System requirements and expectations for defining the scope of practice for Advanced Practice Providers. Standardized procedures are developed collaboratively by nursing, medicine, and administration to comply with the California Business and Profession Code, Nursing Practice Act (NPA) Section 2725 and further clarified in California Code of Regulation (CCR 1480).

Purpose

It is the intent of this document to authorize the Advanced Practice Providers (APP) within the Wilma Chan Highland Hospital Campus in the Department of Anesthesia, Pain Medicine Division to implement the Standardized Procedures without the immediate supervision or approval of a physician. The Standardized Procedures, including all the policies and protocols, are defined in this document, and will be referred to generally as the "Standardized Procedures".

Standardized procedures will be maintained in Policy Tech and reviewed every three (3) years.

Definitions

1. Advanced Practice Provider refers to either Nurse Practitioner or Physician Assistant
    a. **Nurse Practitioner** by definition shall be:
        i. Master's or Doctoral Degree in Nursing
        ii. Current license as a Registered Nurse in California
        iii. Current certification by the State of California, Board of Registered Nursing as a Nurse Practitioner
        iv. California-issued BRN Furnishing Number
        v. Current National Certification
        vi. Active DEA registration number
        vii. National Provider Identification Number
    b. **Physician Assistant** by definition shall be:
        i. Successful completion of a Physician Assistant program of instruction in primary health care approved by the Physician Assisting Examining Committee; OR NCCPA for Physician's Assistant
        ii. Possession of a valid Certificate as a Physician Assistant issued by the California Board of Medical Quality Assurance
        iii. A valid Drug Enforcement Agency (DEA) Number AND Certification by the

National Commission on Certification of Physician Assistants (NCCPA)

iv. National Provider Identifier Number.

All requirements, applications, procedures and duties are the same for both APP classifications, with the exception of issuing drug orders and furnishing, as discussed herein.

2. **Supervising Physician** shall be an attending physician who is a current member in good standing of the Medical Staff, and who holds privileges in the Department of Anesthesia, Pain Medicine Division.

Application

1. In addition to general requirements set forth and described in the Medical Staff Bylaws, Rules and Regulations, policies and privileges forms, the following criteria shall specifically apply to any APPs applying for privileges in the department of Anesthesia, Pain Medicine Division:
   a. A minimum of two (2) years of clinical experience as an APP is preferred. Recent graduates with relevant training may be considered on a case-by-case basis at the discretion of the Division Chief.

Conditions and Standards of Practice

1. **General Conditions**
   a. The APP shall render all care within the standards provided in this document.
   b. The APP shall provide all care in accordance with the laws and regulations of the State of California, and with the Bylaws and Regulations of the Medical Staff and the Department of Anesthesia, Pain Medicine Division.
   c. At no time shall the care rendered by the APP exceed the scope of the licensure. All cases beyond the scope of practice of the APP, and those with which the APP has questions will be referred to the consulting physician.
   d. The APP agrees to work cooperatively with the consulting physician, nursing staff and other health professionals.
   e. The APP shall immediately notify their Division Chief in the event that the practitioner's license to practice is revoked, limited or otherwise affected by action of the Federal or State Health Care Agency, or in the event that they receive any notification or investigation of their license.

2. **Focused Professional Practice Evaluation (FPPE)/Proctoring**

The routine FPPE/Proctoring plan is outlined on the APP privilege form. Once all elements of the FPPE/Proctoring are complete, the outcome of the FPPE will be recorded in the confidential Quality section of the credentials file (maintained by the Medical Staff Office).

During the initial proctoring period, the charts of each patient seen by the APP will be reviewed by the Supervising Physician.

Formal review will be made in writing by the Department Chair or designee initially, and annually, thereafter. The content of such formal evaluation will be discussed with the APP as part of their annual review and kept on file.

3. **Patient Records**

The APP will be responsible for the preparation of a complete medical record for each patient contact per existing Alameda Health System policies and Medical Staff Bylaws, Rules & Regulations and policies.

4. **Supervision**

The APP is authorized to implement the Standardized Procedures in this document without the direct or immediate observation, supervision or approval of a physician, except as may be specified in the Scope of Practice. In accordance with Medical Staff Bylaws, Rules & Regulations and policies, the supervising

physician is ultimately responsible for adherence to this protocol and for the quality of care provided by APP in their respective areas. Physician consultation is available at all times, either on-site, telephone, or by electronic means.

Scope of Practice

1. **Policy**

APPs are authorized to diagnose and treat medical problems according to accepted criteria and management including, but not limited to:

a. Assessment and management of acute, perioperative, chronic and cancer-related pain
b. Performance of pain-focused physical exams
c. Ordering and interpreting imaging and laboratory studies relevant to pain conditions
d. Formulation and implementation of multimodal pain treatment plans, including pharmacologic and non-pharmacologic therapies
e. Patient and family education regarding pain conditions and treatment options
f. Collaboration with interdisciplinary team members including primary care, oncology, palliative care, physical therapy, and behavioral health
g. Coordination of interventional pain procedures, including patient preparation and post-procedural follow-up
h. Prescription and monitoring of controlled substances in compliance with institutional and regulatory guidelines
i. Participation in quality improvement initiatives, clinical documentation, and activities as required by the department or institution

2. **Authorized Duties and Practice**

The APP is authorized to do the following patient-related activities within the scope of practice defined by Title 16:

a. Take the patient's medical history and perform a physical examination for any presenting problem;
b. Order specific laboratory studies and x-rays, and other studies as appropriate for that patient;
c. Collect specimens as indicated for additional tests;
d. Perform pertinent laboratory tests in compliance with Clinical Laboratory regulations;
e. Perform any other procedure for which they have been granted privileges;
f. Counsel patients and their families on health promotion, diagnosis and management options;
g. Diagnose and treat acute, perioperative, chronic and cancer-related pain;
h. Complete medical records for every patient encounter in the department of Anesthesia, Pain Medicine Division computer-based format followed by all providers in the Department of Anesthesia, Pain Medicine Division.

3. **Procedures and Minor Surgeries**

a. APP at time of hire will need to demonstrate competency in each of the basic Pain Medicine skills. Advanced procedures require proctoring and advanced attending approval before procedure is initiated in the Pain Medicine patient. The APP will follow existing Pain Medicine department protocols for each procedure done in the Pain Medicine patient, including sterile procedure, sedation, observation and confirmatory testing.
b. For procedures that require consent APP will be responsible for obtaining informed consent from the patient
c. At the completion of the procedure the APP will write a procedure note that includes and complications and the name of the attending physician.
d. The APP can perform the following list of procedures for Pain Medicine patients once granted privileges and demonstrated competency by direct observation or documented prior work experience.

i. Pain Medicine procedures (in accordance with the privilege form)
   - Trigger point injections
   - Subcutaneous or intramuscular medication administration
   - Peripheral joint or bursal corticosteroid injections (e.g., trochanteric bursa, knee, shoulder)
   - Catheter (e.g., epidural and/or peripheral nerve) removal
   - Wound and dressing change
   - Spinal cord stimulator (SCS) trial lead removal

4. **Protocols**
   a. The APP has been granted privileges within the Alameda Health System to perform the requested procedures.
   b. The APP has been trained to perform the procedure(s), has been observed satisfactorily performing the procedure(s) by another provider competent in that skill, and continued competency is assessed per AHS policy.
   c. The APP is following standard medical technique for the procedures as described in the Resources listed in this document.
   d. Appropriate patient consent is obtained, if necessary, before the procedure.
   e. Unless otherwise exempt, all biopsied tissue is sent for a pathology report.
   f. All other applicable Standardized Procedures in this document are followed during health care management.
   g. All General Policies regarding Review, Approval, Setting, Education, Evaluation, Patient Records, Supervision and Consultation in these Standardized Procedures are in force.

Drug Orders and Furnishing

POLICY
The APP is authorized to furnish or order drugs and devices under the following protocols:

PROTOCOLS
1. The APP has a current Furnishing, NPI, and DEA number.
2. The drugs and devices ordered or furnished are consistent with the APP's educational preparation or for which clinical competency has been established and maintained and listed in the AHS formulary, the patient's insurance formulary, non-formulary medications for which there are no substitutes, or practice recommendations listed in the Resources in this document. Examples are listed in the "Formulary" document at the end of this Standardized Procedure.
3. The drug or device furnished or ordered is appropriate to the condition being treated.
4. APPs may order or prescribe those medications that are FDA approved unless it is used in a clinical investigation, such as a clinical trial, which must be approved by AHS IRB. Additionally, expanded access, sometimes called "compassionate use," may be used when it is outside of a clinical trial of an investigational medical product. Prior IRB review and approval is required, even if only one patient is to be treated under this procedure. Prior approval by the FDA is also required for these cases.
5. "Off label" use, or prescription of FDA-approved medications for uses other than that indicated by the FDA, is permitted when such practices are within the current standard of care for treatment of the disease or condition.
6. Patient education is given regarding the drug or device.
7. The Statement of Approval and Agreement signed by the APP will act as the record of APP authorized to Furnish.

8. No single physician will supervise more than four APPs at any one time.
9. A physician must be available at all times in person or by telephonic contact.
10. All other applicable Standardized Procedures in this document are followed during health care management.
11. All General Policies regarding Review, Approval, Setting, Education, Evaluation, Patient Records, Supervision and Consultation in these Standardized Procedures are in force.

Ordering scheduled Controlled Substances

POLICY
The APP is authorized to furnish or order scheduled controlled substances per the following protocols:

PROTOCOLS
1. The APP follows the provisions of the Standardized Procedure for Furnishing.
2. The controlled substances that may be ordered are included in the formulary(s) or references listed in this document.
3. Relevant scheduled drug contracts, DEA requirements, and all State and Federal regulations are adhered to.
4. Schedule II & III controlled substances are furnished or ordered following the Patient Specific Protocol, in addition to these General Protocols for Scheduled Controlled Substances.
5. The APP may furnish, prescribe or order any medications on the patient's insurance formulary or non-formulary medications for which there is no substitute, within the scope of the provider's license and within the scope of AHS ordering policies.
6. All other applicable Standardized Procedures in this document are followed during health care management.
7. All General Policies regarding Review, Approval, Setting, Education, Evaluation, Patient Records, Supervision and Consultation in these Standardized Procedures are in force.

SCHEDULE III PATIENT SPECIFIC PROTOCOL
1. Schedule III substances may be furnished or ordered when the patient is in one of the following categories, including but not limited to the following conditions:
    a. Acute illness, injury or infection: such as cough, fractures
    b. Acute intermittent but recurrent pain: such as headache
    c. Chronic continuous pain
    d. Hormone replacement

2. Limit order for acute illness, injury or infection to a maximum of 30 days & no refills without re-evaluation.

3. For chronic conditions:
    a. Pain management protocol or department guidelines is/are adhered to, if appropriate.
    b. Amount given, including all refills (maximum of 5 in 6 months per DEA regulations, is not to exceed a 120 day supply as appropriate for the condition.
    c. Treatment plan must be established in collaboration with the patient's primary care provider and reviewed, with documentation, every 6-12 months.
    d. No further refills without reevaluation.

4. Education and follow-up is provided.

SCHEDULE II PATIENT SPECIFIC PROTOCOL

1. Schedule II controlled substances may be ordered when the patient has one of the following diagnoses and under the following conditions.
   a. Pain from cancer, post-operative pain, and trauma.
   b. Pain unresponsive to, or inappropriately treated by CS III-V substances
   c. Attention Deficit Hyperactivity Disorder (ADHD)
   d. Neuropsychiatric Conditions
2. Limit order for acute and chronic conditions as specified above in Schedule III Protocol.
3. No refills for CS II medications are authorized except where authorized by the DEA.
4. Pain Management Protocol or Department guidelines is/are adhered to if appropriate.

Medication Management

POLICY

The APP is authorized to manage drugs and devices under the following protocols:

PROTOCOLS

1. The management of drugs or devices includes evaluating, initiating, altering, discontinuing, furnishing and ordering of prescriptive and over-the-counter medications.
2. Medication evaluation includes assessment of:
   - Other medications being taken.
   - Prior medications used for current condition.
   - Medication allergies and contraindications, including appropriate labs and exams.
3. The drug or device is appropriate to the condition being treated, and:
   - Accepted dosages per references.
   - Generic medications are ordered if appropriate.
4. A plan for follow-up and refills is written in the patient's chart.
5. The prescription must be written in patient's chart including name of drug, strength, instructions and quantity, and signature of the APP.
6. All other applicable Standardized Procedures in this document are followed during health care management.
7. All General Policies regarding Review, Approval, Setting, Education, Evaluation, Patient Records, Supervision and Consultation in these Standardized Procedures are in force

Authorizations

POLICY

The APP is authorized, under the following protocols, to:

- Assess Worker's Compensation injuries and illnesses
- Certify Disability
- Manage Home Health and Personal Care Services
- Order Restraint and Seclusion

PROTOCOLS

1. Workers' Compensation: The Doctor's First Report of Occupational Injury or Illness for a workers' compensation claim can be for a period of time off in relation to injury. The treating physician is required to sign the report and to make any determination of any temporary disability.
2. Certify Disability: The APP has performed a physical exam and collaborated with a physician and surgeon.

3. Home Health and Personal Care Services: Approval, signing, modifying, or adding to a plan of treatment or plan of care
4. Restraint and Seclusion: The APP must be knowledgeable and competent in the Hospital Conditions of Participation for Patients' Rights including the Interpretive Guidelines. Ordering physical or chemical restraint, and/or seclusion, is in strict accordance with the protocols adopted in the Resources section of this document which include the extent of implementation and which meets the intent of the acute medical and surgical hospitals Conditions of Participation for Rights.
5. All other applicable Standardized Procedures in this document are followed during health care management.
6. All general policies regarding review, approval, setting, education, evaluation, patient records, supervision and consultation in these standardized procedures are in force.

5. **Standard of Care**

Standards for adequacy of diagnosis, management and treatment shall be in accordance with hospital Policy and Procedure, clinic protocols, current community standards of care, Anesthesia, Pain Medicine Division Department protocols or current texts/articles on care found in the Department of Anesthesia, Pain Medicine Division.

6. **Consultation and Referral**

The APP will be providing health care as outlined in this document. In general, communication with a physician who is a current member in good standing of the Medical Staff, and who holds privileges in the Department of Anesthesia, Pain Medicine Division will be sought for all the following situations, and any others deemed appropriate. Whenever a physician is consulted, a notation to that effect, including the physician's name, must be made in the chart.

a. Conditions that do not follow clinical protocols, procedures, classic diagnostic patterns, or that have failed to respond to standardized treatments and/or management.
b. Any significant unexplained physical or historical findings.
c. Emergency situations after initial care.
d. When the patient expresses a desire to see a physician.

The following situations are examples (not exhaustive) of those that will likely require physician advice or consultation:

e. Persistent or worsening pain despite standard multimodal therapy, including opioid rotation or escalation.
f. Requests for initiation or continuation of high-dose opioids outside institutional opioid stewardship thresholds.
g. New or worsening neurologic deficits (e.g., foot drop, saddle anesthesia, bowel/bladder changes).
h. Suspected spinal cord compression or cauda equina syndrome.
i. Complications related to interventional procedures (e.g., infection, hematoma, unintentional dural puncture).
j. Requests for interventional procedures requiring physician oversight (e.g., epidural steroid injection, sympathetic blocks, spinal cord stimulator trials).
k. Patient with poorly controlled psychiatric comorbidities impacting pain management (e.g., suicidality, substance use disorder, somatization).
l. Complex diagnostic uncertainty requiring specialist input (e.g., unexplained pelvic pain with negative imaging and labs).
m. Requests for medical cannabis, ketamine, or off-label controlled substances.

7. **Other duties**

The patient must be informed that the provider is an APP and be given the opportunity to request care by a

physician should the patient desire it.

8. **APP - Nursing Staff Relationship**

The APP is authorized to give nursing personnel orders for all laboratory and x-ray studies, treatment and medication for those patients for whom the APP is providing medical care. Orders given by the APP are orders generated in agreement with the Consulting Physician. Any questions regarding these orders that are not satisfactorily resolved through discussion with the APP should be brought to the Consulting Physician before being carried out.

9. **Agreement Review**

The signature on the Attestation by the APP acknowledges agreement to practice within the limits of the foregoing standardized procedures/practice guidelines. Upon its review, if changes are made, new signatures will be necessary.

10. **References/Resources**

- AHS/AH Medical Staff Bylaws
- Medical Staff Advanced Practice Provider policy and procedure manual
- Medical Staff Privilege forms
- Nurse Practice Act in the California Business and Professions Code
- Physician Assistant Practice Act
- References that define Standard of care for the include, but are not limited to:
  - o UpToDate
  - o Roberts and Hedges Procedural Book
  - o AHS Formulary for drug use and current antibiogram

Approvals:

Committee on Interdisciplinary Practice	6/4/25
Credentials Committee	6/12/25
CPC	7/3/25
Medical Executive Committee	7/16/25
QPSC	7/23/25

Signature:

Signature implies the following: approval of all the policies and protocols in this document, the intent to abide by the Standardized Procedures, the willingness to maintain a collegial and collaborative relationship with all the parties, and agreement of all collaborating/supervising physicians within the department.

Nurse Practitioner/Physician Assistant (Printed Name): _____

Signature:_____ Date: _____

ALAMEDA HEALTH SYSTEM	Policy	
	Subanesthetic Ketamine Use for Pain or Withdrawal Policy	**29275 6**
	LEVEL ☐ System ☐ Site	EFFECTIVE DATE: 11/2024

POLICY

To ensure the safe and effective use of subanesthetic intravenous ketamine for the management of pain or withdrawal states.

LEVEL OF CARE RESTRICTION

1. If provider concerned for cardiac history or hemodynamic instability, can be administered in a telemetry monitored bed.

INDICATION OF USE

- Analgesia for:
  - Moderate to severe acute pain
  - Acute or chronic pain (e.g. sickle cell) in the opioid tolerant patient
  - Refractory pain
- Peri- and post- operative adjuvant analgesia
- Withdrawal states (e.g. opioid, alcohol, etc)

CONTRAINDICATIONS TO USE

Absolute

- Hypersensitivity to ketamine or any component of the formulation (e.g. benzethonium)
- Conditions for which a significant elevation in blood pressure would be hazardous 9e.g. uncontrolled/poorly controlled hypertension, acute heart failure, unstable tachyarrhythmias, ACS/MI, acute stroke, unstable angina, severe aortic stenosis, or eclampsia)
- Pregnancy

Relative contraindications

- Cardiac decompensation
- CNS depression
- Tachyarrhythmia
- Increased intraocular pressure
- Aneurysms
- Thyrotoxicosis

PROCEDURE

Provider Responsibilities:

1. Order subanesthetic intravenous ketamine using clinical practice guidelines dosing

recommendations

Nurse Responsibilities:

1. All patients must be educated on ketamine-induced hallucinations and other associated reactions prior to bolus and infusion initiation

2. Be available to be at bedside with the patient for the first 15 min after administration of the ketamine bolus dose.

3. Administer Ketamine IV Infusions via peripheral IV or central IV lines only through the Alaris or CADD Pump using Guardrails Safety System

4. Obtain accurate weight for appropriate weight base dosing of Ketamine

5. Initial Baseline Monitoring
    a. BP, HR, RR, SpO2, history and discussion of emergence reactions, Pain Scale level, location of pain

6. Ongoing Monitoring
    a. BP, HR RR, SpO2, Pain Scale level
    b. Q15min x1 hr, then Q30 minutes x1 hour then every 4 hours until treatment goal

7. Once Ketamine infusion discontinued, then monitor the pts BP, HR, RR, SpO2, and Pain Scale 1-hour post ketamine infusion.

8. Notify ordering physician and continue infusion if:
    a. SBP > 160 mmHg and < 180 mmHg
    b. HR > 120 bpm and < 140 bpm
    c. Agitation

9. Stop the infusion and call the ordering physician IF:
    a. Systemic blood pressure ≥ 180 mmHg
    b. Blood pressure increases > 30 mmHg diastolic or systolic
    c. Heart rate ≥ 140 bpm
    d. Respiratory rate < 8 bpm
    e. spO2% < 93 %
    f. Respiratory distress or respiratory depression
    g. Agitation, unresponsive to midazolam
10. Monitor for signs and symptoms of ketamine toxicity
    a. Respiratory depression
    b. Hypertension

c. Pulmonary edema
d. Hypertensive encephalopathy
e. Cerebral hemorrhage
f. Delirium

Pharmacist Responsibilities:

1. Validate appropriate dosing based on recorded weight
2. Compound Ketamine
    a. To prepare ketamine for bolus administration, dilute ketamine (concentration of 50 mg/mL, 100 mg/mL) 50 mL of D5W or NS and mix well.
    b. To prepare ketamine for infusion, dilute to a 1 mg/mL concentration by combining 10 mL (50 mg/mL) or 5 mL (100 mg/mL) of product with 500 mL of D5W or NS.
    c. If fluid restriction is required, may dilute to a 2 mg/mL concentration by combining in 250 mL diluent

REFERENCE

Radvansky BM, Shah K, Parikh A, Sifonios AN, Le V, Eloy JD. Role of ketamine in acute postoperative pain management: A narrative review. *BioMed Research International,* 2015; 1-10.

Schwenk ES, et al. Consensus Guidelines on the Use of Intravenous Ketamine Infusions for Acute Pain Management from the American Society of Regional Anesthesia and Pain Medicine, the American Academy of Pain Medicine, and the American Society of Anesthesiologists. *Reg Anesth Pain Med 2018;43: 456–466.*

Klugh JM, Puzio TJ, Wandling MW, et al. Ketamine for acute pain after trauma: A pragmatic, randomized clinical trial.

		System	Alameda	AHS Core	San Leandro
System Pain and Addiction	**Date:**	**6/2025**			
System Pharmacy and Therapeutics	**Date:**	**7/2025**			
Clinical Practice Council	**Date:**	**8/2025**			
Medical Executive Committee	**Date:**	**8/2025**			
Board of Trustees	**Date:**	**9/2025**			

ALAMEDA HEALTH SYSTEM

ANTIMICROBIAL STEWARDSHIP PROGRAM POLICY

Effective Date	9/2025	***Date Revised***	7/2025
Document Owner	PRIYA PATEL (MGR SYS MED SAFETY-CLIN PHARM)	***Next Scheduled Review***	9/2028
Executive Responsible	Director, Pharmacy		

PURPOSE

To define the components of the Antimicrobial Stewardship Program, its membership, role, and responsibilities.

POLICY

The Antimicrobial Stewardship Program (ASP) will promote and monitor compliance with evidence based guidelines or best practices regarding antimicrobial prescribing which may include but not limited to the following activities including those recommended by the CDC's Core Elements of a Hospital Antimicrobial Stewardship Program Checklist:

1. Streamlining or de-escalation of therapy
2. Educational activities
3. Antimicrobial management protocols and guidelines
4. Surveillance monitoring
5. Review of appropriate utilization of formulary restricted antimicrobials
6. IV to PO Conversions
7. Pharmacokinetic monitoring (e.g., Vancomycin, Aminoglycosides)
8. Renal dose adjustments
9. Automatic stop orders for antibiotics
10. Antibiogram development and distribution

Components of the Antimicrobial Stewardship Program

Antimicrobial Stewardship Committee

1. Membership:
    a. The Antibiotic Stewardship Committee will be physician directed and chaired by an Infectious Disease physician (or physician who has received specific training in antimicrobial stewardship) with support by a multidisciplinary inter-professional team.
    b. The voting members of the ASP will include, at a minimum:
        i. Physician who has received specific training in antimicrobial stewardship
        ii. Pharmacist who has received specific training in antimicrobial stewardship
        iii. Representative from Clinical Microbiology
        iv. Infection Control

v. Practicing provider. This member may be the same as above (i)

c. Subcommittees may exist at each facility to address facility-specific needs.

2. The committee will meet at least quarterly.
    a. The presence of the physician chair (or surrogate physician chair) and two other voting members of the committee will constitute a quorum sufficient to conduct a meeting*

    * Antimicrobial Stewardship Committee is a subcommittee of Pharmacy and Therapeutics Committee, whose voting members may serve on the Stewardship Committee.

3. Responsibilities of the committee
    a. Develop and publish antibiograms annually
    a. Develop, update and publish an empiric therapy guide for management of common infection syndromes annually
    b. Review and update the antimicrobial formulary annually
    c. Develop and review antimicrobial-related policy and procedure
    d. Review antimicrobial usage and develop means for improvement
    e. Assess and modify ongoing stewardship activities as needed
    f. Develop/update and implement evidence based practice protocols and guidelines that incorporate local microbiology and resistance patterns

4. Reporting – Pertinent reports from the Antibiotic Stewardship committee will be presented at the following committees annually
    a. P&T Committee – Annually and PRN based upon the content of ASP discussion
    b. Medical Executive Committee - Annually
    c. Infection control – Annually
    d. Quality and Safety Council- Annually

5. Education
    a. Practitioners and staff education
        i. Upon hire and annually thereafter

Empiric Therapy Guide

1. The Antibiotic Stewardship Committee at each campus will annually formulate and publish an Empiric Antimicrobial Therapy Guide (ETG). The ETG will contain the following information:
    a. Bacterial antibiograms from the previous calendar year
    b. Empiric antimicrobial therapy recommendations for common infectious diseases and syndromes
    c. Prophylactic antimicrobial regimens for surgeries
    d. Dosing recommendations for common antimicrobials

2. Adherence to the recommendations in the ETG will be strongly encouraged. Alternate therapy might be warranted and, in such situations, providers are encouraged to document in the Electronic Health Record.

3. Recommendations in the ETG will represent consensus of the Antimicrobial Stewardship Committee from evidence-based recommendations and will incorporate the thoughts and views of campus prescribers in relevant fields of practice. The Antibiotic Stewardship Committee will solicit the input of prescribers in relevant fields of practice as a part of all changes and updates to the ETG.

Retrospective or Prospective Antimicrobial Audit

1. A list of antimicrobials deemed at high risk of inappropriate use will be selected by the Antibiotic Stewardship Committee to be targeted for retrospective or prospective audit. This list shall be reviewed at least once yearly by committee. Antimicrobials may be added or removed from the targeted list at the discretion of the committee.

2. Use of the targeted antimicrobials will be reviewed by pharmacist to ensure use of appropriate drug, dose and duration of therapy. The pharmacist may review the charts of identified patients for appropriate use of antimicrobials and may order procalcitonin levels when appropriate to aid in decision making regarding initiation/continuation of antimicrobial therapy. In conjunction with the medical team, decisions will be made regarding appropriate use of the targeted antimicrobials, including (but not limited to):
    a. Appropriate drug
        i. Drug indicated for confirmed and/or suspected pathogens
        ii. Drug spectrum of activity necessary for confirmed and/or suspected pathogens
        iii. Duplicate coverage and/or multiple drugs warranted (if applicable)
    b. Appropriate dose
        i. Adjustment for renal/hepatic function
        ii. Adjustment for body size
        iii. Adjustment for indication/ site of infection
    c. Appropriate duration
        i. Continued coverage necessary for specified indication
        ii. Duration of therapy defined where possible
    d. Recommend Infectious Disease consult

3. All recommendations by the pharmacist shall be communicated to the medical team (except per pharmacy renal dosing adjustment and IV to PO conversion policy). All final decisions regarding use of antimicrobials will be the responsibility of the patient's primary medical team. Additionally, during these communications the pharmacist will practice "handshake stewardship" by providing useful antimicrobial education related to the case at hand.

4. A review of antimicrobial usage data shall be conducted by the pharmacist quarterly to assess for stewardship opportunities and areas for improvement. This assessment shall be presented to the Antimicrobial Stewardship Committee.

D. Formulary Restrictions

1. A list of restricted antimicrobials shall be made available to healthcare providers
2. Utilization of the restricted antimicrobials will be reviewed annually

REFERENCES

1. Antimicrobial Stewardship Standard -The Joint Commission Standard MM.09.01.01-2022https://www.jointcommission.org/-/media/tjc/documents/standards/r3-reports/r3_antibioticstewardship_july2022_final.pd
2. California Department of Public Health Antimicrobial Stewardship Program Toolkit-2015 **https://www.cdph.ca.gov/programs/hai/Documents/ASPToolkit2015FINAL_ADA.pdf**
3. CDC- Core Elements of Hospital Antibiotic Stewardship Programs https://www.cdc.gov/getsmart/healthcare/pdfs/core-elements.pdf

APPROVALS

		System
Antimicrobial Stewardship	**Date:**	**5/2025**
Pharmacy and Therapeutics (P&T)	**Date:**	**7/2025**
Clinical Practice Council (CPC)	**Date:**	**8/2025**
Medical Executive Committee	**Date:**	**9/2025**
Board of Trustees	**Date:**	**9/2025**

ALAMEDA HEALTH SYSTEM

MEROPENEM EXTENDED INFUSION POLICY

Site	Alameda Health System	***Previous Revision Dates***	
Effective Date	9/2025	***Date Revised***	7/2025
Document Owner	MGR SYS MED SAFETY-CLIN PHARM	***Next Scheduled Review***	9/2028
Executive Responsible	DIRECTOR, PHARMACY		

POLICY

To ensure the safe and effective use of extended infusion meropenem for patients with multidrug resistant infections.

RESTRICTIONS TO INDICATION OF USE

1. Must be approved by ID consult attending physician

PROCEDURE

Provider Responsibilities:

1. Confirm ID consult attending physician approval
2. Order Meropenem Extended Infusion using the approved Meropenem Extended Infusion Order Set

Pharmacist Responsibilities:

1. Review order for appropriateness
2. Adjust meropenem dose/frequency as needed for renal function using table below. If no serum creatinine within the past 72 hours, proceed with standard dose, order serum creatinine and adjust dose as necessary.

Meropenem Extended Infusion (3-hour infusion) Renal Adjustments				
Creatinine Clearance (per Cockroft-Gault)	>50 mL/min	26-50 mL/min	10-25 mL/min	<10mL/min, HD
Dose	2g q8h	2g q12h	1g q12h	1g q24h (time doses for late in the day so doses are administered after HD on days the patient is dialyzed)

Nurse Responsibilities:

1. Confirm Y-site compatibility. See common incompatible agents in table below and check Micromedex for any updates
2. Administer Meropenem IV Infusions via peripheral IV or central IV lines only through the Alaris Pump using Guardrails Safety System

Common Y-site Incompatibilities (check Micromedex for updates)

Know Incompatible Agents	Variable compatibility (Consult detailed reference)
• Amiodarone hydrochloride • Amphotericin B conventional colloidal • Amphotericin B lipid complex (Abelcet) • Amphotericin B liposome (AmBisome) • Amphotericin B • Blinatumomab • Calcium gluconate • Ciprofloxacin • Dacarbazine • Daunorubicin citrate liposome • Diazepam • Dolasetron • Doxorubicin hydrochloride • Epirubicin hydrochloride • Eravacycline • Fenoldopam mesylate • Garenoxacin mesylate • Idarubicin hydrochloride • Isavuconazonium sulfate • Ketamine hydrochloride • Mycophenolate mofetil hydrochloride • Nicardipine hydrochloride • Oritavancin • Pantoprazole sodium • Quinupristin-Dalfopristin • Temocillin sodium • Topotecan hydrochloride	• Acyclovir • Doxycycline hyclate • Ondansetron hydrochloride • Propofol • Zidovudine

APPROVALS

Pharmacy Departmental	**Date: 6/2025**
Antimicrobial Stewardship Committee	**Date: 7/2025**
System Pharmacy and Therapeutics	**Date : 7/2025**
CPC	**Date: 8/2025**
Medical Executive Committee	**Date: 9/2025**
Board of Trustees	**Date: 9/2025**

ALAMEDA HEALTH SYSTEM

RADIOPHARMACEUTICALS: PROCUREMENT, RECEIVING, STORAGE AND SECURITY

Effective Date	9/2025	***Date Revised***	7/2025
Document Owner	MGR SYS MED SAFETY-CLIN PHARM	***Next Scheduled Review***	9/2028
Executive Responsible	BOT, QPSC		

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

Policy

It is the policy of Alameda Health System (AHS) to assure that the Nuclear Medicine Division of the Department of Radiology procures, receives, and securely stores radiopharmaceuticals according to standards to protect the general population and employees having contact with radiopharmaceuticals.

Procedure

1. Procurement

a. Only Physician Authorized Users (AU) or a Certified Nuclear Medicine Technologists (CNMT), under supervision of an AU employed by AHS, will order radiopharmaceutical materials ensuring that the requested are FDA approved, currently on the AHS formulary, do not exceed license limits or involve unlicensed isotopes.

b. Will be procured from a licensed Radio-pharmacy by unit dose ranges per P&T approved

c. Only P&T approved radiopharmaceuticals will be procured.

1) The Radiation Safety Officer (RSO) and Nuclear Medicine Division has established and maintains an online tracking system for ordering and receiving radiopharmaceutical materials.

2) The tracking system records supplier, AU, isotope, chemical form, activity, expiration date and time.

3) The online system is used to order all next day unit doses. Same day unit doses will be ordered by calling the radiopharmacy directly. All unit doses will be ordered within the prescribed dose range for that procedure.

d. All doses requiring a written directive are kept in electronic form via the PACS system of Document Capture. The written directive includes the AU performing the procedure, isotope, compound, activity and supplier. The person receiving the radiopharmaceutical material checks the AU's written directive to confirm the materials received is what was ordered.

2. **Receiving**
   a. The authorized radio-pharmacy trained couriers will be instructed to deliver and sign in the radio pharmaceutical materials directly to the Nuclear Medicine Hot Lab and lock up after the delivery. All incoming and outgoing packages will be placed in the appropriately marked areas in the Hot Lab properly labeled.
   b. Packages containing radiopharmaceutical materials will only be opened and inspected by trained Nuclear Medicine personnel in accordance with "Procedures for safely opening packages containing radiopharmaceutical material".

3. Storage and Security
   a. Only trained personnel will be allowed access to the Nuclear Medicine Hot Lab. The RSO, CNMT and trained radio-pharmacy couriers are approved personnel.
   b. Radiopharmaceuticals will only be stored in the hot lab.
   c. Pharmacy will perform a monthly unit inspection to assess proper storage requirements.
   d. Radiopharmaceuticals will be checked daily by CNMT for expiration dates and returned to licensed nuclear pharmacy when properly decayed.

References

TJC MM 03.01.01

Approvals

		System	Alameda	AHS Core	San Leandro
Radiology Department/RSO/Nuclear Medicine Department	**Date:**	**7/2025**			
System Pharmacy and Therapeutics	**Date:**	**7/2025**			
Patient Care Leadership Team	**Date:**				
Clinical Practice Council	**Date:**	**8/2025**			
Medical Executive Committee	**Date:**	**9/2025**			
Board of Trustees	**Date:**	**9/2025**			

ALAMEDA HEALTH SYSTEM	Policy	
	CONTROLLED SUBSTANCE DRUG DIVERSION INVESTIGATION AND REPORTING	**25531 3**
	LEVEL ☐ System ☐ Site	EFFECTIVE DATE: 9/2025

Purpose

To provide guidelines for the auditing, identification, investigation, and reporting of suspected *controlled substance drug diversion* and controlled substance loss (hereinafter "Drug Diversion") by Alameda Health System (AHS) Personnel.

Policy

Controlled Substance Drug Diversion is strictly prohibited by AHS and is required to be reported upon discovery to respective regulatory bodies, including but not limited to the California Board of Pharmacy (CA-BOP), Drug Enforcement Agency (DEA), Board of Registered Nurses (BRN), and Medical Board of California (MBC). Consistent with this commitment, suspected Drug Diversion will be thoroughly investigated. If Drug Diversion is validated, determined to be appropriate corrective and regulatory reporting actions will be taken.[1]

The Chief Operating Officer(COO), Chief Medical Officer(CMO) and Chief Clinical Officer(CCO) in addition to members of the AHS Controlled Substance Diversion Prevention Committee, will jointly confer and determine who shall coordinate and be involved in the investigatory process.

Definitions

1. **Controlled substance:** Medications classified as Schedule I through V by the Federal Drug Enforcement Agency and/or applicable state law.

2. **Drug Diversion:** Use or taking possession of a prescription medication or medical gas without proper authorization from AHS supplies, AHS patients, or through the use of AHS prescription, ordering, and dispensing systems. Examples of drug diversion include, but are not limited to:
    a. Medication theft
    b. Use or taking possession of a medication without a valid order or prescription
    c. Stealing prescription pads or paper
    d. Forging or inappropriately modifying a prescription
    e. Use or taking possession of medication waste (*i.e.*, left over controlled substance medication)

[1] A violation of this policy is subject to corrective action, including but not limited to, suspension/termination of credentials/privileges and/or contract termination.

f. Use or taking possession of medications intended for the administration to patients, but not providing the medication to the patient.
g. Falsifying medication administration records to indicate that medications were provided for patient care, but medications were found to have not been given to the patient.
h. Omission of, or inaccurately performing waste documentation of controlled substance medications

3. **Prescription Medication:** A medication that according to federal law requires a prescription prior to dispensing.

4. **AHS Personnel:** Any consulting staff, administrative staff, allied health staff, fellow, resident, student, volunteer, contract worker, or any other employee or individual who has received an appointment at AHS.

5. **Licensed or registered health care provider:** Health care provider whose license or registration allows him/her to provide care and services within the scope of their respective practices and as authorized from respective regulatory agencies.

6. **Reasonable Suspicion:** Reasonable suspicion of drug diversion may arise from a variety of circumstances, including, but not limited to, the following:

   a. Witnessed incident of probable drug diversion
   b. Behaviors that may indicate an impaired individual
   c. Suspicious activity identified during routine monitoring and/or proactive surveillance
   d. Self-disclosure of drug diversion by an individual
   e. Notification of suspected drug diversion from an external source, such as local law enforcement or a family member of a suspected drug diverter.

Procedure

A. Initial Report and Investigation

1. Please refer to the Control Substance Discrepancies Flow Chart (Table A)

2. If AHS Personnel have a Reasonable Suspicion that Drug Diversion has occurred, the AHS Personnel shall notify his or her supervisor of such events. The department supervisor shall engage with their leadership and the campus Pharmacy leadership to begin review of activity from various sources; including the electronic health record (EHR), automated dispensing cabinets, auditing software.

3. Staff may also anonymously contact the Compliance Hotline and submit an *AHS Safety Alert*. Any employee who reports suspected drug diversion honestly and in good faith will be protected from retaliation.

4. After a Reasonable Suspicion that Drug Diversion has occurred, the department supervisor will be notified if not already done so. The supervisor will notify HR and Compliance within 24 hours from when an AHS Personnel is subjected to reasonable suspicion of Drug Diversion in violation of this policy

5. Upon receipt of a reported Reasonable Suspicion of Drug Diversion, the supervisor must conduct an initial safety assessment. The supervisor's safety assessment will include the following steps:

    a. Determine whether any patient has been harmed or placed at risk of harm and take appropriate action to treat the patient or remove the risk of harm.
        i. If a patient has been harmed or placed at risk of harm, the supervisor will notify the patient's primary staff physician, Patient Safety (patientsafety@alamedahealthsystem.org) and Regulatory Affairs via telephone or via email at RegulatoryAffairs@alamedahealthsystem.org
    b. Determine whether the suspected Drug Diversion involves an impaired AHS Personnel or witnessed drug use by an AHS Personnel. If so, follow the procedure for managing an impaired AHS Personnel (See HR Policy #3.20 Expectations of Conduct).
        i. If an impaired AHS Personnel is involved, the supervisor will reach out to Legal and their HR Business Partner for guidance on reassignment of duties to prevent harm to patients, staff, AHS property or the individual under investigation.
        ii. Further the supervisor will engage with Legal and HR for guidance in the procedure for managing an impaired individual and the standards for AHS Personnel per AHS expectations of conduct. (See HR Policy #3.20 Expectations of Conduct) will be followed.

6. The department supervisor will then conduct an investigation to take steps that are immediately necessary to preserve any readily apparent evidence, such as medication vials or syringes. If evidence involves an infusion pump, the medication will be removed from the pump and placed in a sealed plastic bag. The pump should not be cleared and should be sequestered for further review and investigation.

B. Internal Reporting

1. If there is evidence that Drug Diversion has occurred or probably occurred after the completion of the initial report and preliminary investigation the Manager or Director will notify the Chief Administration Officer(CAO) and the site nurse leader (if nursing staff involved) or CMO and Medical Staff leadership (if physicians involved) or System Director of Pharmacy/System Medication Safety Officer, along with the Pharmacist-in-charge, Regulatory Affairs, Compliance and HR within 24 hours of completion of the initial diversion investigation. As explained above, Pharmacy leadership, Medical Staff leadership and/or Nursing leadership, in conjunction with HR, Regulatory Affairs, Compliance and Legal will meet to manage the investigation process and submission of all reports of suspected/confirmed controlled substance drug diversion.

Any report of a violation of this policy will be forwarded to the COO and CCO (if nursing staff involved), CMO (if medical staff involved) and System Director of Pharmacy/System Medication Safety Officer. Pharmacy and Compliance will be responsible for implementing the procedures set forth in the policy.

C. Reporting to Law Enforcement, Licensing Boards and Other Government Agencies

1. If a controlled substance is determined by multidisciplinary group (Medical staff, HR, Legal, Pharmacy, Nursing, Compliance, Regulatory Affairs, etc.) to have been diverted by any individual, the Pharmacist-in-charge will ensure that appropriate reports are made to the Drug Enforcement Agency (DEA) and the California State Board of Pharmacy within the required time frame.

2. Confirmed drug diversion by licensed or registered health care providers will be reported to the appropriate State licensing board, as detailed in this section. The employee and HR will be notified of the reporting to the applicable licensing board(s).
    a. The Director of Nursing or Vice President of Patient Care Services will report drug diversion by nurses.
    b. The VP of Physician Services will report drug diversion by staff physicians.
    c. The Program Director will report drug diversion by fellows, residents, or students.
    d. The Pharmacist in Charge and/or Pharmacy leadership will report drug diversion or loss attributed to any licensed staff, as required by the Board of Pharmacy and DEA.
    e. The applicable Supervisor or other Departmental leader will report drug diversion by all other licensed or registered health care providers.

3. AHS will also report licensed or registered health care providers to their applicable board when the employee has had three or more losses as defined by the State Board of Pharmacy as applicable by law report to the DEA and CA-BOP.

4. For any employee or individual that presents non-cooperation with AHS investigations for controlled substance diversion and/or there is no reasonable explanation for disposition of unaccounted controlled substance, the individual shall be reported to their respective licensing board.

D. Patient Notification

1. If any patient is harmed by Drug diversion, Patient Safety and Regulatory will be contacted to assist in notifying the patient of the circumstances of the Drug Diversion and its impact on the patient. The patient's primary physician will work with Patient Safety to ensure this communication occurs.

2. All charges to the patient's account for diverted drugs will be reversed.

E. Violation of this policy – Drug Diversion

1. If, upon completion of the investigation, there is substantial evidence indicating that a drug diversion has occurred:
    a. AHS Personnel determined to have violated this policy will be subject to revocation of pyxis access.
    b. AHS Personnel determined to have violated this policy will be subject to corrective action, including but not limited to, suspension/termination of credentials/privileges and/or contract termination.
        i. HR, Medication Safety Officer, Regulatory Affairs, Compliance and Legal will be consulted regarding documentation of a violation of this policy in employment or other records. Any request for information by a prospective employer will be referred to HR and Legal for review.

2. As indicated in Section (C), Drug Diversion by AHS personnel will be reported to all appropriate government, licensing, regulatory, and law enforcement agencies.

F. Collection, Analysis, Drug Diversion Prevention Data

1. Pharmacy may utilize (although not limited to) the below reports to monitor and track controlled substances:
    a. Automated Dispensing Machine Inventory discrepancy report
    b. Automated Dispensing Machine undocumented waste report
    c. Automated Dispensing Machine controlled substance compare report
    d. Automated Dispensing Machine standard deviation report
    e. Automated Dispensing Machine cancelled removal transactions
    f. Automated Dispensing Machine medication override report/Order Reconciliation
    g. Operating Room (OR) Controlled Substance administration record reconciliation
    h. Electronic Health Record Unreconciled Administration vs Automated Dispensing Machine Dispense Activity
    i. Anomalous User Ranking scores

2. Compliance Investigation
    a. Per the "Responsibilities for Compliance Reporting Policy", it is the policy of AHS to report and investigate any suspected actual or potential violation of law, regulation, AHS policy and procedure, or the AHS Code of Conduct.
    b. Upon receipt of a report of potential or known violation, the Compliance Office will:
        - Coordinate a prompt review and determine if Compliance investigation is warranted.
        - Assign an investigator and open a compliance investigation in the system of record.
        - Conduct a compliance investigation, working with stakeholders to gather facts and conduct interviews, as necessary.
        - Determine outcome of investigation and communicate outcome to stakeholders.
        - Ensure follow-up on resolution of compliance issues and concerns.
        - Document all actions taken in response to a compliance issue report, including any steps taken to address identified improper conduct, if any.

3. Anesthesiologist
    a. Undocumented administrations and undocumented waste reports will be audited by pharmacy daily
    b. Reconciliation of controlled substance removal to what was administered will be completed for each patient.

4. Nursing
    a. Undocumented administrations and undocumented waste reports will be audited by pharmacy daily.
    b. Nursing leadership will be contacted to meet with staff nurses in order to review and reconcile undocumented administrations and/or waste

c. A 14-day time frame will be provided for the nursing leader and staff to provide explanation to auditing pharmacy.
d. Once the 14-day deadline for follow-up has been reached, pharmacy shall count the affected medication(s) as loss accumulation.
e. Per CA-BOP Law, if the threshold for reporting is met or exceeded, pharmacy shall commence the required reporting process
f. Automated Dispensing Machine discrepancy reports will be reviewed by pharmacy daily and submitted to the AHS Safety Alert system for follow up.
g. For any non-profiled Automated Dispensing Machine's, random monthly audits of three-way reconciliation (order vs. removal vs. administration) will be expected. Any discrepancies will be submitted to the AHS Safety Alert.
h. Controlled Substance shift counts and inventories shall be performed by each unit/department at the specified intervals.

References

1. DEA 21 CFR 1301.91
2. CMS COP 482.25 (b)(7)
3. ASHP Guidelines on Preventing Diversion of Controlled Substances
4. California State Board of Pharmacy

Approvals

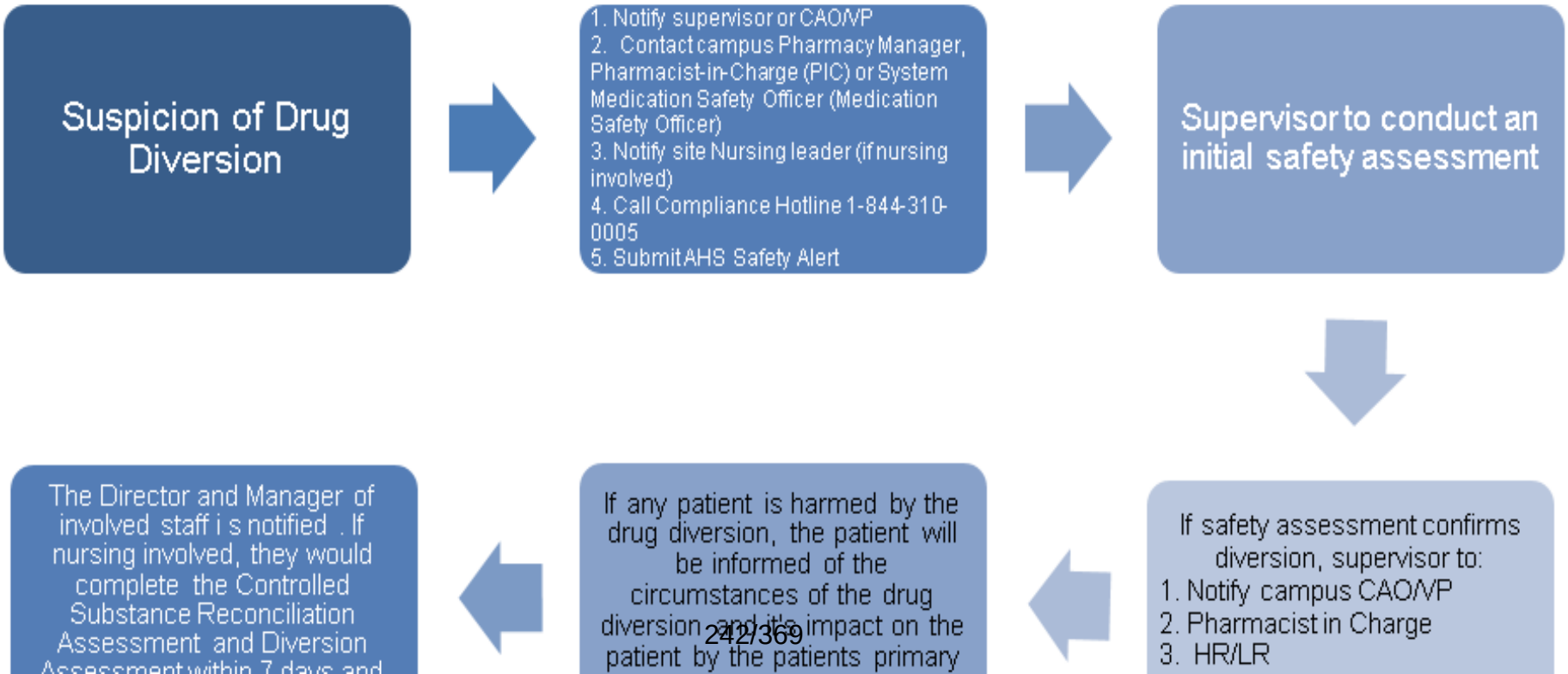
		System	Alameda	SLH/HH/JG
System Pharmacy Leadership	Date:	6/2025		
Regulatory Affairs	Date:	8/2024		
System Controlled Substance Diversion Prevention Committee	Date:	6/2025		
HR/Labor Relations	Date:	9/2024		
Legal Department	Date:	9/2024		
Compliance Department	Date:	6/2025		
System Pharmacy and Therapeutics	Date:	7/2025		
Clinical Practice Council	Date:	8/2025		
Medical Executive Committee	Date:	9/2025		
Board of Trustees	Date:	9/2025		

	Policy	
ALAMEDA HEALTH SYSTEM	**CONTROLLED SUBSTANCE DRUG DIVERSION INVESTIGATION AND REPORTING**	**25531 3**
	LEVEL ☐ System ☐ Site	EFFECTIVE DATE: 3/2025

Table A

ALAMEDA HEALTH SYSTEM

Controlled Substance Drug Diversion Flow Chart



	Policy	
	Clinical Alarm Testing Policy	**Reference # Version**
	Level ■ System ☐ Site	**Effective Date:** 09/05/2025 **Last Review Date**: 03/05/2025
	Document Owner: Biomedical Engineering	

POLICY STATEMENT
Clinical Alarm Testing -systemwide

PURPOSE
a. To ensure the regular scheduled maintenance and testing of alarm systems.
b. To ensure that alarms are activated with appropriate settings and are sufficiently audible with respect to distances and competing noise within the care unit.

SCOPE
a. Biomedical engineering will ensure that all medical equipment alarms included within the equipment management
program is maintained to manufacturer specification.
b. The Biomedical engineering department will collaborate with nursing administration on periodic inventories conducted by Nursing of all audible alarms on medical equipment within each clinical care unit in assessing their effectiveness and documenting any resulting modifications.

DEFINITIONS
Clinical alarm testing for medical devices periodically and as needed to ensure patient safety and effectiveness of alarms.

RESPONSIBILITIES
Biomedical Engineering will test medical device alarms as part of the manufacturer's preventive maintenance procedure. It will align with the MEMP (medical equipment management plan for AHS)

POLICY TEXT
a. Biomed will supply an inventory list of medical equipment (by department) covered under the Medical Equipment Management Program and their subsequent risk classifications.
    i. This list can be used as a starting point, but is NOT an all-inclusive list of alarm systems within the department.
b. Categorize and prioritize alarms
    i. High Risk
    ii. Moderate Risk
    iii. Minimal Risk
c. The Biomed risk classification system can be used as starting point for the prioritizing of clinical alarms for pieces of equipment covered under the Biomed Medical Equipment Management Program.
d. Test the audibility of alarms from the farthest appropriate point within the clinical care unit with competing background noise/alarms.
    i. Acceptable
    ii. Unacceptable
e. Identify and document potential problems
    i. Environmental Factors
    ii. Equipment Configuration

iii. Staff Protocol
iv. Staff Training

f. Develop corrective actions
g. Implement and document changes
h. Monitor success with periodic assessments

REFERENCES

MEMP: Medical Equipment Management Plan

Alameda Health System
Clinical Practice Council Charter

Purpose of the Clinical Practice Council

The Clinical Practice Council (CPC) is under the governance of the Alameda Health System (AHS) Medical Staff. The primary purpose of the Alameda Health System (AHS) Clinical Practice Council (CPC) is to review and approve all organization or clinical policies, cross-department protocols, and plans that impact or affect the delivery of patient care. In addition, CPC will review department-level procedures and guidelines.

Guiding Principles

- Ensure all policies, procedures, guidelines, protocols, and plans within CPC's scope:
  - are evidence-based and align with the best patient care and highest safety standards;
  - reflect consensus-driven patient care across disciplines and departments; and
  - are easily accessible to all employees.
- Support continuous performance improvement and patient safety throughout the Alameda Health System.

Approval Responsibilities & Reporting Structure

- All policies, procedures, guidelines, cross-department protocols, and plans that impact or affect the delivery of patient care will be reviewed in their respective committee prior to submission to CPC for review.
- CPC will review all submissions based on its guiding principles. Policies, protocols, and plans approved by CPC will be sent to the medical executive committee (MEC) for approval.
  - MEC will approve or reject documents submitted by CPC.
  - All documents approved by MEC will be presented to the BOT for final approval.
- CPC will review and provide guidance on department procedures and guidelines
- CPC oversees PolicyTech, which is supported by the quality department via the Policy Coordinator(s).

Review and Appeals Process

- If the MEC rejects or requests changes to a document, the policy coordinator will notify the author and provide feedback from the MEC.
- The revised document will be submitted for secondary review and approval by the next CPC meeting; if unable to meet deadline, the author will provide updates to the CPC chair(s).
- Unresolved disputes and delays should be escalated to the CPC chair who can coordinate resolution.
- Timely review and needed collaboration are expected.
- Efforts will be made at each meeting to move pending documents forward.

Membership Composition

- The Clinical Practice Council is a multidisciplinary committee consisting of members from the medical staff, quality, nursing, pharmacy, informatics, infection control, and other members as deemed necessary and appropriate to fulfill its function. Please see the table for committee membership.
- Committee members are appointed by the Chief of Staff (COS); co-chairs are appointed in consultation with the Chief Medical Officer (CMO) and the Chief Clinical Officer (CCO).
- Members serve a minimum of four years with staggered end dates.
- Members must attend at least 75% of scheduled meetings annually.
- Inactive members (failing to meet attendance requirements) will be replaced to maintain continuity.
- A proxy may vote only when attending in an official capacity for a designated member.

Clinical Practice Council Meetings

- CPC meets monthly.

- Meeting minutes are recorded, disseminated, and stored per regulatory requirements and AHS policy.
- The meeting agenda and materials are emailed to all active members at least five days before the meeting.
- A quorum consists of at least 30% active committee members. At least 3 physicians and 3 nurses must be present.
- Voting
    - Approval requires a majority of committee members that are present at each meeting.
    - Voting eligibility includes co-chairs, official members.
    - Voting may occur in-person or electronically. Electronic voting is permitted only when document approval is time-sensitive for safety or regulatory compliance.
    - Proxy voting is not permitted unless an alternate is officially designated. A proxy will be officially designated by the committee chair(s) following email communication from the appointed committee member. The COS has final approval on the appointment of the proxy voter.

Review & Amendment Process

- This charter will be reviewed every two years or at the request of the COS.
- Amendments to the charter must be approved by voting standards described above and submitted to the MEC for approval.

Table: Committee Membership

Role	Department
Council Co-Chair	Physician of the medical staff
Council Co-Chair	Nursing Leader
Member	VP Quality
Member	CMO or ACMO
Member	CMIO
Member(s)	Chiefs of Staff AHS and AH
Member(s)	Physician representatives from Ambulatory, Anesthesia, Emergency Medicine, Internal Medicine, Obstetrics & Gynecology, Orthopedics, Pathology, Pediatrics, Psychiatry, Radiology, Surgery.
Member	Nurse Informatics
Member(s)	RN (1 from each site) - AH, SL, HGH, JGPH, Amb
Member	Nursing Clinical Educator
Member	Pharmacy/Medication Safety Officer
Member	Infection Control
Member	Director of Regulatory Affairs

ALAMEDA HEALTH SYSTEM

August 27, 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:** B3

Meeting Date: August 27, 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 & AH Medical Staff:

- Medical Staff Credentialing and Privileging of Providers
- Medical Staff Policy for Credentialing Practitioners in the Event of a Disaster

Alameda Health System

MEDICAL STAFF CREDENTIALING AND PRIVILEGING OF PROVIDERS

Department	Medical Staff	***Effective Date***	5/2011
Campus	AHS, AH	***Date Revised***	5/2011, 6/2014, 6/2017, 6/2019, 2/2020, 1/2022, 4/2022; 4/2023; 5/2023; 10/2023; 11/2023; 2/2024; 3/2024; 3/2025; 4/2025; 8/2025
Unit	Medical Staff	***Next Scheduled Review***	8/2028
Manual	Medical Staff	***Author***	Manager, Medical Staff Services
Replaces the following Policies:		***Responsible Person***	Chief of Staff

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

Purpose

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

Policy Statement

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

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

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

Nondiscriminatory Statement and Audit Process

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

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

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

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

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

Procedure

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

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

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

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

Pre-Application

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

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

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

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

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

Initial Application for Appointment

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

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

The following forms must be completed and signed:

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

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

Reappointments

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

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

The following forms must be completed and signed.

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

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

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

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

Verification and Processing

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

withdrawal shall not give rise to hearing and appeal rights pursuant to the Bylaws. In accordance with the Bylaws, the Medical Staff will not take action on an application that is not "complete".

All information gathered on the application will be verified by the primary source (when applicable). Primary source may include oral verification which requires a dated, signed note in the credentialing file stating who at the primary source verified the item, and the date and time of verification.

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

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

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

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

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

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

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

5. Graduation from Medical/Professional School and Completion of Residencies and Fellowships
   Verification of medical/professional school graduation and completion of residency and fellowship training may be obtained from the institution(s) where the training was completed, and/or an agency that is deemed a primary source verification, such as the American Medical Association (AMA) Physician Masterfile or American Osteopathic Association (AOA) Physician Database, National Student Clearing House (NSCH) (upon confirmation the organization uses NSCH as their 3rd party) or Federation of State Medical Boards (FSMB) for closed residency programs or state licensing agency, if the state verifies.

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

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

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

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

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

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

   Signature on the Notice Regarding Background Investigation acknowledges and authorizes Medical Staff Services to search the following databases:
   - Social Security Number (SSN) Trace and Death Index
   - Maiden & Alias Name Search
   - Criminal Records Search – Federal, State and County Levels
   - National Wants and Warrants
   - National Sex Offender Registry
   - General Services Administration (GSA)
   - U.S. Government Terrorist List/Office of Foreign Assets Control (OFAC)

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

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

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

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

14. Continuing Medical Education
    A statement documenting Continuing Medical Education must be included with the application for appointment or reappointment or a signed statement indicating that the practitioner has met or exceeded continuing medical education requirements for licensure.

Courses must reflect appropriate training for the specialty and privileges requested and meet any state mandated CME requirements.

15. Provider Enrollment
    For applicants who are assigning billing, collected information will be distributed to health plans as required for purposes of billing and enrollment. Providers may be required to complete various payor-specific forms. Provider Enrollment has access to the information in the Medical Staff Services database for the purpose of providing accurate credentialing information to health plans and for the publishing of provider directories.

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

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

18. Timeliness of Information
    The established processing time is estimated at 60-90 days following receipt of completed application. Applications for Behavioral Health providers will be assessed for completion and verification of qualifications within 60 days of receipt of an application. Such applicants will be notified within seven (7) business days of receipt and confirmation of whether the application is complete. An application must be signed within 120 days of Credentials Committee review. The attestation must be signed within 180 days of Credentials Committee review. Verification of licensure, board certification, sanctions, current work history, malpractice claims history must be verified within 120 days of Credentials Committee review.

Requests for Modification of Privileges

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

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

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

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

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

Appointment/Privilege Approval Notifications

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

Application Fees

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

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

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

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

AHS and AH Category Assessments

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

Voluntary Resignation

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

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

PROVIDER RIGHTS TO AMEND APPLICATION AND REVIEW CREDENTIALS FILE

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

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

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

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

Approvals:

		AHS	AH
Credentials Committee	**Date:**	**8/14/25**	
Medical Executive Committee	**Date:**	**8/14/25**	**8/20/25**
QPSC/Board of Trustees	**Date:**	**8/27/25**	

Medical Staff Credentialing and Privileging of Practitioners
Attachment A

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

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

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

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

Dear (insert provider's name),

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

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

Sincerely,

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

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

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

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

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

Dear (insert provider's name),

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

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

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

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

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

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

Please contact your Department Chair, regarding the above.

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

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

Dear (insert provider's name)

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

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

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

As of today's date, you have exceeded the 35-day application for reappointment period, as outlined in the invitation to apply for reappointment. Per the Medical Staff Bylaws, failure to

submit a completed application for reappointment with all supporting or requested documentation shall result in automatic termination of your Medical Staff Membership and/or Privileges.

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

Please consider this our final attempt to collect your application for reappointment for processing, which if not received by COB month/date/year, will result in expiration of Medical Staff Membership and/or Privileges.

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

Please contact your Department Chair, regarding the above.

Medical Staff Credentialing and Privileging of Practitioners
Attachment B
Medical Staff Voluntary Resignation Form

I am formally submitting my voluntary resignation from the Medical Staff(s) listed below.
□ *Alameda Health System □ Alameda Hospital

Requested Voluntary Resignation Date (must be a date after this form is submitted to the Medical Staff Office): Date:_____

I attest that my charting and medical records and any care I provided will be completed on or before my voluntary resignation as above (H&Ps, procedure notes, orders, discharge summaries)

I acknowledge and agree that I continue to be bound by the Medical Staff Bylaws until my voluntary resignation date, including but not limited to assuring that I maintain professional liability coverage through that date.

I acknowledge that my AHS network logon and all application access will be automatically deactivated on the date of my voluntary resignation documented above.

Any request to change my voluntary resignation date or a desire to rescind this resignation **MUST** be communicated verbally and in writing to the Medial Staff Office and your Department Chair prior to the date specified above for my voluntary resignation and you must request a date after the requested change is submitted in writing to the Medical Staff Office.

Failure to communicate any changes in dates will result in the resignation being effective as of the date above and all systems access will cease as outlined on this form.

Reason(s) *(please select all that apply):*

□ Layoff / Reduction in Workforce
□ Resignation / Termination of Employment
□ No longer with contracted group
□ No longer utilize AHS Facilities
□ Moved out of state
□ Retired from practice
□ Other _____

_____	_____	_____
Practitioner's Printed Name	Department / Specialty	Medical Group Name *(if applicable)*
_____	_____	
Practitioners Signature	Date	

Please submit your completed form via email or fax: **medicalstaff@alamedahealthsystem.org** Fax: (510) 379-7440

You will receive a letter that confirms your voluntary resignation of membership and/or privileges after the resignation has been accepted by the Board. For any questions, please contact Medical Staff Services at Alameda Health System (510) 437-4292 or Alameda Hospital (510) 813-4035.

**Highland Hospital, San Leandro Hospital, John George Psychiatric Hospital, Fairmont Hospital, Wellness Clinics*

Alameda Health System

DISASTER PRIVILEGES

Department	Medical Staff	***Effective Date***	12/07
Campus	AHS, AH	***Date Revised***	12/07, 6/2017, 6/2019, 6/2019; 8/2025
Unit	Medical Staff	***Next Scheduled Review***	8/2028
Manual	Medical Staff	***Author***	Manager, Medical Staff Services
Replaces the following Policies:		***Responsible Person***	Chief of Staff

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

Purpose

To establish mechanisms to grant temporary privileges for volunteer Licensed Independent Practitioners or Advanced Practice Providers who are not otherwise members or clinical privilege holders of the Medical Staff during a disaster and when the hospital is unable to meet or maintain the immediate needs of patients.

Policy

In the event of a disaster or emergency, in which the hospital's emergency operations plan has been activated, the Chief Executive Officer, Chief of Staff, or their designee, may grant temporary privileges to individuals deemed qualified and competent for the duration of the disaster situation. Granting of these privileges will be handled on a case-by-case basis and are not a right of the requesting provider.

Procedure

Disaster privileges may be granted upon presentation of a valid government-issued photo identification (i.e. driver's license or passport) and one of the following:

1. Current picture identification card from a hospital that clearly identifies professional designation.

2. A current license, certification or registration to practice.

3. Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal response hospital or group.

4. Identification indicating that the individual has been granted authority by a government entity to provide patient care, treatment, or services in disaster circumstances.

5. Confirmation by hospital staff with personal knowledge of the volunteer practitioner's ability to act as a qualified practitioner during a disaster.

Upon being granted privileges, the LIP will be provided with a temporary badge which readily identifies them as having disaster privileges only. This badge shall be distributed by the CEO, Chief of Medical Staff, or designees. The LIP will return the badge to the Health System once the declared emergency has ended.

Primary source verification of the above information shall be considered a priority and occurs as soon as the immediate emergency situation is under control or within 72 hours from the time the volunteer licensed independent practitioner presents themself to the Health System, whichever comes first, by the Medical Staff Office (MSO). A permanent record of this information shall be retained by the MSO. If primary source verification of a volunteer licensed independent practitioner's licensure cannot be completed within 72 hours of the practitioner's arrival due to extraordinary circumstances, the Medical Staff Office will document all of the following:

1. Reason(s) it could not performed within 72 hours of the practitioner's arrival
2. Evidence of licensed independent practitioner's demonstrated ability to continue to provide adequate care, treatment, and services.
3. Evidence of the Health System's attempt to perform primary source verification as soon as possible.

A practitioner's disaster privileges will be immediately terminated in the event that any information received through the verification process indicates any adverse information that suggests the person is not capable of rendering services in an emergency.

To oversee the performance of the voluntary practitioners, LIPs will be paired with currently credentialed medical staff members and shall act only under the direct supervision of a medical staff member. Disaster Privileges are time-limited and expire automatically at the time that an emergency (disaster) situation no longer exists, or sooner if there is no longer a need for the additional assistance. Based on its oversight of each volunteer practitioner who is not a licensed independent practitioner with medical staff privileges, the Health System determines within 72 hours after the practitioner's arrival whether assigned disaster responsibilities should continue.

Practitioner's participation is accomplished through the combined efforts of the MSO and the Chief of Medical Staff as directed in the Administrative Disaster Plan.

Approvals

		AHS Core	Alameda
Credentials Committee	**Date:**	**8/14/25**	
Medical Executive Committee	**Date:**	**8/20/25**	**8/14/25**
QPSC	**Date:**	**8/27/25**	

Contract Approvals
September 2025

1. New agreement with Entisys Solutions, Inc. dba E360 for provision of the Citrix virtual access platform supporting remote and mobile network access. The term of this agreement is effective September 29, 2025 through September 28, 2028. The estimated impact of this agreement is $1,499,410.
Christine Yang, Chief Information Officer

2. Renewal agreement with GuidePoint Security LLC for provision of Arctic Wolf cybersecurity monitoring and recovery services. The term of this agreement is effective September 30, 2025 through June 30, 2028. The estimated impact of this agreement is $1,457,310.
Christine Yang, Chief Information Officer

3. Renewal agreement with Xerox, Inc. for provision of printer equipment and services. The term of this agreement is effective November 1, 2025 through October 31, 2030. The estimated impact of this agreement is $3,983,160.
Christine Yang, Chief Information Officer

Contract Approvals
September 2025

4. New agreement with Anthem Blue Cross Life and Health Insurance Company for the provision of third-party administration services for the Alameda Health System employee health insurance plan. The initial term of this agreement is effective January 1, 2025 through December 31, 2027. The estimated impact of this agreement is $5,930,739.

Arleen Gomez, Chief Human Resources Officer

5. Renewal agreement with Cardea Health for provision of respite housing services. The term of this agreement is effective October 1, 2025 through September 30, 2028. The estimated impact of this agreement is $6,394,800.

Romoanetia Lofton, Chief Clinical Officer

6. Amendment with Lifepoint Rehabilitation of California, LLC to renew terms for provision of management services for the Alameda Health System inpatient rehabilitation facility. The term of this amendment is effective October 1, 2025 through September 30, 2028. The estimated impact of this amendment is $4,211,233.

Mark Fratzke, Chief Operating Officer

Contract Approvals
September 2025

7. Renewal agreement with McKesson Corporation for provision of wholesale pharmaceutical supply services. The term of this agreement is effective April 1, 2026 through March 31, 2031. The estimated impact of this agreement is $447,180,000.

Romoanetia Lofton, Chief Clinical Officer

8. Amendment with Quest Diagnostics to increase funding for provision of reference laboratory test services. The term of this amendment is March 1, 2022 through February 28, 2026. The estimated impact of this amendment is $13,280,743.

Romoanetia Lofton, Chief Clinical Officer

Recommendation: Motion to Recommend Approval for the above contracts to the Board of Trustees

Board of Trustees Contract Summary 2025

Contractor/Vendor Name:	Entisys Solutions, Inc., dba E360 (“E360”)
Description:	E360 is a highly regarded information systems consultancy provider established in 1988. The company delivers a wide range of IT solutions and services, including security, cloud, automation, digital workplace transformation, modern infrastructure, Microsoft platform expertise, and enterprise managed services. Over the years, E360 has developed a strong reputation for providing tailored technology solutions to healthcare and other complex environments, including business and clinical virtualization platforms supporting remote and mobile access (“Virtual Access”). In light of the above and Alameda Health System’s (“AHS”) ongoing need to maintain reliable Virtual Access to mission critical applications, AHS leadership has determined E360 is best positioned to ensure uninterrupted access to the Citrix Virtual Access Platform. Citrix provides AHS’ current Virtual Access platform and has demonstrated the ability to securely and reliably provide Virtual Access to the full spectrum of AHS applications relied upon by clinical and administrative staff systemwide. This capability is vital to maintaining operational continuity, supporting patient care, and enabling flexibility in service delivery. Given this, AHS leadership is requesting Board approval to enter a 3-year licensing agreement (“Agreement”) with E360 under which AHS would maintain access to the Citrix Virtual Access platform (“Platform”) on the terms described below. The proposed Agreement encompasses comprehensive platform licensing, ongoing technical support, and hardware coverage, all of which are essential to minimizing downtime and ensuring overall system stability. In addition, it provides access to technical workshops and executive briefings, which will help optimize performance, align our systems with industry best practices, and ensure that AHS stays ahead of evolving technology requirements. AHS has had a positive and productive working relationship with E360 in prior engagements and wishes to continue that partnership. Their deep technical expertise, healthcare IT experience, and familiarity with our existing environment make them the optimal choice for this agreement. Furthermore, the fixed 3-year pricing structure under the proposed Agreement ensures cost predictability, compliance, and stability, while avoiding any service disruptions that could significantly impact clinical operations and the end-user experience. Under the proposed terms, AHS will retain our license to use the Citrix Virtual Access Platform, technical support, and related professional services. Total cost for the proposed 3-year term is $1,499,410.
Contract Type and Term:	New Agreement 9/29/2025 through 9/28/2028
Termination Clause:	AHS may terminate for cause provided E360 is unable or unwilling to cure the breach within 30 days of notice.
Total Spend with Vendor:	**Description** / **Board Approval** / **Total** **Citrix Platform Licensing Agreement** / **Approval Requested** / **$1,499,410**

<table>
<tr><td>Estimated Cost Savings:</td><td>AHS leadership negotiated a $6,000 annual discount and vendor agreement to fixed pricing over the proposed 3-year agreement. The foregoing help to minimize the impact of significant pricing increases instituted market-wide over the past several years for the Citrix Platform. In light of the material impact of these increases, AHS leadership evaluated alternatives but determined that switching would incur significant operational and capital expenditures as well as operational disruptions that outweigh the impact of the increased costs by incumbent.</td></tr>
<tr><td>Fiscal Implications:</td><td>Cost has been included in FY 26 budget.</td></tr>
<tr><td>Reasons for Recommendation:</td><td>AHS recommends awarding this agreement to E360 due to their proven track record with AHS, specialized healthcare IT expertise, and ability to ensure secure, reliable access to critical applications. Their services provide comprehensive support, operational stability, and cost predictability through a fixed 3-year pricing structure, making them the optimal choice to meet AHS’s virtualization and infrastructure needs.</td></tr>
<tr><td>Impacted Facilities:</td><td>
<table>
<tr><th>JGPH</th><th>Highland</th><th>Fairmont</th><th>San Leandro</th><th>Alameda</th><th>Clinic(s)</th></tr>
<tr><td>X</td><td>X</td><td>X</td><td>X</td><td>X</td><td>X</td></tr>
</table>
</td></tr>
<tr><td>Administrative Review:</td><td>Chief Technology Officer</td></tr>
<tr><td>Prior BOT Review/Action:</td><td>N/A</td></tr>
<tr><td>Executive Sponsor</td><td>Chief Information Officer</td></tr>
</table>

Contractor/Vendor Name:	Arctic Wolf Network via GuidePoint Security LLC
Description:	Arctic Wolf ("AW") is a cybersecurity company that provides security operations solutions. AHS leadership is requesting Board approval to enter a renewal agreement ("Renewal") under which AHS will continue receiving Managed Detection and Response services ("MDR") from AW. Per terms of the proposed Renewal, AHS will receive 24x7 monitoring of AHS networks, endpoints, and cloud environments for cybersecurity risks and/or attacks ("Events"). Upon detection of an Event, AW will assess, respond, and remediate using the resources and processes described below. The MDR solution is delivered by the AW security team ("Security Team") comprised of (1) the Concierge Security Team ("CST" – dedicated resources monitoring AHS networks during normal business hours) and (2) the Security Operations Center ("SOC" – around the clock resource who monitor and ensure timely response after hours). The Security Team will coordinate and provide the below services under the proposed Renewal: 1. Collect AHS data, including AHS system logs, from AHS systems using equipment set up by AHS. 2. Analyze equipment and log data through the correlation of customer data with threat and vulnerability information. 3. Escalate security incidents in need of attention by the AHS Information Security team. • AW will notify and escalate to AHS any non-critical security incidents discovered by AW within 2 hours through a ticket to AHS. Notifications will include a description of the security incident, level of exposure, and a suggested remediation strategy. AHS is responsible for implementing – at its sole discretion – any remediation strategies but may request validation from AW that the strategy is working as expected. • Emergencies –AW will escalate emergencies to AHS within 30 minutes of AW's discovery of the emergency. Any emergency discovered by AHS can be escalated to AW by calling a phone number and AW will respond within 5 minutes. • The CST supporting AHS is available 8:00 to 5:00 PT. • The SOC is staffed 24 hours a day, 7 days a week, including holidays. 4. Conduct monthly external vulnerability scans and deliver a summary security report that includes security incident and emergency notifications.

<table>
<tr><td></td><td>AHS will obtain the AW solution via an arrangement with GuidePoint LLC which serves as an authorized partner (“Partner”) with AW. In its capacity as Partner, GuidePoint LLC serves as an intermediary between AHS and AW facilitating terms of the proposed Renewal and serving as a transaction clearinghouse.</td></tr>
<tr><td>Contract Type and Term:</td><td>Contract Renewal
Term: September 30, 2025 – June 30, 2028</td></tr>
<tr><td>Termination Clause:</td><td>Either party may terminate this Agreement for cause if the other party commits a material breach of this Agreement, provided that such terminating party has given the other party ten (10) days advance notice to try and remediate the breach.</td></tr>
<tr><td>Total Spend with Vendor:</td><td>
<table>
<tr><th>Description</th><th>Board Approval</th><th>Total</th></tr>
<tr><td>Estimated Spend for the Contract Period
September 30, 2025-June 30, 2028</td><td>Approval Requested</td><td>$1,457,310</td></tr>
</table>
</td></tr>
<tr><td>Estimated Cost Savings:</td><td>Providing the same in-house cybersecurity staffing would require 3.5 additional FTEs at a cost of $700K/year coupled with the acquisition and maintenance of additional tools currently provided by AW on our behalf the additional cost of which would equate to an additional $600K/year in operating cost. Over the course of the proposed 3-year Renewal term, the total costs of providing these mission critical services in-house would be $3.9M. Contracting with AW on the terms in the proposed Renewal result in effective cost savings of $2.4M over the 3-year term.</td></tr>
<tr><td>Fiscal Implications:</td><td>Included in the FY 26 budget.</td></tr>
<tr><td>Reasons for Recommendation:</td><td>Arctic Wolf delivers real-time monitoring, threat detection, and incident response to help safeguard AHS’ systems and data around the clock, combining expert analysis with advanced technology without requiring large in-house cybersecurity staffing. Service in the preceding 3-year agreement was deemed excellent by the AHS Chief Information Security Officer. Among other things, Arctic Wolf helped AHS to cut off access to a workforce member who fell for a phishing scam and stopped an attack from a foreign country by determining a user access was deviating from its baseline behavior.</td></tr>
<tr><td>Impacted Facilities:</td><td>
<table>
<tr><th>JGPH</th><th>Highland</th><th>Fairmont</th><th>San Leandro</th><th>Alameda</th><th>Clinic(s)</th></tr>
<tr><td>X</td><td>X</td><td>X</td><td>X</td><td>X</td><td>X</td></tr>
</table>
</td></tr>
<tr><td>Coordination with Medical Staff:</td><td>N/A</td></tr>
</table>

Administrative Review:	Chief Information Security Officer
Executive Sponsor:	Chief Information Officer
Prior BOT Review/Action:	None

<table>
<tr><td>Contractor/Vendor Name:</td><td>Xerox, Inc. (“Xerox”)</td></tr>
<tr><td>Description:</td><td>Xerox is a leading manufacturer of print and digital document business products and services with a long history of innovation and successfully meeting client needs.

Alameda Health System (“AHS” or “System”) entered into a Master Agreement for Services (“Current Agreement”) with Xerox effective December 08, 2014 under the terms of which AHS was able to obtain a range of print document products and managed print services. The Current Agreement allows AHS to procure hardware, software, supplies, technical services, on-site labor, and customer support phone line services, in support of 197 print document devices critical to AHS patient care and operational activities. All devices are leased and deployed throughout the System.

To retain access to these critical services, AHS leadership has negotiated a renewal agreement (“Renewal”) on the following terms:

1. 193 new devices with all maintenance, repairs, and automated toner delivery covered.
2. Costs are locked in with set monthly minimums for black & white and color prints
3. Service and Maintenance:
4. Xerox provides 2 on-site Xerox Associates assigned to AHS full-time who oversee the service, maintenance, and supplies inventory. Xerox also provides two vehicles for the Associates to respond to all AHS campuses for maintenance, service, and supplies
5. Software/Security: Pcounter Software is included which provides security and authentication at every device. The Pcounter also removes unfulfilled print requests within 48 hours.
6. The monthly cost is $58,886.
7. New software is included that will enable the tracking and trending of device usage, further reducing unnecessary copying, reducing supplies used, and landfill avoidance. AHS will be able to continue “right-sizing” its printing footprint to provide the right number with the right capabilities, while supporting savings initiatives.
8. Continued support of Epic. The devices supporting clinical operations are designed to work with Epic. No other manufacturer has the same capabilities to support AHS’s electronic record.</td></tr>
<tr><td>Contract Type and Term:</td><td>Renewal Agreement
5-year term (November 01, 2025 – October 31, 2030)</td></tr>
<tr><td>Termination Clause:</td><td>Either party may terminate this agreement by providing 30 days’ notice.</td></tr>
<tr><td>Total Spend with Vendor:</td><td>
<table>
<tr><th>Description</th><th>Board Approval</th><th>Total</th></tr>
<tr><td>Renewal Agreement
November 01, 2025 – October 31, 2030</td><td>Approval Requested</td><td>$3,983,160</td></tr>
</table>
</td></tr>
</table>

<table>
<tr><td>Estimated Cost Savings:</td><td>AHS leadership negotiated a rate reduction over the Current Agreement. Based on current utilization, AHS will realize ~ $200,000 in savings over the proposed 5-year term. As AHS increases its efforts to reduce paper copies and increase the number of digital copies, savings will increase.</td></tr>
<tr><td>Fiscal Implications:</td><td>Budgeted for FY26.</td></tr>
<tr><td>Reasons for Recommendation:</td><td>Xerox has been a valued partner to AHS since 2014. Maintaining this relationship will enable AHS to continue standardizing equipment and leverage system-wide volumes to reduce ongoing overhead and support costs. Xerox will also help to manage the day-to-day print operations which is their core competency, allowing AHS IS Staff to focus on supporting their physicians, nurses and staff in ensuring the best possible Information Technology infrastructure in support of quality care for AHS patients and the community.</td></tr>
<tr><td>Impacted Facilities:</td><td>
<table>
<tr><th>JGPH</th><th>Highland</th><th>Fairmont</th><th>San Leandro</th><th>Alameda</th><th>Clinic(s)</th></tr>
<tr><td>X</td><td>X</td><td>X</td><td>X</td><td>X</td><td>X</td></tr>
</table>
</td></tr>
<tr><td>Coordination with Medical Staff:</td><td>N/A</td></tr>
<tr><td>Epic Coordination:</td><td>The devices that AHS uses in clinical operations were specifically chosen for their support of Epic.</td></tr>
<tr><td>Administrative Review:</td><td>Primary: IT End User Support Manager
Secondary: Chief Technology Officer</td></tr>
<tr><td>Prior BOT Review/Action:</td><td>Approved October 14, 2020</td></tr>
<tr><td>Executive Sponsor</td><td>Chief Information Officer</td></tr>
</table>

<table>
<tr><td>Contractor/Vendor Name:</td><td>Anthem Blue Cross Life and Health Insurance Company (“Anthem”)</td></tr>
<tr><td>Description:</td><td>Anthem is a third-party administrator organization providing ASO administrative services to Alameda Health System (“AHS”) and offers the following products to AHS employees - a Preferred Provider Option (PPO) plan, Freedom of Choice Plan and the Independence High Deductible Health Plan. Administrative services only (“ASO”) refers to an agreement for employer sponsored insurance plans when the employer funds their employee benefit plan but engages an outside vendor to administer it. In this case, AHS has engaged Anthem Blue Cross to provide ASO services (“Services”).

Anthem is also a major health insurance network provider in the United States. It offers a range of programs including both provider networks as well as Services. Anthem serves approximately 47 million members, making it one of the largest Blue Cross Blue Shield companies nationwide.

AHS has been challenged with managing medical insurance costs and ensuring access to care for our employees. Engaging directly with Anthem Blue Cross to provide Services enables AHS to address gaps in support, coverage and process, as well as provide a direct link to the Anthem network to assure understanding and status of network providers.

AHS has offered and provided self-insured medical benefits to benefit eligible employees for many years. When the prior provider of TPA services (“Incumbent”) was acquired, AHS evaluated vendor options and determined Anthem was best positioned to provide Services going forward. In addition to the enhanced quality of Services being provided, AHS has also negotiated rates that will result in material cost savings compared to rates charged by the prior Incumbent. In sum, this transition will assure increased transparency to plan information, increased responsiveness from our new ASO partner and provide the opportunity for administrative cost reduction due to efficiencies from the Network-ASO relationship.

In light of the above considerations, AHS Leadership is requesting Board approval to enter an agreement under which Anthem would provide Services for an initial term (“Initial Term”) of 3 years with subsequent 1-year term auto-renewal terms subject to approval by AHS leadership.</td></tr>
<tr><td>Contract Type and Term:</td><td>ASO Services Agreement
Term: 01/1/2025 through 12/31/2027. *Annual renewal with rate increases capped during Years 2 and 3. Anthem may continue providing services upon conclusion of the initial 3-year term provided AHS accepts terms.</td></tr>
<tr><td>Termination Clause:</td><td>Employer may terminate this Agreement at any time other than at the end of an Agreement Period by giving Anthem 60 days written notice of its intent to terminate.</td></tr>
<tr><td>Total Spend with Vendor:</td><td>
<table>
<tr><th>Description</th><th>Bd Approval</th><th>Total</th></tr>
<tr><td>Total Requested Amount (January 1, 2025 – December 31, 2027)</td><td>Approval Requested</td><td>$5,930,739</td></tr>
</table>
</td></tr>
<tr><td>Estimated Cost Savings:</td><td>Rate reduction compared to agreement with prior Incumbent will result in estimated annual savings in the amount of $500,000. Over the initial 3-year term, this offset will result in a total off-set in the amount of $1,500,000 and a net cost to AHS of Services in the amount of $4,430,739.

Annual rate increases in Years 2 and 3 are limited to a maximum of 4% in each year.</td></tr>
<tr><td>Fiscal Implications:</td><td>Included in FY 26 budget.</td></tr>
<tr><td>Reasons for Recommendation:</td><td>AHS has offered and provided self-insured medical benefits to benefit-eligible employees. Anthem is an experienced provider of Services with a proven-track record. Their ability to effectively and</td></tr>
</table>

<table>
<tr><td></td><td>efficiently provide Services while reducing costs to AHS justifies was the basis for selection of this vendor.</td></tr>
<tr><td>Impacted Facilities:</td><td>
<table>
<tr><th>AHS</th><th>Highland</th><th>Fairmont</th><th>San Leandro</th><th>Alameda</th><th>Clinic(s)</th></tr>
<tr><td>All locations</td><td></td><td></td><td></td><td></td><td></td></tr>
</table>
</td></tr>
<tr><td>Coordination with Medical Staff:</td><td>N/A</td></tr>
<tr><td>Administrative Review:</td><td>Primary: Director, Total Rewards. Secondary: Chief HR Officer</td></tr>
<tr><td>Prior BOT Review/Action:</td><td>N/A</td></tr>
</table>

Contractor/Vendor Name:	Cardea Health, a non-profit healthcare organization ("Cardea")
Description:	As an integrated public healthcare system, Alameda Health System ("AHS") is a leading provider of emergency and inpatient services to the residents of Alameda County. A number of our patients receive treatment in one of our acute care hospitals. Due to our position as the public safety net provider in conjunction with the unfortunately high rate of homelessness in our service area, AHS annually provides inpatient acute care treatment for approximately 3,012 of the individuals on our Homeless Registry whose rolls currently number 11,495 registered individuals. Our management of the homeless inpatient population described above is governed by Section 1262.5 of the California Health and Safety Code which mandates that acute care hospitals create a discharge planning policy for patients experiencing homelessness. This legislation requires hospitals to identify homeless patients and assess their needs comprehensively, ensuring that their discharge plans address necessary medical, psychiatric, and substance abuse treatments. Hospitals must coordinate with health and social service agencies to ensure continuity of care and provide patients with information on available healthcare services and shelter options upon discharge. The discharge of homeless inpatients presents a series of logistical challenges that significantly affect patient access, resource utilization, financial viability, and legal compliance. The issues ("Issues") we face include: 1. **Prolonged Hospital Stay for Medically Cleared Inpatients:** Patients who are medically ready for discharge remain in the acute care setting due to delays in transitioning to the appropriate next level of care or rehabilitation facilities. This delay impacts our ability to provide timely care to other patients. 2. **Resource Diversion:** The extended stay of these inpatients diverts critical resources, including limited bed availability, thereby delaying the admission and treatment of other patients in need of acute care services. 3. **Financial Impact:** There is a direct financial impact due to sub-optimal resource utilization, leading to reduced professional and facility revenues. 4. **Exceeding Facility Capacity:** The volume of inpatients awaiting discharge often surpasses the capacity of our contracted short-term residential care facilities, hindering efficient patient flow and management. 5. **Facility Limitations:** Many facilities operate in group settings which are not suitable for patients requiring isolation or specific levels of acute care, further complicating the placement process. 6. **Cost Implications of Extended Stays:** Individuals placed in these facilities typically experience longer than average stays, incurring significant costs to AHS. 7. **Emergency Department Backlogs:** Homeless patients frequently occupy the Highland emergency department for extended periods. This leads to backlogs,

throughput issues, and in some cases, unnecessary admissions to inpatient care, where they may not meet the usual criteria for inpatient treatment.

In light of the need to continue addressing the above considerations coupled with our successful engagement with Cardea over the past 2 years, AHS leadership is requesting Board approval to enter a 3-year renewal agreement ("Renewal") expanding services to incorporate an additional 5 beds.

Renewal terms will maintain a 2-tiered rate structure in which the maximum per diem rate is paid for patients meeting length of stay ("LOS") targets. AHS will pay a lower per diem rate for patients exceeding the LOS target to ensure full alignment between Cardea and AHS on this key metric.

Cardea operates an integrated services model under which they can address many of the often unmet needs AHS-discharged homeless patients face through provision of the below program services ("Program" or "Services") using hotel rooms or other residential rooms reserved for use by AHS participants.

Key provisions of the Renewal are as follows:

1. Housing – Cardea will provide a total of 20 Program beds per month via the hotel for individuals discharged from AHS hospitals and acute rehabilitation centers. The per diem rate, inclusive of all services, is $292.00. After 30 days' stay, the per diem rate reduces to $275.00.
2. Direct Care – Clients will receive the following direct care services:
    a. Nursing assessment at the time of admission.
    b. On-site nursing care including direct service, care coordination, and wellness checks.
    c. Three (3) meals a day.
    d. Transportation from the AHS point of discharge to Cardea and for medical appointments during admission.
    e. Housing placement assistance.
3. Discharge Assessment – Cardea will develop a Program discharge plan for each client that addresses both medical and social needs. In conjunction, Cardea & AHS will evaluate client cases that exceed 14 days length of stay to review LOS, necessity of care, disposition plans and the number of patients transitioned to the reduced rate.
4. Designated Medical Personnel – Cardea will offer registered nurses, personal care providers, a housing navigator, and a Medical Director for the program.
5. Discharge From the Program – Patients admitted to the program from an ER will be discharged no later than 7 days from admission. Patients admitted to the program

<table>
<tr><td></td><td>from a hospital or rehabilitation center will be discharged no later than 30 days from admission.

Program effectiveness will be assessed by the following measures:

1. Data Collection – Cardea will collect data that may be required by AHS to generate a complete data set for AHS patients served including ED and inpatient utilization among patients admitted to the Program, disposition at time of discharge from Program and number of unduplicated patients served.
2. Reporting – Cardea will generate a monthly Program Impact Report

Because AHS is fully funding this program, patients' lack of medical insurance coverage has no bearing on whether they will be admitted to the program.</td></tr>
<tr><td>Contract Type and Term:</td><td>Contract Renewal
Term: October 1, 2025-September 30, 2028 (3-years)</td></tr>
<tr><td>Termination Clause:</td><td>Without Cause: Either party may terminate with 30 days' prior written notice.</td></tr>
<tr><td>Total Spend with Vendor:</td><td><table>
<tr><th>Description</th><th>Board Approval</th><th>Total</th></tr>
<tr><td>Estimated Spend for the Contract Period
October 1, 2025-September 30, 2028</td><td>Approval Requested</td><td>$6,394,800</td></tr>
</table></td></tr>
<tr><td>Estimated Cost Savings:</td><td>AHS leadership has negotiated a 23% reduction in the initial daily (days 1-30) rate compared to the Current Agreement. Cardea also agreed to reduce the long-term daily rate (days +31) by 6% over the Current Agreement. Based on the 265 patients served in the past year and the average length of stay of 15 days, with the additional 5 beds and the new pricing, AHS projects realizing net savings of $25,123,691 during the 3-year term.</td></tr>
<tr><td>Fiscal Implications:</td><td>The proposed Agreement will be included in the FY 26 budget.</td></tr>
<tr><td>Reasons for Recommendation:</td><td>As a home health agency, Cardea Health is a reputable provider in the community for unhoused individuals. Many AHS patients are unhoused and require post-acute care. Although AHS contracts with other providers for post-acute care, a sizeable number of our patients still require care. Unlike our current providers, Cardea can care for patients that require isolation, care for patients with a higher level of acuity, and will decrease the average length of stay both in acute hospital setting and in our shelters. This will result in decreased discharge times, decreased new patient wait times.</td></tr>
</table>

Impacted Facilities:	<table><tr><th>JGPH</th><th>HGH</th><th>FMT</th><th>SLH</th><th>ALH</th><th>Clinic(s)</th></tr><tr><td></td><td>X</td><td>X</td><td>X</td><td>X</td><td>X</td></tr></table>
Coordination with Medical Staff:	N/A
Executive Sponsor:	Chief Clinical Officer
Prior BOT Review/Action:	1-Year Renewal of $2,075,025 was approved by the July 2024 Board.

Contractor/ Vendor Name:	Lifepoint Rehabilitation of California, LLC ("Lifepoint")
Description:	The Alameda Health System ("AHS") Inpatient Rehabilitation Facility ("IRF") is a 28-bed program located on the San Leandro Hospital Campus ("SLH"). The AHS IRF is 1 of only 2 such programs in the East Bay. Since December 2014, AHS has managed the IRF in partnership with Lifepoint (previously known as RehabCare), a nationwide leading contract therapy services provider with over 40 years of experience providing rapid program assessment and transformation, performance improvement, marketing, program accreditation, back-office support (i.e. admissions, medical record auditing, denials management, etc.), and facilities planning and business intelligence services. Lifepoint is a division of Lifepoint Health, a national, diversified healthcare delivery network with facilities from coast to coast and capabilities and services that span the healthcare continuum. Our arrangement with Lifepoint has afforded AHS the expertise and resources to enable our progress in the achievement of AHS IRF patient care goals as well as of targeted increases in market share, patient census and profitability. Lifepoint manages the AHS IRF program ("Program") under the current agreement ("Current Agreement") as described below. Lifepoint provides the following personnel and services: 1. Provision of 6 FTEs ("Staff") as described below: a. 1 Program Director – Lifepoint's on-site representative responsible for day-to-day management and operational oversight of the services. b. 2 Clinical Liaisons – Help develop and implement educational programs directed at AHS' medical staff, employees and members of the community in general. Clinical Liaisons are responsible for working with the AHS medical director and various AHS staff to ensure that patients referred and admitted to the program are screened for appropriate admission criteria and receiving care consistent with their condition and prognosis c. 1 Program Secretary – Responsible for providing clerical support and carrying out activities as directed by the Program Director. d. 1 Inpatient Rehabilitation Facility-PAI ("Patient Assessment Instrument") Coordinator – Responsible for monitoring, completing and submitting the CMS Assessments. e. 1 Admissions Coordinator - Responsible for working with the Hospital Medical Director and various Hospital staff to ensure that patients that are referred and admitted to the Program are screened for appropriate admission and receiving care consistent with their condition and prognosis. 2. Development & Oversight of AHS IRF program ("Program"): a. Development and execution of annual Program plan, including volume, financial, regulatory and quality outcomes targets. b. Optimization of admissions criteria and referral flows, compliance oversight, and denials management. c. Staff training and development and provision of appropriate tools, expertise, market analytics, and business intelligence. d. Supported the IRF transition from Fairmont Hospital to San Leandro Hospital ("SLH") and ongoing development of the Program in the new location.

e. Leads and successfully secured Commission on Accreditation of Rehabilitation Facilities ("CARF") accreditation with Stroke Specialty in 2017, maintaining conformance to all standards to achieve reaccreditations in 2020 and 2023 including Stroke Specialty.
f. Expanded access to inpatient rehabilitation services and improved AHS internal throughput, the program increased patients served in FY 2025 over prior FY from 584 to 612 (4.8%); with patients within AHS increasing from 250 to 365 (46%) over prior FY.
g. Implementation and achievement of quality metrics ("Metrics").
h. Risk-sharing incentive plan ("Plan") that ties compensation to achievement of Metrics. As designed, the Plan ensures both Program growth and patient quality outcomes goals are met to achieve between $60,000 to $80,000 of potential incentive compensation per year.

Over the course of our engagement with Lifepoint, the AHS IRF Program has met or exceeded its objectives. In light of this positive track-record, Lifepoint's position as the leading provider of rehabilitation management services, and AHS' need for expert support to deliver the highest quality rehabilitation services to the community, AHS leadership is requesting Board approval to enter an amendment ("Amendment") to extend the Current Agreement on its current terms with the below modifications:

1. The term is being extended through September 30, 2028.

2. Fixed monthly fee is adjusted to $106,645, along with increased labor costs and the cost of replacing the non-clinical Admissions Coordinator position with a licensed Clinical Liaison to address increased CMS focus on the preadmission screening clinical criteria and AHS' goals to continue growing patient access.

3. Updated the Annual Quality Performance Plan measures and targets as described in the table below:

Performance Measures	
Unplanned Return to Acute	
Target	**Performance Score**
> 6%	0
5% - 6%	1
< 5%	2
Patient Satisfaction	
Target	**Performance Score**
< 90%	0
90% - 92%	1
> 92%	2
ADC*	
Target	**Performance Score**
< 23.5	0
23.5 – 25.0	1
> 25.0	2

	<table><tr><th colspan="2">Fall Rate (Per 1,000 Patient Days)</th></tr><tr><th>Target</th><th>Performance Score</th></tr><tr><td>> 4.0</td><td>0</td></tr><tr><td>4.0 – 3.5</td><td>1</td></tr><tr><td>< 3.5</td><td>2</td></tr><tr><th colspan="2">Discharge to Community</th></tr><tr><th>Target</th><th>Performance Score</th></tr><tr><td>< 76.0%</td><td>0</td></tr><tr><td>76.1 – 80.0%</td><td>1</td></tr><tr><td>> 80%</td><td>2</td></tr><tr><th>Performance Score</th><th>Annual Bonus</th></tr><tr><td>0.00 – 0.99</td><td>$0.00</td></tr><tr><td>1.00 – 1.49</td><td>$60,000.00</td></tr><tr><td>1.50 – 2.00</td><td>$80,000.00</td></tr></table> ** If staffing of therapy or nursing are limited, default to a 1 score on ADC.* Performance Measure Definitions/Sources: a. Unplanned Return to Acute: Measures the percentage of patients discharged from the Inpatient Rehabilitation setting back to acute care during Inpatient Rehabilitation stay. (Data Source: UDS) b. Patient Satisfaction: Average Mean percentage score of the Acute Rehabilitation Center survey question "patient overall satisfaction rating." (Data Source: Press Ganey) c. ADC (Average Daily Census): Measures the total patient days divided by total days in the month. (Data Source: UDS) d. Fall Rate per 1000 patient days: Measures the number of all patient falls occurring in the Inpatient Rehabilitation setting calculated by the # falls/patient days x 1000. (Data Source: Entered in Midas) e. Discharge to Community: Measures the percentage of patients discharged from the Inpatient Rehabilitation setting back to a community setting defined as home, board and care, or assisted living. (Data Source: UDS). 4. Fees payable and any bonus amounts are adjusted annually based upon the Medical Care expenditure category of the Consumer Price Index by the same percentage such index has changed, which averages around 2.5% each year.
Contract Type and Term:	9th Amendment of the Master Rehabilitation Agreement Contract Term: October 1, 2025, through September 30, 2028
Termination Clause:	Agreement may be terminated without cause by either party by providing 180 days' notice.

Total Spend with Vendor:	<table><tr><th>Description</th><th>Board Approval</th><th>Total</th></tr><tr><td>**Management Fee 10/1/2025 – 9/30/2028**</td><td></td><td>**$3,971,233**</td></tr><tr><td>**Annual Quality Performance Bonus NTE**</td><td></td><td>**$240,000**</td></tr><tr><td>**Total Estimated Spend:**</td><td>**Approval Requested**</td><td>**$4,211,233**</td></tr></table>
Estimated Cost Savings:	N/A
Fiscal Implications:	The proposed renewal is in budget for FY26 and will be accounted for in future budget requests.
Reasons for Recommendation:	Approval will allow for full funding of this key services agreement, ensuring uninterrupted provision of services throughout the term of the agreement. This program provides patients with access to acute rehabilitation care as well as traditional hospital services in one location.
Coordination with Medical Staff:	Reviewed by Chief of Division of Physical Medicine & Rehabilitation
Administrative Review:	Primary: Chief Administration Officer, Post-Acute Services Secondary: Chief Operating Officer
Prior BOT Review/Action:	November 2019, Board Approval of the 4th Amendment of the Master Rehabilitation Agreement
Executive Sponsor:	Chief Operating Officer

Contractor/Vendor Name:	McKesson Corporation ("McKesson")
Description:	Alameda Health System ("AHS") currently holds a Pharmacy Distribution agreement ("Current Agreement") with McKesson Corporation under which AHS acquires 90% or more of all pharmaceuticals and related products used and distributed systemwide. The Current Agreement is scheduled to expire on March 31, 2026. AHS is a member of the Vizient West Coast Purchasing Coalition Pharmacy Aggregation Group ("Group"), a collaborative of healthcare providers leveraging group spend on pharmaceuticals to realize deeper discounts and better service levels than those available solely under the Group Purchasing Organization ("Vizient"). As a Group member, AHS has opted to enter into an early renewal for full line and medical plasma and biologics ("MPB") distribution services with McKesson. Vizient, representing AHS as a Group member, has negotiated a 5-year renewal agreement ("Renewal") with McKesson. This Renewal encompasses full line and MPB distribution services across multiple AHS locations. As pharmacy distribution services represent the bulk of AHS' pharmaceutical spend, this Renewal secures improved financial terms and service quality, providing greater value compared to the Current Agreement. In light of these advantages, AHS leadership seeks Board approval to proceed with this 5-year Renewal with McKesson.
Contract Type and Term:	Renewal Agreement April 1, 2026 – March 31, 2031
Termination Clause:	a. Termination for Cause. Vizient or McKesson may affect an early termination of this Renewal upon the occurrence of a material breach, as determined in good faith by the non-breaching Party, by the other Party. b. Termination for Adjusted Fill Rate. If Group members, in the aggregate, experience a Facility-wide Adjusted Fill Rate at 94.99% or lower for 2 months, even if McKesson is paying liquidated damages to Group members for such Facility-wide Adjusted Fill Rate performance, Vizient will have the unilateral right to terminate this Renewal with 30 days' written notice. c. McKesson Loss of Vizient Contract. d. McKesson or Vizient Insolvency. e. McKesson Change of Control Event: f. Mutual Consent: If McKesson and Vizient mutually agree to terminate this Renewal, then such termination will be without penalty to McKesson, Vizient, or Group members (including AHS) and will be effective after 60 days' written notice.

<table>
<tr><td>Total Spend with Vendor:</td><td>
<table>
<tr><th>Description</th><th>Board Approval</th><th>Total</th></tr>
<tr><td>Total Requested Amount:</td><td>Approval Requested</td><td>$447,180,000</td></tr>
</table>
</td></tr>
<tr><td>Estimated Cost Savings:</td><td>Execution of this agreement on 4/1/2026 will result in cost savings of approximately 0.84% of total pharmacy spend for AHS, representing average annual savings of approximately $752K, resulting in an estimated $3,760,000 in total savings over the 5-year term.</td></tr>
<tr><td>Fiscal Implications:</td><td>Included in FY26 budget.</td></tr>
<tr><td>Quotes Received</td><td>AHS partnered with our Group Purchasing Organization (“Vizient”) to identify the pharmacy wholesaler best positioned to meet AHS’s needs. Metrics considered included pricing, reliability of supply, and support. Vizient confirmed that the incumbent provider (“McKesson”) was the leading provider and the best placed to continue providing these critical services and supplies to AHS. As part of the proposed renewal agreement, McKesson offered the best terms over a multi-year term.
Although the decision to proceed with McKesson was made based on the value of their offer, it is important to note that AHS would also have incurred substantial costs if we transitioned to a different provider. Ordering and distribution of pharmaceuticals is logistically complex and a transition to a new provider would entail substantial operational disruption, imposing a significant workload burden across the AHS enterprise. Given the scale and complexity of such a shift coupled with the value of McKesson’s renewal offer, continuing the relationship with McKesson represents the most practical, efficient, and fiscally responsible decision.</td></tr>
<tr><td>Reasons for Recommendation:</td><td>McKesson offers the demonstrated industry experience, cost-effectiveness, and service capabilities required to meet the operational and clinical needs of AHS.</td></tr>
<tr><td>Impacted Facilities:</td><td>
<table>
<tr><th>JGPH</th><th>Highland</th><th>Fairmont</th><th>San Leandro</th><th>Alameda</th><th>Clinic(s)</th></tr>
<tr><td>X</td><td>X</td><td>X</td><td>X</td><td>X</td><td>X</td></tr>
</table>
</td></tr>
<tr><td>Coordination with Medical Staff:</td><td>Reviewed by Chair Pharmacy and Therapeutics</td></tr>
<tr><td>Administrative Review:</td><td>Primary: System Director, Pharmacy Operations
Secondary: Manager, System Manager, Clinical Pharmacy</td></tr>
<tr><td>Prior BOT Review/Action:</td><td>Current Agreement approved by Board June 2022.</td></tr>
<tr><td>Executive Sponsor</td><td>Chief Clinical Officer</td></tr>
</table>

Contractor/Vendor Name:	Quest Diagnostics ("Quest")
Description	In 2019, Alameda Health System ("AHS") entered into a system-wide agreement ("Current Agreement") with Quest for esoteric laboratory testing—low-volume, highly specialized assays such as genetic, molecular, oncology, immunology, and specialty infectious disease testing. These diagnostics are essential to patient care but are not feasible to perform in-house due to the significant capital investment, facility modifications, and specialized personnel required. Partnering with Quest ensures continued access to these essential advanced services while avoiding substantial startup and ongoing operational costs, making outsourcing the most cost-effective and operationally sound approach. Services commenced March 2019 under the Current Agreement with an initial 3-year term ("Initial Term") followed by 2 optional 2-year automatic renewal periods ("Auto-Renewal Terms"). Board approval was granted November 2018. Upon conclusion of the Initial Term, services continued under the Auto-Renewal Terms contemplated under the Current Agreement in light of Quest's reliable performance on the metrics described below. • Proven Quality and Compliance – Quest maintains several regulatory accreditations, delivering high-quality, accurate, and defensible results necessary to care for AHS patients. • Cost Savings and Price Stability – Quest maintains Vizient GPO supplier status, qualifying all AHS spend for an annual share-back, and provides AHS with reduced locked-in pricing for the seven-year term. • Established Logistics – Quest has courier routes in place across AHS Labs (WCHHC, SLH, ALH) for timely, efficient specimen transport. • Seamless Data Integration – Quest has an existing bi-directional interface with AHS through Epic for orders and results, ensuring accurate, secure, streamlined data exchange. In light of the above and based on past and projected utilization, AHS leadership is requesting Board approval to commit additional funding in the amount of $13,280,742 to fully cover all expenses incurred for the duration of the Current Agreement. This additional funding will ensure uninterrupted delivery of critical services from a reliable vendor while AHS leadership begins negotiations on a renewal agreement to secure long-term access to these services going forward.
Contract Type and Term:	Amendment to Reference Lab Testing Agreement with Quest March 1, 2022 – February 28, 2026
Termination Clause:	For Cause: The agreement may be terminated by either party for cause upon 30 days' written notice identifying the breach. If the breaching party fails to cure the breach within the 30-day cure period, the non-breaching party may terminate the End User Agreement immediately upon written notice to the breaching party.

<table>
<tr><td>Total Spend with Vendor:</td><td>
<table>
<tr><th>Description</th><th>Board Approval</th><th>Total</th></tr>
<tr><td>Funding Increase</td><td>Approval Requested</td><td>$13,280,743</td></tr>
</table>
</td></tr>
<tr><td>Estimated Cost Savings:</td><td>AHS realizes two categories of cost savings under the Current Agreement: 1) direct contractual savings, and 2) share back (AHS portion of GPO-negotiated vendor discount). Total cost savings over the 4-year term is $1,663,484.</td></tr>
<tr><td>Fiscal Implications:</td><td>Included in FY 26 budget.</td></tr>
<tr><td>Reasons for Recommendation:</td><td>Allows for full funding of a key services agreement ensuring uninterrupted provision of services through the term of the agreement.</td></tr>
<tr><td>Impacted Facilities:</td><td>
<table>
<tr><th>AHS</th><th>JGPH</th><th>Highland</th><th>Fairmont</th><th>San Leandro</th><th>Alameda</th><th>SNFs</th></tr>
<tr><td>X</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
</table>
</td></tr>
<tr><td>Coordination with Medical Staff:</td><td>The Current Agreement was reviewed and approved by the Department Chair of Laboratory Medicine & Pathology.</td></tr>
<tr><td>Administrative Review:</td><td>System Director, Clinical Laboratory Services</td></tr>
<tr><td>Prior BOT Review/Action:</td><td>The Board of Trustees approved the Current Agreement on November 29, 2018.</td></tr>
<tr><td>Executive Sponsor:</td><td>Chief Clinical Officer</td></tr>
</table>

ALAMEDA HEALTH SYSTEM

BOT Previously Approved Contracts - FY26 (July 1, 2025 - June 30, 2026)

#	Vendor	Amount Requiring BOT Approval	Start Date	Ending Date	BOT approved Date	Agenda Summary	Expectation	Executive Sponsor
1	Alliance HealthCare Services, Inc. dba Alliance HealthCare Radiology	$3,333,044	4/23/2025	4/22/2028	FC - 7-2-25 BOT Approved 7-9-25	Provision of mobile imaging services.		Chief Operating Officer
2	CareFusion Solutions, LLC	$7,206,000	8/19/2025	8/18/1930	FC - 7-2-25 BOT Approved 7-9-25	Provision of infusion pumps and supplies.		Chief Clinical Officer
3	East Oakland Community Project	$1,593,600	8/1/2025	7/31/2028	FC - 7-2-25 BOT Approved 7-9-25	Provision of respite care services.		Chief Clinical Officer
4	The Regents of the University of California on behalf of the University of California, San Francisco, Department of Neurological Surgery	$7,594,371	8/1/2025	7/31/2027	FC - 7-2-25 BOT Approved 7-9-25	Provision of neurological surgery professional services.		Chief Medical Officer
	Total Amount for FY 25 year to date	$19,727,015						

Quality OKR Metric Proposal FY2026

QPSC

July 23rd , 2025

Objectives & Key Results (OKRs)

vs.

Key Performance Indicators (KPIs) & Metrics

Objectives

- Aspirational goals tied to organizational mission and vision
  Who we are, who we serve
- Bring "life" to the organizational strategic plan
  Where we're headed
- Inspiring and memorable

Key Results

- ***Critical milestones*** which measure progress toward objectives
- Generally no more than 3-5KRs per objective

Key Performance Indicator

- Data reflecting how the system is working
- key *domain-specific process and outcome metrics*
- Organizations can have hundreds across domains
- KPIs don't necessarily provide broader context for overall Organizational Objectives

Metric

Any measure of something

The difference between KPIs and OKRs. https://www.whatmatters.com/resources/difference-between-okr-kpi

ALAMEDA HEALTH SYSTEM

Quality Care

Pillar Definition:

AHS provides Safe, Timely, Effective, Efficient, Equitable and Patient-Centered care that is accessible to all.

Strategic Objective: Safe place to receive exceptional and compassionate care

Strategic Key Results
Leapfrog Hospital Grades: Target A-B
CMS Hospital STAR Ratings : Shadow Metric Year 1 and 2
CMS Post-Acute STAR Ratings : Maintain 5 STARS
CDPH Quality Incentive Program : Optimal Performance
Quality Perception: Improve staff perception of quality of care

Pocket

Fiscal Year 2026 Quality OKR Proposal: Metric Definitions

OBJECTIVES	KEY RESULTS	Definition	Strategic Key Results Link	Recommendation
Safe Care - Caring, Healing, Teaching All				
Provide safe care	Total Patient Harms	The number of potential health-care acquired patient harms Includes: CLABSI, CAUTI, MRSA BSI, C-Diff, SSI, Patient Falls with injuries, Hospital Acquired Pressure Injuries and Behavior Events that result in Injury	Leapfrog, CMS Star Rating. HAC Penalty, QIP	**Revise** - Reportable HAPIs, Focus 6 Surgical Categories for SSI (Colon, C-Section, Gallbladder, Hysterectomy, Spinal Fusion, Small Bowel)
	Sepsis Bundle	Compliance to Sepsis early recognition and intervention guidelines. This is an "all-or-nothing" measure, meaning all elements must be met to receive credit. Follows CMS/TJC SEP 1 Definition	CMS Star Rating	**Add**
	Sepsis Mortality O/E Ratio	The observed to expected ratio is a comparison of the actual number of sepsis-related deaths in a hospital (observed) to the predicted number of deaths (expected).	CMS Star Rating	**Keep**
Timely, Effective, and Efficient Care				
Promote wellbeing	All Cause 30-day readmission rate	Percentage of inpatient acute med-surg encounters, regardless of payer type, with an unplanned readmission to any AHS facility within 30 days for any cause for acute care inpatients	CMS Star Rating, Readmission Penalty	**Keep**
Provide accessible care	Waitlist time - New Specialty Referral	The amount of days between when a new patient to AHS requests/referred for an initial specialty care appointment to the day of appointment.	Ambulatory Access	**Revise** % of Specialty Clinics at Goal
	ED Boarding Time for Admitted Patients Community/HGH	Median time from Decision to Admit to departure from the emergency department for admitted patients.	CMS Star Rating	**Keep**

Fiscal Year 2026 Quality OKR Proposal : Metric Definitions

OBJECTIVES	KEY RESULTS	Definition	Strategic Key Results Link	Recommendation
Equitable Care				
Serving all: ~~Deliver equitable care~~ Deliver Whole Person Care	Health-related Social Needs Assessment Completed on Hospital Inpatient and Outpatient Encounters	The percentage of hospital inpatient and hospital outpatient encounters where the patient is screened for social determinants of health: food insecurity, housing, transportation, safety and utilities	Process Readmissions Link Stewardship: Grow and optimize resources for the patient care continuum to meet the community need	**Revise** Expand to Hospital Based Outpatient Encounters (ED, Same Day Surgery, Imaging, Testing) **Add** 2nd Metric Screening Positivity Rate
Patient-Centered Care				
Be the most welcoming system to receive care	Likelihood to recommend care composite	Percentage of patients who would recommend AHS (includes rehab, acute, ambulatory, ED, outpatient surgery, dental, radiology)	Leapfrog, Star Rating	**Keep**

DISCUSSION: SCORE Survey Review

AHS Board of Trustees Report

2022-2025 SCORE Survey Analysis

September 17, 2025

Darshan Grewal, MPhil, MBA, MPH, LSSBB, CPHQ, CPHRM, CPPS

Master Certified in Just Culture

System Director of Patient Safety

Why are Culture and Engagement Important?

Organizational culture and employee engagement are critical drivers of performance, safety, and resilience.

The **SCORE** Survey which measures **S**afety, **C**ommunication, **O**perational Risk, **R**esilience/Burnout, and **E**ngagement offers critical insight into the health of the workplace culture

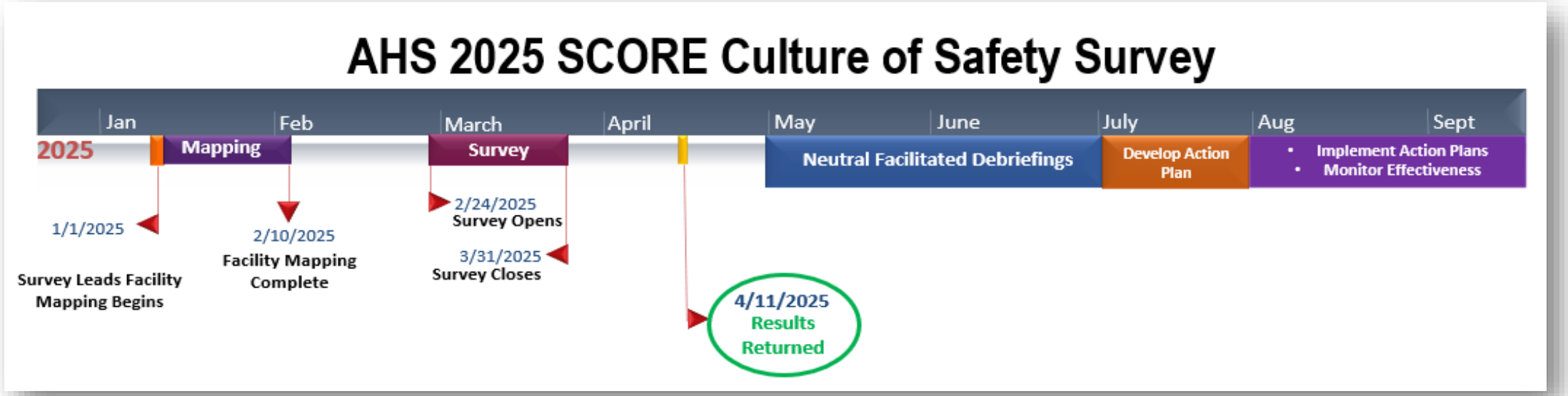
When employees **feel valued, heard, and supported**, they are **more committed, innovative, and accountable**.

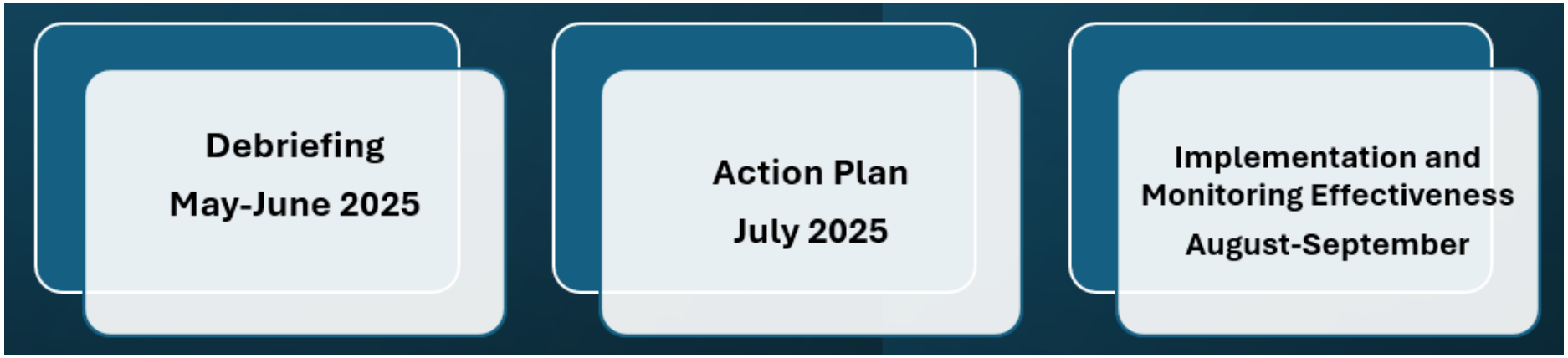
A strong culture:

- Enhances safety and quality outcomes
- Reduces burnout and turnover
- Promotes continuous learning and improvement
- Drives alignment with mission, vision, and values
- Culture and Engagement are the social glue.

2025 SCORE Survey Performance

2025 AHS Survey Timeline





2025 AHS Survey Response Rate – 70%

2025 Goal 75%

Safe and Reliable Healthcare - Alameda Hospital System SCORE Surveys

FACILITY	# RESPONSES	TOTAL ELIGIBLE RESPONDENTS	RESPONSE RATE
AHS Alameda Hospital	251	309	81%
AHS Ambulatory Care Clinics	379	603	63%
AHS Behavioral Health and JGPH	252	290	87%
AHS Highland Hospital	789	1241	64%
AHS Physicians and APPS	314	647	49%
AHS Post-Acute Care	337	386	87%
AHS San Leandro Hospital	306	311	98%
AHS Systemwide Services	735	1026	72%
Overall	**3363**	**4813**	**70%**

302 More Responses Than 2024 – 9% Increase

SCORE Survey Summary Report

Alameda Health System 2025 Facility Rollup Report - Mar 2025

8 Facilities - 3,363 Respondents - Response Rate 70%

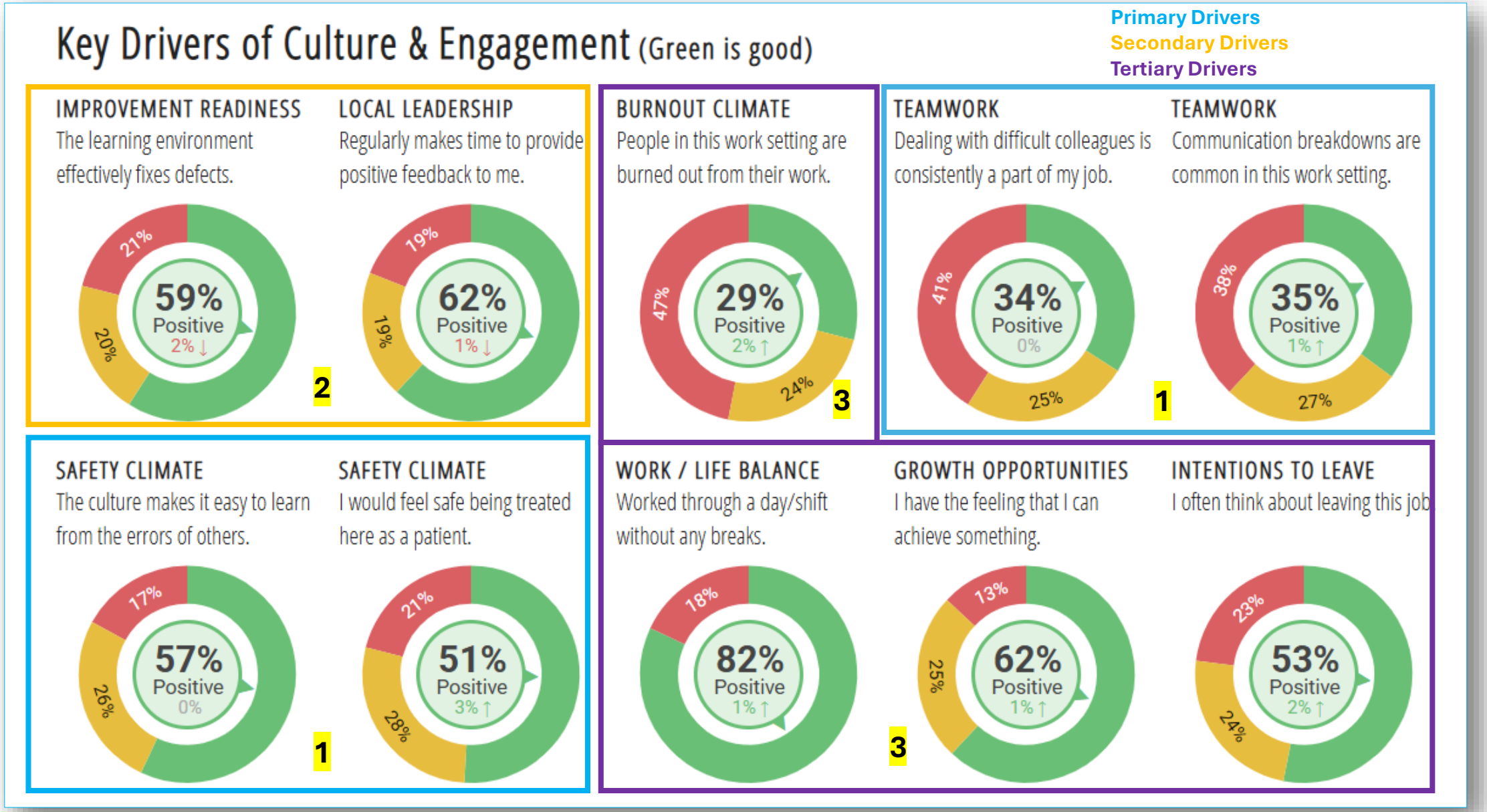
Primary Drivers –
Teamwork & Safety Climate

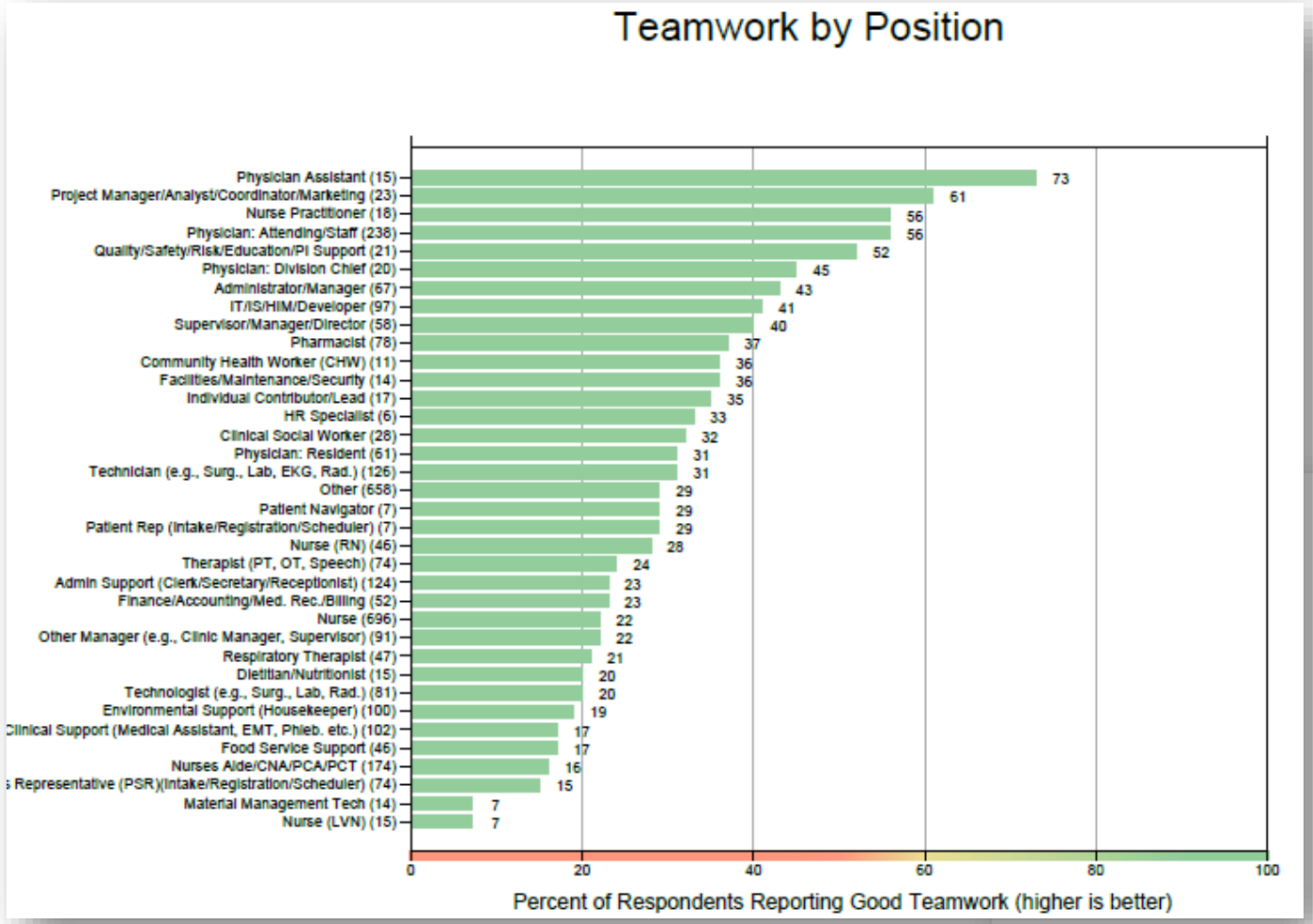
Secondary Drivers –
Improvement Readiness & Local Leadership

Tertiary Drivers –
Employees overall well-being (Physical, Emotional, Mental, and Job Satisfaction)

	Facility Percent Positive	
CULTURE		
Improvement Readiness	**55%**	0%
Local Leadership	**55%**	1% ↓
Burnout Climate‡	**36%**	0%
Personal Burnout‡	**49%**	0%
Emotional Thriving	**54%**	2% ↑
Emotional Recovery	**58%**	1% ↑
Teamwork	**28%**	1% ↓
Safety Climate	**40%**	0%
Work / Life Balance	**73%**	2% ↑
ENGAGEMENT		
Growth Opportunities	**47%**	0%
Job Certainty	**68%**	1% ↑
Intentions to Leave	**87%**	2% ↑
Decision Making	**40%**	1% ↑
Advancement	**19%**	3% ↑
Workload Strain	**68%**	1% ↑

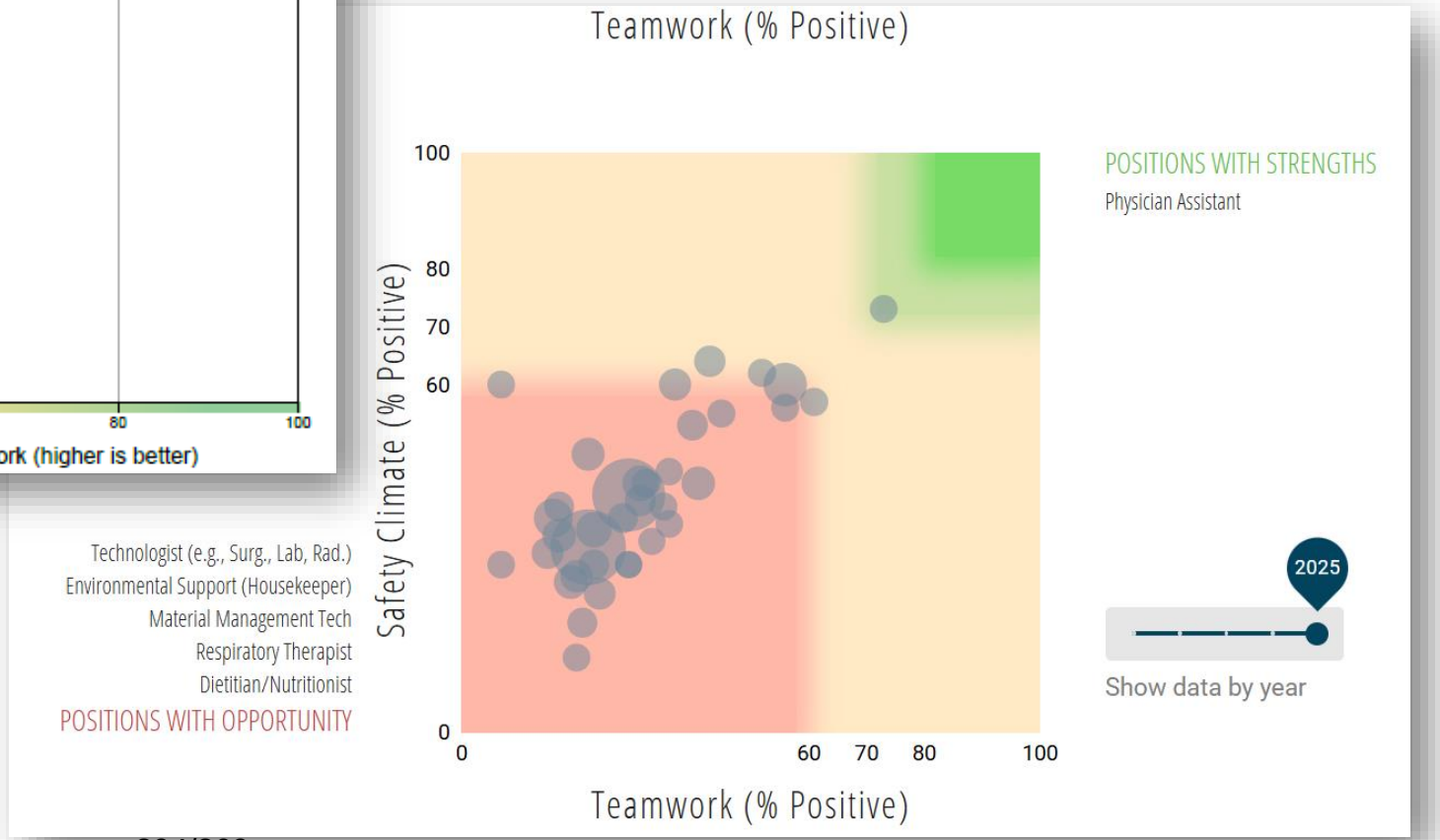
Key Drivers (Actionable, Measurable, and have the greatest impact on the culture of an organization)





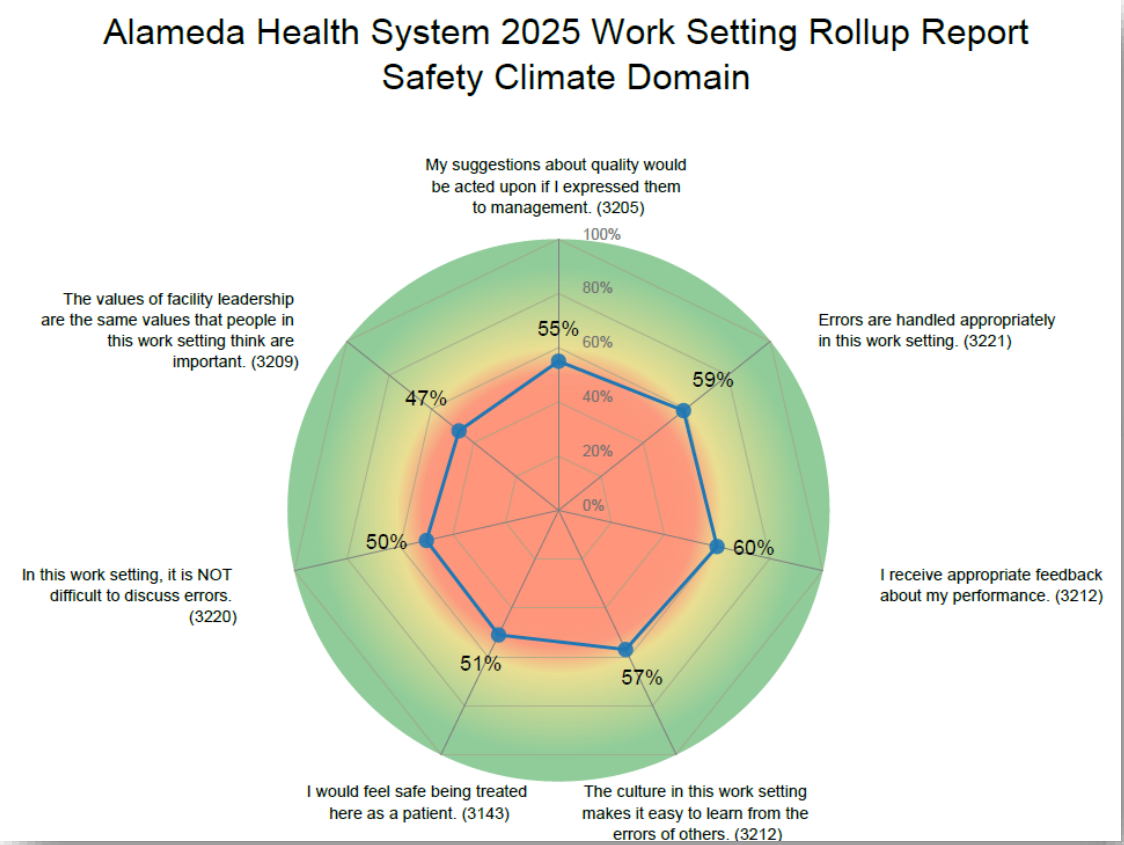
Top Performing Positions

- Physician Assistants
- Project Managers
- Nurse Practitioners
- Physicians
- Quality Services



Lowest Performing:

- Nurse (LVN)
- Material Mgmt
- Admitting
- Nurses Aide/CNA
- Food Services

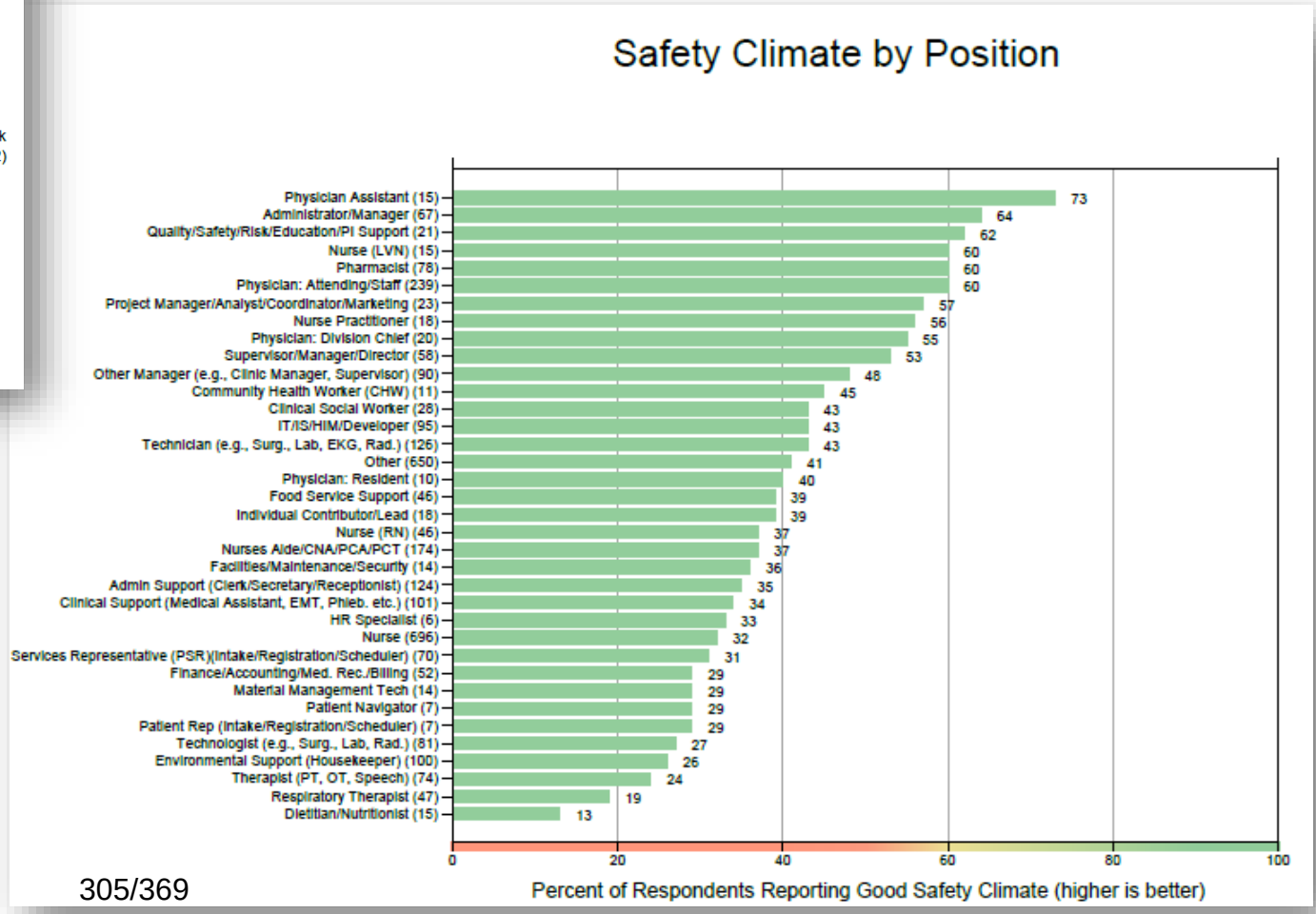


Top Performing Positions

- Physician Assistants
- Administrators/Managers
- Quality Services
- Nurse (LVN)
- Pharmacist
- Physicians – Attending

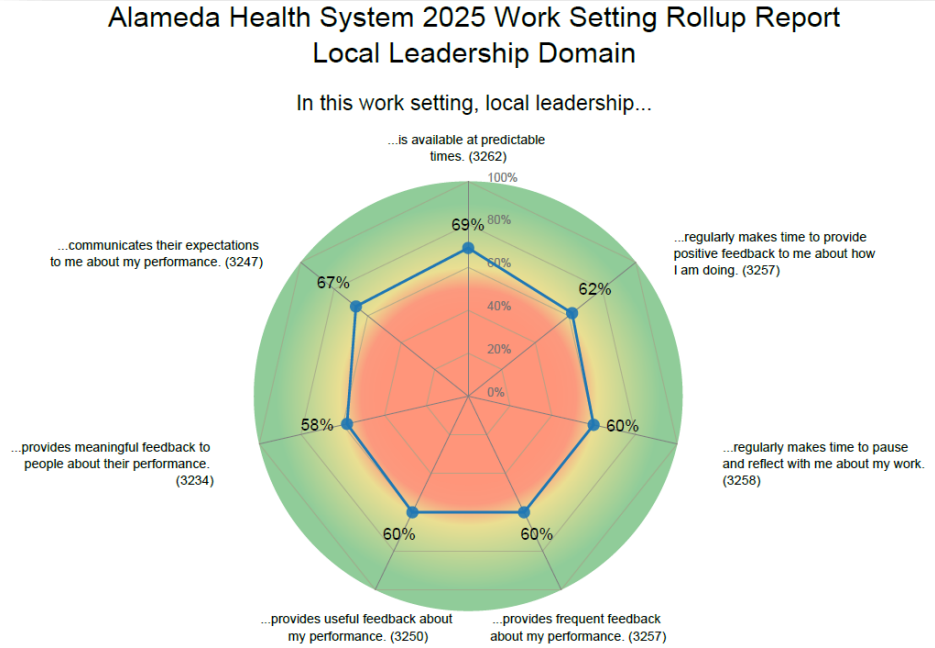
Lowest Performing Positions:

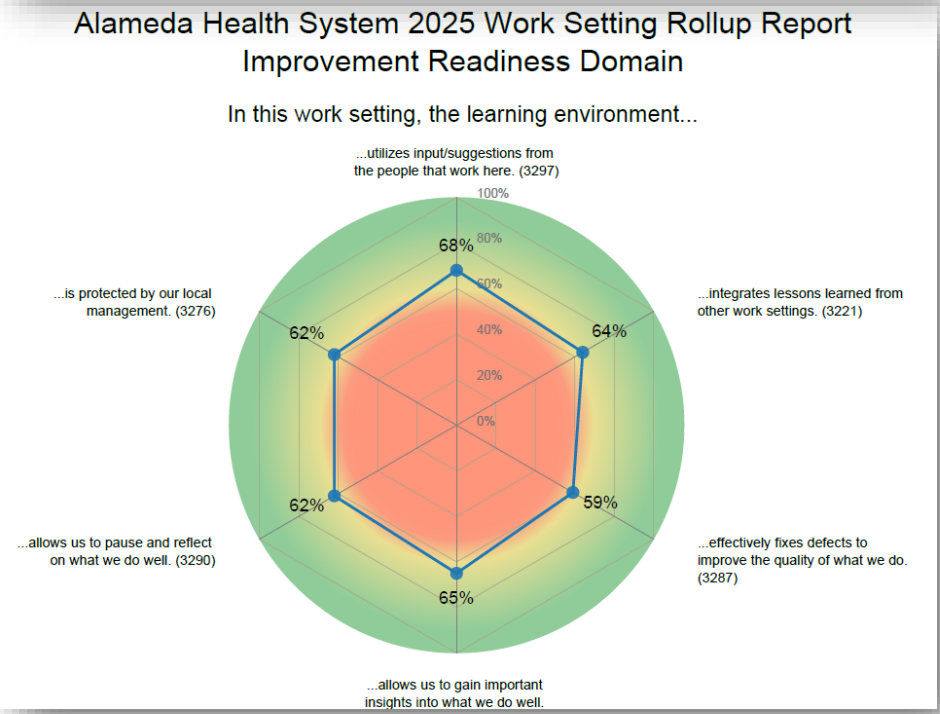
- Dietician
- Respiratory Therapists
- Therapist (PT/OT/ST)
- EVS
- Technologist (Lab, Radiology)



Leadership Metrics

Secondary Drivers



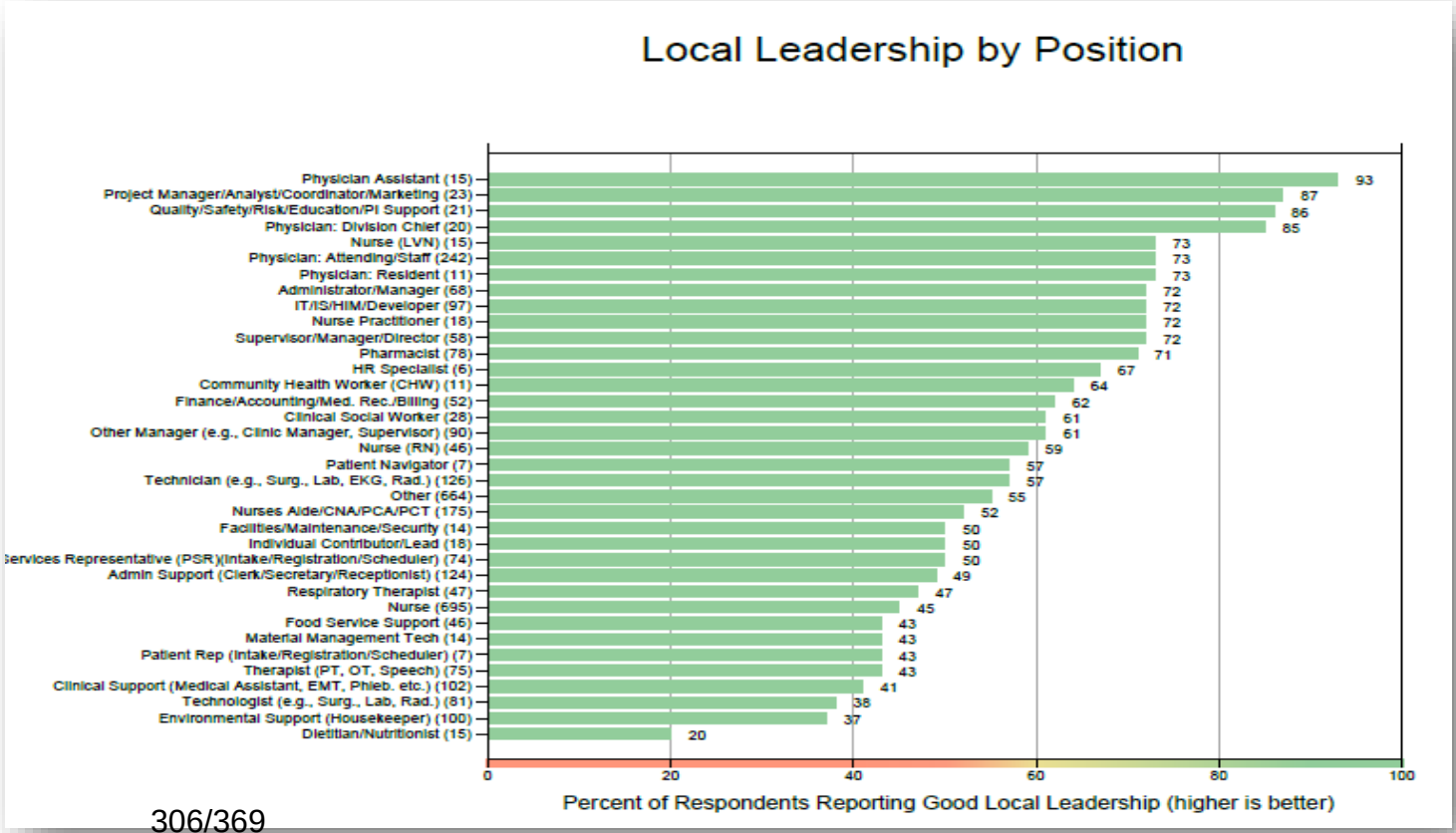


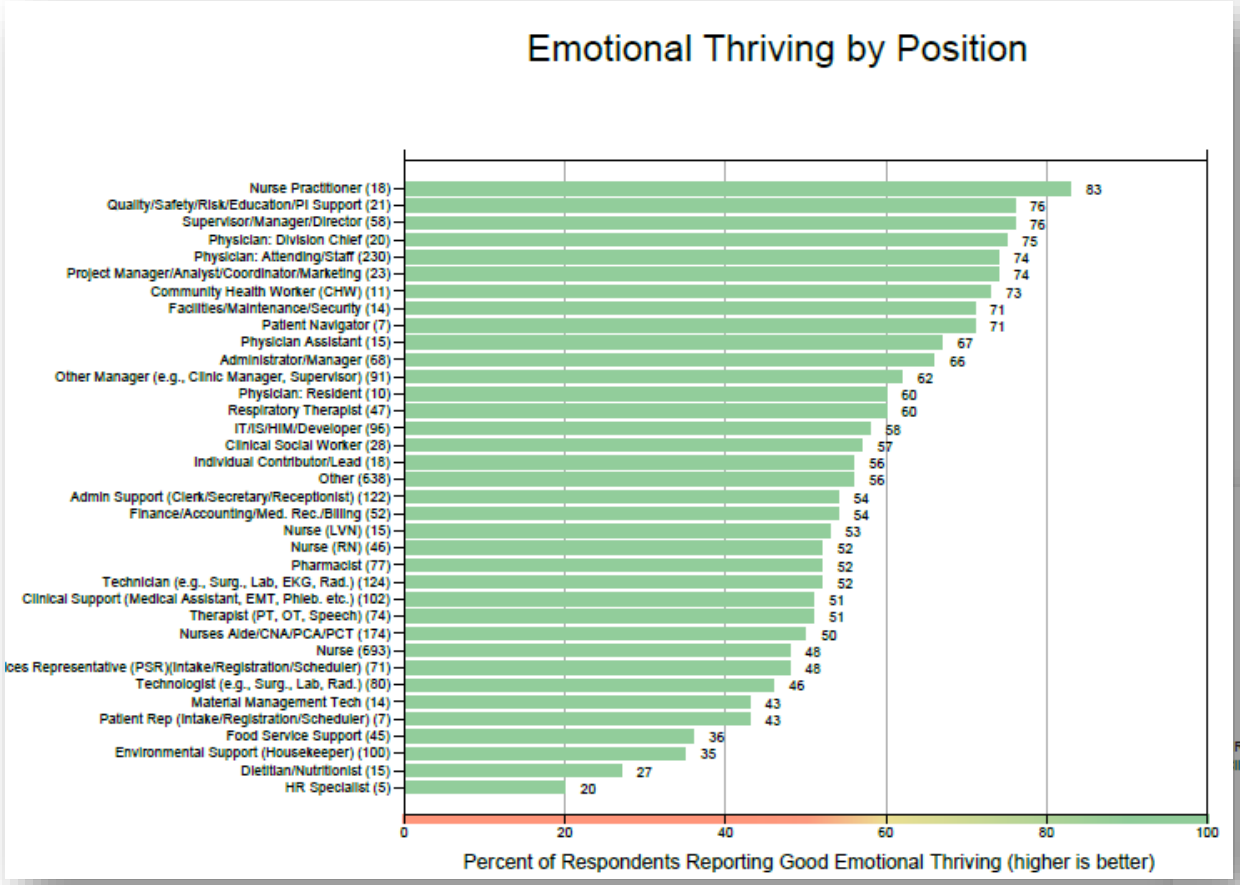
Secondary Driver Top Performing

- Physician Assistants
- Project Managers
- Quality Services
- Physicians – Division Chiefs
- Nurse (LVN)
- Physicians - Attendings

Lowest Performing

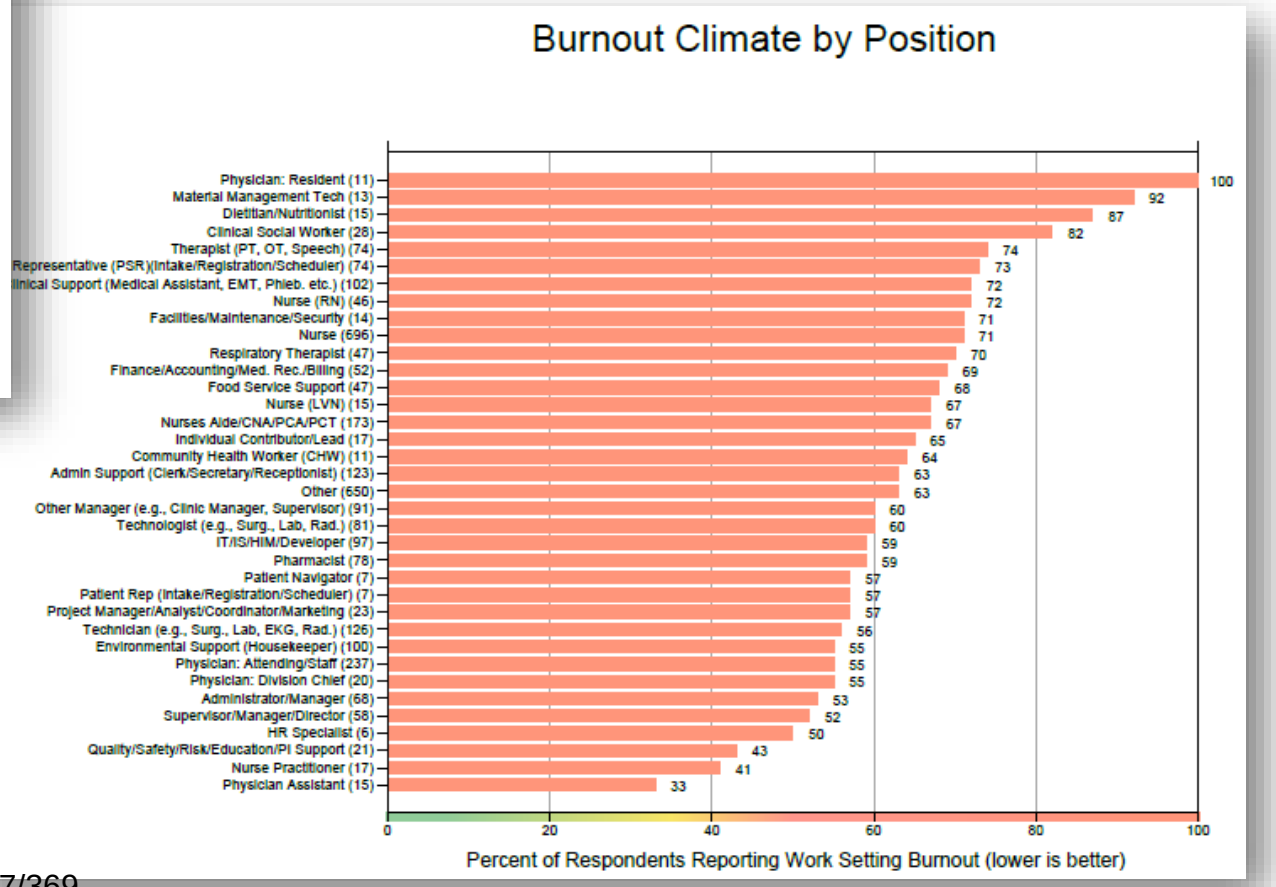
- Dietician
- EVS
- Technologists (Lab/Rad)
- Medical Assistants
- Therapists (PT/OT/ST)
- Patient Rep (Registration)





Top Performing Positions

- Nurse Practitioners
- Quality Services
- Middle Mgmt
- Physicians – Div. Chiefs
- Physicians –Attendings



Lowest Performing Positions:

- Residents
- Material Mgmt
- Dietician
- LCSW
- Therapist (PT/OT/ST)

2022-2025
Trended Data and Performance

2022-2025 Performance

Annually 3,000+ Physicians & Staff Participate

160 Departments are Represented

Systemwide Improvements

Safety Climate – **15% Improvement***
Teamwork – **11% Improvement***
Leadership Scores – **10% Improvement***
Burnout – **13% Reduction***
Work-Life Balance – **11% Improvement***

**Statistically Significant Improvements in Cultural Transformation*

Alameda Health System – 2022-2025 Drill Down Performance

TOP PERFORMING *Greater than 10% Improvement*	CONSISTENT *0-10% Improvement*
Physicians and APPs – **24%**	Highland Hospital – **9%**
San Leandro Hospital – **23%**	Systemwide Services – **4%**
Alameda Hospital – **19%**	
Behavior Health & JGPH – **18%**	

Analysis & Summary for Next Steps…

Make Culture a Strategic Priority

✓ Integrate culture into executive and board agendas, valuing its metrics equally with clinical and financial indicators.

Measure and Benchmark Culture Maturity

✓ Use robust tools to assess cultural maturity, identify gaps, and drive targeted, data-informed improvements (i.e., SCORE Survey)

Lead by Example

✓ Hold leaders accountable for modeling safety, transparency, and accountability. Prioritize visible executive engagement on the front lines.

Empower Frontline Staff

✓ Ensure open, safe communication channels. Involve frontline teams in shaping and sustaining culture.

Align Incentives and Values

✓ Link rewards and evaluations to behaviors that support a just, ethical culture. Recognize and celebrate cultural wins.

Commit to Continuous Learning and Transparency

✓ Invest in continuous leadership and culture development. Share progress and lessons openly to build trust and drive improvement.

Chief Financial Officer Report, July Financial Report

ALAMEDA HEALTH SYSTEM

July 2025 Financial Report
Finance Committee September 3, 2025

June 2025 Preliminary Financial Report
Audit Status

Presentation does not include fiscal year-end entries that will be finalized by October 2025. Final audit report will be presented to Audit Committee on 10/29/25. Year end comparison to Budget and Prior Year will be presented after the audit is complete.

- Net Patient Revenue and Capitation
  - Look back analysis to validate AR reported for June 30, 2025
- Supplemental Program Revenue
  - No additional adjustments anticipated on other programs; however, information may change during the audit.
- Expense related items
  - Self-funded Workers' Compensation (actuarial report)
  - Self-funded Hospital and Medical Malpractice (actuarial report)
  - AHS Defined Benefit retirement plan (actuarial report)
  - Interest for 4th quarter from County on NNB and restricted funds
  - Pending legal settlements
  - AHMG quality incentive bonus
  - Any material invoicing requiring a true-up
- Foundation true-up to mirror balances between the entities
- St. Rose Hospital integration into AHS audit report

FY25 Preliminary Financial Report

	FY2025 Projected as of 6/11/25	FY2025 Actual as of 8/24/25	Variance	% Var	
Operating revenue					
Net patient service revenue	$ 933,578	$ 933,381	$ (197)	0.0%	
Capitation revenue	55,418	55,600	182	0.3%	
Other government programs	544,008	560,025	16,017	2.9%	FY11 old waiver pickup offset by EPP adjustment
Other operating revenue	60,527	63,606	3,079	5.1%	SRH mgt fee, higher retail pharmacy
Total operating revenue	**1,593,531**	**1,612,612**	**19,081**	1.2%	
Operating expense					
Labor costs	1,155,334	1,163,271	(7,937)	-0.7%	higher FTEs, accrued AIP
Physician contract services	42,190	41,338	852	2.0%	
Purchased services	103,493	105,758	(2,265)	-2.2%	
Materials and supplies	154,442	154,414	28	0.0%	
Facilities	37,770	40,566	(2,796)	-7.4%	higher facility repairs and utilities
Depreciation and amortization	37,291	36,849	442	1.2%	
General and administrative	44,553	46,622	(2,069)	-4.6%	
Total operating expense	**1,575,073**	**1,588,818**	**(13,745)**	-0.9%	
Operating income (loss)	**18,458**	**23,794**	**5,336**	28.9%	
Non-operating activity	(4,853)	(4,455)	398	-8.2%	
Net income (loss)	**$ 13,605**	**$ 19,339**	**$ 5,734**	42.1%	
Interest income (expense)	4,600	4,202	(398)	-8.7%	
Depreciation and amortization	37,291	36,849	(442)	-1.2%	
Retirement (deferred)	-	193	193		ACERA based on acturial report
EBIDA adjustments	41,891	41,244	(647)	-1.5%	
EBIDA	**$ 55,496**	**$ 60,583**	**$ 5,087**	9.2%	
EBIDA Margin	3.5%	3.8%			
		2.6%	Target		

July 2025 Financial Report
Finance Dashboard

July-2025

	Metric	FY2026 Goal YTD	Actual YTD	YTD	Trend Lines
Volume					
	Total Adjusted Discharges	2,659	2,553	🔴	
	Total Adjusted Patient Days	30,850	31,193	🟢	
Revenue Cycle					
	Collection Ratio	19.5%	19.3%	🔴	
	Cash as % of Net Revenue	100.0%	98.4%	🔴	
	Gross Days in Patient Receivables	59.0	65.1	🔴	
Labor					
	Productivity %	100.0%	102.4%	🟢	
	Registry as % of Total FTEs	4.2%	4.2%	🟢	
	Overtime % excl Company 30	4.5	5.9	🔴	
	Total FTEs	5,165	5,197	🔴	
	FTE per Adjusted Discharge	1.94	2.04	🔴	
	*Labor Cost/FTE w/o GASB	$234,283	$240,293	🔴	
Profitability					
	Total Cost per Adjusted Discharge	$50,425	$54,083	🔴	
	Total Cost per Adjusted Patient Days	$4,346	$4,427	🔴	
	Net Income	$3,483	($975)	🔴	
	EBIDA Margin	4.5%	1.2%	🔴	
	NNB (Net Negative Balance)	<$95M	-$5,367	🟢	
	Net Position	>$0	-$61,072	🔴	
Capital					
	Capital Spent	$2,439	$1,334	🔴	
	% of Capital Spent		54.7%		

*Labor costs excludes contracted physicians; Includes Registry, travel & housing costs

ALAMEDA HEALTH SYSTEM

July 2025 Financial Report
Volume Highlights – Part 1

	July 2025	Budget	Variance	% Var	PY YTD Actual	Variance	% Var
Total Adjusted Patient Days	31,193	30,850	343	1.1%	30,124	1,068	3.5%
Total Adjusted Discharges	2,801	2,659	142	5.3%	2,553	247	9.7%
GENERAL ACUTE							
GA Patient Days	6,033	6,373	-340	-5.3%	6,270	-237	-3.8%
GA Discharges	1,290	1,221	69	5.6%	1,190	100	8.4%
Average Daily Census	194.6	205.6	-11	-5.3%	202.3	-7.6	-3.8%
Average Length of Stay	4.7	5.2	-0.5	-10.4%	5.3	-0.6	-11.2%
Adjusted Patient Days	11,506	11,833	-326	-2.8%	11,603	-96	-0.8%
Adjusted Discharges	2,460	2,268	193	8.5%	2,202	258	11.7%
GA CMI	1.612	1.7	-0.088	-5.2%	1.699	-0.087	-5.1%
Emergency Visits	9,403	8,764	639	7.3%	9,174	229	2.5%
Left Without Being Seen (LWBS)	421	583	162	38.6%	603	182	43.2%
Trauma Cases	295	313	-18	-5.9%	330	-35	-10.6%
Observation Equivalent Days	696	728	-32	-4.4%	681	14	2.1%
IP Surgeries	329	360	-31	-8.6%	345	-16	-4.6%
OP Surgeries	388	384	4	1.1%	482	-94	-19.5%
Total Surgeries	717	744	-27	-3.6%	827	-110	-13.3%
Deliveries	153	141	12	8.4%	132	21	15.9%
PSYCH							
Psych Patient Days	2,121	1,925	196	10.2%	1,934	187	9.7%
Psych Discharges	213	214	-1	-0.4%	203	10	4.9%
Average Daily Census	68.4	62.1	6.3	10.2%	62.4	6	9.7%
Average Length of Stay	10	9	-1	-10.6%	9.5	-0.4	-4.5%
Adjusted Patient Days	2,671	2,387	284	11.9%	2,410	262	10.9%
Adjusted Discharges	268	265	3	1.2%	253	15	6.1%
PES Equivalent Days	874	719	155	21.5%	719	155	21.5%
REHAB							
Rehab Patient Days	673	699	-26	-3.7%	684	-11	-1.6%
Rehab Discharges	58	53	5	9.7%	50	8	16.0%
Average Daily Census	21.7	22.5	-0.8	-3.7%	22.1	-0.4	-1.6%
Average Length of Stay	11.6	13.2	-1.6	-12.2%	13.7	-2.1	-15.2%
Adjusted Patient Days	673	699	-26	-3.7%	684	-11	-1.6%
Adjusted Discharges	58	53	5	9.7%	50	8	16.0%

ALAMEDA HEALTH SYSTEM

July 2025 Financial Report
Volume Highlights – Part 2

	July 2025	Budget	Variance	% Var	PY YTD Actual	Variance	% Var
SNF with Sub-Acute							
SNF Patient Days	8,725	8,546	179	2.1%	8,384	341	4.1%
SNF Discharges	15	24	-9	-37.7%	21	-6	-28.6%
Average Daily Census	281.5	275.7	5.8	2.1%	270.5	11	4.1%
Average Length of Stay	581.7	354.7	226.9	64.0%	399.2	182.4	45.7%
Adjusted Patient Days	9,034	8,560	474	5.5%	8,642	391	4.5%
Adjusted Discharges	16	24	-9	-35.6%	22	-6	-28.3%
Bed Holds	-27	97	-124	-127.8%	96	-123	-128.1%
CLINIC VISITS	34,996	38,468	-3,472	-9.0%	34,818	178	0.5%
Clinic Visits	29,122	32,266	-3,144	-9.7%	28,973	149	0.5%
Telehealth Visits	5,874	6,202	-328	-5.3%	5,845	29	0.5%
FQHC Visits	29,238	31,404	-2,166	-6.9%	28,875	363	1.3%
Clinic Visits	24,481	26,225	-1,744	-9.7%	23,982	499	2.1%
Telehealth Visits	4,757	5,179	-422	-5.3%	4,893	-136	-2.8%
Non-FQHC Visits	5,758	7,064	-1,306	-18.5%	5,943	178	3.0%
Clinic Visits	4,641	6,041	-1,400	-9.7%	4,991	149	3.0%
Telehealth Visits	1,117	1,023	94	-5.3%	952	29	3.0%
Physician wRVU	136,937	120,894	16,044	13.3%	127,217	9,720	7.6%
PAYOR MIX							
Insurance %	6.14%	6.52%	-0.38%	-5.8%	6.46%	-0.32%	-4.9%
Medi-Cal %	7.13%	9.56%	-2.43%	-25.4%	9.15%	-2.02%	-22.0%
Medi-Cal MC %	52.28%	52.94%	-0.67%	-1.3%	52.95%	-0.67%	-1.3%
Medicare %	23.13%	19.01%	4.12%	21.7%	19.49%	3.64%	18.7%
Medicare MC %	7.03%	7.08%	-0.05%	-0.7%	7.16%	-0.13%	-1.8%
Other Govt %	0.99%	1.78%	-0.80%	-44.8%	1.62%	-0.64%	-39.3%
Self-Pay %	3.30%	3.10%	0.20%	6.3%	3.16%	0.13%	4.3%
Total Payor Mix %	100.00%	100.00%	0.00%	0.0%	100.00%	0.00%	0.0%

July 2025 Financial Report
Medicare GMLOS Benchmark – Trend of Excess Days

Acute Care Hospitals: HGH, SLH, AH (excludes any rehab)

- LOS Variance Days | July: There were 2,670 excess days which is a 0.97% month over month Increase and is a 7.23% Decrease year over year. This reflects the total # of actual days in a bed in excess of the allowed # of days compared to the Medicare acuity model benchmark.

- Medicare GMLOS Benchmark: Compares the total AHS patient population against the Federal regulatory guidelines (Medicare), regardless if the patient is a non-Medicare State (APR) payer or a Medicare Federal (MSDRG) payer.

July 2025 Financial Report Highlights

- Unfavorable MTD revenue variance of $0.3M.
  - Net patient revenue approximated budget; although the collection percentage was 0.2% below budget.
  - Other non-operating revenue unfavorable driven by lower retail pharmacy revenue.

- Unfavorable MTD expense variance of $4.0M.
  - Labor costs unfavorable ($2.2M) - FTE utilization higher than planned (32.0 FTE, $0.5M), wage rates ($0.2M), and benefit/retirement ($1.5M).
  - Non-labor cost unfavorable ($1.8M) with the largest variances in facilities ($0.8M) due to repairs at HGH.

	July 2025				FY 2025	
	Actual	Budget	Variance	% Var	YTD	% Var
Operating revenue	$ 137,440	$ 137,717	$ (277)	(0.2)%	$ 127,571	7.7%
Operating expense	138,093	134,084	(4,009)	(3.0)%	124,436	(11.0)%
Operating income (loss)	**(653)**	**3,633**	**(4,286)**	**(118.0)%**	**3,135**	**(120.8)%**
Other non-operating activity	(321)	(152)	(169)	(111.2)%	(147)	(118.6)%
Net Income (loss)	**$ (974)**	**$ 3,481**	**$ (4,455)**	**(128.0)%**	**$ 2,988**	**(132.6)%**
EBIDA adjustments	2,621	2,781	(160)		3,678	
EBIDA	**$ 1,647**	**$ 6,262**	**$ (4,615)**		**$ 6,666**	
Operating Margin	(0.5)%	2.6%	(3.1)%		2.5%	
EBIDA Margin	1.2%	4.5%	(3.3)%		5.2%	

July 2025 Financial Report
Net Patient Services Revenue Highlights

- Gross patient service revenue is favorable driven by inpatient and outpatient services.
  - Discharges were higher than budget, LOS improved to 4.7 and CMI fell below budget by 5.2% indicating lower complexity of patients and services.
  - Trauma, Inpatient surgery, and HGH Observation lower than budget
  - ED visits favorable to budget by 7.3%. Outpatient surgery favorable to budget by 1.1%.
  - SNF discharges below budget by 37.7%; census favorable by 2.1%.
  - JGP days and PES exceeding budget by 10.2% and 21.5% respectively.
  - Eastmont FQ visits below budget from fewer dental visits.

- NPSR Collection ratio YTD was 19.3% which is lower than expected.
  - A price increase (3%) was implemented in chargemaster (CDM); however, government fee schedule increases and Alliance rates have not yet been realized.
  - Commercial Payer mix fell below budget by 5.8%; driven by lower trauma cases.

	July 2025				FY 2025	
	Actual	Budget	Variance	% Var	YTD	% Var
Inpatient service revenue	$ 220,563	$ 219,734	$ 829	0.4%	$ 212,781	3.7%
Outpatient service revenue	157,189	150,195	6,995	4.7%	144,709	8.6%
Professional service revenue	41,581	44,530	(2,949)	(6.6)%	40,502	2.7%
Gross patient service revenue	419,333	414,459	4,875	1.2%	397,993	5.4%
Deductions from revenue	(338,205)	(333,440)	(4,765)	(1.4)%	(321,063)	5.3%
Net patient service revenue	**81,128**	**81,018**	**110**	**0.1%**	**76,929**	**(5.5)%**
Collection % - NPSR	19.3%	19.5%	(0.2)%		19.3%	
Capitation and HPAC	4,494	4,547	(53)	(1.2)%	4,474	0.4%
Other government programs	45,324	45,415	(91)	(0.2)%	39,714	14.1%
Other operating revenue	6,494	6,736	(242)	(3.6)%	6,454	0.6%
Total operating revenue	**$ 137,440**	**$ 137,369**	**$ (276)**	**(0.2)%**	**$ 127,571**	**7.7%**

July 2025 Financial Report
Governmental and Other Revenue Highlights

- Other government programs approximates budget for the month. Prop 56 had unfavorable variance ($0.1 million). The budget was based on FY2025 receipts which was overstated due to an overpayment. The variance will continue all year.
- Other operating revenue unfavorable by ($0.2M) from lower retail pharmacy ($0.9M) offset by SRH management fees ($0.3M), grant revenue ($0.2M), and other timing differences ($0.2M). The SRH management fees were not budgeted.

	July 2025				FY 2025	
	Actual	Budget	Variance	% Var	YTD	% Var
Net patient service revenue	81,128	81,018	110	0.1%	76,929	(5.5)%
Capitation and HPAC	4,494	4,547	(53)	(1.2)%	4,474	0.4%
Medi-Cal Waiver	8,498	8,474	24	0.3%	8,915	(4.7)%
Measure A and parcel tax	12,760	12,760	0	0.0%	12,785	(0.2)%
Supplemental Programs	24,066	24,182	(116)	(0.5)%	18,014	33.6%
Covid-19	-	-	-	0.0%	-	0.0%
Other government programs	**45,324**	**45,415**	**(91)**	**(0.2)%**	**39,714**	**14.1%**
Grant Revenue	1,205	987	218	22.1%	983	22.7%
Other Operating Revenue	5,289	5,749	(460)	(8.0)%	5,471	(3.3)%
Other operating revenue	**6,494**	**6,736**	**(242)**	**(3.6)%**	**6,454**	**0.6%**
Total operating revenue	**$ 137,440**	**$ 137,716**	**$ (276)**	**(0.2)%**	**$ 127,571**	**7.7%**

July 2025 Financial Report
Expense Highlights excluding Labor

- Physician contract services unfavorable with largest negative variance in General Surgery.
- Purchased services unfavorable from software licenses ($0.2M), management consultants ($0.2M), and remaining variance ($0.3M) spread across many cost centers.
- Material and supplies unfavorable from surgical supplies ($0.4M) offset by favorable variance in non-medical supplies ($0.1M).
- Facilities unfavorable from timing of equipment/building repairs ($0.7M) and utilities ($0.2M). Most of the repair variance was at Highland Hospital ($0.4M).
- Depreciation and amortization favorable from timing of equipment depreciation ($0.4M) offset by lease/software amortization ($0.1M).
- General and administrative approximately on budget.

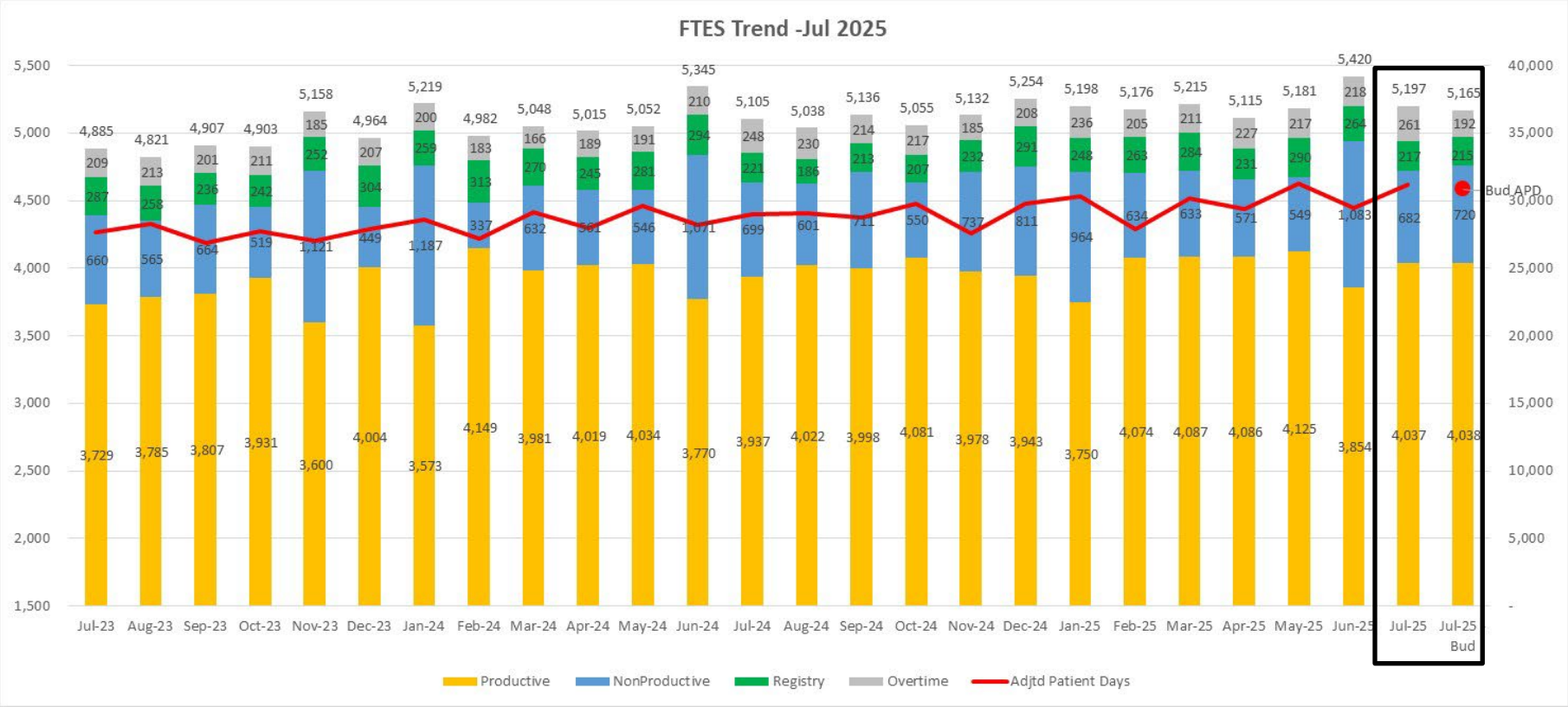
	July 2025				FY 2025	
	Actual	Budget	Variance	% Var	YTD	% Var
Labor costs	$ 104,062	$ 101,824	$ (2,238)	(2.2)%	$ 92,616	(12.4)%
Physician contract services	3,827	3,598	(229)	(6.4)%	3,385	(13.1)%
Purchased services	8,685	7,982	(703)	(8.8)%	8,240	(5.4)%
Materials and supplies	13,145	12,812	(333)	(2.6)%	10,836	(21.3)%
Facilities	3,710	2,827	(883)	(31.2)%	3,257	(13.9)%
Depreciation and amortization	2,290	2,618	328	12.5%	3,518	34.9%
General and administrative	2,374	2,423	49	2.0%	2,584	8.1%
Total operating expense	**$ 138,093**	**$ 134,084**	**$ (4,009)**	**(3.0)%**	**$ 124,436**	**(11.0)%**

July 2025 Financial Report
Expense Highlights – Labor (part 1)

- Staff, physician and registry labor costs were unfavorable to budget driven by higher FTE volume (32 FTEs/$0.5M) and higher rates ($0.2M).
  - AHS continues to roll-out UKG timekeeping for registry and timing differences occur between when invoices are paid and hours are included to calculate FTEs.
- Employee Benefits unfavorable from self-funded health ($1.7M) offset by favorable variance for Kaiser insurance plan ($0.3M).
- Retirement unfavorable from ACERA ($0.2M).

	July 2025				FY 2025	
	Actual	Budget	Variance	% Var	YTD	% Var
Salaries and wages (staff)	$ 63,673	$ 61,902	$ (1,771)	(2.9)%	$ 54,562	(16.7)%
Salaries and wages (physicians)	10,639	11,315	676	6.0%	10,152	(4.8)%
Registry	3,835	4,285	450	10.5%	4,456	13.9%
Employee benefits (taxes, insurance)	17,174	15,774	(1,400)	(8.9)%	15,676	(9.6)%
Retirement	8,741	8,548	(193)	(2.3)%	7,770	(12.5)%
Total labor costs	**$ 104,062**	**$ 101,824**	**$ (2,238)**	**(2.2)%**	**$ 92,616**	**(12.4)%**
Compensation ratio	75.7%	73.9%	-1.8%		72.6%	
Paid FTEs	5,197	5,165	(32)	(0.6)%	5,105	(1.8)%

July 2025 Financial Report
Analysis of Total Labor Expense



- Paid FTEs exceeded budget by 32 (5,197-5,165) and 0.6% for the month.
- Higher hours in overtime were partially offset by fewer non-productive hours. Other categories approximated budget.
- Total adjusted patient days above budget 1.1%; total adjusted discharges above budget by 5.3%.

July 2025 Financial Report
Physician Expenses Variance

Budget Variances by Physician Specialty
(in thousands)

	Current Month - July 2025		
Specialty	**Salaries**	**Contract**	**Total**
Primary	(3)	(23)	(26)
Geriatrics	(26)	0	(26)
Anesthesia	21	0	21
Pathology	(15)	0	(15)
Hospice	(6)	0	(6)
OB/GYN	101	1	102
OMFS	(3)	(14)	(17)
Neurosurgery	0	198	198
Vasculary Surgery	0	230	230
Wellness Centers	261	(38)	223
Radiology	64	(27)	36
Psychiatry	37	74	111
Hospitalist	66	(41)	25
General Surgery	0	(102)	(102)
GME	(2)	(43)	(45)
Other	183	(444)	(261)
	$ 676	**$ (229)**	**$ 446**

**Variances less than ($100k) in "Other"*

July 2025 Financial Report
Balance Sheet Key Metrics

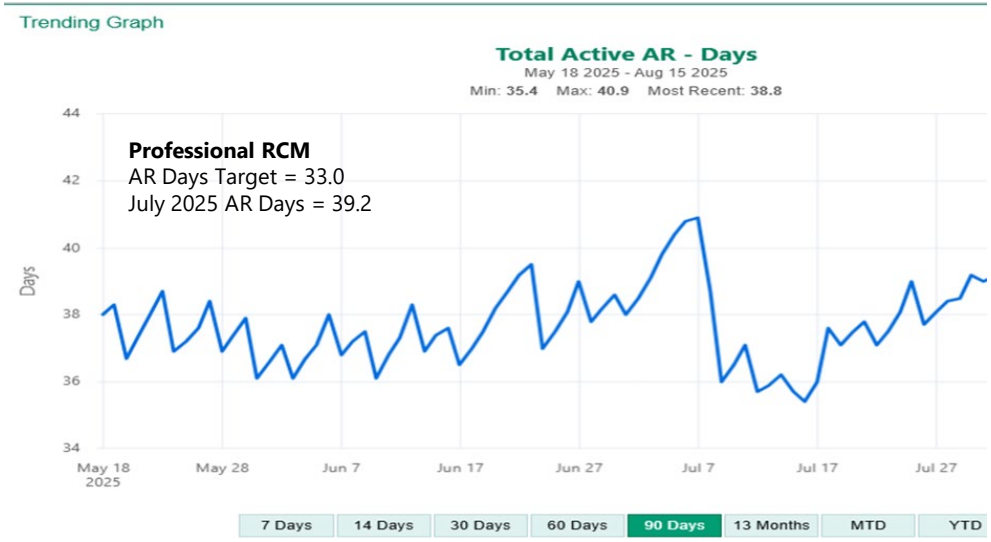
- Days in Cash are 3.1 and higher than year-end; typically, below 5.0 days.
- Gross AR Days increased 2.7 days and Net AR Days increased 0.9 days. See next slide for additional detail.
- Days in Accounts Payable decreased due to timing of the check run and implementation of Hyland/Onbase (automation of AP processes). The target is 30 days.
- Net Position is negative $61.1M and increased $0.8M from June 30, 2025 reflecting YTD Net Income.
- Net Negative Balance is a payable of $5.4M. NNB consists of the liquidity facility (loan) of $32.5M offset by the restricted cash of $27.1M; and is expected to be below the June 30, 2026 credit ceiling of $95.0M at the end of the fiscal year.

	Jul-25	FY 2025
Days in cash	3.1	1.2
Gross days in patient receivable	65.1	62.4
Net days in patient receivable	46.4	45.5
Due from/(to) third-party payors	$ 156,041	$ 154,653
Due from/(to) County	$ 33,290	$ 39,481
Days in accounts payable	32.5	38.1
% of AP over 60 days	5.6%	10.6%
Net position - fund balance/(deficit)	$ (61,072)	$ (60,267)
Net negative balance - receivable/(payable)	$ (5,367)	$ 26,631

July 2025 Financial Report
AR Trending

Hospital Revenue Cycle Key Indicators

- HB AR Days increased by 3.7 days compared to prior month. June AR Days 66.0, July AR Days 69.7
- July collections were $55.4M. Lower than the average of the prior twelve months at $61.6M.



Professional Revenue Cycle Key Indicators

- PB AR Days decreased by 1.2 days compared to prior month. June AR Days 38.0 days, July AR Days 39.2
- July collections were $12.5M. Higher than average of the prior twelve months at $11.1M.

July 2025 Financial Report
Patient Collections

- FY25 Patient collections approximately 9.3% higher than the same period in FY25.
- Payments received in July for JGP represent FY25 for April/May 2025. JGP FY25 contract with the County was amended from $49.2M to $74.2M; total FY25 contract payments through July 2025 is $56.7M. As a reminder, AHS currently accruing at $72.1M consistent with the FY23 contract. Funding does not cover costs.
- JGP FY24 2nd amendment was completed from $61.2M to $73.6M; all remaining funds were received in July 2025.

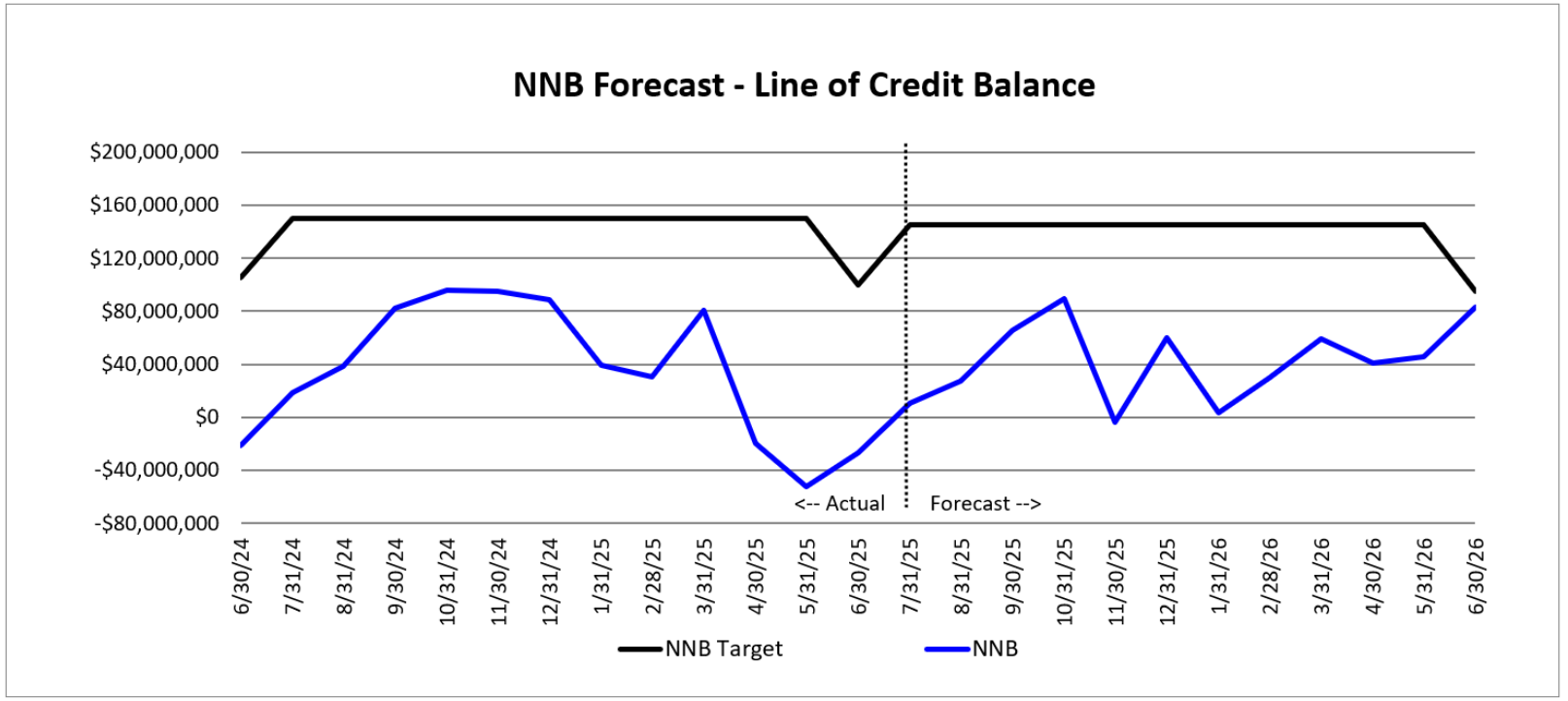
PATIENT COLLECTIONS
(in thousands)

	Behavioral Health	Epic	Total FY 2026	FY 2025	FY 2024	FY 2023	FY 2022
Jul	11,545	67,883	79,428	72,694	79,592	74,260	59,732
Aug	-	-	-	79,768	69,313	58,590	57,374
Sep	-	-	-	69,741	63,322	76,063	61,968
Oct	-	-	-	76,783	63,122	59,796	49,923
Nov	-	-	-	78,747	57,781	56,939	52,057
Dec	-	-	-	94,631	63,867	67,018	68,121
Jan	-	-	-	89,014	68,757	71,452	62,292
Feb	-	-	-	68,511	75,852	57,886	52,269
Mar	-	-	-	91,851	54,720	65,320	62,888
Apr	-	-	-	74,892	61,895	55,307	56,235
May	-	-	-	74,339	102,015	63,795	69,591
Jun	-	-	-	72,211	71,208	70,027	53,187
Total	**11,545**	**67,883**	**79,428**	**943,182**	**831,444**	**776,453**	**705,637**
	% change between fiscal years		9.3%	13.4%	7.1%	10.0%	

July 2025 Financial Report
Line of Credit (NNB) Forecast through 6/30/26

- FY2026 forecast reflects AHS operations consistent with the approved budget and is expected to be compliant at 6/30/26. Changes were as follows.
  - SNF DP-NF CY2024 ($25.8M) cashflow was included to stay below the 6/30/26 threshold of $95.0M as approved as part of the Budget.
  - Old Waiver FY2011 was updated to reflect a final settlement ($29.2M) in November 2025.
  - Payroll and accounts payable draws have increased consistent with negative variance to budget in July.

- Items that were not included in forecast.
  - St. Rose funding for IGT contribution.
  - St. Rose line of credit.



July 2025 Financial Report
Material Items Impacting NNB Forecast

- Medi-Cal Waiver FY2011 was added for $29.2M in November 2025.
- SNF DP-NF CY2024 was added for $25.8M in January 2026.
- Prior year activity for the AB915, Medi-Cal FQHC and Physician SPA settlements are reflected in bottom table as the final settlement and timing are unknown. The Old Waiver FY2011 is expected to be settled by October 2025; resulting in the release of reserves in June 2025 and additional funding ($29.2M) in November 2025.

Material Items Included in NNB Forecast
(in thousands)

	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	FY26 Q3	FY26 Q4
GPP (quarterly)	$ 25,700	$ -	$ 25,700	$ -	$ -	$ 25,700	$ 25,700
EPP (semi-annual)	-	-	21,000	-	-	-	21,000
QIP	-	-	34,364	-	-	-	34,364
Medi-Cal Rate Range	-	-	-	-	-	42,700	-
Medi-Cal Waiver (fy11)	-	-	-	29,169	-	-	-
BHCS (JGP/Alameda County) - fy25	5,206	5,109	-	-	-	-	-
BHCS (JGP/Alameda County) - fy26	-	6,084	6,084	6,084	6,084	18,251	18,251
HPAC	-	-	-	10,800	-	10,800	21,600
AB85 Realignment	-	-	(41,670)	-	-	-	-
SNF DP-NF	-	-	-	-	-	25,797	-
St. Rose Hospital LOC	-	-	-	-	-	-	-
Donation to St. Rose Hospital		-	-	-	-	-	-
	$ 30,906	$ 11,193	$ 45,478	$ 46,053	$ 6,084	$ 123,248	$ 120,915

Prior Year Reimbursement Settlements

Waiver recoupment (fy11)	$ 29,169	Payment expected in Nov-25
AB915 (fy14-fy20)	(17,000)	TBD
Medi-Cal FQHC recoupment (fy08 - fy13)	(40,000)	TBD
Physician SPA (fy08 - fy13)	(25,000)	TBD
	$ (52,831)	

May 2025 Consolidated Results
Financial Summary & YTD Highlights

- SRH YTD net income is $12.7K and favorable to budget.
  Revenue variance of $30.185M
  - Other revenue – receipt of IGT funding in May ($30.3M); however, spread evenly in the budget.
  - Net patient service revenue variance, favorable 2.2% YTD, driven by timing of supplemental revenue (DSH payments)
  - Unfavorable expenses of $156.0K driven by benefit costs for health claims exceeding budget by $1.5M offset by delays opening SNF Subacute.

- MOB YTD net income is $310.4K, exceeding budget by $87.4K (39.2%).
  - Rent revenue higher than budget from additional tenant (LaFamilia)
  - Still deferring repairs and lower than budget property taxes

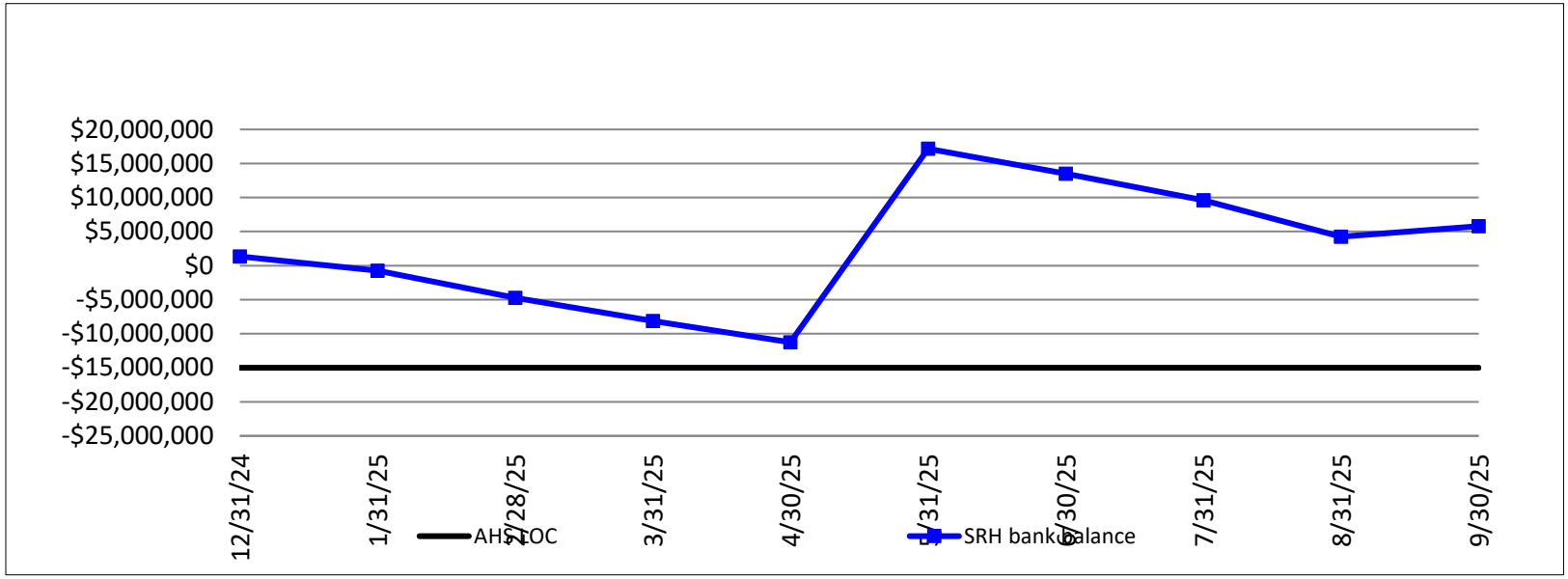
- Foundation YTD net loss is ($634.5K) unfavorable by ($708.5K) driven by the $1M donation to St. Rose Hospital, partially offset by The Dee Jordan Trust ($300K)

	May 31, 2025				Year-To-Date			
	Actual	**Budget**	**Var ($)**	**Var (%)**	**Actual**	**Budget**	**Var ($)**	**Var (%)**
Total Net Patient Service Revenue	$9,484	$8,742	$741	8.5%	$67,951	$66,481	$1,470	2.2%
Total Other Revenue	$30,520	$1,075	$29,444	2738.1%	$40,026	$14,554	25,473	175.0%
TOTAL OPERATING REVENUE	**$40,003**	**$9,818**	**$30,185**	**307.5%**	**$107,977**	**$81,035**	**$26,942**	**33.2%**
Less: Operating Expenses	$11,667	$11,510	($156)	-1.4%	$92,049	$92,221	173	0.2%
EBITDA	**$28,337**	**($1,692)**	**$30,029**	**-1774.4%**	**$15,928**	**($11,187)**	**$27,115**	**-242.4%**
Total Non-Operating Exp/(Income	$439	$392	$47	12.1%	$3,510	$3,162	$349	11.0%
Restr Donation - AA Geropscych)	$0	$292	($292)	-100.0%	$0	$2,333	(2,333)	-100.0%
NET INCOME/(LOSS)	**$27,897**	**($1,793)**	**$29,690**	**-1656.1%**	**$12,418**	**($12,015)**	**$24,433**	**-203.4%**

April 2025
Cash Flow Projection

- SRH started drawing down from AHS LOC in January and has borrowed $11M through May 6th, 2025. Interest has been accruing on the County's cost of fund rate. Total amount drawn, along with the interest incurred to date was paid off on June 12th.
  - SRF donated $1M to SRH on April 16th.
  - Great news! The IGT funding has been received. A check for $30,332,000 arrived on May 28th. Currently catching up paying vendors.

- The current projection indicates that no further drawing is necessary until October 2025. Currently onboarding an Accountant and working on FY2026 budget.



ALAMEDA HEALTH SYSTEM

1411 East 31st Street
Oakland, CA 94602

MEMORANDUM

TO: AHS Finance Committee
FROM: Kim Miranda, CFO
DATE: August 29, 2025
SUBJECT: July 2025 Financial Report

Financial Summary

Net Income for the month was a loss of $1.0 million compared to a budget of $3.5 million and unfavorable to budget by $4.5 million and 128.0%. Operating Revenue was $137.4 million and unfavorable to budget by $0.3 million and 0.2%. Operating Expense was $138.1 million and unfavorable to budget by $4.0 million and 3.0%. Earnings before interest, depreciation, and amortization (EBIDA) were $1.6 million and the EBIDA Margin was 1.2% compared to a budget EBIDA of $6.3 million and a budget EBIDA Margin of 2.6%. For the month, EBIDA was unfavorable to budget by $4.6 million.

	July 2025				FY 2025	
	Actual	Budget	Variance	% Var	YTD	% Var
Operating revenue	$ 137,440	$ 137,717	$ (277)	(0.2)%	$ 127,571	7.7%
Operating expense	138,093	134,084	(4,009)	(3.0)%	124,436	(11.0)%
Operating income (loss)	**(653)**	**3,633**	**(4,286)**	**(118.0)%**	**3,135**	**(120.8)%**
Other non-operating activity	(321)	(152)	(169)	(111.2)%	(147)	(118.6)%
Net Income (loss)	**$ (974)**	**$ 3,481**	**$ (4,455)**	**(128.0)%**	**$ 2,988**	**(132.6)%**
EBIDA adjustments	2,621	2,781	(160)		3,678	
EBIDA	**$ 1,647**	**$ 6,262**	**$ (4,615)**		**$ 6,666**	
Operating Margin	(0.5)%	2.6%	(3.1)%		2.5%	
EBIDA Margin	1.2%	4.5%	(3.3)%		5.2%	

Operating Revenue

Gross Patient Service Revenue

Gross Patient Service Revenue (patient charges) was $419.3 million for the month and favorable to budget by $4.9 million and 1.2%. Inpatient and Outpatient charges were above budget by 0.4% and 4.7%, respectively, and Professional service revenue fell below budget by 6.6%. Acute patient days were below budget for the

	July 2025				FY 2025	
	Actual	Budget	Variance	% Var	YTD	% Var
Inpatient service revenue	$ 220,563	$ 219,734	$ 829	0.4%	$ 212,781	3.7%
Outpatient service revenue	157,189	150,195	6,995	4.7%	144,709	8.6%
Professional service revenue	41,581	44,530	(2,949)	(6.6)%	40,502	2.7%
Gross patient service revenue	419,333	414,459	4,875	1.2%	397,993	5.4%
Deductions from revenue	(338,205)	(333,440)	(4,765)	(1.4)%	(321,063)	5.3%
Net patient service revenue	**81,128**	**81,018**	**110**	**0.1%**	**76,929**	**(5.5)%**
Collection % - NPSR	19.3%	19.5%	(0.2)%		19.3%	
Capitation and HPAC	4,494	4,547	(53)	(1.2)%	4,474	0.4%
Other government programs	45,324	45,415	(91)	(0.2)%	39,714	14.1%
Other operating revenue	6,494	6,736	(242)	(3.6)%	6,454	0.6%
Total operating revenue	**$ 137,440**	**$ 137,716**	**$ (276)**	**(0.2)%**	**$ 127,571**	**7.7%**

month by 5.3%. General Acute Length of Stay (LOS) is 4.7 which was below budget for the month and prior year. Discharges are higher while observation status has decreased. The case mix index (CMI) was below budget for the month and prior year. CMI is an indicator of the overall complexity of inpatient illness and services being provided. The favorable outpatient charges variance was from prior period charges that were released after subsequent review and Emergency Room visits. Outpatient surgeries were at budget. Clinic visits were below budget by 9.0% driven by lower Eastmont Dental visits and budget timing. Physician wRVU were above budget by 13.3% driven by hospital services. Overall, on an adjusted day basis, volumes were slightly above budget for the month. Adjusted discharges were 5.3% above budget due to lower LOS and more discharges than anticipated.

Net Patient Revenue

Net Patient Service Revenue (NPSR) was $81.1 million for the month and at budget. The collection ratio was 19.3% and unfavorable by 0.2%, offset by higher volumes. Government fee schedule increases and the Alliance contract increases have not been realized. The commercial payer mix was unfavorable to budget by 5.8% driven by lower trauma cases. The collections on fully reserved accounts (over 270 days) were consistent with the trend.

Other Government Program Revenue

Other Government Program Revenue for the month was $45.3 million and approximated budget. Prop 56 had an unfavorable variance ($0.1 million) that will continue for the rest of the fiscal year. The budget was based on FY25 receipts that included an overpayment from Alameda Alliance. Also, most of the government programs were accrued at budget since no added information was available.

Other Operating Revenue

Other Operating Revenue for the month was $6.5 million and unfavorable to budget by $0.2 million and 3.6%. Grant revenue was favorable from timing differences ($0.2 million). Other Operating revenue was unfavorable from lower retail pharmacy revenues ($0.9 million) that were offset by the St. Rose Hospital management fee ($0.3 million) which was not included in the budget.

Operating Expense

Operating Expense was $138.1 million for the month and unfavorable to budget by $4.0 million and 3.0%. Labor costs are discussed in a subsequent section.

	July 2025				FY 2025	
	Actual	Budget	Variance	% Var	YTD	% Var
Labor costs	$ 104,062	$ 101,824	$ (2,238)	(2.2)%	$ 92,616	(12.4)%
Physician contract services	3,827	3,598	(229)	(6.4)%	3,385	(13.1)%
Purchased services	8,685	7,982	(703)	(8.8)%	8,240	(5.4)%
Materials and supplies	13,145	12,812	(333)	(2.6)%	10,836	(21.3)%
Facilities	3,710	2,827	(883)	(31.2)%	3,257	(13.9)%
Depreciation and amortization	2,290	2,618	328	12.5%	3,518	34.9%
General and administrative	2,374	2,423	49	2.0%	2,584	8.1%
Total operating expense	**$ 138,093**	**$ 134,084**	**$ (4,009)**	**(3.0)%**	**$ 124,436**	**(11.0)%**

Non-labor expense variances net to an unfavorable variance of $1.8 million for the month as follows.

- Physician contract services were unfavorable to budget by $0.2 million and 6.4%. The largest negative variances are in General Surgery.
- Purchased services were unfavorable to budget by $0.7 million and 8.8% driven by unfavorable variances in software licenses ($0.2 million), management consultants ($0.2 million), and the remaining variance ($0.3 million) spread across many cost centers.
- Materials and supplies were unfavorable to budget by $0.3 million and 2.6% driven by unfavorable variances in surgical supplies ($0.4 million) offset by favorable variances in non-medical supplies ($0.1 million). Retail pharmaceuticals approximated budget for the month.
- Facilities were unfavorable to budget by $0.9 million and 31.2% driven by timing of building/equipment repairs ($0.7 million) and utilities ($0.2 million). Most of the repair variance was for Highland Hospital ($0.4 million).
- Depreciation and amortization were favorable to budget by $0.3 million and 12.5% driven by budget timing for equipment depreciation ($0.4 million) offset by lease/software amortization ($0.1 million).
- General and administrative costs approximated budget.

Labor Costs

Labor costs for the month were $104.1 million and unfavorable to budget by $2.2 million and 2.2%.

	July 2025				FY 2025	
	Actual	Budget	Variance	% Var	YTD	% Var
Salaries and wages (staff)	$ 63,673	$ 61,902	$ (1,771)	(2.9)%	$ 54,562	(16.7)%
Salaries and wages (physicians)	10,639	11,315	676	6.0%	10,152	(4.8)%
Registry	3,835	4,285	450	10.5%	4,456	13.9%
Employee benefits (taxes, insurance)	17,174	15,774	(1,400)	(8.9)%	15,676	(9.6)%
Retirement	8,741	8,548	(193)	(2.3)%	7,770	(12.5)%
Total labor costs	**$ 104,062**	**$ 101,824**	**$ (2,238)**	**(2.2)%**	**$ 92,616**	**(12.4)%**
Compensation ratio	75.7%	73.9%	-1.8%		72.6%	
Paid FTEs	5,197	5,165	(32)	(0.6)%	5,105	(1.8)%

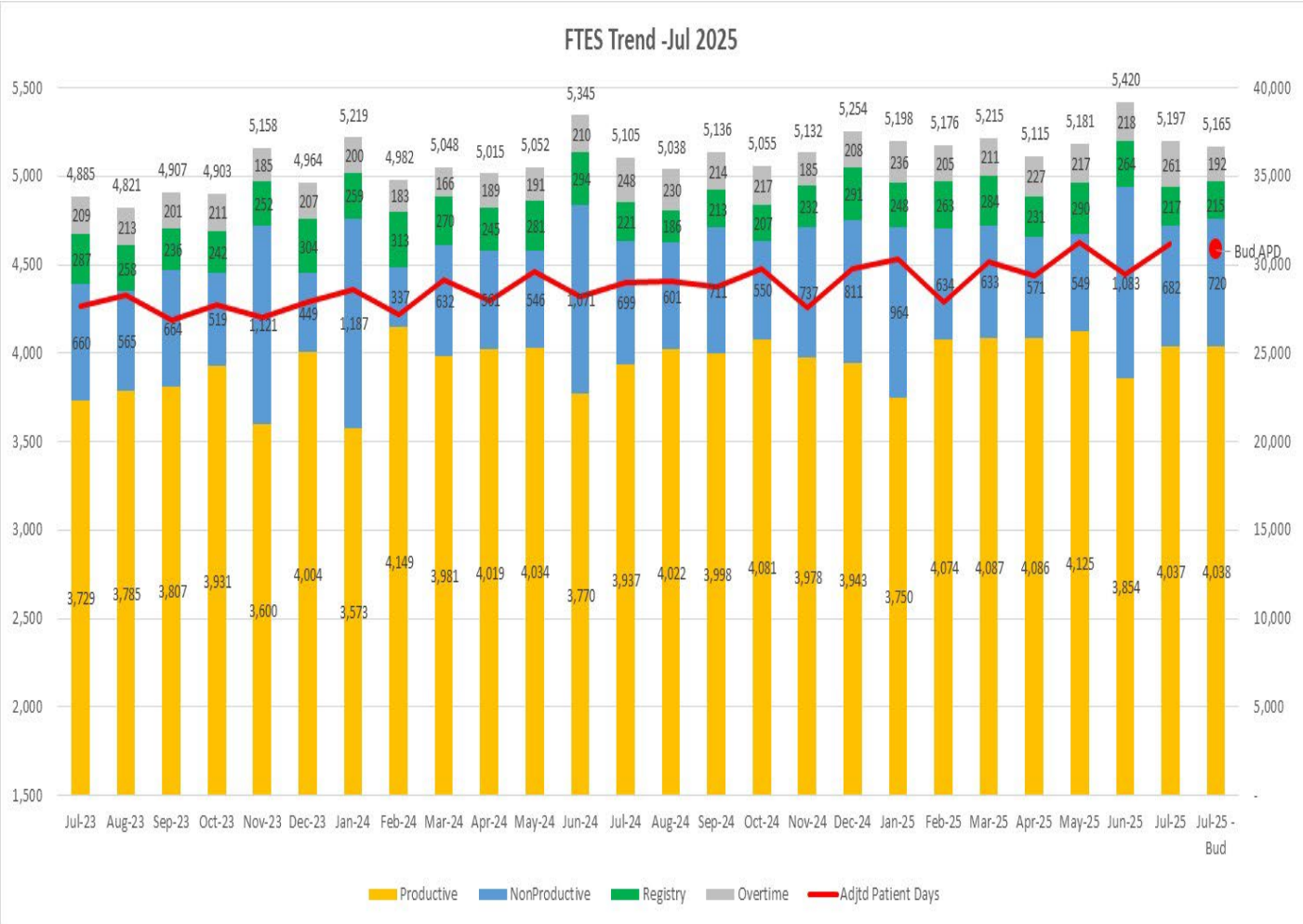
For the month, staff, physician and registry labor costs were unfavorable to budget by $0.6 million and 0.8% driven by higher FTE volume (32 FTEs/$0.5 million) and higher rates ($0.2 million). AHS continues to roll out UKG timekeeping to registry. At this point, timing differences occur between when invoices are paid, and the hours included to calculate FTE causing variances for the month.

Employee benefits were unfavorable by $1.4 million and 8.9% driven by self-funded health insurance ($1.7 million) offset by positive variance for Kaiser insurance plan ($0.3 million).

Retirement expense was unfavorable by $0.2 million and 2.3% from ACERA ($0.2 million).

FTE Trending

For the month, Paid FTE was 5,197 compared to a budget of 5,137 which was unfavorable to budget by 32 and 0.6%. The FTE trend graph below reflects paid FTE and adjusted patient days (Total Gross Revenues / Inpatient Revenues = Outpatient Factor x Patient Days) by the month beginning in July, 2023. Overall, adjusted patient days (red line) exceeded budget this month. The bars reflect Paid FTE for each month and are stacked to include each paid labor component represented by color within the bars. The current month actual and budget are reflected in the last columns on the right of the graph. For the month, overtime (grey) and registry (green) exceeded budget resulting in an unfavorable FTE variance. Non-productive (blue) and productive approximate budget.



Balance Sheet and Financial Condition
The Balance Sheet key financial metrics are reflected in the table below.

	Jul-25	FY 2025
Days in cash	3.1	1.2
Gross days in patient receivable	65.1	62.4
Net days in patient receivable	46.4	45.5
Due from/(to) third-party payors	$ 156,041	$ 154,653
Due from/(to) County	$ 33,290	$ 39,481
Days in accounts payable	32.5	38.1
% of AP over 60 days	5.6%	10.6%
Net position - fund balance/(deficit)	$ (61,072)	$ (60,267)
Net negative balance - receivable/(payable)	$ (5,367)	$ 26,631

Days in Cash
Days in Cash are low as all AHS cash receipts are swept to the County Treasury. The Days in Cash can fluctuate based on timing of cash draws from the County treasury and timing of vendor payments and payroll.

Accounts Receivable (AR)
The Gross Days in AR were 65.1 days and 2.7 days higher than last month due to lower cash receipts. Net Days in AR were 46.4 and 0.9 days higher than the previous month from lower net revenue per calendar day by 3.1%. The calculation reflects 90 days versus actual days for the quarter to standardize the calculation. Utilizing a 90-day period does lead to more fluctuations. Key updates on work in progress within Revenue Cycle are noted below:

- Settlements through arbitration using Sac Law continue to support GRIT.

Patient collections are reflected in the table below. Behavioral Health represents the County receipts under contract for JGP services which total $11.5 million. AHS and the County executed the 2nd amendment in May 2025 increasing the FY2024 contract total from $61.2 million to $73.6 million. Invoices were submitted to the County for the remaining $12.4 million. Payments under the FY2025 contract which was also amended to increase the maximum from $49.2 to $74.2M, total $56.6 million through April 2025. As a reminder the FY2023 contract was $72.1 million, and AHS accrued at this higher level of reimbursement, which is now supported by the recent amendments.

Accounts Payable
Days in Accounts Payable are 32.5 at the end of the month and decreased 5.6 days over the prior month from timing of recurring check runs versus the last day of the calendar month and resolution of ongoing implementation issues with OnBase. The Percent over 60 Days is 5.6% and is above the 5% target. Purchasing and Accounts Payable teams are making positive progress resolving older invoices held in work queues.

PATIENT COLLECTIONS
(in thousands)

	Behavioral Health	Epic	Total FY 2026	FY 2025	FY 2024	FY 2023	FY 2022
Jul	11,545	67,883	79,428	72,694	79,592	74,260	59,732
Aug	-	-	-	79,768	69,313	58,590	57,374
Sep	-	-	-	69,741	63,322	76,063	61,968
Oct	-	-	-	76,783	63,122	59,796	49,923
Nov	-	-	-	78,747	57,781	56,939	52,057
Dec	-	-	-	94,631	63,867	67,018	68,121
Jan	-	-	-	89,014	68,757	71,452	62,292
Feb	-	-	-	68,511	75,852	57,886	52,269
Mar	-	-	-	91,851	54,720	65,320	62,888
Apr	-	-	-	74,892	61,895	55,307	56,235
May	-	-	-	74,339	102,015	63,795	69,591
Jun	-	-	-	72,211	71,208	70,027	53,187
Total	**11,545**	**67,883**	**79,428**	**943,182**	**831,444**	**776,453**	**705,637**
	% change between fiscal years		9.3%	13.4%	7.1%	10.0%	

Supplemental Program Revenue Receivable/Payable

The information presented in the table below provides subsidiary information for Supplemental Program receivables and payables on the Balance Sheet. The net receivable balance for Supplemental Programs is $156.0 million, which increased $1.4 million over last month. Key items are noted below.

- Payment received for Medi-Cal P14 FY2019 Final Settlement ($6.1 million).
- Payment received for GPP CY2025 Q2 ($65.7 million).
- IGT funded for GPP CY2025 Q2 ($39.0 million).
- IGT funded for GME FY2026 Q1 ($3.4 million).
- Minor cost report adjustments and monthly accruals ($30.8 million).

Estimates are necessary to record supplemental income because the ultimate amount that may be collected under the program is uncertain, dependent on costs for services that were ultimately provided, quality metrics achieved, Medi-Cal enrollment, and our ability to identify and claim related costs. The timing of receipts and payments is critical because these cashflows affect the NNB under our Line of Credit with the County. Nearly half of AHS annual revenue comes from supplemental funding.

AHS has significant liability estimates dating back more than 5 years as reflected at the bottom of the schedule. They include the old Medi-Cal Waiver, AB915, Physician SPA and Highland FQHC. Notification of FY2011 Waiver settlement was received in June 2025 from DHCS and adjustments were booked in June to eliminate the reserves ($4.8 million) and recognize receivable ($27.6 million). The result was a favorable pick up of $32.4 million. The preliminary settlement schedule varied from trend which warranted the reserve. However, when the pool finally settled among all the public hospital systems, the preliminary data proved to be valid. Also, AB915 was added to the section for FY2014 through FY2020 as the program audits are delayed by the State. The total estimated amount due is $54.4 million.

Net Reimbursement Supplemental Programs as of 7/31/2025					
Programs	**FY97-20**	**FY21-25**	**FY26**	**Net Balance**	**Comments**
Medicare Cost Report	(1,473)	(4,676)	(55)	(6,204)	Older years pending disputed SSI ratio and outlier holds for both OPPS / IPPS services from CMS.
Medi-Cal P14 Waiver	994	(1,680)	(738)	(1,424)	P14 audits are in various stages of completion. Currently DHCS has finalized up to FY18.
Current Waiver (GPP & CalAIM)	-	(5,618)	8,403	2,785	Global Payment Program (GPP) subsidizing remaining uninsured. GPP extended to 2026 as CalAIM.
AB85 Realignment	0	(86,817)	-	(86,817)	Realignment reserves for HPAC amendment passing through the County for physical health for Medi-Cal and Indigent populations.
Physician SPA	(6,000)	3,842	945	(1,213)	Reconciliation based on P14 utilization file with the State. FY14-FY16 Finalized. Catch-up ACA interim payments began during FY22.
FQHC	(7,922)	(15,405)	(417)	(23,744)	Negotiating settlement for a new FQ rate. The difference between the new FQ rate and FFS rate will determine the settlement for the impacted years. AHS started billing as a FQ in March 2022.
Medi-Cal Managed Care EPP	0	109,624	5,644	115,268	EPP (Enhanced Payment Program). New supplemental program for services provided to Medi-Cal Managed Care.
Medi-Cal Managed Care QIP	0	106,747	6,642	113,388	QIP (Quality Incentive Program). New supplemental program for services provided to Medi-Cal Managed Care.
Medi-Cal Managed Care Rate Range	(0)	69,800	4,317	74,117	Subsidize rates for Medi-Cal Managed Care members in Alameda County.
Medi-Cal Managed Care GME	0	8,237	4,582	12,818	CMS approved in March 2020. GME is paying concurrently with fiscal year.
Medi-Cal Managed Care DP-NF Pass-Through	-	2,150	-	2,150	New payment program assisting AHS with LTC carve-in from FFS to managed care, time-limited CY2023 through CY2025. First year disclosed and received Jan 2025, further years TBA
Medi-Cal SNF Cost Settlement	0	1,967	35	2,002	The State began their reconciliation.
AB915	-	2,353	734	3,087	AB915/Medi-Cal Hospital OP cost settlement. DHCS began reconciling older years during FY23.
All Other Supplemental Programs	0	3,643	620	4,263	Hospital Fee, NDPH & P4P programs
Subtotal	**$ (14,401)**	**$ 194,167**	**$ 30,711**	**$ 210,476**	
Old Waiver (FY11, DSH/SNCP)	27,565	0	0	27,565	All years have been finalized. Just waiting on payments and IGTs. Reserves closed out in June 2025 based on notices being received.
AB915 (FY14-FY20)	(17,000)	0	0	(17,000)	FY14-FY20 Reserve pending on audits.
Physician SPA (FY08-12)	(25,000)	0	0	(25,000)	FY13 final settled.
FQHC (FY12-18)	(40,000)	0	0	(40,000)	Negotiating settlement for Highland FQ clinics is pending for HGH K-6 clinic.
Subtotal	**$ (54,435)**	**$ -**	**$ -**	**$ (54,435)**	
Grand Total	**$ (68,836)**	**$ 194,167**	**$ 30,711**	**$ 156,041**	

Net County Receivable and Payable

Due To/From County of Alameda	Jul-25	FY 2025
Due from County of Alameda	$ 43,672	$ 45,740
Capital designation receivable	7,000	7,000
Due from County of Alameda	**50,672**	**52,740**
Due to County of Alameda	(3,091)	(2,379)
County IGT funding	(3,411)	-
Capital cost payable	(10,880)	(10,880)
Due to County of Alameda	**(17,382)**	**(13,259)**
Net due from/(to) County	**$ 33,290**	**$ 39,481**

The net County receivable and payable due under arrangements with the County are reflected as part of the Due to and Due From accounts reported on the Balance Sheet as follows:

- The County receivable includes the HPAC contract, John George Pavilion (JGP) services agreement and grants.
- The Capital Designation receivable reflects reimbursement expected from the County ($7 million per year) to help fund the Sapphire project. An annual invoice is sent to the County after AHS transfers the funds, and certain contractual requirements are met at the end of the fiscal year. The FY2025 invoice was submitted to the County in June 2025.
- Inter-government transfers (IGT) are ongoing to draw down federal supplemental funding and then paid back to the County.
- The Capital Cost Transfer reflects a payable based on the balance remaining on open cost report settlements associated with County owned buildings ($10.9 million). AHS transfers cost reimbursement estimates to the County each year and AHS has the contractual ability to benefit from these funds to help maintain and invest in County owned facilities. In May 2024, the County accessed $1.2 million to pay for an emergency transformer on the Fairmont campus. AHS is working with the County to develop a workflow to allow AHS to capture costs for future cost reimbursement.

Net Position

The Net Position or Fund Balance of AHS as of July 31, 2025, is negative $61.1 million, which deteriorated $0.8 million over last month reflecting the net loss for the month ($1.0 million) offset by capital contribution from Jaber Funds ($0.2 million).

Net Negative Balance

The Net Negative Balance (NNB) or Line of Credit with the County is $5.4 million payable on July 31, 2025 and remains compliant with the terms of the Permanent Agreement. The Working Capital Loan is reported on the Balance Sheet as a long-term liability labeled “Liquidity Facility – County of Alameda.” To calculate the

NNB, the Liquidity Facility ($32.5 million payable) decreased by the County Restricted Cash Fund ($27.1 million) which is included in Cash.

Contingencies

John George Pavilion (JGP)

Consistent with FY2025 reporting, AHS included revenue of $72.1 million under the County contract in the FY2026 budget and is accruing revenue based on the FY23 contract maximum and our understanding that the change from Short Doyle cost reimbursement to fee for service payments under Cal Aim was not going to reduce funding for behavioral health services. AHS and the County are currently working to execute the FY2026 contract which is expected to increase funding. The amendment for the FY2025 contract was signed in May 2025 increasing the contract maximum from $49.2 million to $74.2 million. The FY2024 2nd contract amendment was also signed in May 2025 increasing the contract maximum from $61.2 million to $73.6 million. AHS has submitted invoices to the County to capture the contract increases and avoid further adjustment.

The County continues to struggle with the implementation of new software, SmartCare, which has delayed billing. JGP technical services have been input into SmartCare to be billed and paid for by the State although AHS has not received any information from the County on denials or payments they have received. AHS and the County partnered to determine appropriate billing of professional fees, which under this new system are payable separate from technical services for the first time. There is a twelve-month timely filing requirement to submit claims. The County has indicated it will ensure claims are paid even if the timely filing deadline means they cannot be federally matched. AHS has submitted professional claims to the County; however, no information has been provided to us on the status of these claims.

Highland Federally Qualified Healthcare Center (FQHC) Settlement

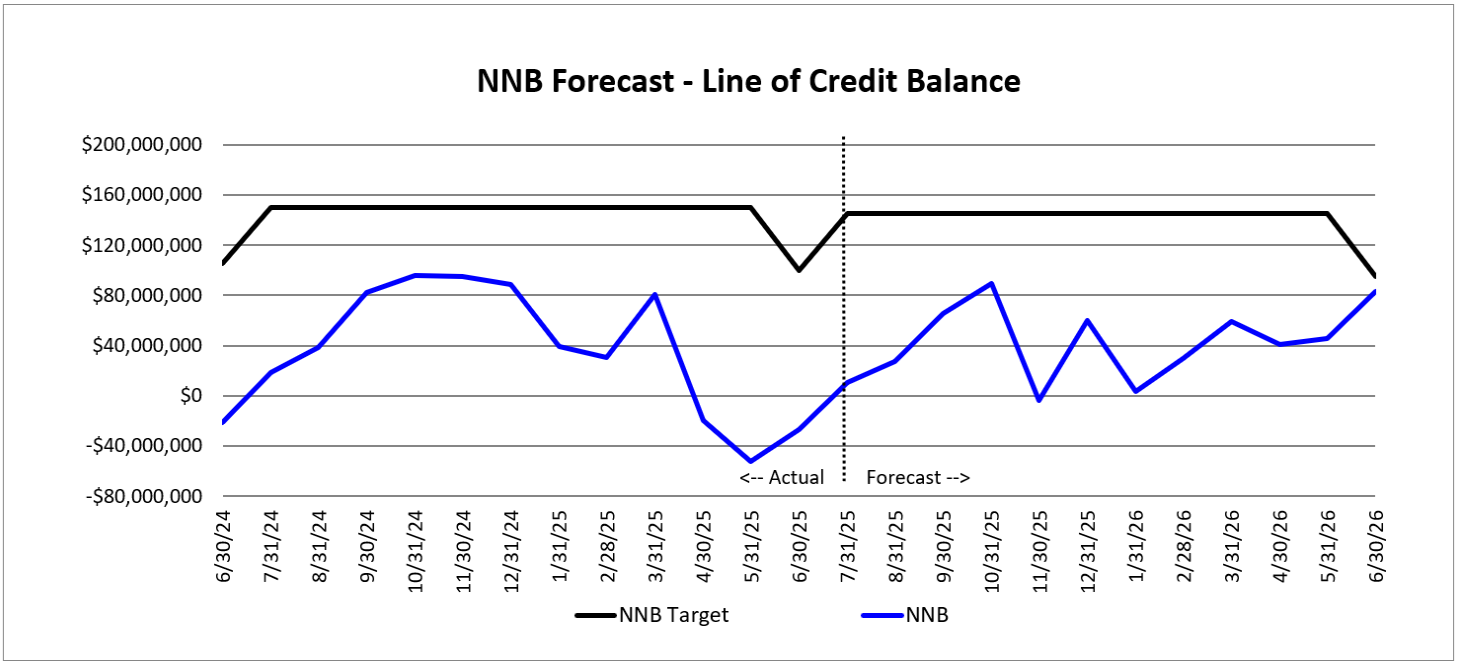
The State reached out to AHS inquiring about a new application that AHS submitted to establish the dental clinic located at Highland as a new FQHC. The State wanted to understand the new application request which started a conversation that ultimately resulted in the State verbally agreeing AHS could resume billing previous service locations on the Highland campus as FQHC. AHS began billing as an FQHC for these service locations on March 1, 2022. AHS and the State started negotiations on a retroactive settlement going back to the FY2012 filing made by AHS to establish an FQHC rate. Once the negotiations progress to a point where a new estimate can be determined, AHS will adjust the current liability on the balance sheet. AHS currently has a pending recoupment of $40.0 million. AHS is being paid at the historical Highland FQ rate for the additional service locations until the new rate is finalized.

Line of Credit (Net Negative Balance) Forecast

The Line of Credit Balance or the Net Negative Balance (NNB) held with the County is forecasted in the line graph below through June 30, 2026 for planning purposes. AHS is currently forecasting that the NNB will be compliant with the terms of the agreement with the County which limits the NNB to $95.0 million on June 30, 2026. The forecast reflects AHS operations consistent with the approved budget and the forecast updates as actual activity is reflected in the cashflow model.

The forecasted NNB on July 31, 2025 improved from recognition of the FY2011 Waiver Final Settlement ($29.2 million) and the expectation of receiving CY2024 SNF DP-NF funding ($25.8 million) partially offset by increased draws for payroll and accounts payable based on July activity. As a reminder, the intent was to preserve SNF DP-NF funds for future investments or to establish reserve fund since these funds are not expected to continue beyond the three-year period (CY23-CY25). However, the Trustees approved the use of

these funds to cover the projected NNB shortfall as part of the annual budget approval. In addition, the approved budget did not contemplate St. Rose Hospital (SRH) funding requirements.



Material items impacting the NNB are summarized in the table below. The top portion of the table provides expected cash flow from sizable items included in NNB forecast. Forecasted items have changed as follows.

- Behavior Health (JGP/Alameda County) was changed from $7.1 million in August and September to $5.2 million and $5.1 million, respectively, to reflect actual payment.
- CY2024 SNF DP-NF funding estimate was added in January 2026.
- SRH is projecting to access the line of credit in October 2025, which was not included in the AHS forecast.
- SRH will need support to maximize the FY26 IGT funding, which is not included in the AHS forecast.
- SRH budget planning is underway for FY2026.

The bottom portion of the table below reflects older year's liability estimates which are not included in the forecast (blue line) due to unknown timing for resolution. However, notice was received from DHCS that the FY11 Waiver settlement would be favorable resulting in a pickup of $29.2 million expected in November which is incorporated in the cashflow forecast. AB915 for FY2014 through FY2020 was added to the schedule because program review for these fiscal years was delayed by the State ($17.0 million). The Federal Qualified Health Center (FQHC) recoupment is a conservative settlement estimate based on the difference between reimbursement rates for services provided at Highland campus locations that were considered qualified and subsequently denied by the State. AHS is in current discussions with the State and once an agreement is reached with the State the FQHC liability will be adjusted Lastly, Physician SPA reconciliations are delayed because the State is having difficulty obtaining claim data.

Material Items Included in NNB Forecast
(in thousands)

	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	FY26 Q3	FY26 Q4
GPP (quarterly)	$ 25,700	$ -	$ 25,700	$ -	$ -	$ 25,700	$ 25,700
EPP (semi-annual)	-	-	21,000	-	-	-	21,000
QIP	-	-	34,364	-	-	-	34,364
Medi-Cal Rate Range	-	-	-	-	-	42,700	-
Medi-Cal Waiver (fy11)	-	-	-	29,169	-	-	-
BHCS (JGP/Alameda County) - fy25	5,206	5,109	-	-	-	-	-
BHCS (JGP/Alameda County) - fy26	-	6,084	6,084	6,084	6,084	18,251	18,251
HPAC	-	-	-	10,800	-	10,800	21,600
AB85 Realignment	-	-	(41,670)	-	-	-	-
SNF DP-NF	-	-	-	-	-	25,797	-
St. Rose Hospital LOC	-	-	-	-	-	-	-
Donation to St. Rose Hospital		-	-	-	-	-	-
	$ 30,906	$ 11,193	$ 45,478	$ 46,053	$ 6,084	$ 123,248	$ 120,915

Prior Year Reimbursement Settlements

Waiver recoupment (fy11)	$ 29,169	Payment expected in Nov-25
AB915 (fy14-fy20)	(17,000)	TBD
Medi-Cal FQHC recoupment (fy08 - fy13)	(40,000)	TBD
Physician SPA (fy08 - fy13)	(25,000)	TBD
	$ (52,831)	

ALAMEDA HEALTH SYSTEM (consolidated)
Statement of Revenues and Expenses
For the Period Ended July 31, 2025
(In Thousands)

	July 2025				FY 2025		
	Actual	Budget	Variance	% Variance	YTD	Variance	% Variance
Operating revenue							
Net patient service revenue	$ 81,128	$ 81,019	$ 109	0.1%	$ 76,929	$ 4,199	5.5%
Capitation revenue	4,494	4,547	(53)	(1.2)%	4,474	20	0.4%
Other government programs	45,324	45,415	(91)	(0.2)%	39,714	5,610	14.1%
Other operating revenue	6,494	6,736	(242)	(3.6)%	6,454	40	0.6%
Total operating revenue	**137,440**	**137,717**	**(277)**	**(0.2)%**	**127,571**	**9,869**	**7.7%**
Operating expense							
Labor costs	104,062	101,824	(2,238)	(2.2)%	92,616	(11,446)	(12.4)%
Physician contract services	3,827	3,598	(229)	(6.4)%	3,385	(442)	(13.1)%
Purchased services	8,685	7,982	(703)	(8.8)%	8,240	(445)	(5.4)%
Materials and supplies	13,145	12,812	(333)	(2.6)%	10,836	(2,309)	(21.3)%
Facilities	3,710	2,827	(883)	(31.2)%	3,257	(453)	(13.9)%
Depreciation and amortization	2,290	2,618	328	12.5%	3,518	1,228	34.9%
General and administrative	2,374	2,423	49	2.0%	2,584	210	8.1%
Total operating expense	**138,093**	**134,084**	**(4,009)**	**(3.0)%**	**124,436**	**(13,657)**	**(11.0)%**
Operating income (loss)	**(653)**	**3,633**	**(4,286)**	**(118.0)%**	**3,135**	**(3,788)**	**(120.8)%**
Non-operating activity							
Interest income (expense)	(331)	(163)	(168)	(103.1)%	(160)	(171)	(107.1)%
Other nonoperating revenue	10	11	(1)	(9.1)%	13	(3)	(23.0)%
Total non-operating activity	**(321)**	**(152)**	**(169)**	**(111.2)%**	**(147)**	**(174)**	**(118.6)%**
Net income (loss)	**$ (974)**	**$ 3,481**	**$ (4,455)**	**(128.0)%**	**$ 2,988**	**$ (3,962)**	**(132.6)%**
EBIDA adjustments							
Interest income (expense)	331	163	168		160	171	
Depreciation and amortization	2,290	2,618	(328)		3,518	(1,228)	
Total EBIDA adjustments	2,621	2,781	(160)		3,678	(1,057)	
EBIDA	**$ 1,647**	**$ 6,262**	**$ (4,615)**		**$ 6,666**	**$ (5,019)**	

ALAMEDA HEALTH SYSTEM (consolidated)
Balance Sheet
As of July 31, 2025
(In Thousands)

	Current Month	FYE 2025
ASSETS		
Cash & cash equivalents	$ 13,538	$ 14,556
Patient account receivables, net	107,502	101,401
Due from third-party payors	347,867	346,479
Due from County of Alameda	50,672	52,740
Due from State of California	26,018	25,635
Inventories	12,506	12,267
Other current assets	22,433	17,592
TOTAL CURRENT ASSETS	**580,536**	**570,670**
Restricted cash equivalents	27,133	27,133
Right-to-use lease assets, net	30,981	31,604
Right-of-use subscription assets, net	4,853	5,050
Capital assets - nondepreciable	9,021	9,021
Capital assets - depreciable, net	128,918	129,675
TOTAL NONCURRENT ASSETS	**200,906**	**202,483**
DEFERRED OUTFLOWS OF RESOURCES	**105,415**	**105,415**
TOTAL ASSETS & DEFERRED OUTFLOWS	**$ 886,857**	**$ 878,568**

LIABILITIES & NET ASSETS		
Accounts payable and accrued expenses	$ 69,428	$ 79,162
Accrued compensation	46,287	63,953
Due to third-party payors	191,826	191,826
Due to County of Alameda	17,382	13,259
Other Payables	42,892	37,834
TOTAL CURRENT LIABILITIES	**367,815**	**386,034**
Liquidity facility - County of Alameda	32,500	502
Net pension obligation	369,662	369,662
Post employment benefit asset	43,255	43,255
Accrued compensated absences, net of current portion	22,604	26,667
Self-insurance liabilities, net of current portion	39,820	39,820
Lease obligations, net of current portion	29,192	29,739
Subscription obligations, net of current portion	1,918	1,993
Other long-term liabilities	0	0
TOTAL LONG TERM LIABILITIES	**538,951**	**511,638**
DEFERRED INFLOWS OF RESOURCES	**41,163**	**41,163**
Fund balance - capital contribution	86,635	86,466
Fund balance - prior years	(146,733)	(166,072)
Current year income/(loss)	(974)	19,339
FUND BALANCE	**(61,072)**	**(60,267)**
TOTAL LIABILITIES, DEFERRED INFLOWS, & FUND BALANCE	**$ 886,857**	**$ 878,568**

ALAMEDA HEALTH SYSTEM (consolidated)
Statement of Cash Flows
For the Period Ended July 31, 2025
(in thousands)

	Current Month	FYE 2025
CASH FLOWS FROM OPERATING ACTIVITIES		
Operating income (loss)	$ (653)	$ 23,794
Depreciation and amortization	2,290	36,849
Net changes in operating assets and liabilities:		
Patient account receivables, net	(6,101)	4,695
Due from/to third-party payors	(1,388)	(9,320)
Due from/to County	6,191	(14,681)
Due from State	(383)	(1,371)
Inventory	(239)	(280)
Other current assets	(4,841)	30
Accounts payable and accrued expenses	(9,732)	(6,325)
Accrued compensation	(17,666)	7,686
Other current payables	5,058	5,192
Net pension liability	-	(56,345)
Other postemployment benefits obligations	-	4,881
Other long-term liabilities	(4,063)	5,936
Deferred outflows/inflows	-	51,010
Net cash provided by (used in) operating activities	**(31,527)**	**51,751**
CASH FLOWS FROM NONCAPITAL FINANCING ACTIVITIES		
Change in liquidity facility	31,998	(4,599)
Interest payments on working capital loan	370	4,402
Receipts of rental income	10	(253)
Net cash provided by (used in) noncapital financing activities	**32,378**	**(450)**
CASH FLOWS FROM CAPITAL AND FINANCING ACTIVITIES		
Purchase and construction of capital assets	(712)	(19,936)
Proceeds from disposals of capital assets	0	0
Repayment of other long-term liabilities	0	(2,783)
Payments of lease liabilies	(547)	(6,730)
Interest payments on lease liabilities	94	1,232
Payments of subscription obligations	(76)	(4,532)
Interest payments on subscription obligations	11	128
Capital contributions and transfers	169	1,015
Net cash provided by (used in) capital and financing activities	**(1,061)**	**(31,606)**
CASH FLOWS FROM INVESTING ACTIVITIES		
Interest and investment income	(806)	(9,964)
Net cash provided by (used in) investing activities	**(806)**	**(9,964)**
CHANGES IN CASH AND CASH EQUIVALENTS	**(1,016)**	**9,731**
CASH AND CASH EQUIVALENTS, beginning of period	41,689	31,958
CASH AND CASH EQUIVALENTS, end of period	**$ 40,673**	**$ 41,689**

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	MONTH				YEAR-TO-DATE				PRIOR YEAR-TO-DATE		
	Actual	Budget	Variance	% Var	YTD Actual	YTD Budget	Var	% Var	PY YTD Actual	Variance	% Var
Campus: AHS ALL CAMPUS											
Total Patient Days	17,552	17,543	9	0.1%	17,552	17,543	9	0.1%	17,272	280	1.6%
Total Discharges	1,576	1,512	64	4.2%	1,576	1,512	64	4.2%	1,464	112	7.7%
Total Adjusted Patient Days	31,193	30,850	343	1.1%	31,193	30,850	343	1.1%	30,124	1,068	3.5%
Total Adjusted Discharges	2,801	2,659	142	5.3%	2,801	2,659	142	5.3%	2,553	247	9.7%
GENERAL ACUTE											
GA Patient Days	6,033	6,373	-340	-5.3%	6,033	6,373	-340	-5.3%	6,270	-237	-3.8%
GA Discharges	1,290	1,221	69	5.6%	1,290	1,221	69	5.6%	1,190	100	8.4%
Average Daily Census	194.6	205.6	-11	-5.3%	194.6	205.6	-11	-5.3%	202.3	-7.6	-3.8%
Average Length of Stay	4.7	5.2	-0.5	-10.4%	4.7	5.2	-0.5	-10.4%	5.3	-0.6	-11.2%
Adjusted Patient Days	11,506	11,833	-326	-2.8%	11,506	11,833	-326	-2.8%	11,603	-96	-0.8%
Adjusted Discharges	2,460	2,268	193	8.5%	2,460	2,268	193	8.5%	2,202	258	11.7%
Occupancy %	65%	69%	-4%	-5.3%	65%	69%	-4%	-5.3%	68%	-3%	-3.8%
GA CMI	1.612	1.7	-0.088	-5.2%	1.612	1.7	-0.088	-5.2%	1.699	-0.087	-5.1%
Emergency Visits	9,403	8,764	639	7.3%	9,403	8,764	639	7.3%	9,174	229	2.5%
Left Without Being Seen (LWBS)	421	583	162	38.6%	421	583	162	38.6%	603	182	43.2%
Trauma Cases	295	313	-18	-5.9%	295	313	-18	-5.9%	330	-35	-10.6%
Observation Equivalent Days	696	728	-32	-4.4%	696	728	-32	-4.4%	681	14	2.1%
IP Surgeries	329	360	-31	-8.6%	329	360	-31	-8.6%	345	-16	-4.6%
OP Surgeries	388	384	4	1.1%	388	384	4	1.1%	482	-94	-19.5%
Total Surgeries	717	744	-27	-3.6%	717	744	-27	-3.6%	827	-110	-13.3%
Deliveries	153	141	12	8.4%	153	141	12	8.4%	132	21	15.9%
PSYCH											
Psych Patient Days	2,121	1,925	196	10.2%	2,121	1,925	196	10.2%	1,934	187	9.7%
Psych Discharges	213	214	-1	-0.4%	213	214	-1	-0.4%	203	10	4.9%
Average Daily Census	68.4	62.1	6.3	10.2%	68.4	62.1	6.3	10.2%	62.4	6	9.7%
Average Length of Stay	10	9	-1	-10.6%	10	9	-1	-10.6%	9.5	-0.4	-4.5%
Adjusted Patient Days	2,671	2,387	284	11.9%	2,671	2,387	284	11.9%	2,410	262	10.9%
Adjusted Discharges	268	265	3	1.2%	268	265	3	1.2%	253	15	6.1%
PES Equivalent Days	874	719	155	21.5%	874	719	155	21.5%	719	155	21.5%
REHAB											
Rehab Patient Days	673	699	-26	-3.7%	673	699	-26	-3.7%	684	-11	-1.6%
Rehab Discharges	58	53	5	9.7%	58	53	5	9.7%	50	8	16.0%
Average Daily Census	21.7	22.5	-0.8	-3.7%	21.7	22.5	-0.8	-3.7%	22.1	-0.4	-1.6%
Average Length of Stay	11.6	13.2	-1.6	-12.2%	11.6	13.2	-1.6	-12.2%	13.7	-2.1	-15.2%
Adjusted Patient Days	673	699	-26	-3.7%	673	699	-26	-3.7%	684	-11	-1.6%
Adjusted Discharges	58	53	5	9.7%	58	53	5	9.7%	50	8	16.0%
Occupancy %	78%	81%	0%	0.0%	78%	81%	0%	0.0%	79%	0%	0.0%

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SNF with Sub-Acute											
SNF Patient Days	8,725	8,546	179	2.1%	8,725	8,546	179	2.1%	8,384	341	4.1%
SNF Discharges	15	24	-9	-37.7%	15	24	-9	-37.7%	21	-6	-28.6%
Average Daily Census	281.5	275.7	5.8	2.1%	281.5	275.7	5.8	2.1%	270.5	11	4.1%
Average Length of Stay	581.7	354.7	226.9	64.0%	581.7	354.7	226.9	64.0%	399.2	182.4	45.7%
Adjusted Patient Days	9,034	8,560	474	5.5%	9,034	8,560	474	5.5%	8,642	391	4.5%
Adjusted Discharges	16	24	-9	-35.6%	16	24	-9	-35.6%	22	-6	-28.3%
Occupancy %	97%	95%	0%	0.0%	97%	95%	0%	0.0%	93%	0%	0.0%
Bed Holds	-27	97	-124	-127.8%	-27	97	-124	-127.8%	96	-123	-128.1%
TOTAL FTE, HOURS, WRVU											
Total Paid FTE	5,197	5,165	-32	-0.6%	5,197	5,165	-32	-0.6%	5,104	-92	-1.8%
Total Productive FTE	4,515	4,441	-74	-1.7%	4,515	4,441	-74	-1.7%	4,406	-109	-2.5%
Total Paid FTE per AOB	5.16	5.19	0.03	0.5%	5.16	5.19	0.03	0.5%	5.25	0.09	1.7%
Worked Hours Per APD	25.6	25.5	-0.1	-0.5%	25.6	25.5	-0.1	-0.5%	25.9	0.3	1.0%
Worked Hours Per AD	286	296	10	3.5%	286	296	10	3.5%	306	20	6.6%
Physician wRVU	136,937	120,894	16,044	13.3%	136,937	120,894	16,044	13.3%	127,217	9,720	7.6%
CLINIC / TELEHEALTH	34,996	38,468	-3,472	-9.0%	34,996	38,469	-3,473	-9.0%	34,818	178	0.5%
Clinic Visits	29,122	32,266	-3,144	-9.7%	29,122	32,266	-3,144	-9.7%	28,973	149	0.5%
Telehealth Visits	5,874	6,202	-328	-5.3%	5,874	6,202	-328	-5.3%	5,845	29	0.5%
FQHC Visits	29,238	31,404	-2,166	-6.9%	29,238	31,404	-2,166	-6.9%	28,875	363	1.3%
Clinic Visits	24,481	26,225	-1,744	-9.7%	24,481	26,225	-1,744	-6.7%	23,982	499	2.1%
Telehealth Visits	4,757	5,179	-422	-5.3%	4,757	5,179	-422	-8.1%	4,893	-136	-2.8%
Non-FQHC Visits	5,758	7,064	-1,306	-18.5%	5,758	7,064	-1,306	-18.5%	5,943	178	3.0%
Clinic Visits	4,641	6,041	-1,400	-9.7%	4,641	6,041	-1,400	-9.7%	4,991	149	3.0%
Telehealth Visits	1,117	1,023	94	-5.3%	1,117	1,023	94	-5.3%	952	29	3.0%
PAYOR MIX											
Insurance %	6.14%	6.52%	-0.38%	-5.8%	6.14%	6.52%	-0.38%	-5.8%	6.46%	-0.32%	-4.9%
Medi-Cal %	7.13%	9.56%	-2.43%	-25.4%	7.13%	9.56%	-2.43%	-25.4%	9.15%	-2.02%	-22.0%
Medi-Cal MC %	52.28%	52.94%	-0.67%	-1.3%	52.28%	52.94%	-0.67%	-1.3%	52.95%	-0.67%	-1.3%
Medicare %	23.13%	19.01%	4.12%	21.7%	23.13%	19.01%	4.12%	21.7%	19.49%	3.64%	18.7%
Medicare MC %	7.03%	7.08%	-0.05%	-0.7%	7.03%	7.08%	-0.05%	-0.7%	7.16%	-0.13%	-1.8%
Other Govt %	0.99%	1.78%	-0.80%	-44.8%	0.99%	1.78%	-0.80%	-44.8%	1.62%	-0.64%	-39.3%
Self-Pay %	3.30%	3.10%	0.20%	6.3%	3.30%	3.10%	0.20%	6.3%	3.16%	0.13%	4.3%
Total Payor Mix %	100.00%	100.00%	0.00%	0.0%	100.00%	100.00%	0.00%	0.0%	100.00%	0.00%	0.0%
CAMPUS CMI											
CMI Alameda	1.362	1.496	-0.133	-8.9%	1.362	1.496	-0.133	-8.9%	1.495	-0.132	-8.9%
CMI Highland	1.694	1.795	-0.101	-5.6%	1.694	1.795	-0.101	-5.6%	1.795	-0.102	-5.7%
CMI San Leandro	1.541	1.521	0.019	1.3%	1.541	1.521	0.019	1.3%	1.518	0.023	1.5%
CMI Behavioral Health	1.384	1.325	0.06	4.5%	1.384	1.325	0.06	4.5%	1.323	0.062	4.6%

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	MONTH				YEAR-TO-DATE				PRIOR YEAR-TO-DATE		
	Actual	Budget	Variance	% Var	YTD Actual	YTD Budget	Variance	% Var	PY YTD Actual	Variance	% Var
Campus: HIGHLAND											
Total Patient Days	4,273	4,513	-240	-5.3%	4,273	4,513	-240	-5.3%	4,414	-141	-3.2%
Total Discharges	810	783	27	3.4%	810	783	27	3.4%	721	89	12.3%
Total Adjusted Patient Days	7,718	7,914	-196	-2.5%	7,718	7,914	-196	-2.5%	7,677	41	0.5%
Total Adjusted Discharges	1,463	1,373	90	6.5%	1,463	1,373	90	6.5%	1,254	209	16.7%
GENERAL ACUTE											
GA Patient Days	4,273	4,513	-240	-5.3%	4,273	4,513	-240	-5.3%	4,414	-141	-3.2%
GA Discharges	810	783	27	3.4%	810	783	27	3.4%	721	89	12.3%
GA OP Factor	1.8127	1.7602	-0.0525	-3.0%	1.8127	1.7602	-0.0525	-3.0%	1.745	-0.0677	-3.9%
Average Daily Census	137.8	145.6	-7.7	-5.3%	137.8	145.6	-7.7	-5.3%	142.4	-4.5	-3.2%
Average Length of Stay	5.3	5.8	-0.5	-8.5%	5.3	5.8	-0.5	-8.5%	6.1	-0.8	-13.8%
Adjusted Patient Days	7,746	7,943	-197	-2.5%	7,746	7,943	-197	-2.5%	7,702	43	0.6%
Adjusted Discharges	1,468	1,378	90	6.5%	1,468	1,378	90	6.5%	1,258	210	16.7%
Occupancy %	82%	86%	-5%	-5.3%	82%	86%	-5%	-5.3%	84%	-3%	-3.2%
Paid FTE	1,826	1,843	17	0.9%	1,826	1,843	17	0.9%	1,782	-44	-2.4%
Productive FTE	1,598	1,585	-13	-0.8%	1,598	1,585	-13	-0.8%	1,540	-58	-3.8%
Paid FTE Per AOB	7.31	7.19	-0.12	-1.6%	7.31	7.19	-0.12	-1.6%	7.17	-0.13	-1.9%
Worked Hours per APD	36.6	35.4	-1.2	-3.4%	36.6	35.4	-1.2	-3.4%	35.4	-1.1	-3.2%
Worked Hours per AD	193	204	11	5.4%	193	204	11	5.4%	217	24	11.1%
Emergency Visits	4,835	4,379	456	10.4%	4,835	4,379	456	10.4%	4,548	287	6.3%
Left Without Being Seen (LWBS)	265	540	275	103.8%	265	540	275	103.8%	531	266	100.4%
Trauma Cases	295	313	-18	-5.9%	295	313	-18	-5.9%	330	-35	-10.6%
Observation Equivalent Days	229	342	-113	-33.1%	229	342	-113	-33.1%	295	-66	-22.4%
IP Surgeries	266	284	-18	-6.5%	266	284	-18	-6.5%	278	-12	-4.3%
OP Surgeries	240	196	44	22.2%	240	196	44	22.2%	208	32	15.4%
Total Surgeries	506	481	25	5.2%	506	481	25	5.2%	486	20	4.1%
Deliveries	153	141	12	8.4%	153	141	12	8.4%	132	21	15.9%
TOTAL FTE, HOURS, WRVU											
Total Paid FTE	1,826	1,828	2	0.1%	1,826	1,828	2	0.1%	1,782	-44	-2.4%
Total Productive FTE	1,598	1,573	-25	-1.6%	1,598	1,573	-25	-1.6%	1,540	-58	-3.8%
Total Paid FTE per AOB	7.33	7.16	-0.18	-2.4%	7.33	7.16	-0.18	-2.4%	7.2	-0.14	-1.9%
Worked Hours Per APD	36.7	35.2	-1.5	-4.2%	36.7	35.2	-1.5	-4.2%	35.5	-1.1	-3.2%
Worked Hours Per AD	194	203	9	4.6%	194	203	9	4.6%	218	24	11.1%
Physician wRVU	3	1	1	84.5%	3	1	1	84.5%	1	1	92.9%
OTHER STATS											
GI Procedures	350	349	1	0.2%	350	349	1	0.2%	354	-4	-1.1%
Cardiac Procedures	139	58	81	140.3%	139	58	81	140.3%	63	76	120.6%
HGH Cath Lab and IR Procedures	787	258	529	205.5%	787	258	529	205.5%	432	355	82.2%
CLINIC / TELEHEALTH											

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Specialty	706	530	176	33.3%	706	530	176	33.3%	583	123	21.1%	
Behavioral Health	652	1,805	-1,153	-63.9%	652	1,805	-1,153	-63.9%	996	-344	-34.5%	
Clinic Visits	1,358	2,335	-977	-41.8%	1,358	2,335	-977	-41.8%	1,579	-221	-14.0%	
Telehealth Specialty	885	739	146	19.8%	885	739	146	19.8%	770	115	14.9%	
Telehealth Behavioral Health	111	187	-76	-40.7%	111	187	-76	-40.7%	92	19	20.7%	
Telehealth Visits	996	926	70	7.6%	996	926	70	7.6%	862	134	15.5%	
TOTAL CLINIC VISITS	2,354	3,261	-907	-27.8%	2,354	3,261	-907	-27.8%	2,441	-87	-3.6%	
PAYOR MIX												
Insurance %	5.90%	7.41%	-1.51%	-20.4%	5.90%	7.41%	-1.51%	-20.4%	7.25%	-1.35%	-18.6%	
Medi-Cal %	7.94%	10.33%	-2.39%	-23.2%	7.94%	10.33%	-2.39%	-23.2%	9.90%	-1.96%	-19.8%	
Medi-Cal MC %	50.31%	52.98%	-2.67%	-5.0%	50.31%	52.98%	-2.67%	-5.0%	53.60%	-3.29%	-6.1%	
Medicare %	22.63%	17.78%	4.85%	27.3%	22.63%	17.78%	4.85%	27.3%	18.18%	4.45%	24.5%	
Medicare MC %	7.82%	6.53%	1.28%	19.6%	7.82%	6.53%	1.28%	19.6%	6.75%	1.07%	15.9%	
Other Govt %	1.15%	2.31%	-1.16%	-50.1%	1.15%	2.31%	-1.16%	-50.1%	1.98%	-0.83%	-41.8%	
Self-Pay %	4.26%	2.65%	1.60%	60.5%	4.26%	2.65%	1.60%	60.5%	2.35%	1.91%	81.3%	
Total Payor Mix %	100.00%	100.00%	0.00%	0.0%	100.00%	100.00%	0.00%	0.0%	100.00%	0.00%	0.0%	
CMI Highland MTD	1.694	1.795	-0.101	-5.6%	1.694	1.795	-0.101	-5.6%	1.795	-0.102	-5.7%	

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	MONTH				YEAR-TO-DATE				PRIOR YEAR-TO-DATE		
	Actual	Budget	Variance	% Var	YTD Actual	YTD Budget	Variance	% Var	PY YTD Actual	Variance	% Var
Campus: ALAMEDA											
Total Patient Days	6,250	6,265	-15	-0.2%	6,250	6,265	-15	-0.2%	6,090	160	2.6%
Total Discharges	236	229	7	3.1%	236	229	7	3.1%	216	20	9.3%
Total Adjusted Patient Days	9,506	9,198	308	3.4%	9,506	9,198	308	3.4%	9,131	376	4.1%
Total Adjusted Discharges	359	336	23	6.8%	359	336	23	6.8%	324	35	10.8%
GENERAL ACUTE											
GA Patient Days	867	975	-108	-11.1%	867	975	-108	-11.1%	999	-132	-13.2%
GA Discharges	230	217	13	6.1%	230	217	13	6.1%	208	22	10.6%
Average Daily Census	28	31.4	-3.5	-11.1%	28	31.4	-3.5	-11.1%	32.2	-4.3	-13.2%
Average Length of Stay	3.8	4.5	-0.7	-16.2%	3.8	4.5	-0.7	-16.2%	4.8	-1	-21.5%
Adjusted Patient Days	1,653	1,755	-102	-5.8%	1,653	1,755	-102	-5.8%	1,826	-173	-9.5%
Adjusted Discharges	438	390	48	12.4%	438	390	48	12.4%	380	58	15.3%
Occupancy %	42%	48%	-5%	-11.1%	42%	48%	-5%	-11.1%	49%	-6%	-13.2%
Paid FTE	409	403	-7	-1.6%	409	403	-7	-1.6%	414	4	1.1%
Productive FTE	349	346	-2	-0.7%	349	346	-2	-0.7%	355	6	1.6%
Paid FTE Per AOB	7.68	7.11	-0.56	-7.9%	7.68	7.11	-0.56	-7.9%	7.02	-0.65	-9.3%
Worked Hours per APD	37.4	35	-2.4	-7.0%	37.4	35	-2.4	-7.0%	34.4	-3	-8.7%
Worked Hours per AD	141	157	16	10.4%	141	157	16	10.4%	165	24	14.7%
Emergency Visits	1,734	1,563	171	10.9%	1,734	1,563	171	10.9%	1,657	77	4.6%
Left Without Being Seen (LWBS)	63	0	-63	-100.0%	63	0	-63	-100.0%	30	-33	-52.4%
Observation Equivalent Days	216	175	41	23.6%	216	175	41	23.6%	185	31	16.7%
IP Surgeries	13	18	-5	-26.5%	13	18	-5	-26.5%	14	-1	-7.1%
OP Surgeries	1	0	1	0.0%	1	0	1	0.0%	86	-85	-98.8%
Total Surgeries	14	18	-4	-20.9%	14	18	-4	-20.9%	100	-86	-86.0%
SNF with Sub-Acute											
SNF Patient Days	5,383	5,290	93	1.7%	5,383	5,290	93	1.7%	5,091	292	5.7%
SNF Discharges	6	12	-6	-50.9%	6	12	-6	-50.9%	8	-2	-25.0%
Average Daily Census	173.6	170.7	3	1.7%	173.6	170.7	3	1.7%	164.2	9.4	5.7%
Average Length of Stay	897.2	433.3	463.9	107.1%	897.2	433.3	463.9	107.1%	636.4	260.8	41.0%
Adjusted Patient Days	5,438	5,298	140	2.6%	5,438	5,298	140	2.6%	5,116	322	6.3%
Adjusted Discharges	6	12	-6	-50.4%	6	12	-6	-50.4%	8	-2	-24.6%
Occupancy %	96%	94%	0%	0.0%	96%	94%	0%	0.0%	91%	0%	0.0%
Bed Holds	-49	68	-117	-172.6%	-49	68	-117	-172.6%	66	-115	-174.2%
Paid FTE	208	211	2	1.1%	208	211	2	1.1%	187	-21	-11.3%
Productive FTE	184	182	-2	-1.4%	184	182	-2	-1.4%	162	-22	-13.7%
Paid FTE per AOB	1.19	1.23	0.04	3.6%	1.19	1.23	0.04	3.6%	1.13	-0.05	-4.7%
Worked Hours per APD	6	6.1	0.1	1.3%	6	6.1	0.1	1.3%	5.6	-0.4	-6.9%
Worked Hours per AD	5387	2635	-2752	-104.5%	5387	2635	-2752	-104.5%	3573	-1814	-50.8%
TOTAL FTE, HOURS, WRVU											
Total Paid FTE	618	609	-8	-1.4%	618	609	-8	-1.4%	601	-17	-2.8%

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Total Productive FTE	533	525	-8	-1.6%	533	525	-8	-1.6%	517	-16	-3.2%
Total Paid FTE per AOB	2.01	2.05	0.04	1.9%	2.01	2.05	0.04	1.9%	2.04	0.03	1.3%
Worked Hours Per APD	9.9	10.1	0.2	1.7%	9.9	10.1	0.2	1.7%	10	0.1	0.9%
Worked Hours Per AD	263	277	14	4.9%	263	277	14	4.9%	283	20	6.9%
CLINIC / TELEHEALTH											
Specialty	1,526	1,275	251	19.7%	1,526	1,275	251	19.7%	1,200	326	27.2%
Clinic Visits	1,526	1,275	251	19.7%	1,526	1,275	251	19.7%	1,200	326	27.2%
Telehealth Specialty	18	28	-10	-35.7%	18	28	-10	-35.7%	28	-10	-35.7%
Telehealth Visits	18	28	-10	-35.7%	18	28	-10	-35.7%	28	-10	-35.7%
TOTAL CLINIC VISITS	1,544	1,303	241	18.5%	1,544	1,303	241	18.5%	1,228	316	25.7%
PAYOR MIX											
Insurance %	7.92%	7.14%	0.78%	10.9%	7.92%	7.14%	0.78%	10.9%	7.57%	0.35%	4.6%
Medi-Cal %	5.51%	5.85%	-0.34%	-5.8%	5.51%	5.85%	-0.34%	-5.8%	6.33%	-0.81%	-12.9%
Medi-Cal MC %	52.69%	50.03%	2.66%	5.3%	52.69%	50.03%	2.66%	5.3%	47.35%	5.34%	11.3%
Medicare %	23.90%	21.76%	2.15%	9.9%	23.90%	21.76%	2.15%	9.9%	22.16%	1.75%	7.9%
Medicare MC %	7.02%	11.23%	-4.22%	-37.5%	7.02%	11.23%	-4.22%	-37.5%	10.85%	-3.83%	-35.3%
Other Govt %	1.44%	1.53%	-0.09%	-5.9%	1.44%	1.53%	-0.09%	-5.9%	1.33%	0.11%	8.1%
Self-Pay %	1.51%	2.47%	-0.95%	-38.6%	1.51%	2.47%	-0.95%	-38.6%	4.42%	-2.90%	-65.7%
Total Payor Mix %	100.00%	100.00%	0.00%	0.0%	100.00%	100.00%	0.00%	0.0%	100.00%	0.00%	0.0%
CMI Alameda MTD	1.362	1.496	-0.133	-8.9%	1.362	1.496	-0.133	-8.9%	1.495	-0.132	-8.9%

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	MONTH				YEAR-TO-DATE				PRIOR YEAR-TO-DATE		
	Actual	Budget	Variance	% Var	YTD Actual	YTD Budget	Variance	% Var	PY YTD Actual	Variance	% Var
Campus: JOHN GEORGE											
Total Patient Days	2,121	1,925	196	10.2%	2,121	1,925	196	10.2%	1,934	187	9.7%
Total Discharges	213	214	-1	-0.4%	213	214	-1	-0.4%	203	10	4.9%
Total Adjusted Patient Days	2,572	2,316	256	11.0%	2,572	2,316	256	11.0%	2,332	240	10.3%
Total Adjusted Discharges	258	257	1	0.4%	258	257	1	0.4%	245	13	5.5%
Psych Patient Days	2,121	1,925	196	10.2%	2,121	1,925	196	10.2%	1,934	187	9.7%
Psych Discharges	213	214	-1	-0.4%	213	214	-1	-0.4%	203	10	4.9%
Average Daily Census	68.4	62.1	6.3	10.2%	68.4	62.1	6.3	10.2%	62.4	6	9.7%
Average Length of Stay	10	9	-1	-10.6%	10	9	-1	-10.6%	9.5	-0.4	-4.5%
Adjusted Patient Days	2,671	2,387	284	11.9%	2,671	2,387	284	11.9%	2,410	262	10.9%
Adjusted Discharges	268	265	3	1.2%	268	265	3	1.2%	253	15	6.1%
PES Equivalent Days	874	719	155	21.5%	874	719	155	21.5%	719	155	21.5%
PES Visits	884	891	-7	-0.8%	884	891	-7	-0.8%	17,265	-16,381	-94.9%
PES Hours	20,978	16,585	4,393	26.5%	20,978	16,585	4,393	26.5%	17,265	3,713	21.5%
PES Hours per Visit	24	19	-5	-27.5%	24	19	-5	-27.5%	1	-23	-2273.1%
TOTAL FTE, HOURS, WRVU											
Worked Hours Per APD	23.6	23.3	-0.4	-1.6%	23.6	23.3	-0.4	-1.6%	24.7	1.1	4.3%
Worked Hours Per AD	235	209	-26	-12.3%	235	209	-26	-12.3%	235	0	-0.1%
Physician wRVU	8,738	10,102	-1,365	-13.5%	8,738	10,102	-1,365	-13.5%	10,067	-1,329	-13.2%
PAYOR MIX											
Insurance %	5.25%	3.12%	2.13%	68.3%	5.25%	3.12%	2.13%	68.3%	2.74%	2.51%	91.3%
Medi-Cal %	7.09%	11.21%	-4.12%	-36.7%	7.09%	11.21%	-4.12%	-36.7%	11.55%	-4.46%	-38.6%
Medi-Cal MC %	61.66%	53.47%	8.19%	15.3%	61.66%	53.47%	8.19%	15.3%	53.15%	8.52%	16.0%
Medicare %	21.97%	20.42%	1.56%	7.6%	21.97%	20.42%	1.56%	7.6%	21.75%	0.22%	1.0%
Medicare MC %	4.28%	3.20%	1.07%	33.5%	4.28%	3.20%	1.07%	33.5%	3.00%	1.28%	42.7%
Other Govt %	-3.74%	0.45%	-4.19%	-931.7%	-3.74%	0.45%	-4.19%	-931.7%	0.10%	-3.84%	-3727.0%
CMI Behavioral Health	1.384	1.325	0.06	4.5%	1.384	1.325	0.06	4.5%	1.323	0.062	4.6%

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	MONTH				YEAR-TO-DATE				PRIOR YEAR-TO-DATE		
	Actual	Budget	Variance	% Var	YTD Actual	YTD Budget	Variance	% Var	PY YTD Actual	Variance	% Var
Campus: SAN LEANDRO											
Total Patient Days	1,566	1,584	-18	-1.2%	1,566	1,584	-18	-1.2%	1,541	25	0.02
Total Discharges	308	274	34	12.3%	308	274	34	12.3%	311	-3	(0.01)
Total Adjusted Patient Days	3,249	3,314	-64	-1.9%	3,249	3,314	-64	-1.9%	3,250	-1	-
Total Adjusted Discharges	639	574	65	11.4%	639	574	65	11.4%	656	-17	(0.03)
GENERAL ACUTE											
GA Patient Days	893	885	8	0.9%	893	885	8	0.9%	857	36	0.04
GA Discharges	250	221	29	12.9%	250	221	29	12.9%	261	-11	(0.04)
Average Daily Census	28.8	28.6	0.3	0.9%	28.8	28.6	0.3	0.9%	27.6	1.2	0.04
Average Length of Stay	3.6	4	-0.4	-10.6%	3.6	4	-0.4	-10.6%	3.3	0.3	0.09
Adjusted Patient Days	2,134	2,169	-36	-1.6%	2,134	2,169	-36	-1.6%	2,118	16	0.01
Adjusted Discharges	597	543	55	10.1%	597	543	55	10.1%	645	-48	(0.07)
Occupancy %	46%	45%	0%	0.9%	46%	45%	0%	0.9%	44%	2%	0.04
Emergency Visits	2,834	2,822	12	0.4%	2,834	2,822	12	0.4%	2,969	-135	(0.05)
Left Without Being Seen (LWBS)	93	43	-50	-53.5%	93	43	-50	-53.5%	42	-51	(0.55)
Observation Equivalent Days	250	210	40	19.1%	250	210	40	19.1%	201	50	0.25
IP Surgeries	50	58	-8	-13.6%	50	58	-8	-13.6%	53	-3	(0.06)
OP Surgeries	147	187	-40	-21.6%	147	187	-40	-21.6%	188	-41	(0.22)
Total Surgeries	197	245	-48	-19.7%	197	245	-48	-19.7%	241	-44	(0.18)
REHAB											
Rehab Patient Days	673	699	-26	-3.7%	673	699	-26	-3.7%	684	-11	(0.02)
Rehab Discharges	58	53	5	9.7%	58	53	5	9.7%	50	8	0.16
Average Daily Census	21.7	22.5	-0.8	-3.7%	21.7	22.5	-0.8	-3.7%	22.1	-0.4	(0.02)
Average Length of Stay	11.6	13.2	-1.6	-12.2%	11.6	13.2	-1.6	-12.2%	13.7	-2.1	(0.15)
Adjusted Patient Days	673	699	-26	-3.7%	673	699	-26	-3.7%	684	-11	(0.02)
Adjusted Discharges	58	53	5	9.7%	58	53	5	9.7%	50	8	0.16
Occupancy %	78%	81%	0%	0.0%	78%	81%	0%	0.0%	79%	0%	-
TOTAL FTE, HOURS, WRVU											
Total Paid FTE	492	457	-35	-7.7%	492	457	-35	-7.7%	463	-28	(0.06)
Total Productive FTE	422	384	-39	-10.1%	422	384	-39	-10.1%	400	-22	(0.06)
Total Paid FTE per AOB	4.69	4.27	-0.42	-9.8%	4.69	4.27	-0.42	-9.8%	4.42	-0.27	(0.06)
Worked Hours Per APD	23	20.5	-2.5	-12.3%	23	20.5	-2.5	-12.3%	21.8	-1.2	(0.06)
Worked Hours Per AD	117	118	1	1.1%	117	118	1	1.1%	108	-9	(0.08)
PAYOR MIX											
Insurance %	6.08%	6.30%	-0.23%	-3.6%	6.08%	6.30%	-0.23%	-3.6%	6.12%	-0.04%	(0.01)
Medi-Cal %	6.33%	8.89%	-2.56%	-28.8%	6.33%	8.89%	-2.56%	-28.8%	8.85%	-2.52%	(0.29)
Medi-Cal MC %	45.58%	49.04%	-3.46%	-7.1%	45.58%	49.04%	-3.46%	-7.1%	48.79%	-3.21%	(0.07)
Medicare %	28.97%	22.12%	6.85%	31.0%	28.97%	22.12%	6.85%	31.0%	22.70%	6.27%	0.28
Medicare MC %	8.76%	8.97%	-0.21%	-2.4%	8.76%	8.97%	-0.21%	-2.4%	9.14%	-0.39%	(0.04)
Other Govt %	2.01%	1.23%	0.78%	63.8%	2.01%	1.23%	0.78%	63.8%	1.30%	0.71%	0.55
Self-Pay %	2.29%	3.45%	-1.17%	-33.8%	2.29%	3.45%	-1.17%	-33.8%	3.11%	-0.82%	(0.27)
Total Payor Mix %	100.00%	100.00%	0.00%	0.0%	100.00%	100.00%	0.00%	0.0%	100.00%	0.00%	-
CMI San Leandro	1.541	1.521	0.019	1.3%	1.541	1.521	0.019	1.3%	1.518	0.023	0.02

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	MONTH				YEAR-TO-DATE				PRIOR YEAR-TO-DATE		
	Actual	Budget	Variance	% Var	YTD Actual	YTD Budget	Variance	% Var	PY YTD Actual	Variance	% Var
Campus: FAIRMONT											
Total Patient Days	3,342	3,255	87	2.7%	3,342	3,255	87	2.7%	3,293	49	1.5%
Total Discharges	9	12	-3	-24.2%	9	12	-3	-24.2%	13	-4	-30.8%
Total Adjusted Patient Days	4,357	4,502	-145	-3.2%	4,357	4,502	-145	-3.2%	4,443	-86	-1.9%
Total Adjusted Discharges	12	16	-5	-28.6%	12	16	-5	-28.6%	18	-6	-33.1%
SNF with Sub-Acute											
SNF Patient Days	3,342	3,255	87	2.7%	3,342	3,255	87	2.7%	3,293	49	1.5%
SNF Discharges	9	12	-3	-24.2%	9	12	-3	-24.2%	13	-4	-30.8%
Average Daily Census	107.8	105	2.8	2.7%	107.8	105	2.8	2.7%	106.2	1.6	1.5%
Average Length of Stay	371.3	274	97.3	35.5%	371.3	274	97.3	35.5%	253.3	118	46.6%
Adjusted Patient Days	3,606	3,261	345	10.6%	3,606	3,261	345	10.6%	3,529	77	2.2%
Adjusted Discharges	10	12	-2	-18.4%	10	12	-2	-18.4%	14	-4	-30.3%
Occupancy %	99%	96%	0%	0.0%	99%	96%	0%	0.0%	97%	0%	0.0%
Bed Holds	22	30	-8	-25.6%	22	30	-8	-25.6%	30	-8	-26.7%
Paid FTE	284	286	2	0.7%	284	286	2	0.7%	289	5	1.6%
Productive FTE	246	246	0	0.0%	246	246	0	0.0%	246	0	-0.1%
Paid FTE per AOB	2.44	2.72	0.28	10.2%	2.44	2.72	0.28	10.2%	2.54	0.09	3.7%
Worked Hours per APD	12.1	13.4	1.3	9.6%	12.1	13.4	1.3	9.6%	12.3	0.2	2.0%
Worked Hours per AD	4493	3667	-826	-22.5%	4493	3667	-826	-22.5%	3128	-1365	-43.7%
TOTAL FTE, HOURS, WRVU											
Total Paid FTE	293	305	12	4.0%	293	305	12	4.0%	296	3	1.1%
Total Productive FTE	254	263	9	3.4%	254	263	9	3.4%	253	-1	-0.6%
Total Paid FTE per AOB	2.09	2.1	0.02	0.9%	2.09	2.1	0.02	0.9%	2.07	-0.02	-0.8%
Worked Hours Per APD	10.3	10.4	0	0.2%	10.3	10.4	0	0.2%	10.1	-0.3	-2.5%
Worked Hours Per AD	3839	2838	-1001	-35.3%	3839	2838	-1001	-35.3%	2554	-1285	-50.3%
CLINIC / TELEHEALTH											
Behavioral Health	1,743	2,499	-756	-30.3%	1,743	2,499	-756	-30.3%	2,173	-430	-19.8%
Rehab	14	6	8	150.8%	14	6	8	150.8%	13	1	7.7%
Clinic Visits	1,757	2,505	-748	-29.9%	1,757	2,505	-748	-29.9%	2,186	-429	-19.6%
Telehealth Behavioral Health	103	79	24	29.6%	103	79	24	29.6%	77	26	33.8%
Telehealth Visits	103	79	24	29.6%	103	79	24	29.6%	77	26	33.8%
TOTAL CLINIC VISITS	1,860	2,584	-724	-28.0%	1,860	2,584	-724	-28.0%	2,263	-403	-17.8%
PAYOR MIX											
Insurance %	2.73%	0.68%	2.05%	304.0%	2.73%	0.68%	2.05%	304.0%	0.97%	1.76%	180.8%
Medi-Cal %	1.65%	6.38%	-4.73%	-74.1%	1.65%	6.38%	-4.73%	-74.1%	5.78%	-4.13%	-71.4%
Medi-Cal MC %	79.94%	69.12%	10.82%	15.7%	79.94%	69.12%	10.82%	15.7%	70.84%	9.10%	12.8%
Medicare %	15.63%	20.05%	-4.42%	-22.0%	15.63%	20.05%	-4.42%	-22.0%	18.59%	-2.95%	-15.9%
Medicare MC %	0.39%	3.09%	-2.69%	-87.2%	0.39%	3.09%	-2.69%	-87.2%	2.86%	-2.47%	-86.2%
Other Govt %	0.02%	0.12%	-0.10%	-82.8%	0.02%	0.12%	-0.10%	-82.8%	0.19%	-0.17%	-89.6%
Self-Pay %	-0.37%	0.58%	-0.94%	-163.4%	-0.37%	0.58%	-0.94%	-163.4%	0.77%	-1.13%	-147.5%
Total Payor Mix %	100.00%	100.00%	0.00%	0.0%	100.00%	100.00%	0.00%	0.0%	100.00%	0.00%	0.0%

Public Affairs and Community Engagement Report

ALAMEDA HEALTH SYSTEM

TO: Board of Trustees

FROM: Jeanette Dong, Chief, Public Affairs and Community Engagement

DATE: September 9, 2025

SUBJECT: Public Affairs and Community Engagement Report

Public Affairs and Community Engagement (PACE) provides collaborative and integrated strategic communications and meaningful engagement with stakeholders that supports, promotes, and amplifies AHS' mission and vision while reinforcing its brand identity. PACE has four main functional areas: Government and Legislative Affairs, Community Engagement, Communications, and Media. This report provides an overview of key activities.

Government and Legislative Affairs

The primary responsibility of Government and Legislative Affairs is to develop and maintain relationships with elected officials at local, state, and federal levels, to track and analyze legislation's impact on AHS, and facilitate the participation of AHS' interested parties in legislative and policy development.

Three hearings were recently held, one at the County level and two at the State level, to discuss the impact of H.R.1, also known as the Big Bill.

On September 4, the Alameda County Board of Supervisors' Together for All Ad-Hoc Committee convened to review how federal policies and budget proposals are affecting local programs. Community stakeholders and County leaders provided updates, including AC Health Interim Director Aneeka Chaudhry, who outlined potential impacts to the County's health care delivery systems, including to AHS. The Committee agreed to move forward with a letter to the Board to address community needs. In addition, the Committee requested that these updates be provided to the full Board later in the fall.

At the State level, the Assembly Health Committee and Senate Health Committee held a joint informational hearing on August 19 with three panels that focused on:

1. The impact of H.R.1 on Medi-Cal
2. The effects of recent immigration enforcement actions on community health
3. Federal administrative changes affecting access to health care and data sharing

The following day, on August 20, the Assembly Budget Subcommittee 7 on Accountability and Oversight convened a hearing to examine H.R.1's potential effects on the State budget and key programs, including Medi-Cal, education and environmental initiatives. Panelists included representatives from the Department of Finance and the Legislative Analyst's Office.

Throughout both hearings, Committee members voiced strong concern about the Big Bill's effects on health care in California, especially for low-income and working families who rely on subsidized coverage. Members underscored the risk of reduced access to care and destabilization of the State's health care safety net.

The California State Legislature reconvened from summer recess on August 18 and held a series of debates on the redistricting plan. The plan was passed and will appear on the ballot in a special election on November 4. The Legislature has until September 12 to pass bills to the Governor. Appendix A includes a list of State bills AHS is currently tracking.

At the Federal level, Congress was back in session on September 2. Without congressional action, cuts to Medicaid Disproportionate Share Hospital (DSH) funding are scheduled to take effect on October 1. For AHS, the estimated impact would be $60.5 million annually over the next three years.

Community Engagement

The community engagement team supports and participates in activities throughout the year that align with organizational priorities and strategies. Engagement efforts help develop and maintain relationships with key community-based organizations, local business groups, and elected officials, in addition to enhancing the health and well-being of the communities we serve. Outreach and engagement initiatives support AHS's mission and strategic goals.

Below is a recap of activities for August 2025 and a preview of activities for September 2025.

*Contact Louise Nakada, LNakada@alamedahealthsystem.org for more information.

Date	Location	Event	Description
August 7, 2025 10:30 a.m. –1:30 p.m.	Kennedy Park, Hayward	WIC World Breastfeeding Event	The AHS Obstetrics, Midwifery, and Gynecology department participated in Alameda County's World Breastfeeding Week event and offered information about lactation services, AHS resources, and health education.
August 9, 2025 10:00 a.m. – 3:00 p.m.	Allen Temple Baptist Church, Oakland	Allen Temple Baptist Church Holistic Health Fair	AHS and physician residents offered health screenings and health and wellness information at this annual community event.
August 9, 2025 10:00 a.m. – 1:00 p.m.	Davis Street Health Center, San Leandro	Davis Street Community Outreach and Resource Fair	AHS participated in this annual community event, which was attended by over a thousand community members. Information about AHS services and health and wellness was offered.
August 14, 2025 5:30 p.m.	Alameda Shoreline, Alameda	Let's Go For a Walk with CEO James Jackson	AHS family and friends joined CEO James Jackson on this 2-mile walk along the Alameda shoreline. This event offered an opportunity to connect with colleagues.

August 21, 2025 5:00 p.m. – 9:00 p.m.	Downtown Hayward, Hayward	Hayward Street Party	AHS, in partnership with St. Rose Hospital, participated in this community celebration. Health education and information about St. Rose Hospital and AHS services were provided to community. AHS developed a new brochure to promote SRH for distribution.
August 23, 2025 10:00 a.m. – 2:00 p.m.	Oakland Arena, Oakland	AEG Oakland Community Foundation Back to School Shoe Giveaway and Community Fair	In partnership with the Latinos Unidos Affinity Group, AHS participated in this community event, which featured community programs focusing on family resources.
August 23/24, 2025 10:00 a.m. – 5:00 p.m.	Oakland Chinatown, Oakland	Oakland Chinatown Streetfest	AHS and physician residents offered health screenings and health and wellness information at this annual community street festival.
August 29, 2025 11:00 a.m. – 5:00 p.m.	Alameda Hospital, Alameda	Alameda Hospital Community Blood Drive	In partnership with the American Red Cross, AHS/Alameda Hospital hosted a successful community blood drive to help save lives and alleviate the blood supply shortage.
September 7, 2025 11:00 a.m. – 5:00 p.m.	Downtown Oakland, Oakland	Oakland Pride Parade and Festival	In partnership with the AHS LGBTQIA+ and Allies group, family and friends are invited to join the AHS parade contingent as we celebrate the community's inclusiveness and diversity. AHS / Internal Medicine Department/residents will offer a variety of health screenings and health and wellness information at the Pride Festival.
September 9, 2025 10:00 a.m. – 12:00 p.m.	Newark City Hall, Newark	City of Newark Employee Health Fair	AHS / Newark Wellness will participate in this health fair for City of Newark employees. Health screenings will be offered
September 20, 2025 8:30 a.m. – 11:30 a.m.	Alameda County Community Food Bank, Oakland	AHS Employee Volunteer Event	AHS family and friends are invited to join CEO James Jackson at this volunteer event that supports the Alameda County Community Bank (ACCFB). ACCFB is an important community partner.
September 21, 2025 7:30 a.m.	Alameda Point, Alameda	Alameda Running Festival	AHS / Alameda Hospital sponsors the Wellness Expo for this annual running event, which includes a 5k, 10k, half-marathon, and kids' run. Health and wellness information and information about AHS services are provided.

September 25, 2025 9:00 a.m. – 2:00 p.m.	Oakland Zoo, Oakland	22nd Annual Healthy Living Festival	AHS sponsors and participates in this annual event that promotes health and wellness for Alameda County residents 55 and older. The event is hosted by Alameda County Supervisor Nate Miley and the United Seniors of Oakland and Alameda County.
September 25, 2025 11:00 a.m. – 1:30 p.m.	USS Hornet, Alameda	Alameda Chamber Economic Forecast and Business Expo	AHS/Alameda Hospital leaders will attend this annual event hosted by the Alameda Chamber & Economic Alliance. The event will feature elected officials and economic experts.
September 25, 2025 5:00 p.m. – 7:30 p.m.	Casa Peralta, San Leandro	San Leandro Chamber Multicultural Mixer	AHS will participate in this relationship-building event hosted by the San Leandro Chamber of Commerce, Oakland Chinatown Chamber of Commerce, San Leandro Black Chamber of Commerce, and Oakland Latino Chamber of Commerce. Health and wellness tips and information about AHS services will be provided.

COMMUNICATIONS

The PACE Communications Team develops and implements communication strategies and plans for key organizational initiatives. Updates are provided as of September 4, 2025.

Unique Stories

From July 1 to August 31, PACE created 41 unique stories to spotlight Alameda Health System (AHS) programs and departments. These stories were shared via the AHS intranet, the internet, CEO Chronicles and social media.

CEO Chronicles Newsletter

The CEO Chronicles is a monthly newsletter sent to nearly 6,000 AHS employees, 612 St. Rose Hospital staff, and 645 community stakeholders, including elected officials, community partners, and local businesses. PACE drives the strategy, planning and content development for each newsletter.

When compared to industry standards, as published by Constant Contact Email Content Management System, the AHS newsletter typically performs at or above industry benchmarks.

The CEO Chronicles is sent to three separate distribution lists: AHS staff, St. Rose Hospital staff and external partners. This report provides data for the July 2025 issue. Historically, a newsletter is not issued in August.

The July 2025 newsletter's open rate was 55% for AHS staff distribution, 42% for St. Rose Hospital distribution, and 54% for external distribution. The benchmark for open rate (i.e., the percentage of newsletter emails that are opened) is 27%.

The July 2025 CEO Chronicles CEO video featured our community engagement efforts and the new gold pin program. The Real People, Real Care Spotlight video featured Fanny Domijan, senior learning and development specialist.

This newsletter included two stories about AHS Emergency Departments (EDs). The first was about the expansion of HIV, HCV and syphilis screening across our EDs, and the second was about our three EDs receiving the prestigious Quest for Zero Quality Award from the BETA Healthcare Group.

In addition, we spotlighted a new one-of-a-kind dermatology clinic at the Wilma Chan Highland Hospital Campus that focuses on hidradenitis suppurativa and we announced the MyChart Bedside mobile launch. The AHS Index focused on AI and chatbots.

For the AHS staff distribution, the CEO video was the most viewed, and the dermatology clinic was the second most viewed. For the St. Rose Hospital distribution, the CEO video was number one, followed by the Hayward Summer Street Parties calendar of events. For the external distribution, the Alameda Walks calendar of events was number one, followed by the dermatology story.

Leadership Desktop Chat

PACE supports employee and physician engagement by producing Leadership Desktop Chats every Wednesday. This includes coordinating and preparing talking points, determining the run of show, booking guest speakers and special presentations, coordinating follow-up to employee questions, tracking and posting frequently asked questions, and posting Chat videos and FAQs on the intranet for those who were unable to attend.

The webinar is hosted by the Director of Corporate Communications and Marketing. Regular panelists include our Chief Executive Officer, Chief Operating Officer, Interim Chief Human Resources Officer, Interim Chief Medical Officer, Chief Nursing Officer, Vice President of Support Services and the Chief Information Officer. Finance attends monthly to provide updates.

Attendees hear a report from the CEO and have an opportunity to ask questions of leadership. Guest panelists are invited to provide information about key AHS initiatives.

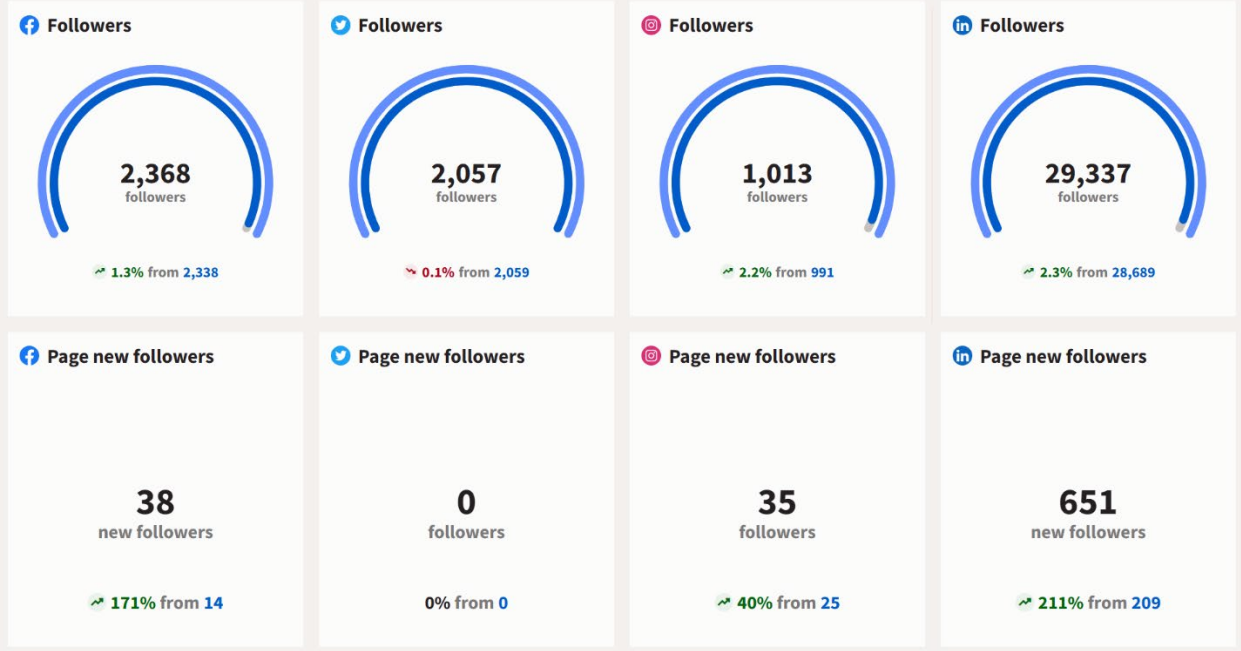
In July 2025, staff received a finance update and presentations on the wayfinding project, MyChart Bedside, and a regulatory update. In August 2025, staff received presentations on the impacts of the Big Bill, COVID-19, the new Center of Operational Transformation (COT) and the contributions of AHS Community Health Workers.

For July 2025, the Chat averaged 500 total participants every Wednesday and in August 2025 the Chat averaged 504 total participants. Total participants include all panelists and attendees.

Social Media Report
Date Range of Report: July 1 to August 31, 2025

Number of Followers/Fans Compared to Previous 30 Days

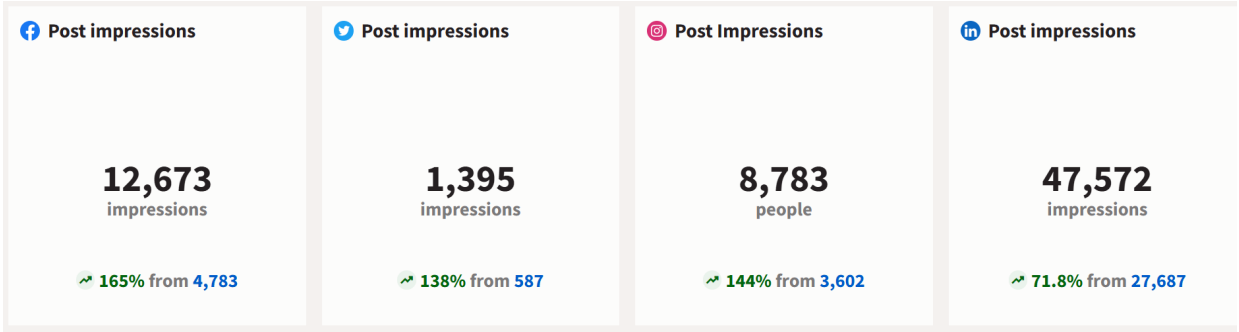
Facebook | **X** (formerly Twitter) | **Instagram** | **LinkedIn**



Engagement Report Compared to the Previous 30 Days

Post engagement is the number of interactions (reactions, comments, shares and more) our posts received. Post impressions is the number of times content we published during the time frame was displayed on a person's screen. Content includes statuses, photos, links, videos and more.

Facebook | **X** (formerly Twitter) | **Instagram** | **LinkedIn**



Social media engagement is the measure of interactions - comments, likes, shares, posts, etc. that our audience has with the content AHS posts.

Top 3 Social Media Posts Based on Engagement On All Social Media Platforms
July 1 to August 31, 2025 Compared to Previous 30 Days

Facebook

Post engagement

1,551
engagements

131% from 670

Top posts

AHS's emergency departments at Highland, Alameda & San Leandro Hospitals earned the Quest for Zero Quality Award for their

42 likes and reactions

At AHS, we actively seek to engage and partner with our communities. Through 50+ engagement events each year, we build trust

24 likes and reactions

Alameda Health System was proud to celebrate community and unity by participating in the City of Alameda's 4th of July parade. Our team

24 likes and reactions

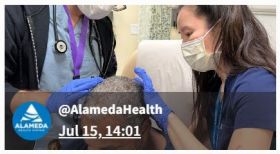
X (formerly Twitter)

Tweets

39
tweets

144% from 16

Top tweets



AHS launched the only hidradenitis suppurativa clinic in the East Bay, led by Dr. Leon Clark. The clinic provides vital care for this painful skin

9 engagements

This month, Alameda Health System was out in the community at the Oakland Chinatown Fair, Hayward Street Market, AEG Shoe Giveaway and

8 engagements

Today, we celebrate the incredible Graduate Medical Education professionals at AHS. Your passion and hard work are vital to shaping the

6 engagements

Instagram

Post engagement

377
engagements

231% from 114

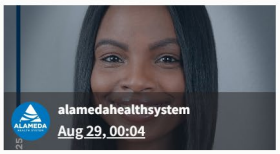
Top posts

This National Community Health Worker Awareness Week, we celebrate the dedication and impact of our Community Health Workers!

53 engagement

Today, we celebrate the incredible Graduate Medical Education professionals at AHS. Your passion and hard work are vital to shaping the

47 engagement



Meet Latina Howard, Mobile Health Specialist with our Dental Mobile Clinic. Her work bridges clinical care and daily life, building trust and

28 engagement

LinkedIn

Post reactions

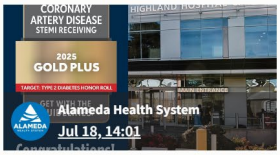
1,144
reactions

70.7% from 670

Top posts

AHS's emergency departments at Highland, Alameda & San Leandro Hospitals earned the Quest for Zero Quality Award for their

111 reactions



Congratulations to Wilma Chan Highland Hospital Campus for earning the AHA Get With The Guidelines-CAD STEMI Receiving Gold Plus

102 reactions

Today, we celebrate the incredible Graduate Medical Education professionals at AHS. Your passion and hard work are vital to shaping the

98 reactions

Media and Communications

Media and Communications is responsible for press coverage, media relations, and public relations that champion Alameda Health System (AHS) and our critical role in the community. We amplify stories that inform the public, elevate the profiles of AHS leadership, publicize the heroic acts our staff perform every day, and establish AHS as the community health pillar within Alameda County.

Audience & Reach

PACE uses Critical Mention, an all-in-one platform for real-time media monitoring across television, radio, social media, and online news. Critical Mention calculates our audience and publicity values using data from industry-leading media data providers such as LexisNexis, Nielsen and Podchaser. The performance metrics below are a measure of media mentions, audience size, and publicity value associated in the United States.

Mentions are the number of instances in which Alameda Health System, Alameda Hospital, Highland Hospital, John George Psychiatric Hospital, San Leandro Hospital, or The Wilma Chan Highland Hospital Campus were mentioned across all media. The audience estimate represents the number of people who potentially viewed the AHS mentions. The publicity value estimate represents the cost to advertise for a specific time, program, and/or platform used multiplied by the audience number.

Time Period	Mentions	Audience	Publicity Value
July 1- Aug. 31, 2025	235	81,214,134	$2,256,236

Media Highlights – July 1 – Aug. 31, 2025

East Bay Times: Alameda Health System confronts ‘nuclear option’ budget after Medicaid cuts

East Bay News Group interviewed AHS CEO James Jackson and patient Loretta Medellin for this article on how The Big Bill will impact AHS and its patients.

Alameda Post: Recognizing Signs of Stroke Can Save a Life

“Healthy Alameda” is a new health care column by Alameda Health System that’s published monthly in The Alameda Post. This August’s column shared the story of Denny Goodman, an Alameda resident who passed away from a stroke, plus tips on how to recognize the signs of a stroke fast.

[Alameda Post: How Alameda's Medicaid-funded wound center saved a woman's life]

This "Healthy Alameda" column features one patient's story of how Medi-Cal coverage enabled her to access life-changing care.

"Medicaid is not just a safety net, it's a path back to dignity, recovery, and stability," Loretta Medellin said. "Medicaid made it possible for me to get the care I needed. Without it, I don't believe I'd still have my leg—or my life."

Appendix A – AHS Activities on Key State Bills – 9/3/2025

Bill No.	Author	Title	Summary	Status	AHS Activities & Potential Impact
AB 339	Ortega	Local public employee organizations: notice requirement	Would require public entities, including public hospitals and health systems, to give recognized employee organizations a minimum of 45 days' written notice before issuing requests for proposals, requests for quotes, or renewing or extending existing contracts that affect job classifications represented by these organizations.	Senate Floor	AHS is monitoring this bill
AB 447	González	ED patient prescriptions: dispensing unused portions upon discharge	Would allow physicians or authorized prescribers to dispense an unused portion of a non-controlled medication to an emergency department (ED) patient upon discharge if all of the following conditions are met: the drug is not a controlled substance, it was previously ordered and administered to the patient during their ED visit, it was administered from single patient use multidose packaging and can be self-administered by the patient, and dispensing the remaining portion is necessary to continue the patient's treatment.	Governor's desk	AHS is monitoring this bill
AB 1312	Schiavo	Hospital Pricing	Would require hospitals, beginning July 1, 2027, to presume financial assistance eligibility prior to discharge for patients who are experiencing homelessness, enrolled in means-based government assistance programs (e.g., CalFresh, CalWORKs), or who were eligible for financial assistance in the previous six months. Hospitals must also screen patients for financial assistance if they are uninsured, enrolled in or eligible for Medi-Cal, or enrolled in a Covered California health plan. The bill would prohibit a hospital from requiring that a patient apply for financial assistance as part of the screening process, but hospitals may collect necessary information and verification needed to determine eligibility. By July 1, 2027, hospitals would have to develop and submit a written screening process and disclose any third-party screening tools to the Department of Health Care Access and Information.	Senate Floor	AHS is monitoring this bill

Bill No.	Author	Title	Summary	Status	AHS Activities & Potential Impact
SB 81	Arreguín	Health facilities: information sharing	Would prohibit health facilities from collaborating with, providing access to, or providing information about patients to immigration authorities.	Governor's desk	AHS collaborated closely with CAPH on this bill to ensure its feasibility for implementation and alignment with current hospital practices.
SB 596	Menjivar	Health facilities: administrative penalties	Would redefine a hospital's "on-call list" and to specify that a hospital contacting, or attempting to contact, licensed nurses who are not scheduled to be on call and who are not assigned to a float pool for the unit and shift where an alleged violation occurred is not considered as exhausting an on-call list.	Asm. Floor	AHS is monitoring this bill

Bills that are not moving forward this year

Bill No.	Author	Title	Summary	Status	AHS Activities & Potential Impact
AB 315	Bonta	Medi-Cal: Home and Community-Based Alternatives Waiver	Would require the Department of Health Care Services to expand capacity in the Medi-Cal Home and Community-Based Alternatives (HCBA) waiver and submit a study to the Legislature on rates and rate-setting methodologies for HCBA waiver services by March 1, 2026.	Held in Asm. Appropriations	AHS monitored this bill
AB 1337	Ward	Information Practices Act of 1977	Would require all local agencies, including district and public hospitals, to comply with an expanded list of protected information under the Information Practices Act.	Held in Sen. Judiciary	AHS monitored this bill
AB 1386	Bains	Health facilities: perinatal services	Would require perinatal services to be considered a basic service at general acute care hospitals, as well as establish a process for hospitals that do not provide this service to submit a compliance plan to the California Department of Public Health (CDPH) for approval or denial. The plan must include information on the hospital's transfer agreements, financial limitations, efforts to establish perinatal care, and other requirements as determined by CDPH.	Held in Asm. Appropriations	AHS monitored this bill

Bill No.	Author	Title	Summary	Status	AHS Activities & Potential Impact
AB 1460	Rogers	Prescription Drug pricing	Would prohibit prescription drug manufacturers from discriminating against qualifying nonhospital 340B community clinics by imposing conditions or restrictions on their ability to purchase or receive federally discounted drugs based on the type of pharmacy they use, including contract pharmacies, to dispense the medication to eligible patients.	Held in Sen. Health	AHS is monitoring this bill
SB 632	Arreguín	Workers' compensation: hospital employees	Would create a series of workers' compensation rebuttable presumptions for hospital employees for a variety of infectious and respiratory diseases, including COVID-19 and severe acute respiratory syndrome, and extend the presumptions after the employee's termination.	Held in Asm. Insurance	AHS is monitoring this bill