BOARD OF TRUSTEES MEETING

WEDNESDAY, OCTOBER 8, 2025
5:00pm to 9:00pm

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

LOCATION:

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

ZOOM Meeting Link:[1]
https://alamedahealthsystem.zoom.us/j/9361457125?pwd=4JnAmhDnBaLqY4GWf4PQBwp3w0Puy2.1&omn=81991842007
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)
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+1 646 518 9805 US (New York)

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

MEMBERS

Alan E. Fox — Greg Garrett
Lilavati Indulkar, MD — Donna Linton
Nicholas Moss, MD — Nely Obligacion
Rachel Richman — 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 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. Audit and Compliance Committee: September 17, 2025
Sblend Sblendorio, Chair

C2. Quality Professional Services Committee: September 24, 2025
Lilavati Indulkar, MD, Chair

C3. Finance Committee: October 1, 2025
Alan Fox, Committee Chair

D. CONSENT AGENDA: ACTION

D1. Approval of the September 17, 2025 Board of Trustees Meeting Minutes.

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

- HR: Sexual Harassment Policy

Recommendation from the Quality Professional Services Committee on September 17, 2025 to approve the policies listed below.

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

- Medication Profile Review and Verification Policy
- Breach Notification Policy
- Business Associate Policy
- Compliance Exclusion Screening Review Policy
- De-Identified Health Information Policy
- HIPAA Violation Sanctions Policy
- Privacy Use and Disclosure of Limited Data Set Policy
- Uses and Disclosure Based on Public Policy Which Do Not Require the Patients Authorization Policy
- Blood Borne Pathogen Exposure Control Plan
- Quality Improvement Work Policy: Primary Care - Adult Medicine and Pediatrics and Urgent Care

Recommendation from the Quality Professional Services Committee on September 17, 2025 to approve the policies listed below.

D4. Recommendation to the Board of Trustees for approval of the AHS Medical Staff Policies and Procedures listed below:

AHS Medical Staff:

- Standardized Procedures for Advanced Practice Providers in The Department of Anesthesia
- AHS Medical Staff Committees

AHS and AH Medical Staff:

- Introduction of a New Privilege for a Specific Department of Specialty

Recommendation from the Finance Committee on October 1, 2025 to approve the contracts listed below.

D5.Contracts

D5a. New agreement between Hayward Sisters Hospital doing business as St. Rose Hospital and Nelson T. Lewis Construction Co., Inc. for catheterization lab upgrade. The term of this agreement is effective October 15, 2025 through June 15, 2026. The estimated impact of this agreement is $3,197,080.
Mario Harding, Chief Administrative Officer

D5b. New agreement with ePlus Technology Inc. for provision of data loss protection services. The term of this agreement is effective date last signed for a 3-year term. The estimated impact of this agreement is $1,800,000.
Christine Yang, Chief Information Officer

D5c. Renewal agreement with Switch, Ltd. for provision of data center services. The term of this agreement is effective February 16, 2026 through February 15, 2031. The estimated impact of this agreement is $1,509,294.
Christine Yang, Chief Information Officer

D5d. New agreement with Lescure Company, Inc. for architectural and structural work for the Alameda Hospital HVAC replacement project. The term of this agreement is effective November 1, 2025 through March 31, 2027. The estimated impact of this agreement is $1,668,200.
Mark Fratzke, Chief Operating Officer

D5e. New agreement with Matrix HG, Inc. for installation of COVID prevention HVAC upgrades at John George Psychiatric Hospital. The term of this agreement is effective November 1, 2025 through October 31, 2026. The estimated impact of this agreement is $1,214,436.
Mark Fratzke, Chief Operating Officer

E. ACTION/DISCUSSION

E1. DISCUSSION: Center for Operational Transformation
Mark Fratzke, Chief Operating Officer

E2. DISCUSSION: AHS AI Program Review
Sarah Rahman, MD, Associate Chief Medical Information Officer

F. DISCUSSION: Board Calendar and Tracking

G. STAFF REPORTS (Written)

G1. Chief Financial Officer Report, August 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 Involving Trade Secrets**
   [Health and Safety Code 101850(ae)(1)]
   Strategic Planning

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

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

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

5. **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
10/8/2025
Board of Trustee Meeting

Reflection

Dear James Jackson,

I hope this message finds you well. I wanted to take a moment to express how honored I am to work in the Obstetric, Midwifery, and Gynecology department aka OMG.

Being part of such a dedicated and compassionate team is truly inspiring. The commitment to patient care and the support we provide to families during such significant moments in their lives is both rewarding and fulfilling. I am continually amazed by the professionalism and expertise of my colleagues, and I am proud to contribute to our shared mission.

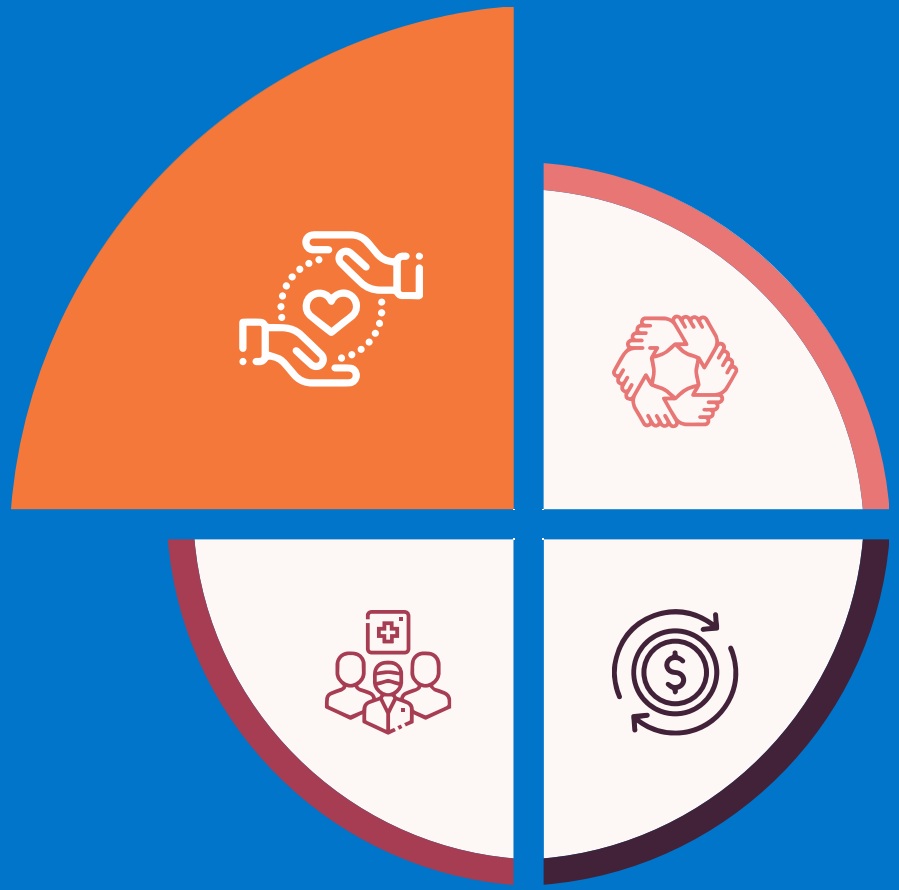
Thanking this hard-working team for their leadership and dedication for fostering an environment where we can thrive and make a difference in the lives of our patients. Thank you, I am forever grateful for such a job and space here at AHS.

Warm regards,
Auntie Holly 😊

AHS Pillars

Quality Care

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



AHS Recognized for BETA HEART® Excellence

Alameda Health System (AHS) is honored to receive the 2025 BETA HEART® Validation, highlighting our commitment to healing, empathy, accountability, resolution and trust (HEART).

This year marks a monumental milestone as AHS achieved validation in all five HEART domains, as well as in OB Quest, which improves safety and quality in obstetric care, and ED Quest, which enhances safety and patient care in the emergency department for Highland, Alameda and San Leandro Hospitals.

For the past five years, AHS has actively participated in BETA HEART®, earning ongoing recognition for our focus on patient safety, transparency and continuous improvement. This achievement reflects our dedication to creating a safe, reliable and compassionate care environment across the system.

The BETA HEART® recognition program, awarded by BETA Healthcare Group in collaboration with the Hospital Quality Institute (HQI), acknowledges health care organizations that successfully build and sustain a transparent and reliable culture of safety.

It supports systems for patient healing, empathic responses to harm events, accountability for safety and trust among patients and providers, with recognition given for meeting established criteria.

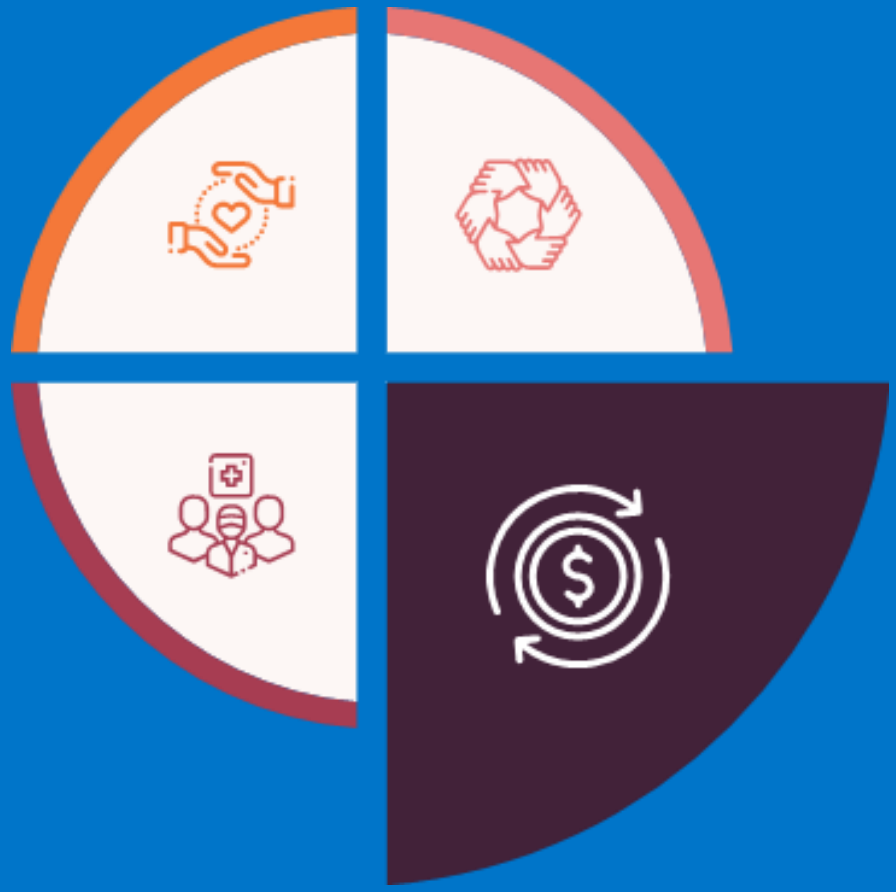
This recognition not only celebrates AHS' focus on patient-centered care and our mission to serve all patients safely and inclusively, but it also honors the staff whose dedication and teamwork made this achievement possible. For more information, visit the BETA HEART® Validation recognition program.

AHS Recognized for BETA HEART® Excellence

AHS Recognized for BETA HEART® Excellence

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.

St. Rose Projects

1. Core Switching Replacement & High Availability Project

- Status: $411K funded; currently in procurement.
- Purpose: Replace end-of-life core switches that serve as the central control point for all network access across the St. Rose campus.
- Key Drivers:
  - Support Critical Initiatives: A fully supported, secure, and high-availability switching infrastructure is required to enable the AHS Wellness Center and future Epic access at St. Rose Hospital (SRH).
  - Current Risks:
    - End of Life / End of Support: Existing core switches are no longer supported by the manufacturer.
    - Single Point of Failure: A failure could result in campus-wide network downtime lasting several days.
    - Lack of Replacement Parts: Uncertainty around part availability due to aging hardware.
- Outcome: Improved network reliability, reduced downtime risk, and readiness for future clinical expansion.

2. Results Integration for Rad & Lab Referrals (Newark/Hayward Wellness Centers → St. Rose)

- Go-Live Date: September 23, 2025
- Scope: Integration of lab and imaging results from referrals originating in Newark and Hayward Wellness Centers, transmitted directly and real-time from SRH Meditech into the AHS Epic system.
- Benefits:
  - Automated Results Delivery: Top 20 imaging exams and top 10 lab tests are now automatically returned to Epic.
  - Workflow Enablement: Essential for operational workflows at the upcoming AHS Wellness Center on the St. Rose campus.
  - Scalable: Additional tests and exams will be incorporated over time.

AHS Pillars

Staff & Physician Experience

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

ALAMEDA HEALTH SYSTEM

Welcome our new Chief Human Resources Officer Jet Chapman

I am pleased to announce the appointment of Jet C. Chapman as the Chief Human Resources Officer (CHRO). She will begin her tenure with AHS on October 6.

Ms. Chapman has over 35 years of exceptional leadership experience in the executive management of human resources, labor relations, and strategic workforce development. She is an expert at fostering high-performing teams, navigating complex labor negotiations, and achieving organizational excellence. Also, Jet has a proven track record in designing and implementing effective system strategies that drive business growth and enhance operational efficiency.

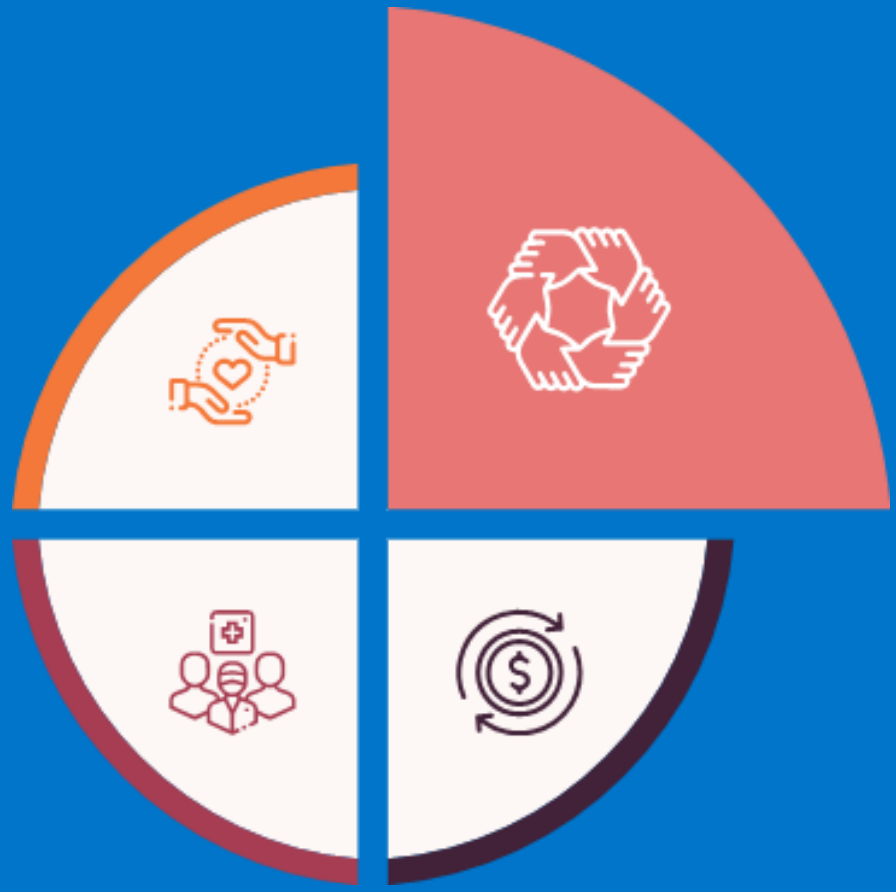
Ms. Chapman has been the chief negotiator for both the public and private sector agencies. She has designed collective bargaining and labor-management training programs; managed large labor relations teams and grievance resolutions.

She also has been an incredible Alameda County healthcare leader with a deep knowledge in county health care systems and the delivery of health care services. She has spent over a decade with Alameda Health first as a Human Resources Officer, then Deputy Human Services Director and ultimately the Chief Human Resources Administrator. Jet understands the critical importance of the county partnership with AHS and our safety net patients.

Jet brings a wealth of experience, knowledge and wisdom to AHS and I am excited to have her on our team. Please join me in welcoming Jet as our new CHRO.

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.



ALAMEDA HEALTH SYSTEM

AHS leader honored for decades of service in Alameda County

Sambo Ly, Alameda Health System's (AHS') manager of interpreter services, has won the Icon Award from Bay Area news station KPIX in recognition of her decades of service to refugees and community members in Alameda County.

The Icon Award highlights people who have made a significant and impactful contribution to their community. KPIX reporter Sharon Chin spoke with Ly about her childhood in Cambodia, how she survived the Khmer Rouge genocide, and her current work serving safety-net patients at Alameda Health System. Watch the story here.

Ly leads AHS' interpreter services department, which receives about 2,000 interpreter requests every day, in 100 different languages, from AHS patients who need help communicating with their health care providers. Alameda County is one of the most ethnically and linguistically diverse counties in the United States, and many AHS patients arrive with limited ability to communicate in English.


FILIPINO AMERICAN
HISTORY MONTH

ALAMEDA HEALTH SYSTEM

The Oakland Private Industry Council, 10-2-25
Son Of Oakland Honoree

We're proud to share that all Alameda Health System skilled nursing and sub-acute facilities have been recognized on Newsweek's America's Best Nursing Homes 2026 list!

Under the leadership of our CAO of Post-Acute Services, **Richard Espinoza**, our skilled nursing facilities have been ranked among the best five times. Richard attributes this recognition to the compassionate team members who care for our residents like family and our strong, reliable and effective practices. Congratulations to our incredible teams who make this recognition possible! Read more: **https://lnkd.in/ePYnUtTD**

Alameda County Community Food Bank Volunteer Day, 9-20-25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AED


50 LBS. NET WT.
22.68 Kg.
PRODUCT OF U.S.A.
MALIN, OREGON 97632

ALAMEDA HEALTH SYSTEM

Alameda Hospital Community Health Fair 2025

Saturday, October 18, 2025

9:00 a.m. – 12:00 p.m.

Alameda Hospital parking lot, 2070 Clinton Avenue, Alameda

- Free flu shots (6 months and older)
- Free bike helmets (12 years and younger)
- Health screenings
- Emergency preparedness
- Stroke prevention
- Health and wellness information
- Community resources
- And much more!

For more information | 510-754-9885 | PACE@alamedahealthsystem.org

Questions

James Jackson
10/8/2025
Board of Trustee Meeting

MEDICAL STAFF REPORTS

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

October 8, 2025

Berenice Perez, MD, AHS 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.

Joint Commission Standard -- MS.03.01.01: The organized medical staff (OMS) ***oversees the quality of patient care***, treatment and services provided by licensed independent practitioners (LIPs) privilege through the medical staff process.

Overview

- Credentialing and Privileging
- Peer Review Redesign & Ongoing Professional Practice Evaluation (OPPE)
- Quality and Patient Safety
- Orthopaedic Surgery Department Report
- Committee Reports
  - Patient Safety Committee
  - Quality Steering Committee

Credentials Committee

Policies:

- Standardized Procedures for Advanced Practice Providers in the Department of Anesthesia

Privileges:

- Emergency Medicine Multifacility (existing form updated)
- Pediatric Neonatal – Perinatal Medicine (existing form updated)
- Anesthesia Advanced Practice (new)

Credentialing & Privileges:

Routine Credentialing & Privileging and Telemedicine Credentialing by Proxy

Clinical Performance:

- Ongoing Professional Practice Evaluation (OPPE) assesses clinical performance and factored into reappointment decisions.

Ongoing Professional Practice Evaluation (OPPE)

- OPPE assess a practitioner's clinical competence and professional behavior to ensure patient safety and quality of care.
- Involves collecting both qualitative data and quantitative data
  - Chart reviews, patient complaints
  - Procedure success rates, infection rates
- OPPE is conducted every 12 months aggregate data is used to see if there are concerns which may trigger a Focused Review for Cause- (FPPE-C)

OPPE Journey

Current State

- Evaluation of competencies of physician and advanced practice providers
- Specialty Specific Metrics
  - Robust score cards
  - Identification of 1-2 metrics
  - Challenges with development & resources

Future State

- Expand Specialty Specific Metrics
- Leverage EPIC data with uniform evaluation criteria
- Standardization of Metrics and integration of patient safety data
- Clinical outcomes, peer review to assess provider performance
- Integrate with continuous quality improvement initiatives

Quality and Patient Safety

- Patient Safety Committee (Aug 8)—RCAs, operational issues that affect quality and patient safety
- Quality Steering Committee (Aug 9)—OKRs and KPI dashboards
- Clinical Practice Council (Sept 4)--Forwarded multiple policies/order sets to MEC for approval

CPC provides a robust governance for clinical changes that affect the quality of patient care

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 HEALTH SYSTEM

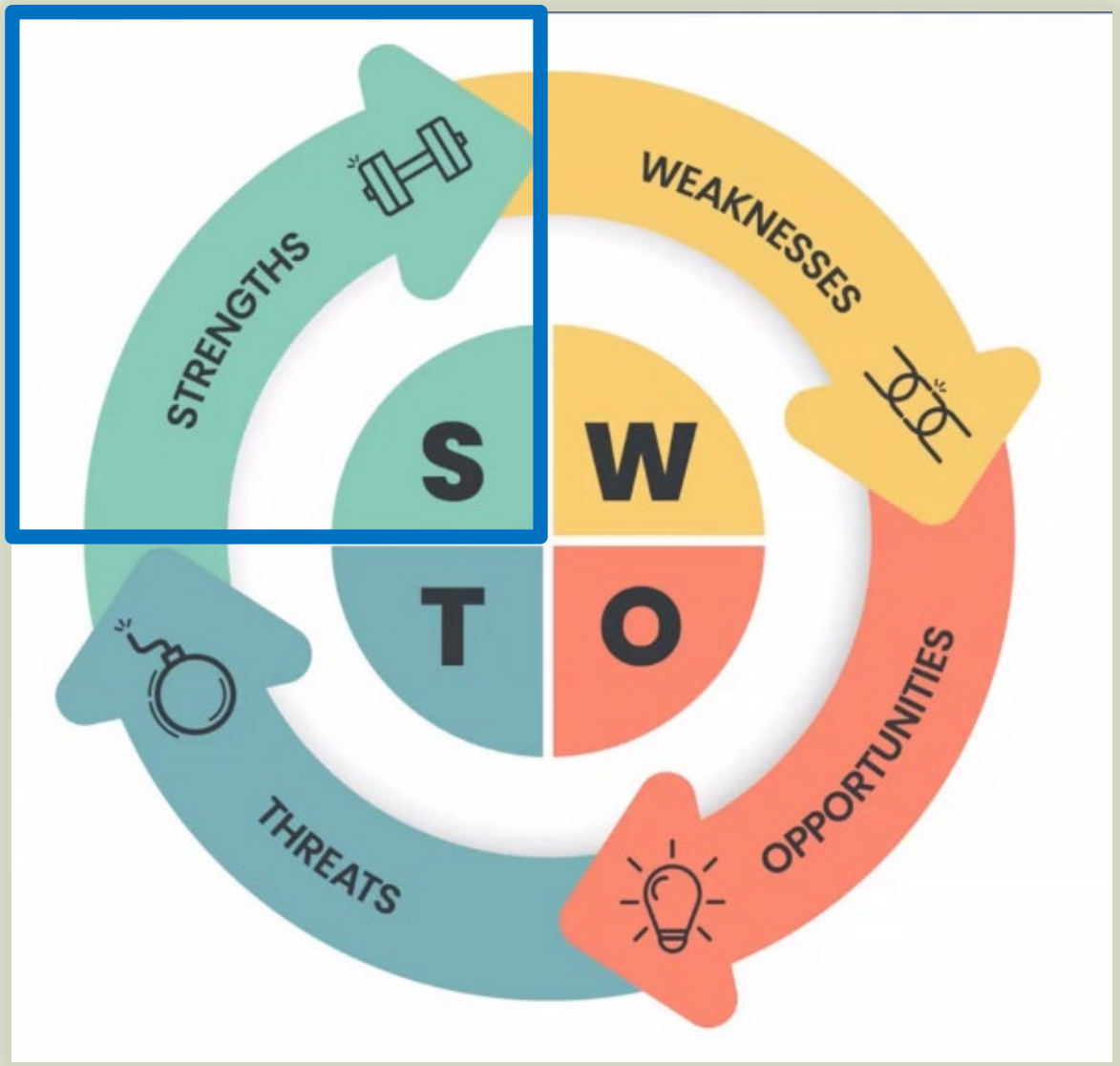
Orthopaedic Departmental Report

James Guido DiStefano, MD

October 8th, 2025

ORTHOPAEDIC DEPARTMENT

- Orthopaedic Surgery
- Podiatry
- Physical Medicine & Rehabilitation


STRENGTHS
WEAKNESSES
S
W
T
O
THREATS
OPPORTUNITIES

ORTHO SERVICE LINE DIRECTOR

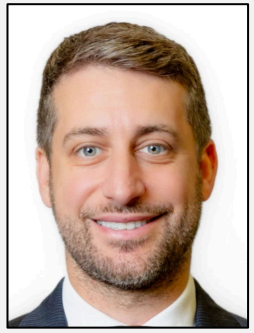
Sue Fairbanks, M.B.A.

- Program Director for AHS Creedon Advance Wound Care
- Executive director Crossroads home health and hospice
- Manager of Admin services and EHR Donor Network West
- Special projects and contract administrator for San Ramon Regional Medical Center
- Director of Operations for Hope Hospice

- Started with Ortho Department: 5/19/25

SUBSPECIALTY CARE

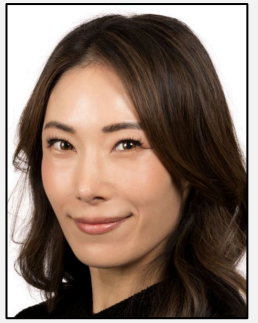
Ortho Trauma | Sports Medicine | Arthroplasty | Hand/Elbow | Spine | Foot/Ankle








APP TRIAGE OF REFERRALS

- All incoming Ortho referrals triaged by APP's
  - Internal/external emergency departments
  - Internal/external ambulatory referrals
  - Hospital discharge follow-up

- Patient safety
- Scheduling accuracy

- **6,813 referrals validated and triaged by APP's** (10/8/24 – Present)

ORTHO PHYSICIANS ASSISTANTS

Left to Right: James Poon, Cynthia Galvez, Cindy Pfeiff (Lead PA), Tiffany Shem and Daniel Thai

Left to Right: Meghan Markowski (Lead PA), Stephanie Heninger, Liz Andrews, Jonathan Cardenas and Lisa Topiol.

ALAMEDA HEALTH SYSTEM

REHABILITATION AND PM+R SPORTS

SLH Rehab Medical Director

In patient Rehab/PM+R Consult/Spasticity

PM+R Sports

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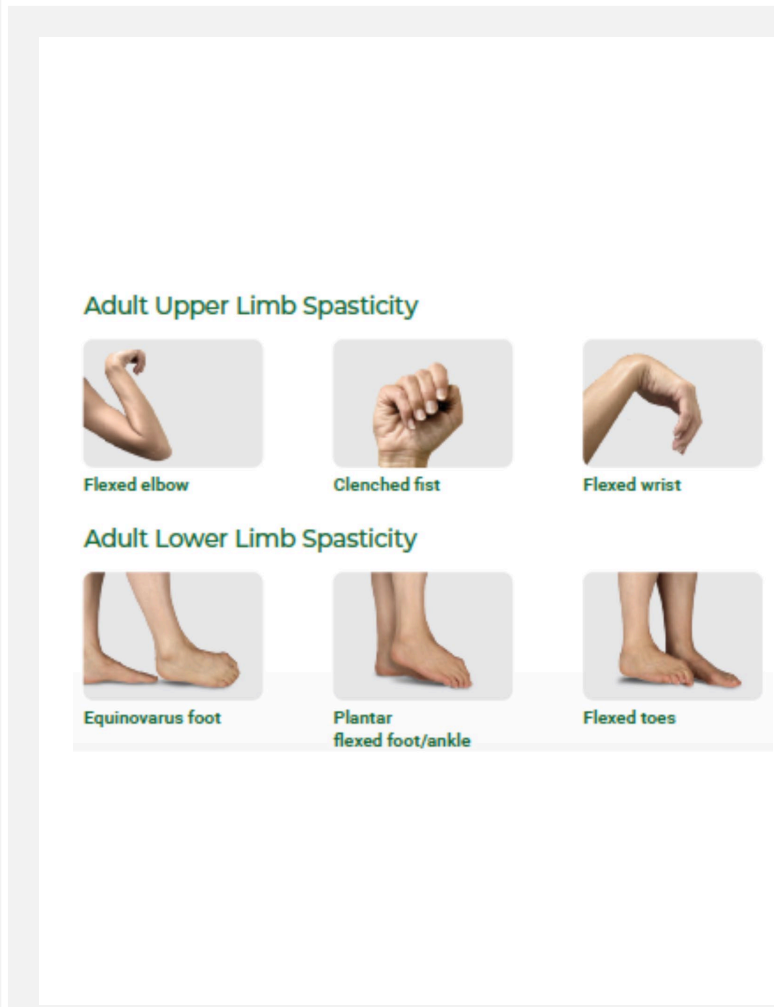


ADVANCED SPASTICITY CLINIC

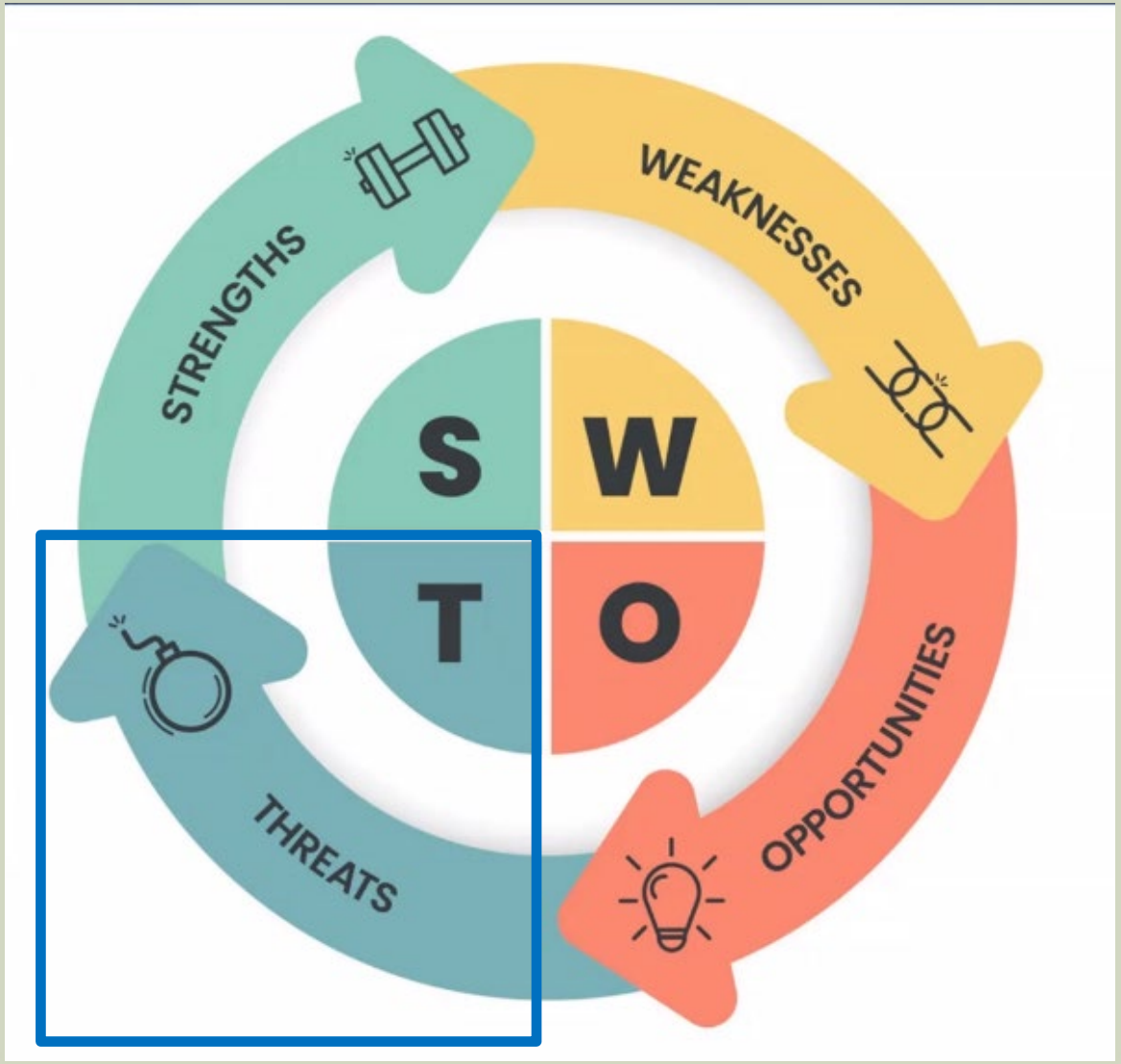
- Spasticity patient evaluation and botulinum toxin injections
- Where: Highland HCP4 Clinic
- When: 2nd/4th Thursday Mornings
- Go Live September 11th, 2025

ALAMEDA HEALTH SYSTEM

OUR MISSION TO EDUCATE

- UCSF St. Mary's Orthopaedic Residents
- Highland Emergency Department Residents
- UCSF St. Mary's Podiatric Residents
- Highland Medicine Residents
- Lifelong Primary Care Residents
- Samuel Merritt Physician Assistant Students

ALAMEDA HEALTH SYSTEM



ALAMEDA HEALTH SYSTEM

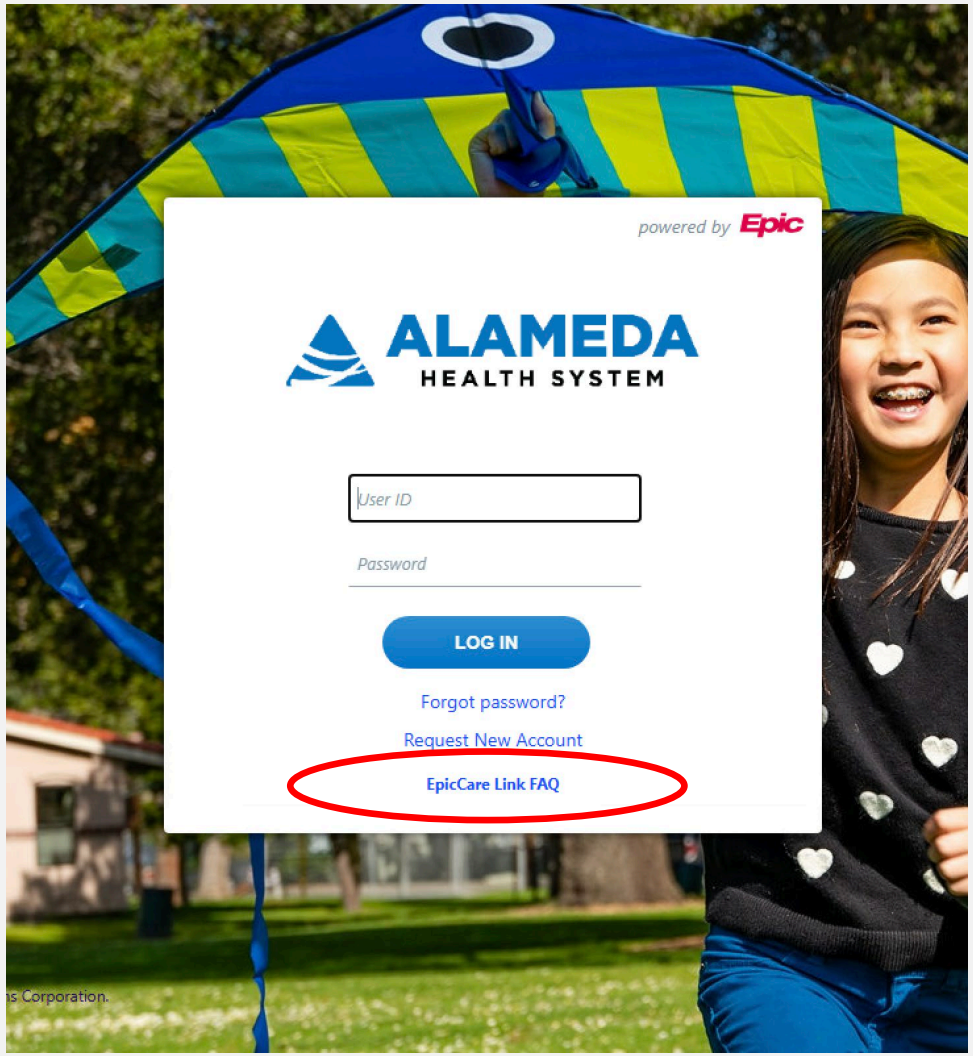
External referring providers:

- *"It is difficulty to refer patients to AHS"*
- *"I'm not confident my patient will get an appointment."*
- *"We used to fax referrals to AHS Ortho but when that option went away, we started referring elsewhere."*

Internal ED provider:

- *"The patient has very good private insurance, should we send them somewhere else?"*

ALAMEDA HEALTH SYSTEM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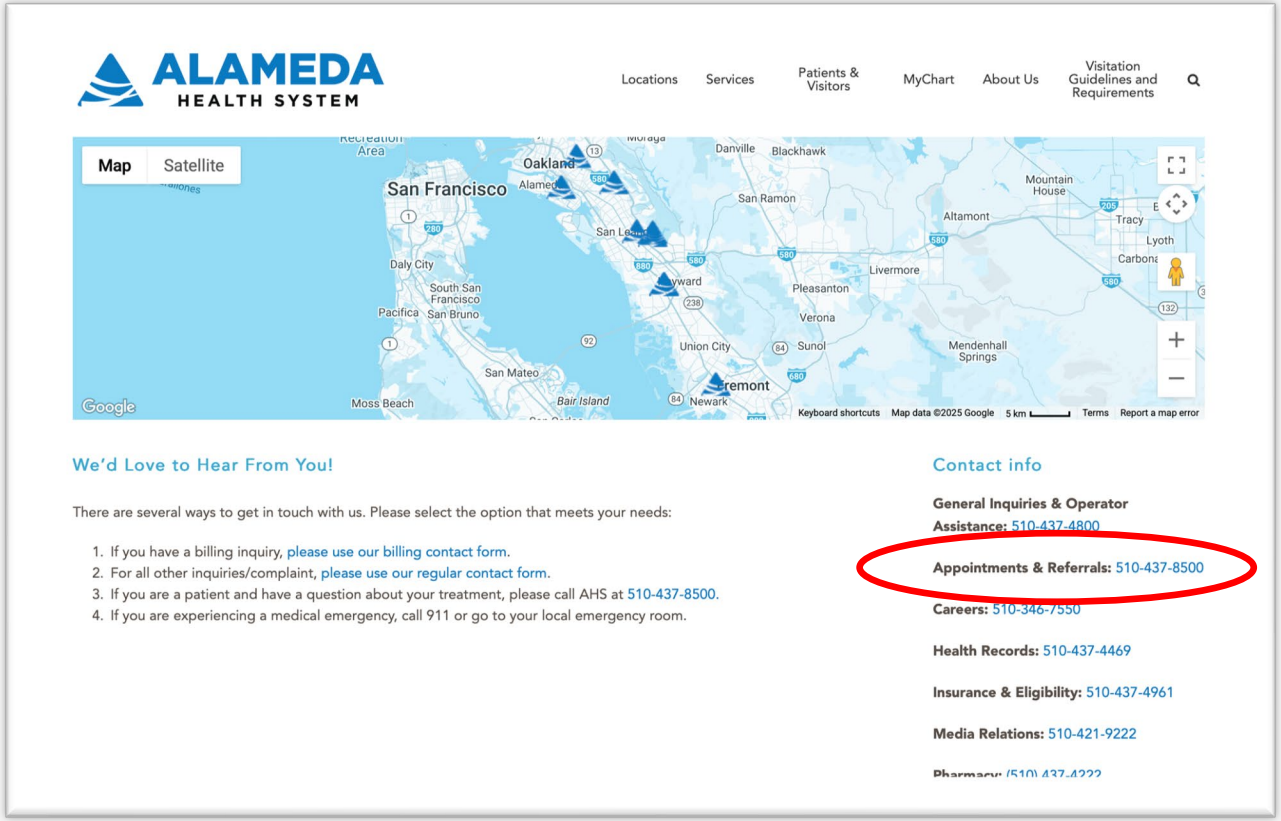
ALAMEDA
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Visitation Guidelines and Requirements
Map
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2. For all other inquiries/complaint, please use our regular contact form.
3. If you are a patient and have a question about your treatment, please call AHS at 510-437-8500.
4. If you are experiencing a medical emergency, call 911 or go to your local emergency room.
Contact info
General Inquiries & Operator Assistance: 510-437-4800
Appointments & Referrals: 510-437-8500
Careers: 510-346-7550
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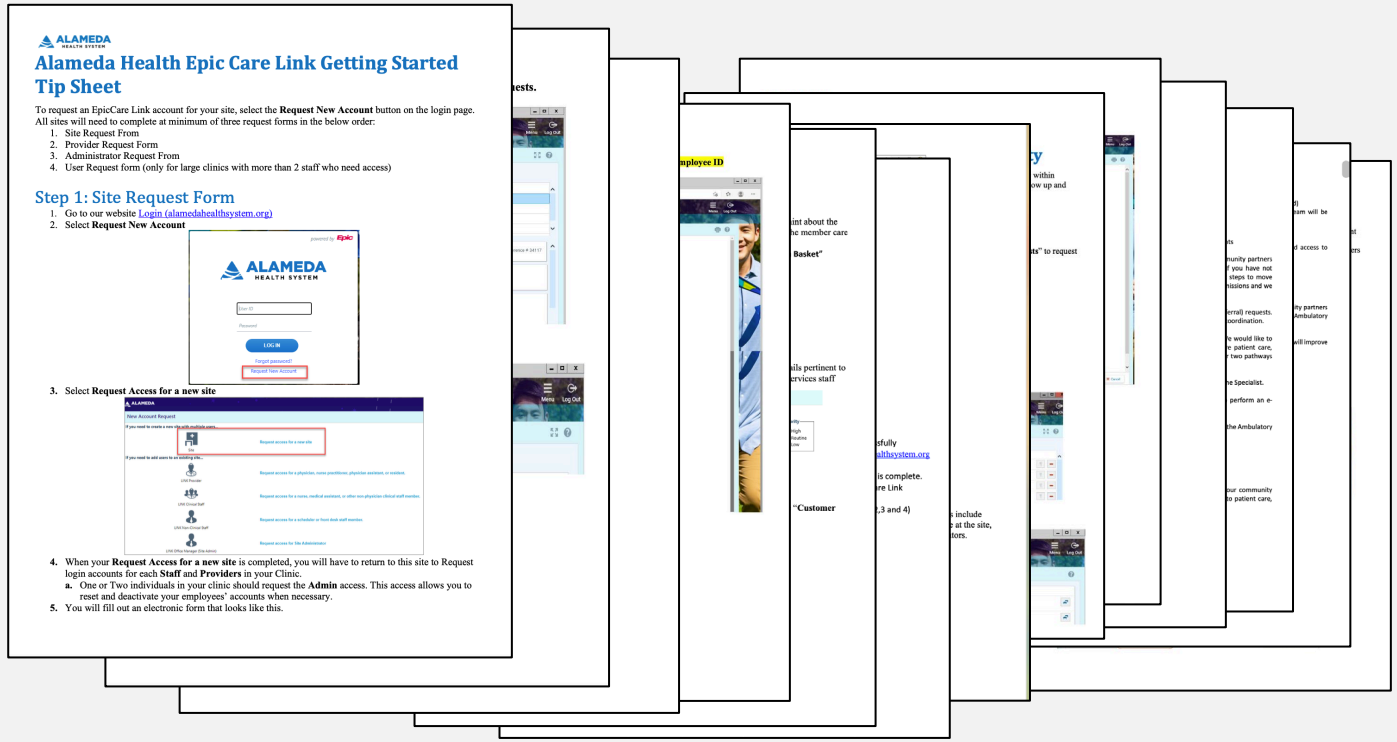
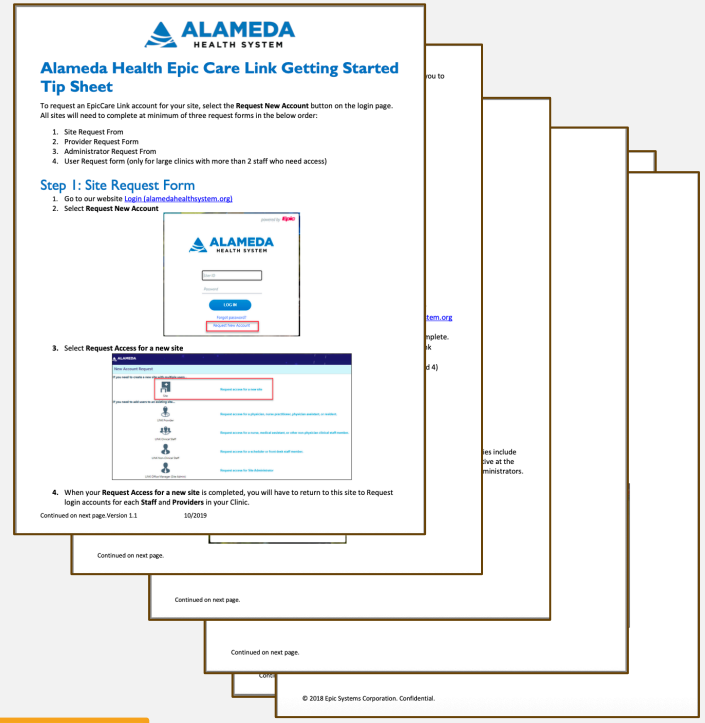
Media Relations: 510-421-9222

EPICCARE LINK SETUP TIP SHEETS: 27-PAGES → 6-PAGES





Site-level agreement time	1-2 business days wait
Enrollment	7-10 business

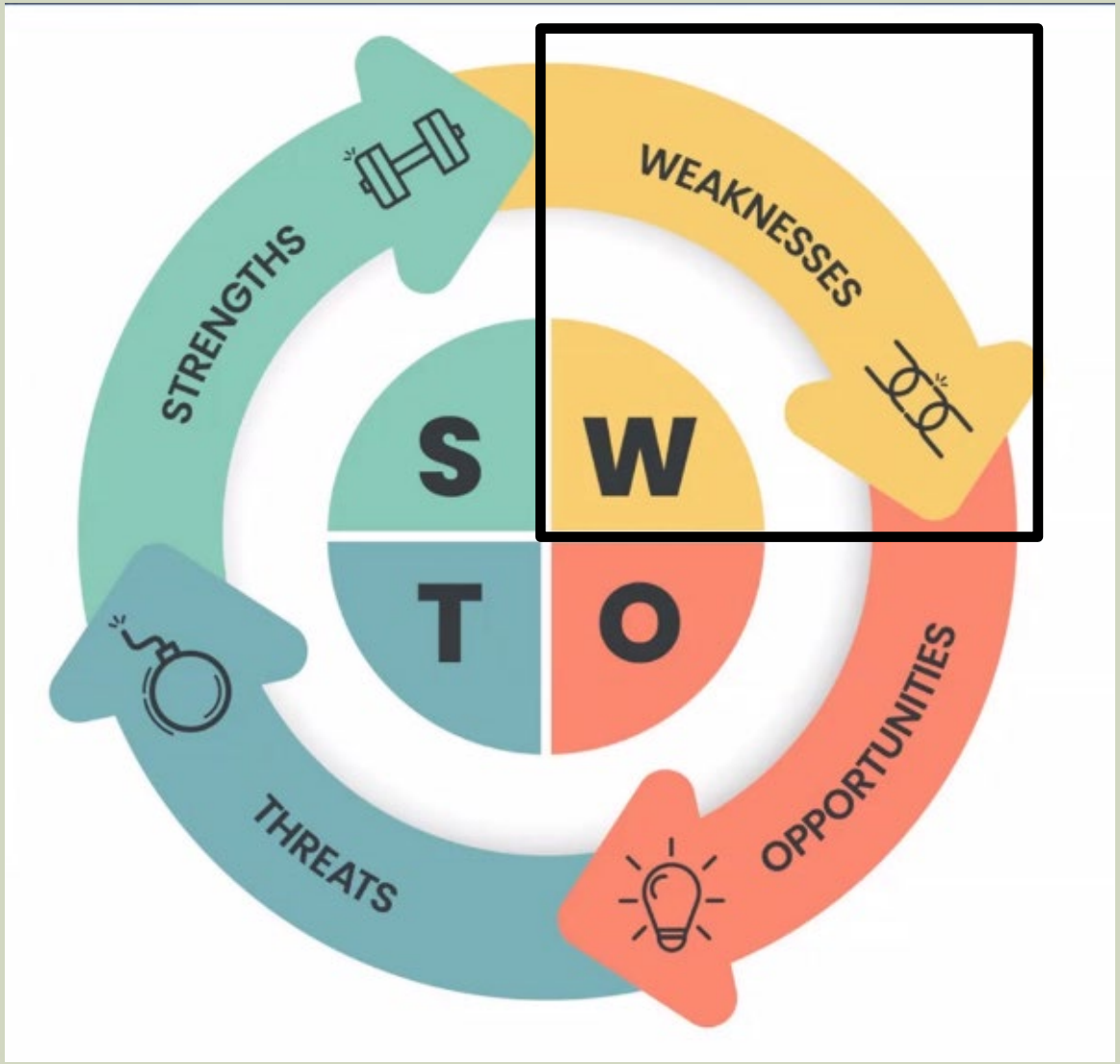
REFERRAL PATHWAYS

	AHS	Sutter	UCSF	SFGH	Stanford
• EpicCare Link	✓	✗	✗	✓	✗
• Epic Care Everywhere Referral	✗	✓	✓	✗	✓
• Fax	✗	✓	✓	✓	✓
• Email	✗	✓	✓	✓	✓
• Online portal	✗	✓	✓	✗	✓
• Self referral (select insurances)	✗	✓	✓	✓	✓

REFERRAL REVIEW KAIZEN

- Deep dive into referral process/scheduling on 7/23/25
- Kaizen Facilitator: Shari Johnson, Chief Revenue Cycle Officer
- Orthopedics:
  - Developing process to accept fax referrals to re-establish relationships with lost referral sources.
  - Need to develop pathway for patients with insurance that allows self referral

ALAMEDA HEALTH SYSTEM


STRENGTHS
WEAKNESSES
S
W
T
O
THREATS
OPPORTUNITIES

UNCAPTURED WORK REVENUE

- Marina Wellness Clinic not licensed — No facility fees billed
- Ortho APP's listed in Epic as residents — No first assist fees billed
- Epic procdoc errors — Not billing for supplies/meds

ORTHO REFERRAL CONCERNS

- Internal AHS Clinics/ED's

- Leakage of referrals out of the system

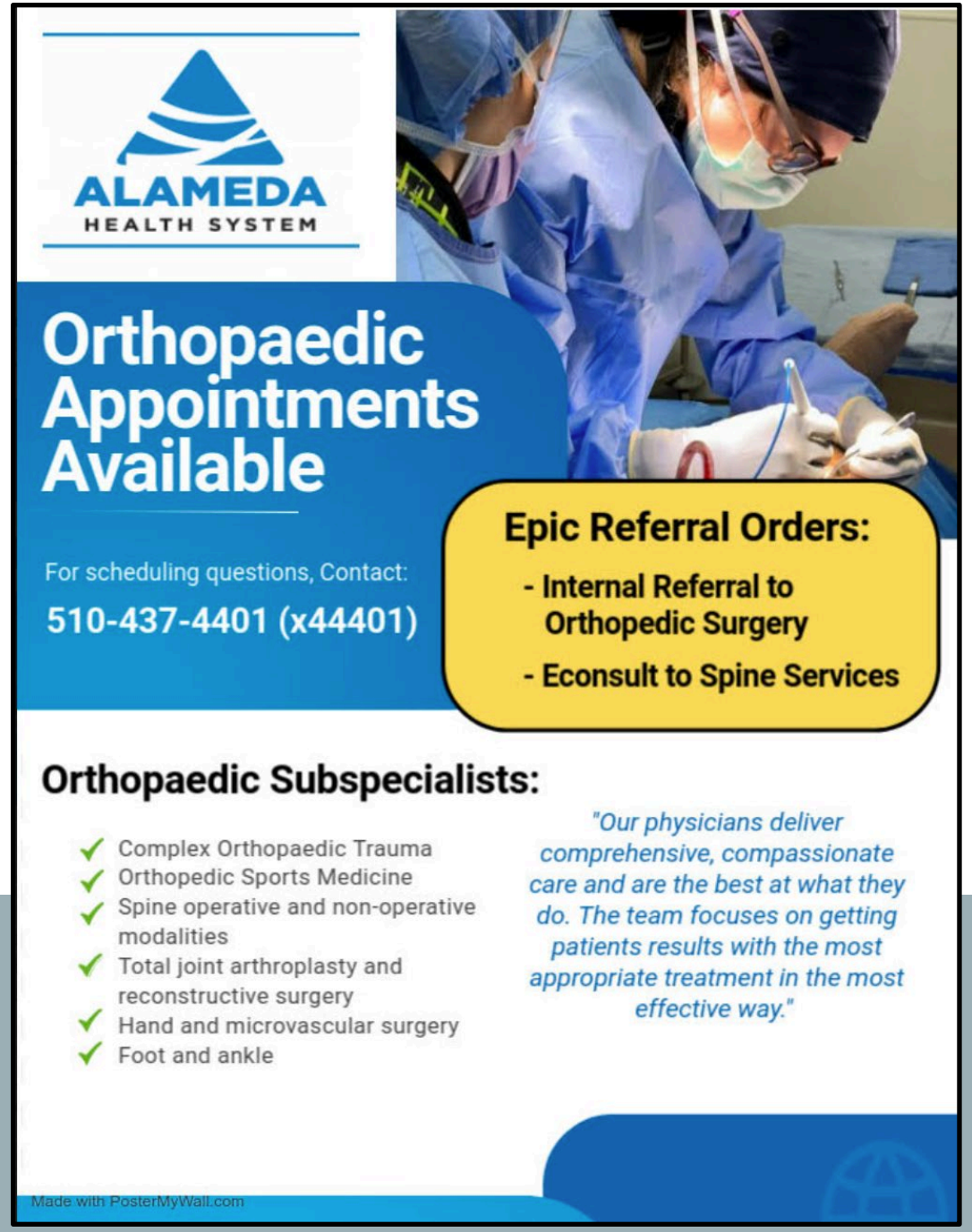
- External Clinics/ED's

- Difficulty of referring into the system

- No external marketing

ALAMEDA HEALTH SYSTEM

INTERNAL MARKETING AND OUTREACH



REFERRAL TIP SHEET

Orthopedic URGENT Referral
- Acute fracture or infection
- Acute joint dislocation/instability
- Acute tendon tear/laceration
- Acute block to joint motion

Orthopedic STANDARD Referral
- Arthritic joint conditions (Acute/chronic)
- Atraumatic tendinopathies
- General MSK pain
- Stable neuropathies (ie, Carpal tunnel)

Conservative Treatment Options
- Rest/Elevation/Activity modification
- Ice/Heat application
- Compression with brace/ACE wrap
- NSAIDS: Meloxicam, Naproxen, Voltaren, Ibuprofen
- Assist devices: Cane, Walker, Wheel chair
- Physical Therapy
- If considering cortisone injection:
  - X-ray imaging FIRST
  - Confirm no fracture/infection/tumor
  - No plan for surgery within 3 months

X-RAYS: First-line imaging study to obtain. Weight bearing for all lower extremity (*unless concern for fracture*).

Neck pain	3 View C-spine:	Upright AP, Lateral, Open mouth odontoid
Mid back pain	2 View T-spine:	Standing AP, Lateral
Low back pain	2 View L-spine AND AP Pelvis X-ray	Standing AP, Lateral Low Standing Pelvis – 1 view
Clavicle	2 View Clavicle	AP, 30° Cephalad tilt
Shoulder pain	3 View Shoulder:	Scapular AP, Scapular Y, Axillary
Arm pain	2 View Humerus:	AP, Lateral
Elbow pain	3 View Elbow:	AP, Lateral, Oblique
Forearm pain	2 View Forearm:	AP, Lateral
Wrist pain	3 View Wrist:	AP, Lateral, Oblique
Hand pain	3 View Hand:	AP, Fan lateral, Oblique
Hip pain	2 View Hip AND 2 View L-spine	Standing Low AP pelvis, Cross table lateral Standing AP, Lateral
Thigh pain	2 View Femur:	AP, Lateral
Knee pain	4 View Knee:	Standing AP, Lateral, 45° PA, Sunrise
Lower leg pain	2 View Tib/fib:	AP, Lateral
Ankle pain	3 View Ankle:	Standing AP, Lateral, Mortise
Foot pain	3 View Foot:	Standing AP, Lateral, Oblique

DO NOT ORDER MRI IF:
- If knee/hip x-rays are positive for ARTHRITIS
- The patient has medical contraindications to an operative intervention

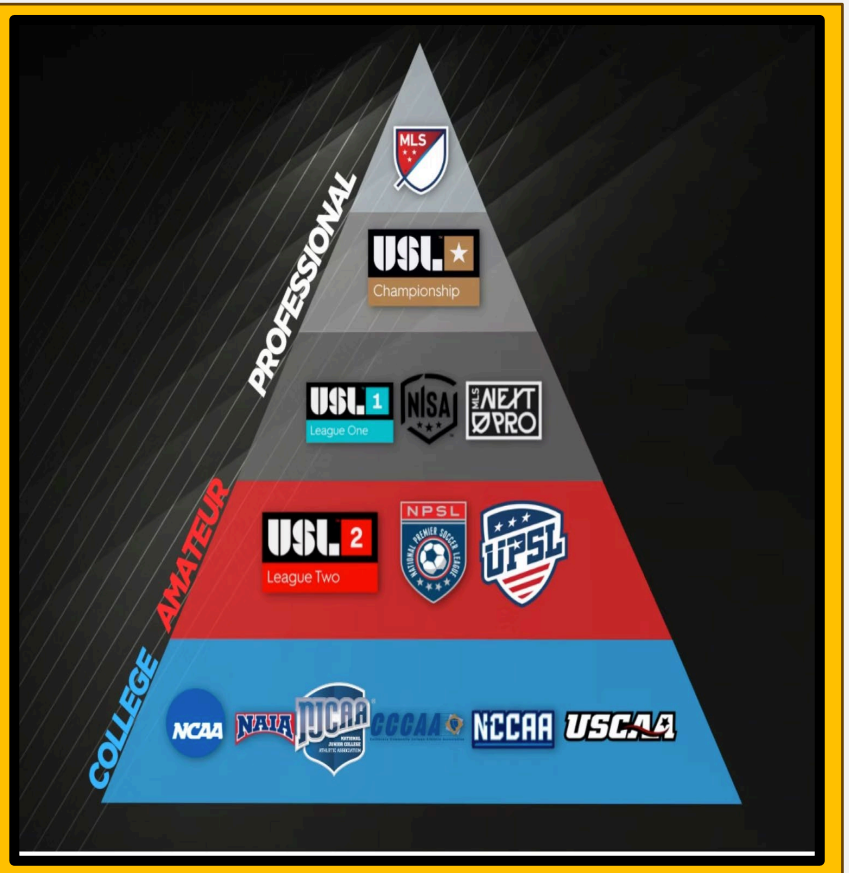
Indications for MRI (After completion of x-rays):
- "Nerve type" radiating pain down arms/legs, please order spine MRI
- Workup of mass concerning for malignancy (with and without IV contrast)
- All other MRI studies will be ordered as indicated by Orthopedic Subspecialist

ALAMEDA HEALTH SYSTEM

OAKLAND PROFESSIONAL SPORTS TEAMS

OAKLAND ROOTS

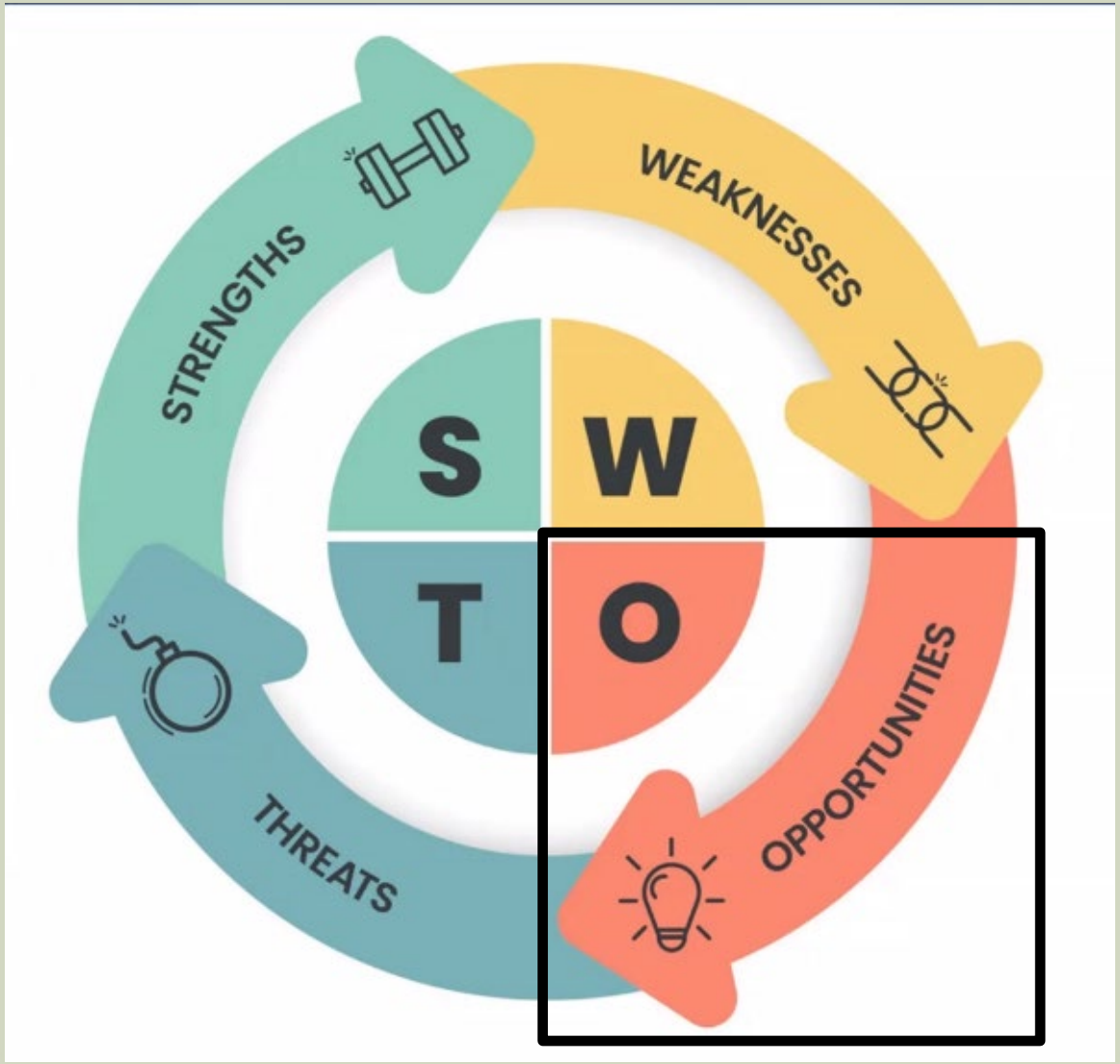
OAKLAND SOUL



The **Pioneer Baseball League** is a professional baseball league based in the Western United States. It operates as one of four Major League Baseball (MLB) Partner Leagues in the American independent baseball league system without MLB team affiliations. The league is

PIONEER
BASEBALL LEAGUE

ALAMEDA HEALTH SYSTEM


STRENGTHS
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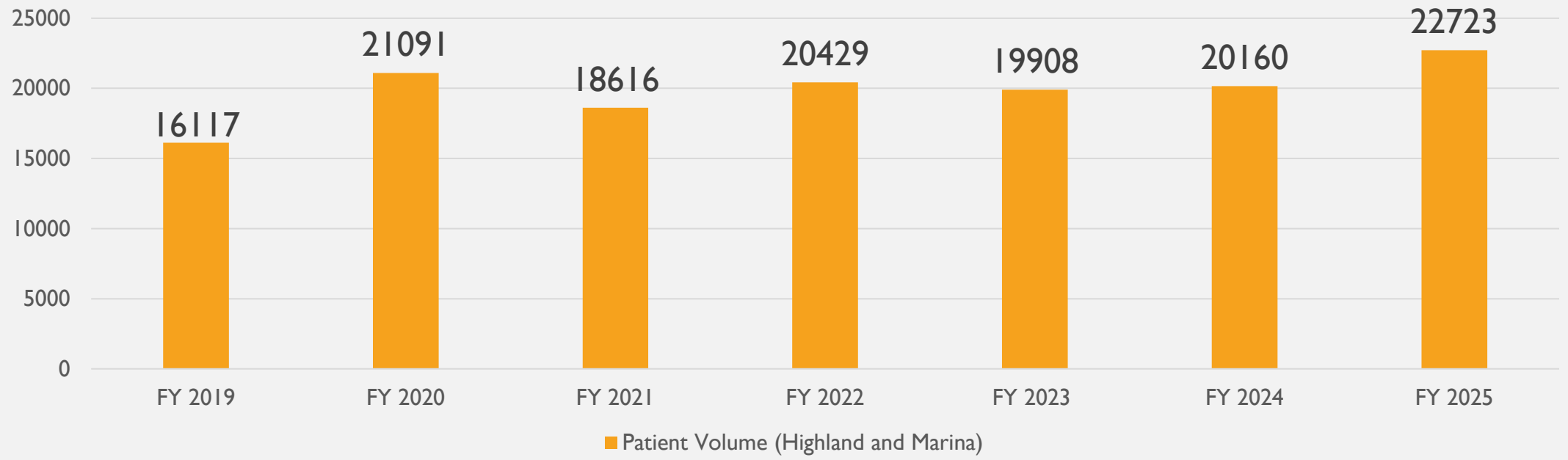
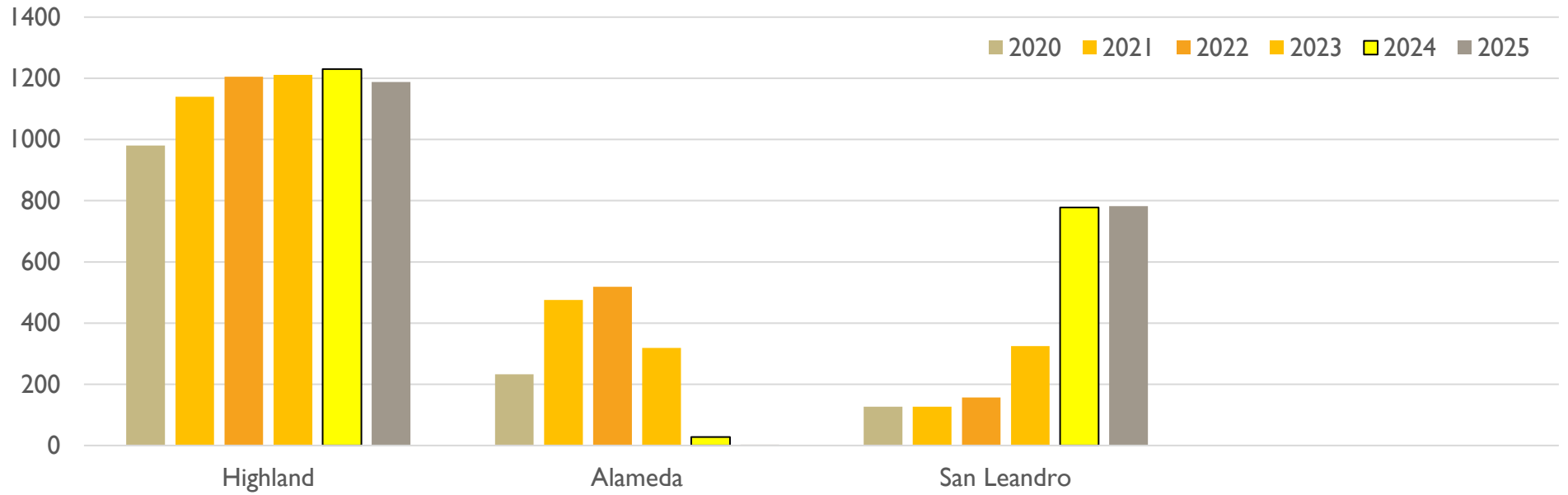
OPPORTUNITIES

ORTHOPAEDIC/PODIATRY AMBULATORY VOLUME



ALAMEDA HEALTH SYSTEM

ORTHO/PODIATRY OPERATIVE VOLUME



ORTHO BLOCK UTILIZATION: HIGHLAND

Block Utilization - HGH OR (8/1/2025 - 8/31/2025) Expand All | Credited | Uncredited | Export | Show Search Summary | Settings

Block	Util % (In Block)	Scheduled % For Util % (In Block)	In Block	Overbook	Out of Block	Available	Manual Rel	Cases
Dentistry	78%	100%	658	0	1,238	840	0	11
ENT	100%	95%	1,269	0	391	1,275	0	11
General	82%	77%	8,853	2,104	7,113	10,815	0	97
Gynecology	93%	77%	3,684	65	3,011	3,975	0	42
Maxillofacial	69%	73%	1,289	465	487	1,860	0	8
Neurosurgery	38%	34%	704	0	0	1,860	0	3
Ophthalmology		80%		0		1,860	0	17
Orthopedics	88%	76%	9,736	2,809	3,757	11,025	885	76
Monday		83%		351		1,860	0	15
Tuesday		74%		644		1,860	0	13
Wednesday	88%	86%	1,630	455	517	1,860	0	12
Thursday	98%	89%	1,653	769	376	1,680	0	10
Friday	73%	63%	2,767	590	1,092	3,765	885	26
Plastics	97%	99%	988	0	597	1,020	0	8
Podiatry	72%	62%	1,346	0	81	1,860	0	11
Urology	89%	87%	5,910	0	869	6,675	0	48
Vascular	66%	64%	1,221	0	836	1,860	0	6
Total:	83%	77%	37,324	5,443	18,512	44,925	885	338

ALAMEDA HEALTH SYSTEM

ORTHO LEVEL I TRAUMA METRICS

Value	Count	Percentage	Time to OR	Target
Total Activations	4606			
Femur Fracture	225	4.9	25 hours	<24 hours
Tibia Fracture	188	4.1	22 hours	<24 hours
Hip Fracture	18	0.4	41 hours	<24-48 hours

Admissions from 7/1/24-6/30/25

ALAMEDA HEALTH SYSTEM

ORTHO BLOCK UTILIZATION: SAN LEANDRO

Block Utilization - SLH OR (8/1/2025 - 8/31/2025) Expand All | Credited | Uncredited | Export | Show Search Summary | Settings

Block	Util % (In Block)	Scheduled % For Util % (In Block)	In Block	Overbook	Out of Block	Available	Manual Rel	Cases
Breast	74%	82%	752	0	149	1,020	0	7
ENT	89%	75%	904	0	123	1,020	255	9
General	75%	78%	761	0	178	1,020	0	10
Gynecology	39%	38%	728	0	19	1,860	0	5
Maxillofacial		76%		0		1,170	105	11
Ophthalmology		88%		0		2,700	0	49
Orthopedics	92%	89%	5,534	884	1,037	6,000	420	44
Monday		90%		48		1,020	0	9
Tuesday	94%	86%	1,751	229	187	1,860	0	11
Wednesday	97%	95%	1,804	602	153	1,860	0	14
Thursday	92%	83%	1,158	5	194	1,260	420	10
Total:	83%	79%	**12,234**	**884**	**2,308**	**14,790**	**780**	**135**

PRE-OP CLEARANCE WORK GROUP

Standardizing pre-op work-up and clearance guidelines for AHS

- Jordan Band, MD
  - Anesthesia POET Director
- Guido DiStefano, MD
  - Ortho Chair

- Patricia Foo, MD
  - Primary care K6 Director
- Dee Ghosh, MD
  - Same Day Clinic Director

ALAMEDA HEALTH SYSTEM

STANDARD PRE-OP CLEARANCE DOTPHRASE

User SmartPhrase – PREOPORTHOCLEARANCE [188020]

ⓘ Do not include PHI or patient-specific data in SmartPhrases.

Insert SmartText | Insert SmartList

ELECTIVE ORTHOPAEDIC PREOPERATIVE MEDICAL CLEARANCE FORM

I have evaluated @name@ for {elective ortho list:35810} on @TODAYDATE@

1. Pre-surgical:
-Past Surgical History: @SURGICALHX@.
- Complications from anesthesia in the past? {Yes/No:34599}
- Activity level: {Activity level:39213}

- ☐ Able to walk up 1 flights of stairs (4 mets)
- ☐ Able to walk up >1 flight of stairs (4+ mets)
- ☐ Can patient lay flat without getting SOB? {YES/NO:200010}
- ☐ Unintended >10% weight loss in the last 6 months? {YES/NO:200010}
- ☐ Recent hospitalization(s) within the past 6 months? {Yes/No:34599}
- ☐ ***

2. Cardiac:
{cardiac clearance:39209}

3. Diabetes:
{Diabetes pre-op:39212}

4. Additional Co-morbidities:
{jdcomorbid:32252}

5. Perioperative anticoagulation plan:
{jdanticoag:32253}

6. Perioperative antiplatelet plan:
{antiplt:39198}

7. Immunomodulatory medications or DMARDS:
{jdimmuno:32258}

8. GLP-1 Receptor agonists:
{GLP-1:39076}

9. Substance use history:
{jd substance use:29652}

DETERMINATION: {jdcleared:32255}

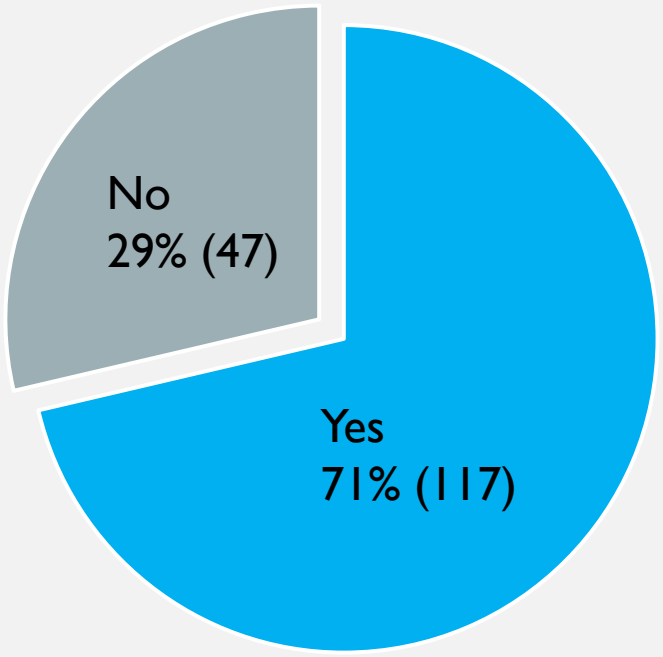
- ☐ Medical problems are optimized and patient is considered {DESC; LOW/MEDIUM/HIGH:21264} risk for elective surgery
- ☐ Medical problems are NOT optimized and patient is considered {DESC; LOW/MEDIUM/HIGH:21264} risk for elective surgery
- ☐ The patient requires additional workup including: ***
- ☐ The patient is NOT a candidate for elective Orthopaedic surgery
- ☐ ***

ALAMEDA HEALTH SYSTEM

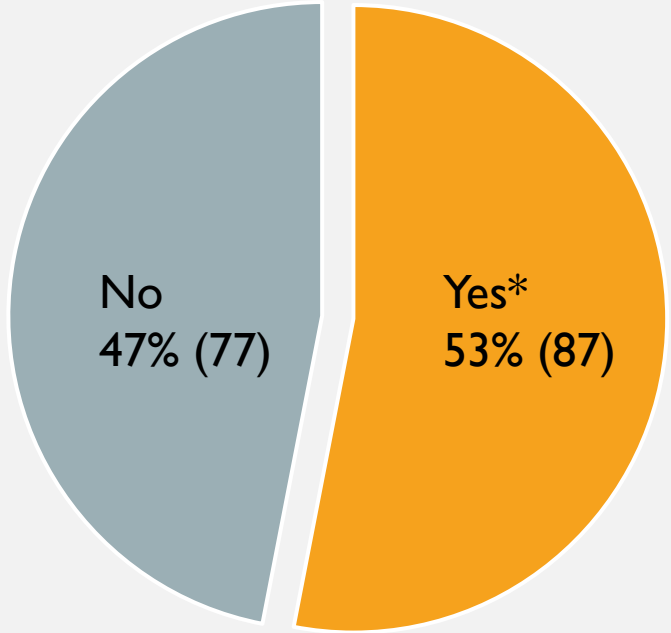
OPERATIVE BACKLOG: 9/10/25

164 Patients

Optimized for Surgery



Assigned to AHS for PCP

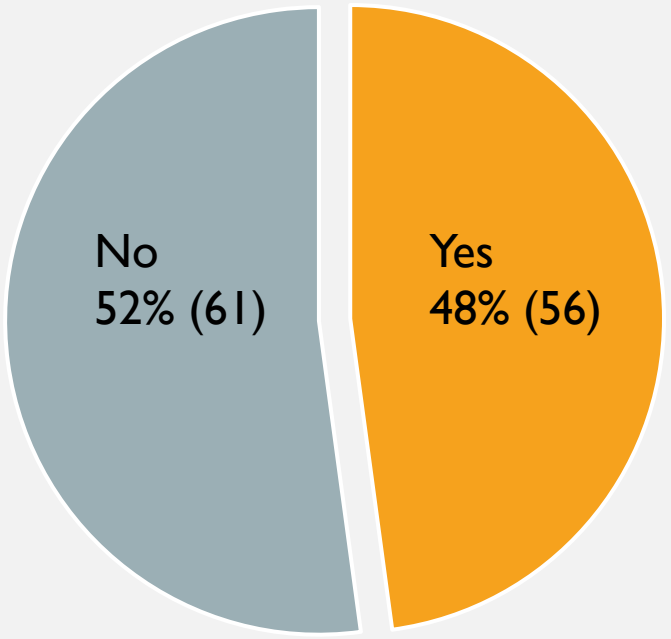


ALAMEDA HEALTH SYSTEM

* 3 patients not established

OPTIMIZED PATIENTS

Assigned to AHS for PCP



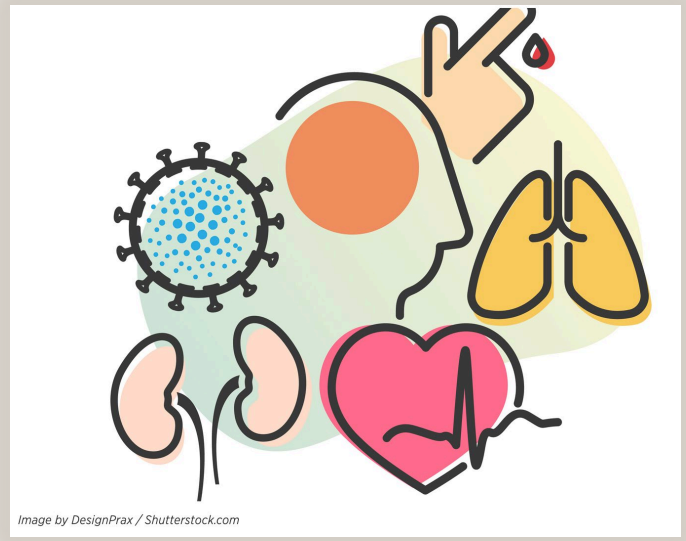
Clearance needs	# of Patients (117)
Primary Care Provider	114
Dental	78
Cardiology	16
Neurology	3
Nephrology	2
Rheumatology	3
Vascular	3
Pulmonology	2

Other: Immunology, Endocrinology, Hematology, Oncology

ALAMEDA HEALTH SYSTEM

NON-OPTIMIZED PATIENTS

- Most common comorbidities not optimized:
  - Diabetic glycemic control (HA1C elevated)
  - Active nicotine use
  - Elevated BMI
  - Drug/ETOH use disorder
  - Lack of social support



ALAMEDA HEALTH SYSTEM

POET/DENTAL SCREENING EFFICIENCY PILOT (2023-2024)

- Highland HCP4 Ortho Clinic
- Dental tech and physician
  - Dental x-rays
  - Dental screenings
- Anesthesia POET provider
  - In person evaluation
  - Assess if there are contra-indications to proceed with surgery

POET

RDA-EF

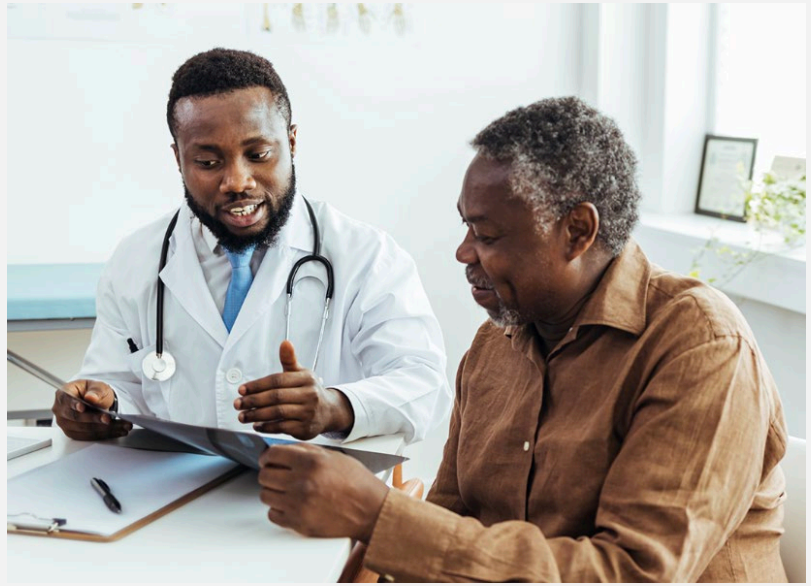
Dental

ALAMEDA HEALTH SYSTEM

THE EVOLUTION OF POET

- Comprehensive pre-operative evaluation to assess surgical and anesthesia risk

- Goals:
  - Improve efficiency of surgical booking
  - Patient education and planning for surgery
  - Decrease peri-operative complications
  - Improve surgical outcomes

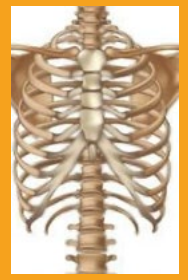


ALAMEDA HEALTH SYSTEM

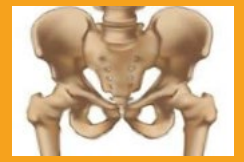
Ortho
Hand

PM&R
Sports

Ortho/
Spine



Anesthesia
Pain

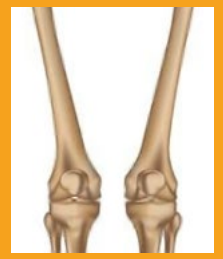


Ortho
Joints

APP
Clinics

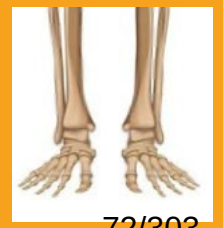
POET

Ortho
Sports



PM&R
Spasticity

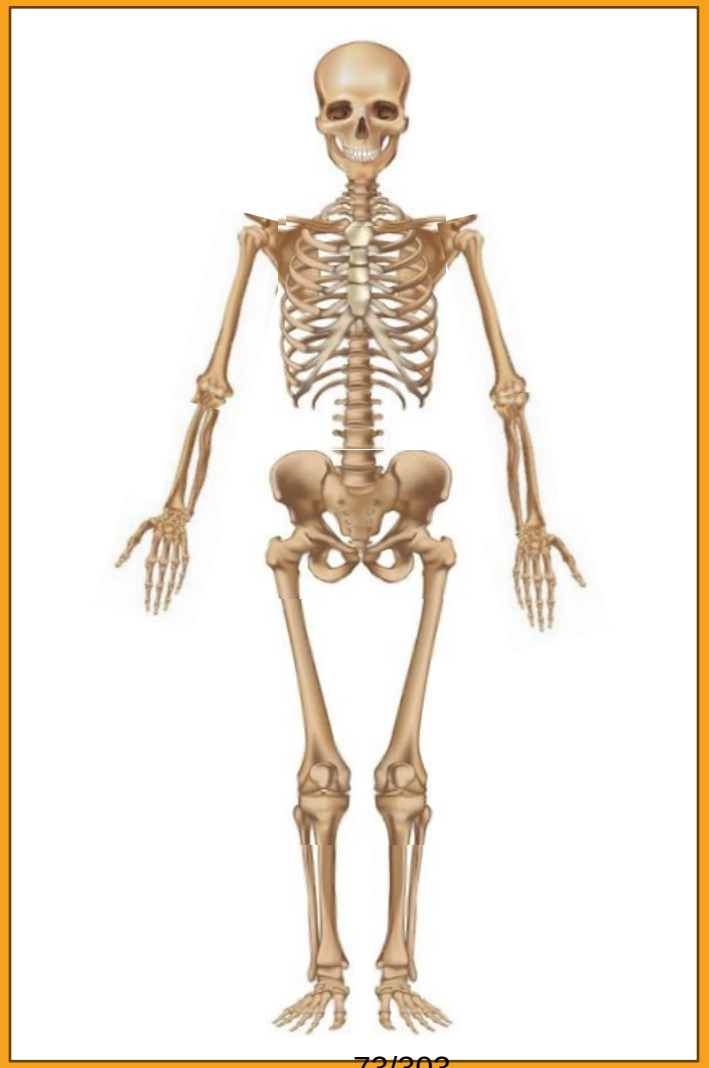
Geriatrics



Podiatry

ALAMEDA
HEALTH SYSTEM

PUTTING THE PIECES TOGETHER



ALAMEDA HEALTH SYSTEM

Comprehensive Musculoskeletal Center

Non-operative/Injection

- PM&R Sports
- Anesthesia- Pain
- General Orthopaedic
- APP ClinicsOrt
- PM&R Spasticity

Operative

- Orthopaedic Spine
- Neurosurgery Spine
- Total joint arthroplasty
- Orthopaedic Sports
- Hand/Upper extremity
- Podiatry

Peri-op Coordination

- POET
- Surgery coordinators
- Community Health Worker

ALAMEDA HEALTH SYSTEM

SAN LEANDRO MSK AMBULATORY PROJECT

- 2/26/25: Meeting with AHS Chief strategy officer and Chief operating officer
- 3/4/25: Meeting with CAO of San Leandro Hospital
- 3/21/25: San Leandro walk through with CAO, Chief of engineering and architect
- 6/9/25: Architect draft proposal review
- 6/17/25: Capital approval of $8.4 million for San Leandro build out (over 3 years)

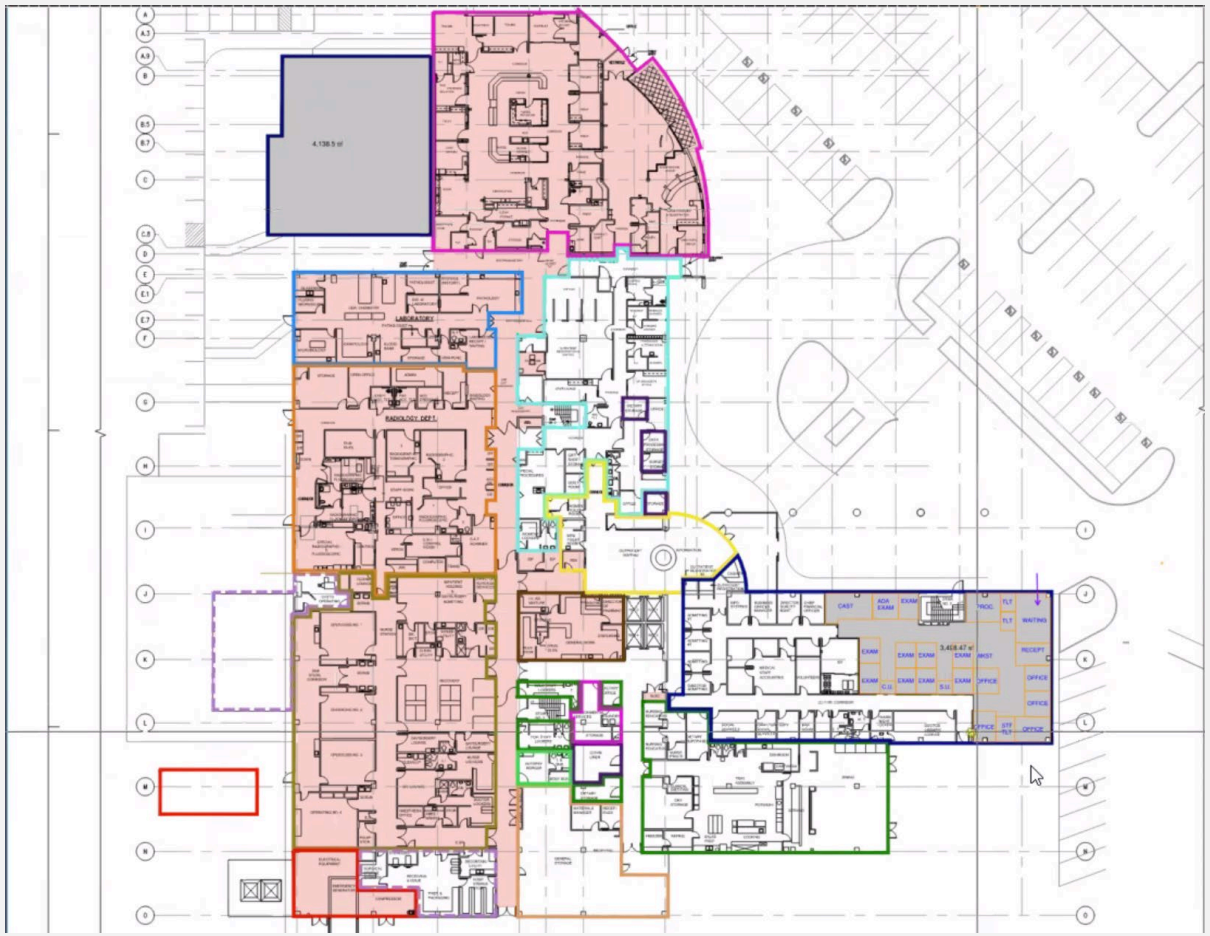
ALAMEDA HEALTH SYSTEM

MSK Wellness Center: Space planning

San Leandro Hospital

- X-ray + CT on site

- Exam Rooms
- Procedure room
- DME
- Physical therapy
- Occupational therapy



ALAMEDA HEALTH SYSTEM

ORTHOPAEDIC DEPARTMENT REPORT

Sustainability

Initiatives:
- Referral process rebuild/optimization

System Integration:
- Standardization of pre-operative clarance
- Develop pilot medical clinic focusing on optimizing and clearing patients for elective surgery

Finance:
- Focus on operative utilization and process improvement

Performance Metrics:
- Departmental ambulatory and operative volume
- Ortho trauma metrics: Time to surgery
- Infection and DVT rates
- Readmission rates

Quality Care

QRC:
- Monthly meeting led by Ortho Quality Director
- Reviewing patient Press Ganey and CAHPS scores
- Reviewing any unplanned return to the OR

Regulatory:
- None

Community Connection

Current Projects:
- Tip sheets for referring providers

Opportunities:
- Partner with community organizations
- Minimize AHS providers referring to Ortho outside the system
- Meet with CHCN and other external providers to discuss expanded services offered at AHS

Staff & Physician Experience

Staffing:
- All budgeted positions filled

Workforce Development:
- Optimization of provider clinic templates, ambulatory and surgical volume.

Culture:
- Protected time for all providers to participate in regular department meetings, grand rounds and QRC meetings.

ALAMEDA HEALTH SYSTEM

ALAMEDA HEALTH SYSTEM

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, 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

MEMBERS

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

THE MEETING WAS CALLED TO ORDER AT 5:04 pm

ROLL CALL WAS TAKEN AND THE FOLLOWING TRUSTEES WERE PRESENT: Alan Fox, Greg Garrett, Lilavati Indulkar, MD, Donna Linton, Nicholas Moss, MD, Rachel Richman, David Sayen and Sblend Sblendorio (left at 6:15pm)

ABSENT: Nely Obligacion, excused

PUBLIC COMMENT:

Mwata Kamora spoke regarding management of San Leandro Hospital ignoring issues around staffing and security in the ER. She has been advocating for better patient care in light of issues with security staff and patient safety, and they have tried to fire her in retaliation.

Keith Brown requested the recension of disciplinary letters against Mwata Kamora, accountability from the security staff in the ER at San Leandro, for AHS to follow the CNA MOU and not replace nurses with travelers, and he requested no retaliation against union leaders at St. Rose Hospital.

Angela Marie Walker spoke regarding Mwata Kamora's patient advocacy. When they bring an unsafe situation to management they expect it to be fixed. The ER at San Leandro Hospital was not a safe environment.

Ana Danon said cutting hours worked against the mission. She spoke about the importance of 12 hour shifts. If shifts were cut off at eight hours most surgeries would require a shift change hand-off mid surgery. Not all staff members were willing or able to stay late for surgery.

A. CEO REPORT

James E.T. Jackson, Chief Executive Officer

Trustee Linton said making Dr. Francis the Community Health Officer for AHS was a good idea and she looked forward to his greater involvement.

Trustee Garrett agreed and added that Dr. Francis's commitment, energy, enthusiasm, and leadership was outstanding. This was an important role, and he was a good fit for it.

B. MEDICAL STAFF REPORTS

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

Trustee Linton asked about the changes to the Writ Hearing procedures. She said they used to hold those hearings at John George and asked if that was now offsite. Dr. Perez said that was her understanding, but she would get additional information. Ms. Olson said they were exploring reopening the court room at John George. There was no ETA at this time.

Trustee Garrett asked about the operating room efficiency initiative and comments they heard earlier about decreasing nursing hours. Mr. Fratzke said they were related.

Trustee Fox said it would be helpful to have the exit interview data to find out why people were leaving and how long those who were leaving had been on staff. Dr. Perez said this was a work in progress, and she would be happy to bring back the data when they had it.

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

Trustee Linton asked what the impact would be of the delayed payment from the Alliance. Ms. Miranda said she believed it was $3M. Trustee Linton asked if the $3M was for a year. Ms. Miranda said it was for six months.

Trustee Fox asked if the other hospitals in the County also agreed to delay payments from the Alliance. Mr. Jackson said it was his understanding that other hospitals did make similar concessions to keep the Alliance out of receivership.

Trustee Garrett asked if a report on the work the COT (Center for Operational Transformation) was doing would come to the full Board. Trustee Sayen said they could bring it to the full Board.

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

Trustee Indulkar said they talked a lot about AI. She requested occasional updates from the AHS AI working group. Ms. Yang said her team was presenting an AI report to the full Board at the October meeting and agreed that regular updates would be a good idea.

Trustee Linton said there was a strong feeling among the Trustees that they wanted the Board to move more into governance rather than simply receiving reports. They wanted to really set up governance structures. In terms of AI, setting the guardrails and determining how AI could assist them in delivering the mission. She wanted to see the ability of the Board to talk about and help guide the parameters of the governance structure of AI.

Trustee Fox said they were advised not to jump in all the way with AI, rather to start with something that was easier to get their arms around. He suggested that the report include some ideas on where to start as an organization.

Trustee Garrett said at the retreat they could discuss how the Board sets guidance and policy around the priority of capital and operational spending. Mr. Fratzke said he welcomed the conversation. The update on COT at the October Board meeting will be different than what the Finance Committee heard.

Trustee Linton said it was important to know the Foundation received monies to purchase the Simulation Lab equipment. It was important for the Foundation to know what was on the priority list and why it was important.

Trustee Sblendorio left at 6:15

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 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

Moved by Trustee Moss 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 Fox, Garrett, Indulkar, Linton, Moss, Richman, Sayen, Sblendorio
NAYS: None
ABSTENTION: None

E. ACTION/DISCUSSION

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

Trustee Fox said the work life balance metric was favorable and the burn out metric indicated a high level of burn out in the organization. Those two things did not seem to go together. Ms. Grewal said the work life balance component came from not impacting on employees' personal time by allowing their breaks and allowing them to end work on time. This indicates that once an employee leaves work, AHS was very good about not intruding in their personal time. The burn out climate was about while people were at work.

Trustee Indulkar said there was value around the pulse surveys. It could be difficult for someone to capture everything they were feeling in a survey that takes place once a year given the mind set they may have that day.

Trustee Sayen asked how this compares to other organizations. Ms. Grewal said she hasn't been able to get that information. The survey was administered by Vizient, and they administered surveys for 20% of the healthcare systems across the nation. She is working with them to get data on like organizations and hopes to be able to share that information soon.

Trustee Garrett asked about safety climate by position. The RNs were the largest group of respondents, and they had a 32 for safety climate. Ms. Grewal said that was correct and it meant there was a 32% positive rating. Trustee Garrett asked what was being done about that. Ms. Grewal said they did action plans based on each area's response at the individual unit level. She was creating more pivot tables to look more closely at the data and work with the executive leaders to address the issues.

Trustee Moss asked, regarding the low scores in a specific post-acute group, if there was reason to believe it might have been a coordinated response. Mr. Espinoza said that when the survey was conducted, that group was going through union negotiations, and they were unhappy. What

people are feeling at the moment when the survey occurs has a direct impact on what the outcome is and then that stays with you until the next survey is taken.

Trustee Indulkar said there was a blurred line between employee engagement surveys and culture of safety surveys. Reiterating with staff the idea that those were different things could help address some of these disparities. Ms. Grewal said they were looking at separating those two surveys. HR would lead the engagement survey and Patient Safety would conduct the culture of safety survey.

F. DISCUSSION: Board Calendar and Tracking

Trustee Sayen spoke about the November 7 Board retreat agenda. Christy Roberg would present a market analysis that goes deeper than she did at the July Board meeting. Matt Woodruff from the Alameda Alliance will give a presentation regarding the Federal budget. Fifty two percent of AHS's business was managed care Medicaid, and that was Mr. Woodruff's business, so the Alliance members were at risk, and he should be able to share some good insight. AHS's new Chief Medical Officer may talk a bit. And they are looking into having a Governance Institute presenter come to discuss governance versus management and what the trustee role is. They also may want to discuss AI.

Truste Fox said they should use some time to discuss strategy and strategic direction. They created a strategic plan, but it was awhile ago. It was time to consider whether it needs to be refreshed or if a new plan needed to be created.

Trustee Sayen said he hoped to address some of that with the market survey presentation. Ms. Dong said the refreshed strategic plan with the OKRs did come to the Board earlier this year. Mr. Fratzke said their intent was to merge the existing strategic plan into the operating plan. The work should be completed in time for the retreat.

Trustee Garrett agreed that the strategic plan needed to be discussed. Interweaving the strategic plan with the priorities might cause some OKRs to need to be adjusted. Mr. Fratzke said that was the difficulty right now as the OKRS might not exactly mirror the metrics for the operational plan.

Trustee Garrett said he understood the need to be adaptable to change the OKRs to accommodate priorities. He said it was important for the Trustees to have a role in the process and not to just be told what the new priorities were. They wanted to be more involved in governance rather than just exist in a listening role.

Trustee Fox the Federal budget was a strategic issue that needed to be considered as they discussed how they would move forward. What services, initiatives, and capital would be prioritized given this obstacle.

Trustee Garrett said that, regarding the market analysis report, they have all heard the report in committee. And while an overview is good, they did not need to hear the report again. They needed to hear what was being done about the changing demographics and how it will impact our direction.

Trustee Linton said it was also important to discuss if they are shifting to picking up more Medicare fee for service.

Trustee Linton said she also wanted to discuss more about the strategic direction for St. Rose.

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

Trustee Indulkar said she would recuse herself from agenda item 2, the SEIU conference.

Ms. Olson 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. **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

Ms. Olson said the Board met in closed session and there was no reportable action.

OPEN SESSION

TRUSTEE COMMENTS

ADJOURNMENT

	Policy	
ALAMEDA HEALTH SYSTEM	**HR SECTION 3.00 - POLICY 3.12** **Sexual Harassment**	**Reference # tbd**
	LEVEL ☐ System ☐ Site	EFFECTIVE DATE: 9/2025

POLICY STATEMENT
Sexual harassment in the workplace will not be tolerated by Alameda Health System (AHS). This policy applies to all employees, supervisors, and to non-employees who have contact with employees during working hours. Any employee or supervisor who engages in sexual harassment will be subject to disciplinary action, up to and including termination.

Sexual Harassment includes but is not limited to:

1. Unwelcome sexual advances, requests for sexual favors and other verbal or physical conduct of a sexual nature when:
    a. Such conduct has the purpose or effect of unreasonably interfering with an individual's work performance or creating an intimidating, hostile, or offensive working environment;
    b. Submission to such conduct is made either explicitly or implicitly a term or condition of an individual's employment; or,
    c. Submission to or rejection of such conduct by an individual is used as the basis for employment decisions affecting such individual.

PURPOSE
To establish rules of conduct in the area of sexual harassment and to provide guidelines for the reporting, investigation, determination, and necessary action for resolving complaints of sexual harassment.

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

PROCEDURES
All complaints of sexual harassment are regarded as serious and will be promptly and thoroughly investigated.

1. If an employee feels they are being subjected to sexual harassment, they should report the matter as soon as possible to either their department manager/supervisor or to Human Resources.

2. Upon receiving a complaint of sexual harassment, department managers/supervisors should immediately contact the Vice President, Human Resources who will then initiate a prompt and appropriate investigation of the complaint. All employees must cooperate fully in the investigation and provide whatever evidence AHS deems relevant.

3. Confidentiality regarding both the complaint and the investigation will be maintained to every extent possible consistent with AHS's responsibility for investigating complaints of harassment.

Human Resources will expect all parties who are contacted as part of the investigation to maintain confidentiality.

4. As part of the investigation, Human Resources will also discuss the charge with the person against whom the complaint was filed.

5. After a decision is reached the employee who made the complaint will be informed.

6. Employees are assured that they may follow this complaint procedure without fear of censure and/or reprisal. AHS will not tolerate retaliation against or intimidation of any individual who has made a complaint in good faith or cooperated in the investigation of a complaint.

7. Employees are encouraged to use Alameda Health System's procedure for resolving complaints of sexual harassment however, employees may file complaints of discrimination, including complaints of sexual harassment, with the California Department of Fair Employment and Housing (DFEH) or the Equal Employment Opportunity Commission (EEEO):

   California Department of Fair Employment and Housing 1515 Clay Street, Suite 701
   Oakland, CA 94612-2941
   (510) 622-2941

   Equal Employment Opportunity Commission 1301 Clay Street, Suite 1170N
   Oakland, CA 94612-5217
   (510) 637-3230

8. Sexual Harassment Training will be given to all employees on a periodic basis.

REFERENCES
The California Fair Employment and Housing Act (FEHA)
Equal Employment Opportunity Commission (EEOC)
HR Section 3.00 - Policy 3.11 Unlawful Harassment

Alameda Health System			CPC Executive Summary to AHS and AH Medical Executive Committee(s) – September 2025			
Policies and Procedures				Chairs: Kelley Bullard, MD & Wacheera Davis, DNP, MSN, BSN, RN, MBA		
TOPIC or TITLE OF POLICY	**Document Owners**	**Summary of Changes**	**Last Approved Date**	**Next review date after BOT approval**	**Purpose**	**History of Review Committee**
AHS System Wide Policies & Procedures						
Medication Profile Review and Verification Policy	Priya Patel, PharmD	• TJC Triennial Review • System P&T approved 8/2025 • Consent Item - Policy		09/2028		• System P&T 8/2025 • CPC 9/04/2025 • MEC 9/17/2025
Breach Notification Policy	Akemi Renn, CHC, CHPC, CPC	• Up for review • No revisions since it was last approved • PolicyTech Policy		09/2028		• CPC 9/04/2025 • MEC 9/17/2025
Business Associate Policy	Akemi Renn, CHC, CHPC, CPC	• Up for review • No revisions since it was last approved		09/2028		• CPC 9/04/2025 • MEC 9/17/2025
Compliance Exclusion Screening Review Policy	Akemi Renn, CHC, CHPC, CPC	• Up for review • No revisions since it was last approved		09/2028		• CPC 9/04/2025 • MEC 9/17/2025
De-Identified Health Information Policy	Akemi Renn, CHC, CHPC, CPC	• Up for review • No revisions since it was last approved		09/2028		• CPC 9/04/2025 • MEC 9/17/2025
HIPAA Violation Sanctions Policy	Akemi Renn, CHC, CHPC, CPC	• Up for review • No revisions since it was last approved		09/2028		• CPC 9/04/2025 • MEC 9/17/2025
Privacy Use and Disclosure of Limited Data Set Policy	Akemi Renn, CHC, CHPC, CPC	• Up for review • No revisions since it was last approved		09/2028		• CPC 9/04/2025 • MEC 9/17/2025
Uses and Disclosure Based on Public Policy Which Do Not Require the Patients Authorization Policy	Akemi Renn, CHC, CHPC, CPC	• Up for review • No revisions since it was last approved		09/2028		• CPC 9/04/2025 • MEC 9/17/2025

Alameda Health System			CPC Executive Summary to AHS and AH Medical Executive Committee(s) - August 2025			
Policies and Procedures				Chairs: Kelley Bullard, MD & Wacheera Davis, DNP, MSN, BSN, RN, MBA		
TOPIC or TITLE OF POLICY	**Document Owners**	**Summary of Changes**	**Last Approved Date**	**Next review date after BOT approval**	**Purpose**	**History of Review Committee**
HR: Sexual Harassment Policy	Akemi Renn, CHC, CHPC, CPC Arleen Gomez	• Moved to new Policy Template • Added References & Scope • Updated who to contact since Director of HR is not a current position • No updates to actual language of the policy		09/2028		• CPC 9/04/2025 • MEC 9/17/2025
Blood Borne Pathogen Exposure Control Plan	Deborah Ellis, PhD, MPH, CIC, CPHQ, FACHE	• Revised • Approved by IPC		09/2028		• CPC 9/04/2025 • MEC 9/17/2025
Quality Improvement Work Policy: Primary Care - Adult Medicine and Pediatrics and Urgent Care	Porshia Mack, MD, MBA	• Document was discussed at the August meeting. • Bringing back to CPC for clarification		09/2028		• CPC 9/04/2025 • MEC 9/17/2025

ALAMEDA HEALTH SYSTEM

MEDICATION VERIFICATION AND PROFILE REVIEW

Site	Alameda Health System	***Previous Revision Dates***	
Effective Date	10/2025		
Document Owner	MGR SYS MED SAFETY-CLIN PHARM	***Next Scheduled Review***	10/2028
Approvals	BOT, QPSC		

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

PURPOSE

To ensure medication safety to patients through the verification of all medication orders prior to dispensing.

POLICY

All prescriptions or medication orders are reviewed by a pharmacist for appropriateness unless a licensed independent practitioner controls the ordering, preparation and administration of medications in an urgent situation when resulting delay would harm the patient.

PROCEDURE

Review and Verification of Prescriptions/Orders by pharmacists will include:

1. Pharmacists are required to review all details of a medication order including independent evaluation of clinical safety parameters that may influence medication appropriateness.
    a. Medication details include drug selection, dose, frequency, duration, dosage form to dispense, dispensing details and special administration notes.
    b. Clinical evaluation includes: previous doses administered, allergies, therapeutic duplications, labs, indications, renal and hepatic dose adjustments, drug interactions or drug-food interactions, and potential adverse effects
    c. In pharmacies not open 24 hours, review and verification of orders will be done remotely by offsite pharmacists.

2. Medication prescriptions or orders that are in question will be clarified with the prescriber prior to dispensing the medication and will be documented by the pharmacist in the EHR intervention system as either an i-vent or patient note.

3. Pharmacists will develop an urgent order decision tree to prioritize and evaluate as urgent medication orders including consistent prioritization of STAT orders.

4. In the case of an order which requires 1st and 2nd verification, both the 1st and 2nd verifying pharmacists must perform their own independent check of the order details as outlined above.

Medication Profiles

1. A medication profile is available in the electronic pharmacy system on all inpatients.

2. The information contained in the medication profile includes but not limited to: age, gender, current medication, pertinent diagnoses and conditions, pregnancy and lactation status, allergies and sensitivities.
3. Patient profiles are available on the electronic medical record on all inpatients where relevant lab values and vitals can be reviewed along with provider clinical notes.

Monitoring Effects on Patients

1. The pharmacist will monitor and assess the patient's medical records, relevant lab results, clinical response, and medication profile.

2. The pharmacist will notify the physician as appropriate of patient response and document changes to medication orders in the intervention section of the electronic pharmacy system.

3. D.U.E. (drug use evaluations) processes are in place to review specific "high-risk target drug therapies" on an ongoing basis.

REFERENCES

TJC Medication Management 01.01.01

APPROVALS

		System	Alameda	AHS/Highland/John George/San Leandro
Department	**Date:**	8/2025		
Pharmacy and Therapeutics (P&T)	**Date:**	8/2025		
Clinical Practice Council (CPC)	**Date:**	9/2025		
Medical Executive Committee	**Date:**	9/2025		
Board of Trustees	**Date:**	10/2025		

ALAMEDA HEALTH SYSTEM

BREACH NOTIFICATION POLICY

Department	Internal Audit and Compliance	***Effective Date***	05/2013
Campus	AHS System	***Date Revised***	02/2013, 09/2015, 09/2018, 07/2020, 8/2025
Category	Administrative	***Next Scheduled Review***	08/2028
Document Owner	Privacy and Regulatory Counsel	***Executive Responsible***	Vice President, Internal Audit and Compliance

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

PURPOSE

The purpose of this Breach Notification Policy is to provide guidance to Alameda Health System (AHS) workforce members for breach notification when an impermissible or unauthorized access, acquisition, use and/or disclosure of patient protected health information (PHI) occurs. Breach notification will be carried out in compliance with the American Recovery and Reinvestment Act (ARRA)/Health Information Technology for Economic and Clinical Health Act (HITECH) as well as any other federal or state notification law.

POLICY

AHS workforce members will maintain the privacy and security of patients' PHI consistent with AHS's policies and applicable laws and regulations. AHS's Compliance Department will notify the affected individual(s) and appropriate regulatory agencies when there is a breach of unsecured PHI unless AHS can demonstrate a low probability that the information has been compromised.

DEFINITION

Breach means the acquisition, access, use, or disclosure of PHI in a manner not permitted under HIPAA, which compromises the security or privacy of the PHI. Breach excludes:

1. Any unintentional acquisition, access, or use of PHI by a workforce member or person acting under the authority of a covered entity or business associate if such acquisition, access, or use was made in good faith and within the scope of authority and does not result in further use or disclosure in a manner not permitted under HIPAA.

2. Any inadvertent disclosure by a person who is authorized to access PHI at a covered entity or business associate to another person authorized to access PHI at the same covered entity or business associate, or organized health care arrangement in which the covered entity participates, and the information received as a result of such disclosure is not further used or disclosed in a manner not permitted under HIPAA.

3. A disclosure of PHI where a covered entity or business associate has a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information.

4. The use or disclosure involves PHI that has been "secured" according to standards published by HHS. This applies to electronic patient information that has been properly encrypted consistent with standards published by HHS.

Discovery of Breach means that a breach shall be treated as discovered as of the first day on which such breach is known to AHS or, by exercising reasonable diligence, would have been known to AHS or any person, other than the person committing the breach, who is a workforce member of AHS.

Protected Health Information (PHI) means individually identifiable health information that is transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium.

Unsecured Protected Health Information (Unsecured PHI) is PHI that has not been rendered unusable, unreadable, or indecipherable to unauthorized persons through the use of a technology or methodology specified by the Secretary of HHS in guidance.

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

PROCEDURE

1. **Mitigating Potential Breaches**. If a workforce member improperly accesses, acquires, uses or discloses PHI and immediate action may cure or mitigate the effects of such uses or disclosures, the workforce member should take such action. For example, if a workforce member improperly accesses or acquires PHI, they should immediately stop, close, and/or return the information. If a workforce member mistakenly discloses PHI to the wrong person, they should immediately request the return of the information and confirm that no further improper disclosures will be made. If the potential breach is significant or requires further action to mitigate its effects, the workforce member should immediately contact their supervisor and the Compliance Department for assistance and direction.

2. **Reporting Potential Breaches to the Compliance Department**. AHS workforce members shall immediately report any suspected breach of PHI in violation of the HIPAA Rules and AHS's privacy policies to the Compliance Department.

3. **Investigating Potential Breaches.** The Compliance Department shall promptly investigate any reported privacy breach or related complaint to determine whether there has been a "breach" of PHI as defined above, and if so, how notice should be given. To determine whether a breach has occurred, the Compliance Department shall consider:

a. Whether the alleged breach involved PHI, i.e., individually identifiable information concerning a patient's health, health care, or payment for health care, including financial or account information. (45 CFR § 164.402)
b. Whether the alleged breach violates the HIPAA privacy rule. Disclosures that are incidental to an otherwise permissible use or disclosure (*e.g.*, a patient overhears a physician speaking with another patient, or sees information about another patient on a whiteboard or sign-in sheet) do not violate the privacy rule so long as AHS implemented reasonable safeguards to avoid improper disclosures. (45 CFR § 164.502)
c. Whether there is a low probability that the PHI has been compromised considering relevant factors, including at least the following: (1) the nature and extent of the information involved; (2) the unauthorized person who used or received the information; (3) whether the information was actually acquired or viewed; and (4) the extent to which the risk to the information has been mitigated. (45 CFR § 164.402)
d. Whether the alleged breach fits within one of the exceptions identified in the Breach definition above. (45 CFR § 164.402)
e. The Compliance Department will document the investigation and conclusions, including facts relevant to the risk assessment. (45 CFR §§ 164.414 and 164.530)

4. **Notice – In General.** If the Compliance Department determines that a breach of unsecured PHI has occurred, the Compliance Department shall notify the individual(s), CDPH, HHS, and the media (if required) consistent with this Policy and the requirements of 45 CFR §§ 164.404- .408 et seq. Any notice provided pursuant to this Policy must be approved and provided by the Compliance Department.

5. Notice to Individuals.

I. **State**: Upon determination that breach notification is required, the Compliance Department shall notify the affected individual(s) or the individual's representative without unreasonable delay and in no case later than 15 business days after the breach is discovered based on California breach notification law (see Cal. Civ. Code § 1798.29(a)).

II. **Federal:** Upon determination that breach notification is required, the notice shall be made to individual(s) without unreasonable delay and in no case later than 60 calendar days after the discovery of the breach. It is the responsibility of AHS to demonstrate that all notifications were made as required, including evidence demonstrating the necessity of delay.

III. **Contents of Notification.** The notice shall be written in plain language and include to the extent possible:
1) a brief description of what happened (e.g. the date(s) of the breach and its discovery);
2) a description of the types of information affected (e.g., whether the breach involved names, social security numbers, birthdates, addresses, diagnoses, etc.);
3) steps that affected patients should take to protect themselves from potential harm resulting from the breach;
4) a brief description of what AHS is doing to investigate, mitigate, and protect against further harm or breaches; and

5) contact procedures for affected persons to ask questions and receive information, which includes a toll-free telephone number, an e-mail address, website, or postal address. (45 CFR § 164.404)

IV. Methods of Notification. The Compliance Department shall notify the individual by first-class mail to the individual's last known address or, if the individual agrees to electronic notice and such agreement has not been withdrawn, by electronic mail. The notification may be provided in one or more mailings as information is available. If the organization knows that the individual is deceased and has the address of the next of kin or personal representative of the individual, written notification by first-class mail to the next of kin or personal representative shall be carried out.

a. **Substitute Notice.** In the case where there is insufficient or out-of-date contact information (including a phone number, email address, etc.) that precludes direct written or electronic notification, a substitute form of notice reasonably provided to reach the individual shall be provided. A substitute notice need not be provided in the case in which there is insufficient or out-of-date contact information that precludes written notification to the next of kin or personal representative.
    1. **Fewer than 10 affected individuals.** In a case in which there is insufficient or out-of-date contact information for fewer than 10 individuals, then the substitute notice may be provided by an alternative form of written notice, telephone, or other means.
    2. **10 or more affected individuals.** In the case in which there is insufficient or out-of-date contact information for 10 or more individuals, then the substitute notice shall be in the form of either a conspicuous posting for a period of 90 days on the home page of AHS's website, or a conspicuous notice in a major print or broadcast media in AHS's geographic areas where the individuals affected by the breach likely reside. The notice shall include a toll-free number that remains active for at least 90 days where an individual can learn whether his or her PHI may be included in the breach.
b. If AHS determines that notification requires urgency because of possible imminent misuse of unsecured PHI, notification may be provided by telephone or other means, as appropriate in addition to the methods noted above.

6. **Notification to California Department of Public Health (CDPH).** AHS will notify CDPH as soon as possible without unreasonable delay, but in no case later than fifteen (15) business days of the discovery of the reportable breach. The CDPH Breach Incident Report notification will be sent via email to the appropriate CDPH district representative.

7. **Notification to the California Attorney General.** If the breach affected more than 500 California residents, the Compliance Department shall submit a single sample copy of the notice that excludes any PHI electronically to the Attorney General. The notice shall be submitted online at https://oag.ca.gov/ecrime/databreach/report-a-breach.

8. **Notification to Department of Health & Human Services (HHS).** If the Compliance Department determines that a breach of PHI has occurred, the Compliance Department will also notify HHS of the breach as described below.
    a. **Fewer than 500 Affected Individuals.** If the breach involves the PHI of fewer than 500 individuals, the Compliance Department may either 1) report the breach immediately to HHS or 2) maintain a log of the breaches and annually submit the log to HHS annually within 60 days of the end of the calendar year. (45 CFR § 164.408(c))
    b. **500 or More Affected Individuals.** If the breach involves 500 or more individuals, the Compliance Department will notify HHS of the breach at the same time the Compliance Department notifies the patient or next of kin. (45 CFR § 164.408(b))

9. **Notification to Media.** In the event the breach affects more than 500 residents of a state, prominent media outlets serving the state and regional area will be notified without unreasonable delay and in no case later than 60 calendar days after the discovery of the breach. The notice shall be provided in the form of a press release.

10. **Notification to Alameda Alliance.** In the event of a breach involving the following: (i) data provided by Alameda Alliance for Health (AAH) to AHS; (ii) data AHS creates for its own purposes from data that AHS received from AAH; or (iii) data that is created, received, transmitted or maintained by AHS on behalf of AAH, AHS shall provide AAH with information regarding the breach within twenty-one (21) calendar days, per the requirements of the BAA.

11. **Notification from Business Associates.** If AHS's business associate discovers a breach of PHI, the business associate shall immediately notify the Compliance Department of the breach. The business associate shall, to the extent possible, identify each individual whose information was breached and provide such other information needed by AHS to comply with this Policy and AHS's Business Associate Agreement.

12. **Delay of Notification Authorized for Law Enforcement Purposes**. If a law enforcement official states to AHS that a notification, notice, or posting would impede a criminal investigation or cause damage to national security, AHS shall:
    a. If the statement is in writing and specifies the time for which a delay is required, delay such notification, notice, or posting of the time period specified by the official; or
    b. If the statement is made orally, document the statement, including the identity of the official making the statement, and delay the notification, notice, or posting temporarily and no longer than 30 days from the date of the oral statement, unless a written statement as described above is submitted during that time.

13. **Workforce Training**. AHS will train all workforce members on the policies and procedures with respect to PHI as necessary and appropriate for the workforce members to carry out their job responsibilities. Workforce members shall also be trained as to how to identify and report suspected privacy breaches to the Compliance Department.

REFERENCES

1. 45 CFR PARTS 160 and 164
2. HITECH Act Section 13402
3. Cal. Civ. Code § 1798.29(a)

APPROVALS

		System	Alameda	AHS/Highland/John George/San Leandro
Department	**Date:**	N/A 8/2025	07/2020	07/2020
Pharmacy and Therapeutics (P&T)	**Date:**	N/A	N/A	N/A
Clinical Practice Council (CPC)	**Date:**	08/2020 9/2025	N/A	N/A
Medical Executive Committee	**Date:**	9/2025	08/2020	08/2020
Board of Trustees	**Date:**	09/2020 10/2025	N/A	N/A

Alameda Health System

BUSINESS ASSOCIATES

Department	All	***Effective Date***	12/2008
Campus	All	***Date Revised***	10/2011, 2/2013, 7/2016, 1/2020, 8/2025
Unit	All	***Next Scheduled Review***	8/2028
Manual	Administrative	***Author***	Privacy and Regulatory Counsel
Replaces the following Policies:		***Responsible Person***	VP, Internal Audit and Compliance

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

Policy

Alameda Health System (AHS) will obtain "satisfactory assurance" in the form of a written contract that AHS's business associates will appropriately safeguard and limit their access, use and disclosure of Protected Health Information (PHI) prior to AHS disclosing to or allowing such business associates to create or receive PHI without patients' authorization.

Definition

Business Associates

People or entities that perform, on behalf of a health care organization, a function regulated by HIPAA, especially including the use and disclosure of individually identifiable health information, or that provide to a health care organization legal, actuarial, accounting, consulting, data aggregation, management, administrative or accreditation services that involve the disclosure of individually identifiable health information.

Procedure

1. AHS will not disclose PHI to a business associate or permit a business associate to create or receive PHI on AHS's behalf unless the business associate has given AHS the requisite "satisfactory assurance" by written contract.
    a. Business Associate Agreement –-Prior to disclosing, creating or receiving PHI to a business associate on AHS's behalf, AHS will enter into a Business Associate Agreement (BAA) with that business associate. Such business associate contract should be approved in advance by Legal/Contracting Department.
    b. Minimum Necessary Disclosures–For disclosures to a business associate, except those related to AHS's treatment, payment, and health care operations, the information disclosed should be the minimum necessary to achieve the purpose of the disclosure. (See "Minimum Necessary Standard" policy).

2. Business Associate Responsibility—It is the responsibility of the Business Associate to implement and use formal policies and procedures that address appropriate

administrative, physical and technical safeguards to prevent any access, use or disclosure of the PHI other than uses and disclosures expressly provided for by the BAA. Business Associates must ensure that any agents, including subcontractors, to whom it provides PHI, agree in writing to the same restrictions and conditions that apply through the BAA to Business Associate with respect to such PHI and implement administrative, physical and technical safeguards. Business Associate shall implement and maintain sanctions against agents and subcontractors that violate such restrictions and conditions and shall mitigate the effects of any such violation, 45 C.F.R. Sections 164.530(f) and 164.530(e)(1).

3. Business Associate Material Non-Compliance–If AHS learns that a business associate has materially breached or violated the "satisfactory assurance" of its BAA with AHS, AHS must take prompt reasonable steps to see that the breach or violation is cured. If the business associate does not promptly and efficiently cure the breach or violation, AHS must terminate its contract with the business associate, or if contract termination is not feasible, report the business associate's breach or violation to HHS.
4.

5. AHS as a Business Associate–AHS will provide a covered entity with "satisfactory assurance" that AHS will appropriately safeguard PHI when AHS serves as a business associate of a covered entity. AHS will also restrict the access, use or disclosure of the PHI created by AHS or received for or from the covered entity to what is allowed by the BAA

References

45 C.F.R. Sections 160.103; 164.308(b); 164.501; 164.502(e)(2); 164.504(e)(1) [primary reference section]; 164.504(e)(2)(ii)(D); 164.524; 164.526; and 164.528.

Approvals

Departmental	**Date: 7/2016**
VP, Internal Audit and Compliance	**Date: 7/2016**
Clinical Practice Council	**Date: 9/2016, 9/2025**
Medical Executive Committee	**Date: 9/2016, 9/2025**
Board of Trustees	**Date: 11/2016, 10/2025**

Alameda Health System

Compliance Exclusion Screening Review Policy

Department	All	***Effective Date***	4/2018
Campus	All	***Date Revised***	12/2019, 8/2025
Unit	All	***Next Scheduled Review***	8/2028
Manual	All	***Author***	System Director Compliance
Replaces the following Policies:		***Responsible Person***	VP, Compliance & Internal Audit

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

Purpose

To ensure the accurate and timely completion of exclusion screenings against the required government exclusion lists and to establish a review and corrective action process for positive matches.

Background

1. The Department of Health and Human Service' Office of Inspector General (OIG) issued an Special Advisory bulletin on September 28, 1999 and a Federal Register Publication (FR Doc. 99-25427) on September 30, 1999 recommending health care providers to determine whether potential and current employees, physicians and contractors are excluded for participation in federal health care programs, including Medicare and Medicaid. On May 8, 2013, the OIG issued an Updated Special Advisory Bulletin on the Effect of Exclusion from Participation in Federal Health Care Programs which clarified the scope and expectations regarding the frequency of screening.

2. The Office of Inspector General has the authority to impose civil monetary penalties against excluded individuals and entities that seek reimbursement from federal health care programs and health care providers that employ or enter into contracts with excluded individuals to provide items or services to federal program beneficiaries.

Definitions

"Screened Person or Entity" means all AHS officers, directors, current employees, contractors, agents, practicing medical staff, allied health professionals, students, volunteers, or vendors.

"Ineligible Person or Entity" means an individual or entity (a) currently excluded, suspended, debarred, or otherwise ineligible to participate in Federally funded health care programs or in federal procurement or non-procurement programs or (b) that has been

convicted of a criminal offense that falls within the ambit of 42 USC § 1320a-7(a) but has not yet been excluded, debarred, suspended, or otherwise declared ineligible.

Ineligible Persons or Entities may include nurses, credentialed physicians or allied health practitioners, coders, students, residents, other staff (whether employed, contract or temporary), or vendors.

"Exclusion Lists" includes but is not limited to Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE), the System for Award Management (SAM), and applicable state Medicaid exclusion databases.

Policy

1) Alameda Health System ("AHS") shall not employ, contract with, accept referrals from or use the services of any Ineligible Persons.

2) AHS shall ensure that all Screened Person or Entities are screened against the Exclusion Lists.

3) Except as otherwise provided in this policy, AHS may accept a written representation affirming that a school has screened its own residents or students against the Exclusion Lists and that no resident or student who is performing a rotation at AHS is an Ineligible Person upon commencement of that rotation. In addition, AHS requires the school to notify the responsible department of any changes in the exclusion status that would render the student an Ineligible Person.

4) All Screened Persons shall disclose immediately to his or her supervisor, or other individual as designated in the relevant contract, any debarment, exclusion, suspension, or other event that makes that person or entity an Ineligible Person.

5) If any department unit of AHS receives notice that a Screened Person or Entity has become an Ineligible Person or Entity, the department unit shall immediately contact the Compliance Department and remove such Screened Person or Entity from their responsibilities and/or discontinue the use of their services.

6) The Compliance Department shall coordinate with appropriate department units to develop a corrective action plan to address any regulatory obligations, including refunding payments for the services of Ineligible Persons or Entities. Human Resources, the Office of General Counsel, and other departments may also be consulted about appropriate actions.

Procedure

1. Monthly Review of Exclusion Screening by the Compliance Department:

a. A database of the following information is obtained from the following sources:

#	Data	Source
1	Employees	HRIS
2	Medical Staff	Medical Staff Services
3	Volunteers	Volunteer Program
4	Non-Provider Contractors	Vizient
5	Rotation Students	HR Compliance
6	Nursing Students	Clinical Education
7	Board Members	Compliance
8	Non-Vizient Contractors	System Ancillary Support Operations
9	Vendors Paid > $10K	Accounts Payable

b. The data needed for exclusion screening validation includes, at a minimum: First Name, Last Name, Date of Birth, Social Security Number, and Address History. Because of the sensitive nature of this private data, Compliance takes measures to ensure that this information is secure, and only accessed by those with a valid need to know.

c. Once all databases are received, a consolidated worksheet is developed to upload into the Verify Comply system which is used to track the review and results of each AHS workforce member and vendor.

d. The following websites are reviewed for any potential matches to the database:

   i. U.S. HHS OIG List of Excluded Individuals and Entities (LEIE) http://exclusions.oig.hhs.gov/

   ii. U.S. GSA System for Award Management (SAM) https://www.sam.gov

   iii. U.S. Department of the Treasury Office of Foreign Assets Control (OFAC) Specially Designated Nationals (SDN) http://www.treasury.gov/resource-center/sanctions/SDN-List/Pages/default.aspx

   iv. California Department of Health Care Services Suspended and Ineligible Provider List http://files.medi-cal.ca.gov/pubsdoco/SandILanding.asp

   v. Other state databases as available within the Verify Comply tool.

e. If a match is confirmed, the relationship with that individual/entity will be discontinued immediately, and self disclosure of the issue will be evaluated by Compliance, in consultation with Legal, before reporting via the OIG Provider Self-Disclosure Protocol.

2. Human Resources shall conduct an exclusion screening during the hiring process according to HR procedures.

3. Medical Staff upon initial or reappointment of physicians or non-physician practitioners shall conduct an exclusion screening.

4. Contracting Department shall conduct an exclusion screening prior to contract signing to prevent engaging in business relationships with any ineligible individual/entity.

References

1. OIG Special Advisory Bulletin on the Effect of Exclusion from Participation in Federal Health Care Programs - UPDATED, May 8, 2013

2. OIG's Provider Self-Disclosure Protocol, April 17, 2013

3. Federal government and California web sites that track excluded individuals and entities:

    i. U.S. HHS OIG List of Excluded Individuals and Entities (LEIE) http://exclusions.oig.hhs.gov/
    ii. U.S. GSA System for Award Management (SAM) https://www.sam.gov
    iii. U.S. Department of the Treasury Office of Foreign Assets Control (OFAC) Specially Designated Nationals (SDN) http://www.treasury.gov/resource-center/sanctions/SDN-List/Pages/default.aspx
    iv. California Department of Health Care Services Suspended and Ineligible Provider List http://files.medi-cal.ca.gov/pubsdoco/SandILanding.asp
    v. Other state exclusion web sites, as applicable.

Approvals

Departmental	**Date: 8/2025**
CPC	**Date: 9/2025**
Medical Executive Committee	**Date: 9/2025**
Board of Trustees	**Date: 10/2025**

Alameda Health System

DE-IDENTIFIED HEALTH INFORMATION

Department	All	***Effective Date***	5/2013
Campus	All	***Date Revised***	2/2013, 7/2016, 8/2020, 8/2025
Unit	All	***Next Scheduled Review***	8/2028
Manual	Administrative	***Author***	Privacy and Regulatory Counsel
Replaces the following Policies:		***Responsible Person***	VP, Internal Audit and Compliance

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Policy

Requests for de-identified health information must be approved by the Compliance Department prior to release.

"Definitions:

De-identified Information: the HIPAA Privacy Rule provides the standard for de-identification of protected health information. Under this standard, health information is not individually identifiable if it does not identify an individual and if the covered entity has no reasonable basis to believe it can be used to identify an individual.

Procedure

1. Health information may be de-identified as follows:
    a. Creating de-identified health information–AHS may use protected health information and disclose it to a business associate to create de-identified health information.
    b. Scientific/Statistician de-identification–AHS may employ a statistical expert, with knowledge and experience in generally accepted statistical and scientific principles and methods for rendering information not personally identifiable, to determine and document that the risk is very small that health information AHS has had de-identified could not be used, alone or in combination with other reasonably available information, by an anticipated recipient to identify the individual who is its subject.
    c. "Safe harbor" de-identification–AHS may remove the following identifiers of the individual, relatives, employers and household members associated with the health information and consider the health information de-identified as long as AHS has no actual knowledge that the information stripped of these identifiers could be used, alone or in combination with other information, to identify the individual:
        i. Names;
        ii. Geographic subdivisions smaller than a State, including street address, city, county, precinct, zip code, and their equivalent geographical codes;
        iii. All elements of dates (except year) for dates directly related to an individual, including birth date, admission date, discharge date,

date of death, and all ages over 89 and all elements of dates (including year) indicative of such age;

iv. Telephone and fax numbers;
v. Electronic mail addresses;
vi. Social security, medical record, health plan beneficiary, and account numbers;
vii. Certificate or license numbers;
viii. Vehicle identifiers and serial numbers, including license plate numbers;
ix. Device identifiers (such as model numbers) and serial numbers;
x. Web universal resource locators (URLs) and internet protocol (IP) address numbers;
xi. Bio-metric identifiers, including finger and voice prints;
xii. Full face photographic images and any comparable images; and
xiii. Any other unique identifying number, characteristic or code (such as clinical trial record numbers).

d. Re-identification–Any code or means AHS may employ to permit re-identification should not be accessed, used or disclosed for any other purpose, should not be derived from or relate to any individual whose information has been de-identified, and should not be capable of being translated to identify an individual.

2. Requests for release of de-identified data should be submitted to the Compliance Department for review and approval. Requests should identify the recipient of the data and the purpose of providing data.

Reference

45 CFR Parts 164.514(a)

Approvals

Departmental	**Date: 7/2016**
VP, Internal Audit and Compliance	**Date: 7/2016**
Clinical Practice Council	**Date: 9/2016, 9/2025**
Medical Executive Committee	**Date: 9/2016, 9/2025**
Board of Trustees	**Date: 11/2016, 10/2025**

Alameda Health System

HIPAA VIOLATIONS SANCTIONS POLICY

Department	Compliance/Privacy	***Effective Date***	5/2013
Campus	AHS System	***Date Revised***	2/2013, 7/2016, 8/2018, 8/2021, 8/2025
Unit	All	***Next Scheduled Review***	08/2028
Manual	Administrative	***Author***	Privacy and Regulatory Counsel
Replaces the following Policies:		***Responsible Person***	VP, Internal Audit and

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

Purpose

This policy sets forth guidelines for enforcing the confidentiality of individually identifiable patient health information, also known as "Protected Health Information" ("PHI").

Background

Alameda Health System (AHS) follows HIPAA, HITECH and California law requirements in determining whether a breach of PHI occurred. These laws apply to the organization, as well as to all AHS workforce members.

There are consequences to the individual and the organization when we are not in compliance with Privacy laws. Federal and State Privacy laws impose civil fines up to $25,000 per violation to be paid by the employer, and criminal fines up to $250,000 to be paid by the employer and/or the individual employee. HITECH provides a tiered system for assessing the level of each HIPAA violation with penalties ranging from $100 to $50,000, not exceeding $1,500,000 in a calendar year. Some cases can also result in imprisonment of the offending employee up to one year for a standard violation. The criminal penalties increase to $100,000 and up to five years imprisonment of the offending employee if the wrongful conduct involves false pretenses, and to$250,000 and up to 10 years imprisonment of the offending employee if the wrongful conduct involves the intent to sell, transfer, or use identifiable health information for commercial advantage, personal gain or malicious harm. Additionally, violating AHS' policies can lead to disciplinary actions, up to and including termination.

Policy

AHS is committed to complying with State and Federal laws regarding the use and disclosure of protected health information. Alameda Health System's workforce member may not access, use, or disclose any protected health information except for the purpose of Treatment, Payment, or Health Care Operations, also known as "TPO" or unless expressly authorized by the patient or otherwise permitted or required by law.

Unauthorized individuals who attempt to access, use, disclose, and/or assist others to access PHI when it is not authorized, will be sanctioned appropriately. It is the policy of AHS to take appropriate disciplinary action against any AHS workforce member that violates AHS' privacy policies, in addition to state and federal confidentiality laws or regulations.

AHS will provide a confidential and non-retaliatory process for AHS workforce members to report potential violations to the laws and policies governing the privacy and confidentiality of health information. All AHS workforce members should only access, use and disclose PHI as necessary for their job duties.

Definition

AHS Workforce Member – consists of employees, contractors, medical staff, volunteers or any other individual who is working at AHS.

Authorized Access or Disclosure – access or disclosure of Protected Health Information that is necessary to support treatment, payment or business operations when authorized by the patient or as otherwise permitted by law.

Confidentiality of Medical Information Act (CMIA) – A state law that adds to the federal protection of personal medical records under the Health Information Portability and Accountability Act (HIPAA). CMIA protects the confidentiality of individually identifiable medical information.

Health Insurance Portability and Accountability Act (HIPAA) – A federal law that sets standards to protect the privacy and security for use and disclosure of patient health information.

Health Information Technology for Economic and Clinical Health Act (HITECH Act) - enacted to promote the adoption and meaningful use of health information technology. Subtitle D of the HITECH Act addresses and enhances the privacy and security protections associated with the electronic transmission of health information, in part, through several provisions that strengthen the civil and criminal enforcement of the HIPAA rules.

Protected Health Information (PHI) – is any element of personal information sufficient to allow identification of the individual, such as the patient's name, address, electronic mail address, telephone number, social security number, patient billing, health insurance information, or other information that alone or in combination with other publicly available information, reveals the individual's identity. Additionally, it is any individually identifiable health information that applies to a patient's past, present or future physical, mental health or condition.

Unauthorized Access or Disclosure – The inappropriate review or viewing of patient medical information without a direct need for diagnosis, treatment or other lawful use.

Violation – A violation is an act that is contrary to the meaning of HIPAA and AHS guidelines to guarantee the confidentiality of protected health information.

Procedure

A. Reporting a potential privacy-related violation
AHS workforce members must immediately report all alleged, apparent, or potential violations of confidentiality to his/her supervisor, the Compliance Department, or via the Compliance Hotline.

Compliance Department
Email: Compliance AHS (Global Address List)
Phone: (510) 535-7788

AHS Confidential Compliance Hotline
Compliance uses a third party vendor called Lighthouse Services for our hotline, which is available 24 hours a day, 7 days a week.

- Telephone:
  - English speaking: 844-310-0005
  - Spanish speaking: 800-216-1288
- Website: lighthouse-services.com/alamedahealthsystem
- E-mail: reports@lighthouse-services.com (must include AHS name with report)
- Fax: (215) 689-3885 (must include AHS name with report)

All AHS workforce members are responsible for reporting suspected violations of privacy laws or policies immediately, **but no later than 24 hours after discovery.** No employee will be subject to retaliation, retribution or harassment for reporting a potential violation of the law, regulation, or policies; whether anonymously or not. Should an employee not require anonymity, it is suggested they contact their immediate supervisor, and follow the chain-of- command for all reports or issues. Failure to report privacy violations will result in disciplinary action.

Upon receiving a report, the Compliance Department will immediately conduct a thorough investigation and coordinate corrective measures, as necessary. All reports will be handled confidentially.

B. Breach Notification – *see Breach Notification Process Policy*

C. Violations
The unauthorized access, use or disclosure of PHI is a privacy violation. State and Federal laws impose civil and/or criminal liability, including fines, on the organization and the workforce member who inappropriately accesses PHI. In addition, the workforce member may be subject to disciplinary action, up to and including termination.

There are two levels of privacy violations. The following list provides an outline of some, but not all, types of violations under each level.

Level 1 –unintentional violations include, but are not limited to:

a. Misdirecting faxes or emails that contain PHI
b. Discussing PHI in public areas where the public could overhear conversation
c. Leaving computer and/or documents with PHI unattended or in a non-secure area
d. Accidentally accessing the wrong patient medical record
e. Accidentally providing a patient's PHI to another patient

Level 2 –intentional violations include, but are not limited to:

a. Committing multiple (2 or more using a one year look back) Level 1 violations
b. Obtaining PHI under false pretenses
c. Access, use or disclosure of PHI without a job-related reason
d. Discussing PHI with any unauthorized individual
e. Requesting or assisting an individual in gaining unauthorized access to PHI
f. Sharing computer information, such as passwords, that allows others to access PHI
g. Using PHI for commercial or personal purposes
h. Falsifying information or failing to cooperate during a privacy investigation

D. Sanctions and Enforcement

Failure to comply with AHS' policies and procedures will result in disciplinary action. A Level 1 violation will result in a Final Reminder and a Level 2 violation will result in **immediate** termination. Compliance Department will collaborate with the Human Resources Department regarding appropriate disciplinary action. Results of the investigation and decision will be documented in writing and records will be retained in the employee's HR file.

Contractors/Vendors:

Failure of a contractor/vendor to follow any provisions of this policy or mitigate any unauthorized access, use or disclosure of PHI upon mutually agreeable terms may result in termination of the contract and/or vendor agreement.

References

45 CFR § 160.103
45 CFR § 164.308(1)(i)
45 CFR § 164.506(a)
45 CFR § 164.530 (e)(1)
Breach Notification Process Policy
California Health & Safety Code
1280.15
Compliance Non-Retaliation and Non-Retribution Policy
U.S. Department of Health & Human Services

Approvals

Departmental	**Date: 08/2018**
VP, Internal Audit and Compliance	**Date: 08/2018**
Clinical Practice Council	**Date: 08/2018, 9/2025**
Medical Executive Committee	**Date: 09/2018, 9/2025**
Board of Trustees	**Date: 10/2018, 10/2025**

Alameda Health System

PRIVACY: USE AND DISCLOSURE OF LIMITED DATA SET

Department	All	***Effective Date***	9/2003
Campus	All	***Date Revised***	12/2008, 2/2013, 11/2018, 8/2025
Unit	All	***Next Scheduled Review***	9/2028
Manual	Administrative	***Author***	Privacy Counsel
Replaces the following Policies:		***Responsible Person***	DIR, SYSTEM COMPLIANCE

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

Policy

Alameda Health System (AHS) will only access, use or disclose Protected Health Information in a Limited Data Set (as defined below) for research, public health and Health Care Operations purposes unless it has obtained an individual authorization or waiver of the authorization requirement regarding research that involves treatment. Further, AHS will access, use or disclose the Limited Data Set only pursuant to a valid Data Use Agreement (as defined below).

A "Limited Data Set" is Protected Health Information that excludes the following direct identifiers of the individual who is the subject of the Protected Health Information or a relative, employer or household member of the individual:

1. Names;
2. Postal address information, other than town, city, state or zip code;
3. Telephone numbers;
4. Fax numbers;
5. Electronic mail address;
6. Social Security numbers;
7. Medical record numbers;
8. Health plan beneficiary numbers;
9. Account numbers;
10. Certificate/license numbers;
11. Vehicle identifiers and serial numbers (including license plate numbers);
12. Device identifiers and serial numbers;
13. Web Universal Resource Locators (URLs);
14. Internet Protocol (IP) address numbers;
15. Biometric identifiers (including finger and voice prints); and
16. Full face photographic images and any comparable images.

Procedure

1. Requirements: AHS may access, use or disclose Protected Health Information in a Limited Data Set without an individual authorization or waiver or authorization, only when the following conditions are met:

a. Valid Purpose: The purpose(s) of the access, use or disclosure of the Limited Data Set is Research, public health or Health Care Operations; and
b. Data Use Agreement: AHS has entered into a valid Limited Data Set use agreement (the "Data Use Agreement") with the Limited Data Set recipient (the "Data User").
    -
c. Minimum Necessary Rule: AHS must limit the information disclosed pursuant to this Policy to the minimum necessary information needed for the Research, public health or Health Care Operations purposes specified in the Data Use Agreement.

References

45 CFR § 164.514(e)

Approvals

Departmental	**Date: 6/03, 2/2013**
General Counsel	**Date: 3/2013**
Clinical Practice Council	**9/2025**
Medical Executive Committee	**Date: 9/03, 3/2013, 9/2025**
Board of Trustees	**Date: 9/03, 5/2013, 10/2025**

Alameda Health System

USES AND DISCLOSURES BASED ON PUBLIC POLICY WHICH DO NOT REQUIRE THE PATIENT'S AUTHORIZATION

Department	All	***Effective Date***	9/03
Campus	All	***Date Revised***	4/03, 12/08, 2/2013, 11/2018,7/2022, 8/2025
Unit	All	***Next Scheduled Review***	9/2028
Manual	Administrative	***Author***	Privacy Counsel
Replaces the following Policies:		***Responsible Person***	VP Compliance & Internal Audit

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Policy

1. Under certain circumstances, the Privacy Rule permits the Alameda Health System (AHS) to access, use and disclose a patient's Protected Health Information without first obtaining the patient's Authorization pursuant to the Notification Policy based on public policy considerations, as detailed in this policy.
2. This policy does not apply to AHS's uses and disclosures of HIV/AIDS Related Information, Genetic Information, Venereal Disease Information or Tuberculosis Information.

Procedures

1. Uses and Disclosures Required by Law
    a. AHS may access, use or disclose Protected Health Information when required to do so by law; provided that the access, use or disclosure meets and is limited to the relevant requirements of such law.
    b. However, if such access, use or disclosure is covered under the categories of "Victims of Abuse, Neglect or Domestic Violence" (Section 3 below), "Judicial and Administrative Proceedings" (Section 5 below) or "Law Enforcement Officials" (Section 6 below), then AHS must meet the requirements of these sections as applicable.

2. Public Health Activities. AHS may disclose Protected Health Information for the following public health activities and purposes:
    a. to report Protected Health Information to public health authorities for the purpose of:
        i. preventing or controlling disease, injury or disability;
        ii. the conduct of public health surveillance, public health investigations, and public health interventions; or
        iii. at the direction of a public health authority, to an official of a foreign government agency that is acting in collaboration with a public health authority.
    b. to report child abuse and neglect to public health authorities or other government authorities authorized by law to receive such reports;

c. to report information to a person subject to the jurisdiction of the U.S. Food and Drug Administration ("FDA") about FDA-regulated products or activities for which that person has responsibility, for the purpose of activities related to the quality, safety or effectiveness of such FDA-regulated product or activity. Such purposes include:
    i. to collect or report adverse events (or similar activities with respect to food or dietary supplements), product defects or problems (including problems with the use or labeling of a product), or biological product deviations;
    ii. to track FDA-regulated products;
    iii. to enable product recalls, repairs or replacement, or lookback (including locating and notifying individuals who have received products that have been recalled, withdrawn, or are the subject of lookback); or
    iv. conduct post-marketing surveillance;
d. to alert a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition, if AHS is authorized by law to notify such person as necessary in the conduct of a public health intervention or investigation; or
e. to report information to the patient's employer if:
    i. AHS provides a health care service to the patient at the request of the employer either to (i) conduct an evaluation relating to medical surveillance of the workplace or (ii) evaluate whether the patient has a work-related illness or injury;
    ii. the Protected Health Information that is disclosed consists of findings concerning a work-related illness or injury or a workplace-related medical surveillance;
    iii. the employer needs such findings in order to comply with its obligations under OSHA or the Mine Safety and Health Act, or under any state law having a similar purpose, to record such illness or injury or to carry out responsibilities for workplace medical surveillance; and
    iv. AHS provides written notice to the patient that the Protected Health Information relating to the medical surveillance of the workplace and work-related illnesses and injuries is disclosed to the employer:
        - by giving a copy of the notice to the patient at the time the health care is provided; or
        - if the health care is provided on the worksite of the employer, by posting the notice in a prominent place at the location where the health care is provided.

3. <u>Victims of Abuse, Neglect or Domestic Violence</u>
    a. Except for child abuse reporting, covered under Section 2 above, AHS may disclose Protected Health Information about a patient whom AHS reasonably believes to be a victim of abuse, neglect or domestic violence under one of the three circumstances described below:
        i. If the patient agrees to the disclosure;
        ii. If AHS is *required* by law to make such disclosure; provided that the disclosure complies with and is limited to the relevant requirements of such law; or

iii. If AHS is expressly *permitted* by statute or regulation to make such disclosure and:
- AHS, in the exercise of professional judgment, believes the disclosure is necessary to prevent serious harm to the patient or other potential victims; or
- the patient is unable to agree to the disclosure because of incapacity, and a law enforcement or other public official authorized to receive the report represents that:
  - the PHI for which disclosure is sought is not intended to be used against the patient; and
  - an immediate enforcement activity that depends upon the disclosure would be materially and adversely affected by waiting until the patient is able to agree to the disclosure.

b. Such disclosures may only be made to a government authority authorized by law to receive reports of abuse, neglect or domestic violence.
c. AHS must inform the patient that a report has been (or will be) made, unless:
   i. AHS, in the exercise of professional judgment, believes informing the patient would place the patient at risk of serious harm; or
   ii. AHS would be informing a personal representative, and AHS reasonably believes the personal representative is responsible for the abuse, neglect or other injury, and that informing such person would not be in the best interests of the patient as determined by AHS, in the exercise of professional judgment.

4. Health Oversight Activities.
   a. AHS may disclose Protected Health Information to a health oversight agency for oversight activities authorized by law, including audits; civil, administrative or criminal investigations; inspections; licensure or disciplinary actions; civil, administrative or criminal proceedings or actions; or other activities necessary for appropriate oversight of:
      i. the health care system;
      ii. government benefit programs for which Protected Health Information is relevant to beneficiary eligibility;
      iii. entities subject to government regulatory programs for which Protected Health Information is necessary for determining compliance with program standards; or
      iv. entities subject to civil rights laws for which Protected Health Information is necessary for determining compliance.
   b. For purposes of this exception, a health oversight activity does not include an investigation or other activity in which the patient is the subject of the investigation or activity and such investigation/activity is not related to the receipt of health care, a claim for public benefits related to health, or qualification for, or receipt of, public benefits or services when a patient's health is integral to the claim for public benefits or services.

5. Judicial and Administrative Proceedings

a. AHS may disclose Protected Health Information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal, provided that AHS discloses only the information expressly authorized by such order.
b. AHS also may disclose Protected Health Information pertaining to the claim of an injured or deceased person in response to the request of (i) a person against whom the patient has commenced a lawsuit for compensation or damages for personal injuries or death resulting from personal injuries, (ii) such person's insurance carrier, (iii) the injured person who has asserted or is about to assert a claim for compensation or damages for personal injuries or death resulting from personal injuries, or (iv) such injured person's legal representative, if one of the following two conditions is true:
    i. AHS receives satisfactory assurance from the party seeking the information that reasonable efforts have been made by such party to ensure that the patient who is the subject of the requested Protected Health Information has been given notice of the request. AHS has received "satisfactory assurance" if it has received from the party seeking the information a written statement and accompanying documentation demonstrating that:
        - such party has made a good faith attempt to provide written notice to the patient (or if the patient's location is unknown, to mail a notice to the patient's last known address);
        - the notice included sufficient information about the litigation or proceeding in which the Protected Health Information is requested to permit the patient to raise an objection to the court or administrative tribunal; and
        - the time for the patient to raise objections to the court or administrative tribunal has elapsed and (a) no objections were filed, or (b) all objections filed by the patient have been resolved by the court or the administrative tribunal and the disclosures being sought are consistent with such resolution.
    ii. AHS receives satisfactory assurance from the party seeking the information that reasonable efforts have been made by such party to secure a qualified protective order (i.e., an order of a court or of an administrative tribunal or a stipulation by the parties to the litigation or administrative proceeding that (i) prohibits the parties from using or disclosing the information for any purpose other than the litigation or proceeding for which such information was requested, and (ii) requires the return to AHS or the destruction of the information and all copies thereof at the end of the litigation or proceeding). AHS has received "satisfactory assurance" if it has received from the party seeking the information a written statement and accompanying documentation demonstrating that:
        - the parties to the dispute giving rise to the request for information have agreed to a qualified protective order and have presented it to the court or administrative tribunal with jurisdiction over the dispute; or
        - the party seeking the Protected Health Information has requested a qualified protective order from such court or administrative tribunal.

c. AHS also may disclose Protected Health Information pertaining to the claim of an injured or deceased person in response to the request of a person specified in Section 5.b. above, without receiving satisfactory assurance from the requesting party, if AHS makes reasonable efforts to provide notice to the patient (in the manner prescribed by Sections 5.b.1) above) or to seek a qualified protective order (in the manner prescribed by Section 5.b.1) above).

6. Law Enforcement Officials.
   a. AHS may disclose Protected Health Information for a law enforcement purpose to a law enforcement official under the following circumstances:
      i. as required by law, including laws that require the reporting of certain types of wounds or other physical injuries;
      ii. in compliance with and as limited by the relevant requirements of:
         - a court order or court-ordered warrant, or a subpoena or summons issued by a judicial officer;
         - a grand jury subpoena;
         - an administrative request, including an administrative subpoena or summons, a civil or an authorized investigative demand, or similar process authorized under law, provided that:
            - the information sought is relevant and material to a legitimate law enforcement inquiry;
            - the request is specific and limited in scope to the extent reasonably practicable in light of the purpose for which the information is sought; and
            - the identified information could not reasonably be used.
   b. In response to a law enforcement official's request for information about a patient who is or is suspected to be a victim of a crime, AHS may disclose Protected Health Information provided:
      i. the disclosures are not authorized by, and subject to the conditions regarding public health activities under Section 2 of this policy or victims of abuse, neglect or domestic violence under Section 3 of this policy; and
      ii. the patient agrees to the disclosure, or AHS is unable to obtain the patient's agreement because of incapacity or other emergency circumstance. If AHS is unable to obtain the patient's agreement because of incapacity or other emergency circumstance, then the following three conditions must be met:
         - the law enforcement official represents that such information is needed to determine whether a violation of law by a person other than the victim has occurred, and such information is not intended to be used against the victim;
         - the law enforcement official represents that immediate law enforcement activity that depends upon the disclosure would be materially and adversely affected by waiting until the patient is able to agree to the disclosure; and
         - the disclosure is in the best interests of the patient as determined by an AHS physician, in the exercise of professional judgment, taking into account the risk of further harm to the patient.

c. AHS may disclose Protected Health Information about a patient who has died to a law enforcement official for the purpose of alerting law enforcement of the death of the patient if AHS has a suspicion that the death may have resulted from criminal conduct.
d. AHS may disclose to law enforcement official Protected Health Information that AHS believes in good faith constitutes evidence of criminal conduct that occurred on the premises of AHS.
e. If AHS furnishes emergency health care in response to a medical emergency, other than on AHS's premises, AHS may disclose Protected Health Information to a law enforcement official if: disclosure appears necessary to alert law enforcement to:
    i. the commission and nature of a crime;
    ii. the location of such crime or of the victim(s) of such crime; and
    iii. the identity, description and location of the perpetrator of such crime.

7. Decedents
    a. AHS may disclose Protected Health Information to a medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law. AHS may disclose Protected Health Information to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent. If necessary for funeral directors to carry out their duties, AHS may disclose the Protected Health Information prior, and in reasonable anticipation of, the patient's death.

8. Organ and Tissue Procurement
    a. AHS may disclose Protected Health Information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of cadaveric organs, eyes, or tissue for the purpose of facilitating organ, eye or tissue donation and transplantation. This exception does not allow disclosures in connection with live donor activities. In live donor situations, an authorization will be required.

9. Research
    a. AHS may access, use or disclose Protected Health Information without the patient's authorization only in accordance with the Patient's Right to Access Protected Health Information Policy.

10. Specialized Government Functions
    a. Military and Veterans Activities
        i. AHS may access, use and disclose the Protected Health Information of the patients who are Armed Forces personnel for activities deemed necessary by appropriate military command authorities to assure the proper execution of the military mission, if the appropriate military authority has published by notice in the Federal Register the following information:
            - appropriate military command authorities; and
            - the purposes for which the Protected Health Information may be used or disclosed.

ii. AHS may access, use and disclose the Protected Health Information of patients who are foreign military personnel to their appropriate foreign military authority for the same purposes for which uses and disclosure are permitted for Armed Forces personnel.
iii. Other accesses, uses and disclosures regarding such patients are subject to the general HIPAA privacy requirements addressed in these policies.

b. National Security and Intelligence Activities -- AHS may disclose Protected Health Information to authorized federal officials for the conduct of lawful intelligence, counter-intelligence, and other national security activities authorized by the National Security Act and implementing authority (for example, Executive Order 12333).
c. Protective Services for the President and Others -- AHS may disclose Protected Health Information to authorized federal officials for the provisions of protective services to the President or other persons as authorized by 18 U.S.C. § 3056, or to foreign heads of state or other persons authorized by 22 U.S.C. § 2709(a)(3), or for the conduct of investigations authorized by 18 U.S.C. §§ 871 and 879.

11. Correctional Institutions

a. AHS may disclose Protected Health Information about an inmate or other individual to a correctional institution or a law enforcement official having lawful custody of an inmate or other individual if the correctional institution or such law enforcement official represents that such Protected Health Information is necessary for:
   i. the provision of health care to such individuals;
   ii. the health and safety of such individual or other inmates;
   iii. the health and safety of such individuals and officers or other persons responsible for the transporting of inmates or their transfer from one institution, facility or setting to another;
   iv. law enforcement on the premises of the correctional institution; or
   v. the administration and maintenance of the safety, security and good order of the correctional institution.

12. Workers' Compensation

AHS may disclose Protected Health Information as authorized by, and to the extent necessary to comply with, laws relating to workers' compensation or other similar programs.

References

45 C.F.R. Part 164.512

Approvals

Departmental	**Date: 4/03, 2/2013**
General Counsel	**Date: 3/2013**
Clinical Practice Counsel	**Date: 9/2025**
Medical Executive Committee	**Date: 6/03, 3/2013, 9/2025**
Board of Trustees	**Date: 9/03, 5/2013, 10/2025**

	Policy	
ALAMEDA HEALTH SYSTEM	**BLOODBORNE PATHOGEN EXPOSURE PREVENTION AND CONTROL PLAN**	**Reference # tbd**
	Level ☐ System ☐ Site	**Effective Date:** 6/2012 **Last Review Date**: 5/2012, 1/2013, 1/2014, 7/2015, 7/2025 ***Next Scheduled Review 7/2026***
	Document Owner: Infection Prevention and Control	***Executive Responsible*** Vice-President, Quality

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Contents

I. Background

The California Department of Industrial Relations ("Cal OSHA") Bloodborne Pathogen (BBP) Standard is a series of regulations to protect workers from contracting disease through direct contact

with contaminated blood and other potentially infectious materials1 ("OPIM").
The Bloodborne Pathogens standard requires employers to protect those employees reasonably at risk (employer designated medical care providers and other employees who are assigned responsibility for responding to incidents involving blood or OPIM) from exposure to bloodborne pathogens.

II. Purpose

a. Eliminate or minimize employee occupational exposure to blood or certain other body fluids.
b. Comply with the Cal/OSHA Bloodborne Pathogens Standard, California Code of Regulations, Title 8, Section 5193.

III. Definitions

Blood

The human blood, human blood components, and products made from human blood

Bloodborne Pathogens (BBP)

The pathogenic microorganisms that are present in human blood and can cause disease in humans. These pathogens include, but are not limited to, hepatitis B virus (HBV), hepatitis C virus (HCV), and human immunodeficiency virus (HIV).

Bloodborne Pathogen exposure (BBPE)

A bloodborne pathogen exposure occurs when a person comes into contact with blood or other potentially infectious materials (OPIM) that contain microorganisms capable of causing disease

Engineering and Work Practice Controls

Engineering controls aim to physically isolate or eliminate workplace hazards using equipment or technology. (e.g., sharps disposal containers, needleless systems and sharps with engineered sharps injury protection)

Work practice controls focus on modifying how tasks are performed to reduce exposure. Essentially (e.g., prohibiting recapping of needles by a two-handed technique and use of patient-handling techniques).
Engineering controls address the hazard, and work practice controls address the worker's behavior.

Engineered Sharps Injury Protection

A physical attribute built into a needle device used for withdrawing body fluids, accessing a vein or artery, or administering medications or other fluids, which effectively reduces the risk of an exposure incident by a mechanism such as barrier creation, blunting, encapsulation, withdrawal or other effective mechanisms; or
A physical attribute built into any other type of needle device, or into a non-needle sharp, which effectively reduces the risk of an exposure incident.

Exposure Incident

A specific eye, mouth, other mucous membrane, non-intact skin, or parenteral contact with blood or other potentially infectious materials that results from the performance of an employee's duties.

Needle or Needle Device

A needle of any type, including, but not limited to, solid and hollow-bore needles.

Needleless system

A device that does not utilize needles for the withdrawal of body fluids after initial venous or arterial

access is established or administration of medication or fluids;

Occupational Exposure

Reasonably anticipated skin, eye, mucous membrane, or parenteral contact with blood or other potentially infectious materials that may result from the performance of an employee's duties.

One-Hand Technique

A procedure wherein the needle of a reusable syringe is capped in a sterile manner during use. The technique employed shall require the use of only the hand holding the syringe so that the free hand is not exposed to the uncapped needle.

Other Potentially Infectious Materials (OPIMs)

a) The following human body fluids: semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, pericardial fluid, peritoneal fluid, amniotic fluid, saliva in dental procedures, and other body fluid that is visibly contaminated with blood such as saliva or vomitus, and all body fluids in situations where it is difficult or impossible to differentiate between body fluids such as in an emergency response.
b) Any unfixed tissue or organ (other than intact skin) from a human (living or dead); and
c) Any of the following, if known or reasonably likely to contain or be infected with *Human Immunodeficiency virus* (HIV), *Hepatitis B virus* (HBV), or Hepatitis *C virus* (HCV):
    - Cell, tissue, or organ cultures from humans or experimental animals
    - Blood, organs, or other tissues from experimental animals; or
    - Culture medium or other solutions.

Parenteral Contact

A piercing mucous membranes or the skin barrier through such events as needlesticks, human bites, cuts, and abrasions.

Regulated Waste

The waste that is intended to be disposed of and contains or consists of any of the following:

a) Liquid or semi-liquid blood or OPIMs;
b) Contaminated items that:
    - contain liquid or semi-liquid blood, or
    - are caked with dried blood or OPIMs; and
    - are capable of releasing these materials when handled or compressed.
c) Contaminated sharps.
d) Pathological and microbiological wastes containing blood or OPIMs

Sharp object, Sharp Injury, Sharp Injury Log

Sharp object used or encountered in the industries covered by subsection (a) that can be reasonably anticipated to penetrate the skin or any other part of the body, and to result in an exposure incident, including, but not limited to, needle devices, scalpels, lancets, broken glass, broken capillary tubes, exposed ends of dental wires and dental knives, drills and burs.

Sharp injury caused by a sharp, including, but not limited to, cuts, abrasions, or needlesticks.

Sharp injury log is a written or electronic record of each exposure incident involving a sharp and is required by OSHA Bloodborne Pathogens Standard (29 CFR 1910.1030(h)(5)(i)). The purpose is to generate a record of exposure incidents in the employer's facility that will include enough information about the cause of the incidents to allow the employer to analyze them and take preventive action. The

Sharps Injury Log must be maintained for five (5) years from the date of the occurrence of the exposure incident and must be made available to employees and their representative, to the Chief of the Division of Occupational Safety and Health, to the California Department of Health Services, and to the Director of the National Institute for Occupational Safety and Health (NIOSH).

- The minimum requirement is as follows:
    - Type and brand of device involved: If known, the log should specify the type of sharps device (e.g., syringe, scalpel) and its brand name that caused the injury.
    - Department or work area: The location within the facility where the injury occurred should be recorded.
    - Explanation of how the incident occurred: A brief description of the incident, including the procedure being performed, the action causing the injury, and the body part involved.

Additional information often included:

- The date and time of the sharps-related exposure incident;
- The type and brand of the sharp involved in the incident; and
- A description of the incident including:
    i. The job classification of the exposed employee;
    ii. The department or work area where the incident occurred;
    iii. The procedure being performed;
    iv. How the incident occurred;
    v. The body part injured;
    vi. For sharps with engineered sharps injury protection or ESIP, if the safety mechanism was activated; and
    vii. If the incident occurred before action, during activation or after activation of the mechanism; for sharps without ESIP, the employee's opinion if ESIP could have prevented the injury.

Source Individual

Any individual, living or dead, whose blood or OPIM may be a source of occupational exposure to the employee. Examples include, but are not limited to, hospital and clinic patients; clients in institutions for the developmentally disabled; trauma victims; clients of drug and alcohol treatment facilities; residents of hospices and nursing homes; human remains; and individuals who donate or sell blood or blood components.

CDC Approaches to BBPE prevention and control

a) Universal precautions (UP)

Originally recommended by the CDC in the 1980s, was introduced as an approach to infection control to protect workers from HIV, HBV, and other bloodborne pathogens in human blood and certain other body fluids, regardless of a patients' infection status.[2] UP is an approach to infection control in which all human blood and certain human body fluids are treated as if they are known to be infectious. ***Although the BBP standard incorporates UP, the infection control community no longer uses UP on its own.***

b) Standard precautions (SP)

SP was introduced in 1996 in the CDC/Healthcare Infection Control and Prevention Advisory Committee's "1996 Guideline for Isolation Precautions in Hospitals," added additional infection prevention elements to UP in order to protect healthcare workers not only from pathogens in human blood and certain other body fluids, but also pathogens present in body fluids to which UP does not

apply. SP includes hand hygiene; the use of certain types of PPE based on anticipated exposure; safe injection practices; and safe management of contaminated equipment and other items in the patient environment. ***SP is applied to all patients even when they are not known or suspected to be infectious.***

IV. AHS Employee Risk Categories Based On The Job Classification

4.1 Risk category I

All employees in but not limited to the following job classifications who have consistent possibility of exposure to blood or other potentially infectious material (OPIM) while performing regular duties.

Department	Job Classifications of Risk Category I
Acupuncture	Acupuncturist
Anesthesiology	1. Nurse Anesthetist Surgical Technician Anesthesia Technician
Central Supply	2. Central Supply Technician
Clinical Laboratory	3. Clinical Lab Clinical Lab Technician Clinical Lab Scientists Lab Assistants Clinical Lab Operations Manager Clinical Lab Scientists 4. Lab Assistants Morgue Attendant 5. Chief Clinical Lab Scientist Pathologist
Cardiology	6. Electrocardiograph Tech Chief Cardiology Tech Cardiology Tech
Dental Clinic	7. Dental Assistant Sup. Dental Assistant Dentist 8. Oral Surgeon
Electroencephalography	9. EEG Tech II
Environmental Services	10. Hospital Maintenance Porter Housekeeping Worker Housekeeping Services Worker Housekeeping Supervisor Housekeeper
Nursing	11. Medical Clerk - Unit Mid-level Practitioner Nurse Intern 12. CN I CN II CN III CN IV CN V LVN 13. Employee Health Nurse Employee Health Manager Director of Nursing Certified Nurse Mid-Wife Nursing Assistant 14. Surgical Attendant Orthopedic Technician Clinical Nurse Specialist Clinical Instructor 15. Public Health Nurse Assistant II Public Health Nurse 16. Medical Assistant GI Technician
Physicians	17. Staff Physician Physician-Resident, Physician-Podiatrist 18. Mid-Level Practitioner
Psychiatry	19. Psychiatric Tech
Radiology	20. Radiology Technologist Supervising Radiology Tech Chief Radiology Tech
	21. Sonographer MRI Tech 22. Mamo/Quality Assurance Tech

Respiratory	23. Respiratory Care Practitioners Inhalation Therapy Aide 24. Chief Respiratory Therapist Supervising Respiratory Care Practitioner 25. Pulmonary Function Tech Respiratory Therapist
Speech Pathology/Audiology	26. Speech Language Pathologist Audiologist
Vascular Diagnostic	27. Cardiovascular Technician

4.2 Risk category II

Employees in (but not limited to) the following job classifications who have possible exposure to blood or (OPIM).

Department	Job Classifications of Risk Category II
Engineering	Chief Engineer Boiler Operator Plumber Building Maintenance Laborer Building Equip Maintenance Worker Electrician Stationary Engineer
Clinical Lab	Specialist Clerk Medical Clerk Supervising Clerk Secretary
Food and Nutrition	Food Service Worker Services Sr. Food Service Worker Sup. Food Service Worker Dietician Nutrition Assistant Diet Clerk
Social Services	Medical Social Worker Psychiatric Social Worker Substance Abuse Counselor Community Outreach Worker Rehabilitation Counselor Rehab Admissions Coordinator Mental Health Specialist Marriage/Family Child Counselor Chaplain
Translation Services	Medical Translator Medical Translator/Interpreter

4.3 Risk category III

Unlikely to have exposure to blood or (OPIMs) while performing regular job duties. Example; mailroom, medical records, business office, cashier.

V. Responsible Personnel

Position/Committee Responsible	Responsibilities
Infection Prevention and Control Department (IP)	1. The facility's IP manager/director is the BBPE plan's "administrator" and is responsible for the establishment, implementation, and maintenance of the BBPE plan and infection prevention and control procedures. 2. Oversee implementation of the Cal-OSHA standards in a timely manner. 3. Review, evaluate, update and approve BBPE Control Plan.
Employee Health Services (EHS)	1. Collaborate and support the implementation of BBP exposure control plan 2. Organize Sharps Safety Sub-Committee to collaborate and consult with other departments and stakeholders to ensure a comprehensive approach to bloodborne pathogen control 3. Manage post-exposure evaluation and follow-up 4. Ensure affected employees receive **medical evaluations** and **post-exposure prophylaxis**. 5. Maintain accurate records of employee's vaccinations, exposure incidents, and post-exposure medical evaluation and follow-up 6. Identify training opportunities and collaborate with stakeholders to ensure safe work practices
Human Resources Department	1. Update employee newly designed job classifications, including job duties and responsibilities as changes occur. 2. Oversee employee annual competency in all departments and maintain records of such training. 3. Supports compliance with **OSHA regulations** regarding employee rights and safety.
Nursing Clinical Education Department	1. Oversee both new nurse orientation and ongoing professional development programs 2. In-service education on various topics relevant to nursing practice, including new procedures, technologies, and evidence-based guidelines to ensure safe work practices
Environmental Health and Safety Department (Environmental of Care Department formerly)	1. Ensure proper cleaning, disinfection, and waste disposal procedures to prevent the spread of infections 2. EVS staff must be trained in safe handling of sharps, the use of personal protective equipment (PPE), and the proper disposal of regulated waste. 3. Participate in exposure incident investigations and report any potential exposures 4. Ensure regulated waste must be disposed of according to **medical waste management regulations** (specifically under California's **Medical Waste Management Act**) and maintain **waste disposal records**
Supply Chain Management **Value Analysis Committee (VAC)**	1. Ensuring the availability of necessary supplies and equipment to minimize exposure risks 2. Stay current with the latest advancements and safer medical devices in evaluating their feasibility for implementation in the workplace
Engineering Department	1. Inspect and maintain equipment regularly to ensure that equipment like sharps disposal containers, biosafety cabinets, and needleless systems are in place and functioning correctly

Position/Committee Responsible	Responsibilities
Laboratory Department	1. Laboratory Safety Policies & Procedures on BBPE 2. Coordinate post-exposure follow-up and reporting procedures 3. Ensure training is provided to all lab personnel
Department Managers	1. Identifying new tasks or procedures with potential for occupational exposure to blood or other infectious material and submit in writing to have Employee Health Services (EHS) review the potential for occupational exposure. 2. Ensure employee compliance with policies and procedures 3. Report and document noncompliance for taking disciplinary action; incorporate employee compliance into the performance evaluation process. 4. Ensure that employees who may be occupationally exposed to BBP receive: a. BBPE prevention training initially and annually. b. Appropriate and accessible personal protective equipment (PPE). c. Training on the use of engineering controls for BBP 5. Review new and current work practices for potential occupational exposure to BBP. 6. Ensure the availability of equipment and tools that are required to implement the work practice controls.
All employees, physicians, contractors, and volunteers	1. Follow Standard precautions—treat all blood/OPIM as if infectious. 2. Use personal protective equipment (PPE) such as gloves, gowns, and face shields. 3. Adhere to safe handling and disposal of sharps and other biohazardous materials. 4. Participate in vaccination programs, especially for Hepatitis B if applicable. 5. Report any exposure incidents immediately to supervisors and Employee Health.
Chief Executive Officer or another Designee Officer	Ensure, to the best of authority and ability, that there are adequate resources available for developing and implementing the BBP Exposure Control Plan for AHS.

VI. Methods of Compliance

6.1 Engineering Control – Specific requirements

Engineering controls means controls (e.g., sharps disposal containers, needleless systems, and sharps with engineered sharps injury protection) that isolate or remove the bloodborne pathogen hazard from the workplace.

Technology	AHS Practices	Device Example
a) Needleless system Refers to a device or system used for the collection of bodily fluids, medication delivery, or fluid administration that does not use needles for access	(1) withdrawal of body fluids after initial venous or arterial access is established; (2) administration of medication or fluids; performance of any other procedure involving the potential for an exposure incident	– **IV connectors and ports with Luer-lock** or luer-activated mechanisms. – **Jet injectors** (which use high pressure to deliver medication through the skin). – **Blunt cannulas** for withdrawing medication from vials. – **Vacuum collection systems** for blood draws (e.g., butterfly systems with protected or retractable needles for initial draw, followed by needleless transfer).
b) Engineered sharps injury protection (ESIP) Refers to a device that has characteristics: Built-in safety mechanisms: Part of the device design—not add-on accessories. Protect users from accidental contact with contaminated needles. **Engineered sharps injury protection (ESIP)** is designed to activate after or during use, often without requiring extra steps.	(1) accessing a vein or artery (2) withdrawal of body fluids after initial venous or arterial access is established; (3) administration of medication or fluids; (4) performance of any other procedure involving the potential for an exposure incident.	– **Retractable needles:** Needle withdraws into the barrel after injection. – **Self-sheathing needles:** A sheath automatically or manually covers the needle after use. – **Blunt-tip or blunt cannula devices:** Replaces sharp needles in some applications. – – **Needles with hinged safety caps:** Caps snap over the needle after use to prevent exposure.
c) **Non-needle sharps** Any sharp objects or instruments that are not needles but still pose a risk for punctures, cuts, or other injuries that could result in exposure to bloodborne pathogens **Importance:** Even though they don't have needles, they can still pose significant health risks.	**Safety and Handling:** (1) **Use of puncture-resistant containers** for disposal. (2) **Personal protective equipment (PPE)** like gloves and face shields should be worn when handling non-needle sharps. (3) **Avoid hand-to-hand transfer** of sharp instruments to minimize risk.	– **Scalpel blades:** Small, sharp blades used in surgical procedures or dissections. – **Surgical instruments:** Scissors, forceps, or other tools with sharp edges. – **Staples:** Used in surgical procedures or medical dressings. – **Glass slides:** Often used in laboratories for microscopy. – **Broken glassware:** Laboratory containers or vials that can break and create sharp edges. – **Lancets:** Devices used for obtaining small blood samples (e.g., for glucose testing). – **Pipettes:** may break or be used with sharp tips.

6.2 Engineering Control - Exceptions to the use circumstances

Engineering controls (i.e., needleless systems or engineered sharps injury protection for needle devices or non-needle sharps) must be used to prevent sharps injuries *except in circumstances where the engineering control:*

(1) Is not available in the marketplace.

(2) Jeopardizes the patient's safety or the success of a medical, dental, or nursing procedure as determined by the health care professional caring for the patient.

(3) Is not more effective than the control currently in use.

(4) Lacks the necessary safety performance information.

6.3 Work Practice Control – Mandatory Practices

Both Cal OSHA and the CDC emphasize work practice controls as a key part of preventing bloodborne pathogen exposure. These controls focus on modifying work procedures to reduce the risk of exposure, such as using safer medical devices and preventing needle sticks. Key work practice controls include implementing Standard Precautions, avoiding needle sticks, and proper handling of sharps.

Standard Precautions

Treat all blood and potentially infectious materials as if they are infectious: This proactive approach helps prevent exposure to unknown pathogens.

i. Implement a comprehensive Exposure Control Plan (ECP): This plan outlines procedures for minimizing exposure, handling incidents, and providing training.

ii. Use Personal Protective Equipment (PPE): Wear appropriate gloves, gowns, masks, and eye protection to create a barrier against exposure.

iii. Hand Hygiene: Wash hands thoroughly after patient care, removing PPE, or when potentially contaminated

iv. For more information, prefer to AHS Standard Precautions and Hand Hygiene, link *HAND HYGIENE v.5*

Preventing Needle Sticks and Sharps Injuries

v. **Use engineering controls:** Utilize devices like self-sheathing needles, needleless systems, and sharps disposal containers to minimize the risk of needle sticks and sharps injuries, says OSHA.

vi. **Follow proper sharps disposal procedures:** Dispose of sharps immediately and properly in designated containers.

vii. **Avoid recapping needles with two hands:** Use one-handed recapping techniques or avoid recapping altogether.

Establish clear procedures for handling and disposing of contaminated waste: For cleaning procedures, prefer to AHS Environmental Services Training and Cleaning Manual policy on PolyTech, link *ENVIRONMENTAL SERVICES TRAINING AND CLEANING MANUAL v.1*

6.4 Work Practice Control – Prohibited Practices

i. Storing food and drinks in refrigerators, freezers, cabinets, on shelves, countertops, or benchtops where blood or OPIM is present

ii. Eating, drinking, smoking, applying cosmetics or lip balm, and handling contact lenses in an area where there is a reasonable likelihood of occupational exposure

iii. Shearing or breaking of contaminated needles and other sharps

iv. Bending, recapping, or removal of contaminated sharps from devices *except when:*

- The procedure is performed using a mechanical device or a one-handed technique; *and*

- It can be demonstrated that there is no feasible alternative or that a specific medical or dental procedure requires such actions.

v. Storing or processing of sharps contaminated blood and OPIM in a way that requires employees' hands to reach into contaminated containers

vi. Reusing disposable sharps

vii. Picking up contaminated broken glassware by hand. Instead, mechanical means (dustpan and brush, tongs, or forceps) are required for cleanup activities.

viii. Reaching inside sharps containers before proper decontamination or reprocessing

ix. Opening, emptying, or cleaning of sharps containers in a manner that would expose employees to the risk of a sharps injury

x. Mouth pipetting or suctioning of blood or OPIM

VII. AHS Practice Guidelines for Bloodborne Pathogen Exposure Prevention

7.1 Sharp Safety Sub-Committee

Purpose

To oversee and enhance sharps safety practices, reduce occupational exposure to bloodborne pathogens, and ensure compliance with regulatory standards (e.g., OSHA's Bloodborne Pathogens Standard).

Goals

1. **Prevent Sharps Injuries** among healthcare personnel.
2. **Promote Safe Practices** related to handling, disposal, and selection of sharps devices.
3. **Support the Culture of Safety** by involving frontline staff in evaluating and improving sharps safety.
4. **Ensure Compliance** with regulatory and accreditation requirements.
5. **Monitor and Reduce Exposure Incidents** through data-driven strategies.

Objectives

- **Review Injury Data:** Analyze trends from needle-stick and sharps injuries to identify root causes and target interventions.
- **Evaluate Safety Devices:** Assess and recommend safer needle devices and engineering controls.
- **Policy Development:** Create and update policies and procedures on safe sharps handling and disposal.
- **Staff Training & Education:** Support ongoing training on sharps safety protocols and post-exposure procedures.
- **Engage Frontline Staff:** Solicit feedback on device usability and safety concerns from direct care providers.
- **Regulatory Compliance:** Monitor adherence to OSHA, CDC, and state-specific requirements.
- **Reporting:** Provide regular reports to the facility's Infection Control or Safety Committee.

7.2 Handle and Dispose Sharp Item Protocol

a) Work Practice Control

To handle contaminated sharp safely, all AHS employees must follow these guidelines:

(1) Safe practices:

- **Never Recap:** Used needles should never be recapped, as this increases the risk of needlestick injuries.
- **Never Bend or Break:** Needles and other sharps should not be bent, broken, or sheared, as this can damage the sharps or create hazards.
- **Use a Sharps Container:** Never discard sharps in regular trash or biohazard bags. Always use a designated sharps container.
- **Never Insert Fingers:** Do not reach into the sharp's container with your fingers or hands.
- **Handle Only One Sharp at a Time:** Keep sharps visible and handle only one sharp at a time to prevent accidental contact or injury
- **Use Appropriate Tools:** If necessary, use tongs or other tools to push needles back into the container if they are sticking out.

(2) Proper Disposal:

- **Immediate Disposal**: Sharps should be disposed of immediately after use in the appropriate sharp's container.
- **Do Not Overfill**: Sharps containers should not be overfilled, as this can increase the risk of needlestick injuries or cuts.
- **Replace Regularly**: Containers should be replaced when they are two-thirds full, or as recommended by the manufacturer

b) Proper Sharps Container (dispenser) requirements

(1) **Puncture-resistant:** The container must be able to withstand punctures from sharp, preventing injuries.
(2) **Leakproof:** The container must be leakproof on the sides and bottom to prevent spills and contamination
(3) **Closable:** The container must have a lid, flap, or other mechanism to close securely and prevent accidental opening.
(4) **Labeled or Color-coded:** The container must be labeled or color-coded, typically with a red color, to indicate that it contains regulated waste
(5) **Easy Access:** Sharps containers should be readily available and within easy reach of where sharps are used or can be reasonably anticipated to be found (e.g., laundries).
(6) **Portable**: if necessary to ensure employees' easy access to sharps containers. The sharps container can be placed on a mobile cart and lock the container inside.
(7) **Replaced when the container is about three-quarters full** to prevent overfilling and potential safety hazards like needlestick injuries.

7.3 Handle and Dispose Non-Sharp Regulated Wastes Protocol

a) Regulated waste identification

Identify the item qualifies as **regulated waste**:

- **Soaked or caked with blood or OPIM** (Other Potentially Infectious Materials)
- Capable of releasing these if compressed
- Includes PPE, dressings, or materials contaminated with blood during medical or laboratory procedures
- **Human feces, urine, vomiting, nasal secretions, sweat, sears, saliva (except in dental procedures):** these bodily fluids are **not considered infectious or regulated waste** under OSHA's Bloodborne Pathogens Standard unless **blood is visibly present** or are part of a situation involving potential exposure to **bloodborne pathogens** (e.g., HIV, HBV, HCV)

b) Work Practice Control - Requirements

(1) Use standard precautions when handling waste (treat all waste as potentially infectious).

- **Ensure hand hygiene** after handling regulated waste, even after glove removal.
- **PPE (Personal Protective Equipment):** Always wear gloves and appropriate protection (gowns, face protection if splashing is possible).

(2) Handle and contain the waste properly

- Handle containers carefully to avoid spills or exposure.
- Place immediately in a:
  - **Red biohazard bag** or container
  - Container that is **closable**, **leak-proof**, and **labeled with the biohazard symbol**
- Do **not** overfill waste bag or container.
- If outside contamination of a bag or container occurs, place it into a second bag or container that meets the same standards (closable, leak-proof, color-coded or labeled).
- Ensure that all waste bags or containers are **securely closed/sealed** once full, before pickup or disposal.

(3) Store safely (temporarily)

- Keep in a designated, secure biohazard waste storage area
- Follow **time limits** (e.g., within **7 days** if unrefrigerated in California)

(4) Use a Licensed Medical Waste Hauler

- Waste must be picked up by a **registered medical waste transporter**
- Do not dispose of regulated waste in general trash

(5) Maintain Records

- Keep documentation of waste pickup and disposal
- Include transporter information and dates as required by California's Medical Waste Management Act

c) Work Practice Control – Prohibited Practices

🚫 **Do NOT:**

- Place loose contaminated materials in regular trash
- Transport regulated waste without proper labeling and containment
- Dispose of it using public dumpsters or standard waste services

7.4 Blood Spill Cleanup Procedure

a) General Rule

Treat **all blood or OPIM** (Other Potentially Infectious Materials) as **potentially infectious** (HIV, HBV, HCV).
For minor blood spills (small quantities) on surface, follow 2-step cleaning and disinfecting to decontaminate the area using an **EPA-registered hospital disinfectant** effective against bloodborne pathogens after removing the waste.

b) Step-by-step Procedure

1. Restrict the Area

- Keep others away from the spill
- Post warning signs if necessary

2. Put on Appropriate PPE

- **Gloves** (disposable, non-permeable)
- **Eye protection** and **face mask** if there's a splash risk
- **Gown or apron** if large spill or risk of contact with clothing

3. Prepare Disinfectant

- Use an **EPA-registered disinfectant** labeled effective against **HBV and HIV**
  OR
- Mix fresh **bleach solution**:
  1 part bleach to 10 parts water (10% solution)

4. Remove the Bulk of the Spill

- Use **absorbent materials** (paper towels or disposable cloths)
- Carefully soak up blood, working from the **outside in** to avoid spreading
- Dispose of used materials in a **red biohazard bag**

5. Clean the Surface

- Wash area with soap and water if visibly soiled
- Rinse and dry before disinfection (optional but helps efficacy)

6. Disinfect the Area

- Apply disinfectant thoroughly to the entire area
- Allow proper **contact time** per product label (typically **10 minutes** for bleach)
- Wipe up with new disposable towels
- Dispose of towels in **biohazard waste**

7. Remove PPE Carefully

- Avoid touching the outer surfaces of gloves
- Dispose of gloves and PPE in **biohazard waste**
- Wash hands immediately with soap and water

8. Dispose of Waste Properly

- Place all contaminated materials (towels, gloves, PPE) in a **red biohazard bag**
- Seal and store in designated regulated waste area until pickup by licensed medical waste hauler

9. Document of the Incident (if required)

- Complete exposure or spill incident report per your facility's policies
- Notify supervisors or infection prevention and control team as needed

VIII. Bloodborne Pathogen Post-Exposure Evaluation and Follow-Up Protocol

8.1 AHS BBPE Evaluation and Follow-up protocol is designed based on the consent status of

the source patient and CDC treatment guidance

Employee Health Services Protocol Summary

Procedure Step	Source Patient	
	Consented for Testing	Refused for Testing
1. Immediate First Aid	• **Needlestick or Cut:** Wash the area with soap and water. • **Splash to Nose, Mouth, or Skin:** Flush with water. • **Splash to Eyes:** Irrigate with clean water, saline, or sterile irrigates for at least 15 minutes.	
2. Documentation of the Exposure	• Notify your **supervisor** or **Employee Health Services** immediately • Identification of source individual if known and consented • Complete the forms in the **BBP Exposure pac**ket a. Date and time b. Description of the incident: – How it occurred, activity being performed during the incident – Location and type of exposure – Route of exposure (e.g., needlestick, splash) – Type, manufacture and amount of fluid involved – PPE used	
3. Document Source Consented or Refusal	Clearly document: • That the source was informed of the need for testing • That they **signed the consent form located in BBPE source packet for HIV, HepC and HepB**	Clearly document: • That the source was informed of the need for testing • That they signed the **declination form located in the BBPE source packet for HIV, HepC and HepB** • Any efforts made to encourage voluntary testing
4. Source Individual/ patient Evaluation	Collect source's blood specimen to test HBV, HCV, and HIV Results shared with the exposed employee, maintaining confidentiality	Contact Hospital Laboratory department to test the blood specimen of the source patient who refused blood drawn if it was available
4. Evaluation of the Exposed employee	Medical evaluation by a healthcare professional (Employee Health Services and/Occupational Health Clinic) Blood testing for: • Hepatitis B virus (HBV) • Hepatitis C virus (HCV) • Human Immunodeficiency Virus (HIV) Documentation of vaccination status and proof immunity for Hepatitis B)	
5. Counseling and Follow-Up for Exposed Individual	Employee Health provides information on: • Potential risk even when source status is unknown • Preventive behavior (e.g., using protection during sexual activity, avoiding blood donations) • Consult with Post - Exposure Prophylaxis Line (PEP) to confirm exposure risk, if neededSigns and symptoms to watch for Schedule **follow-up blood tests (For High-Risk Exposure/Unknown Status or if Source test positive for HIV, Hep C or Heb B)**:	

Procedure Step	Source Patient Consented for Testing ||| Refused for Testing
	• HIV: baseline, 6 weeks, 3 months, 6 months • HCV: baseline, 4–6 weeks (HCV RNA), and 6 months (antibody) • HBV: depending on immunization status Monitor for symptoms of infection
6. Record Keeping	All records, including the source's refusal, must be kept confidential. Confidential medical records maintained for **duration of employment + 30 years** Provide the exposed employee with a **written healthcare professional's opinion**, stating: • The exposure occurred • That the employee has been informed of the results of the evaluation Whether PEP or further medical follow-up is required
7. Training and Prevention	Unit Manager conducts a R**oot Cause Analysis (RCA)** of the incident with the exposed individual and submit completed RCA to Employee Health Assess whether PPE, safety devices, or procedural failures contributed. Review of training and engineering controls Consider retraining or updating safety procedures

California law **Health and Safety Code section 120262** does allow for testing a source individual's blood without their consent under specific circumstances. When the source individual's consent cannot be obtained, or is not required by law, California law permits testing of the source's available blood, documenting the results, and providing those results to the exposed employee. Source link: California Health and Safety Code Section 120262

- **Testing Without Consent:**

If the source individual refuses consent to testing for communicable diseases after a documented effort to obtain it, or if consent is not obtainable due to their death, testing of available blood or patient samples is permitted, according to California law.

- **Documentation and Disclosure:**

The results of the test must be documented and provided to the exposed individual.

- **Exceptions:**

If the source individual's known status for HBV or HIV is already documented, testing may not be necessary.

- **Confidentiality:**

While the exposed employee must be informed of the results, the source individual's identity may need to be protected, and HIV-related information generally cannot be released without their written consent, according to some sources

8.2 Refer to AHS Employee Health BBPE Evaluation and Follow-up Protocol

IX. Clinical Training and Education

Training program contains the following elements: Copy of the regulatory text of the Bloodborne Pathogen Standard and an explanation of its contents available at:
http://www.dir.ca.gov/title8/5193.HTML

(1) Explanation of the epidemiology and symptoms of bloodborne diseases

(2) An explanation of the modes of transmission of bloodborne pathogens

(3) Copy of this exposure control plan is available on the AHS POLICYTECH under Infection Control

(4) Tasks and other activities that may involve exposure to blood and other potentially infectious materials are listed in three categories of high risk to no risk

(5) Information on use and limitations of methods that will prevent or reduce exposure including appropriate engineering controls, work practices, and personal protective equipment; in addition to paying attention to details and being careful will prevent most incidents

(6) Information on the types, proper use, location, removal, decontamination and disposal of personal protective equipment

(7) Explanation of the basis for selection of personal protective equipment

(8) Information on the hepatitis B vaccine, including information on its efficacy, safety, method of administration, the benefits of being vaccinated, and that the vaccine and vaccination will be offered free of charge

(9) Information on the appropriate actions to take and persons to contact in an emergency involving blood or other potentially infectious materials

(10) An explanation of the procedure to follow if an exposure incident occurs, including the method of reporting the incident and the medical follow-up that will be made available

(11) Information on the post-exposure evaluation and follow-up that the employer is required to provide for the employee following an exposure incident

(12) An explanation of the signs and labels and/or color-coding required for biohazard waste

(13) An opportunity for interactive questions and answers with the person conducting the training session during monthly general orientation and hospital specific nursing orientation

(14) All employees with potential for occupational exposure to blood and other infectious materials shall participate in a training program provided at no cost to the employee and during working hours.

(15) Training shall be provided at the time of initial assignment of the tasks where occupational exposure may take place and annually thereafter to reinforce initial training and during initial training.

(16) Training material shall be appropriate in content, vocabulary, educational level, literacy and language of employees.

(17) Active involvement will be obtained each year from employees in reviewing and updating the exposure control plan with respect to the procedures performed by employees in their respective work areas or departments in the following manner:

- ✓ A letter, questionnaire, and the Bloodborne Pathogen Exposure Control Plan will be sent to AHS leaders for dissemination to their employees.
- ✓ Leaders will review the plan with staff as well as post the plan on staff communication boards.
- ✓ Leaders will disseminate the questionnaire to all staff and collect the completed questionnaires.
- ✓ Leaders will submit the completed questionnaires to the Employee Health Manager.
- ✓ The Employee Health Manager will review the questionnaires and revise the plan as needed.

(18) For any new procedures that require the use of engineering controls identified, the procedure type and requirement for engineering controls will be referred to the Value Analysis Team. This request will trigger a product search and will then follow the path of all new products, i.e., user trial, evaluation and eventual product selection.

(19) Department head/manager shall be responsible for assuring employees attendance at the training and for scheduling make-up sessions.

(20) Communication of Hazards to Employees:

Warning labels shall be affixed to containers of regulated waste, refrigerators and freezers containing blood or other potentially infectious materials and other containers used to store, transport or ship blood or other potentially infectious materials in order to alert workers to the risks posed by blood borne pathogens.

(21) Hepatitis B Vaccine:

a) Hepatitis B vaccine shall be made available to all employees with occupational exposure to blood and other infectious materials within 10 days of an employee's initial assignment at no cost to employees unless the employee has previously received the complete hepatitis B vaccination series, antibody testing has revealed that the employee is immune, or the vaccine is medically contraindicated.

b) Employees will be informed about Hepatitis B vaccine:

i. Available and free of charge
ii. Benefits of being vaccinated
iii. Efficacy and safety of Hepatitis B vaccine
iv. Method of administration
v. Hepatitis B vaccine declination statement (mandatory for employees who decline vaccination).

c) Employee Health Services under the supervision of the medical director shall maintain records of employee vaccination status of signed declination statements.

(22) Post Exposure Follow-up: Refer to the Bloodborne Pathogen Exposure Follow-up Protocol attached to this policy.

X. Record Keeping

Employees' Medical Records

Refer to AHS Employee Health BBPE Evaluation and Follow-up Protocol

Training Records

a) Training records shall include:

i. Dates of training sessions: The dates on which employees completed training sessions are recorded and can be accessed by requesting an official employee transcript through the AHS Learning Center.
ii. Content or summary of training sessions: A detailed summary or the full content of the training session is available upon request for reference or audit purposes.
iii. Name and qualifications of person conducting the training: This training is conducted as an online eLearning course administered through the AHS Learning Center.
iv. Names and Job Titles of Training Participants The names and job titles of individuals who participated in the training are available upon request via transcripts or training reports generated through the AHS Learning Center.

b) Records of attendance shall be kept for 3 years following training.

c) A record of the training session will be kept in each employee education file, located in Human Resources.

XI. References

i. Bloodborne Pathogen, Employee Safety – Alameda County Administrator's Office Risk Management. Link: Safety Topics - Risk Management Unit - Alameda County

ii. County of Alameda Safety and Health, Sample Bloodborne Pathogens Exposure Control Plan, Revision 01/26/2006. Link: BloodBorne Pathogens.1

iii. The California Occupational Safety and Health Administration (CalOSHA) Bloodborne Pathogen (BBP) Standard (8 CCR 5193). Link: California Code of Regulations, Title 8, Section 5193. Bloodborne Pathogens.

iv. Cal/OSHA A Best Practices Approach for Reducing Bloodborne Pathogens Exposure. Link: A Best Practices Approach for Reducing Bloodborne Pathogens Exposure

v. Cal/OSHA Exposure Control Plan for Bloodborne Pathogens. Link: Exposure Control Plan for Bloodborne Pathogens

vi. CDC Workbook for Designing, Implementing, and Evaluating a Sharps Injury Prevention Program – 2008 version. Link: Workbook for Designing, Implementing, and Evaluating a Sharps Injury Prevention Program

vii. CDC Sharps Safety for Healthcare Professionals Brochure. Link: Sharps-Safety-Brochure-P.pdf'

viii. California law **Health and Safety Code section 120262** California Health and Safety Code Section 120262

1 **Approvals**

Infection Prevention & Control Committee	**Date: 3/2012, 1/2013, 1/2014, 7/2025**
Clinical Practice Council	**Date: 11/2022**

Medical Executive Committee	**Date: 3/2012, 1/2013, 11/2022**
Board of Trustees	**Date: 5/2012, 3/2013, 11/2022**

[i] NOTE: Regulated waste includes medical waste regulated by Health and Safety Code Sections 117690.

ALAMEDA HEALTH SYSTEM	Policy	
	Quality Improvement Work Policy: Primary Care - Adult Medicine and Pediatrics and Urgent Care	**29931 1**
	LEVEL ☐ System ☐ Site	EFFECTIVE DATE: 10/2025 NEXT REVIEW DATE: 10/2028

Site	Alameda Health System Wellness Centers	***Previous Revision Dates***	
Effective Date	2/2025	***Date Revised***	
Document Owner	Ambulatory ACMO	***Next Scheduled Review***	1/2027
Executive Responsible	Ambulatory ACMO		

Purpose

The purpose of this policy is to create a path and set guidelines for quality improvement (QI) work proposed and led by providers in Adult Medicine, Pediatric, and Urgent Care service areas, for providers who do not have sufficient administrative or leadership time in their roles.

Background

Important components of a high functioning primary care clinic are ongoing QI work to improve patient care and physician engagement and job satisfaction. Providers working in front-line care have key insights into the strengths and areas of opportunity of a clinic's clinical care and operations. They are highly motivated to improve quality and processes that impact their patients' wellbeing and have the skills and leadership to effectively make change. Engaging them in such work adds value to patient care while reducing provider burnout and increasing job satisfaction.

This policy allows providers to design and execute QI projects based on clinical interest and need.

Policy

Any full- or part-time provider may propose a QI project related to patient care at their clinic. The project must be specific, measurable, achievable, relevant, and time-bound. Multi- disciplinary teamwork is encouraged, as long as the personnel resources are available. At the end of the project, the provider is responsible for demonstrating an impactful contribution to the clinic.

A provider may also be invited to participate in a site-based or Ambulatory-based QI project organized by an AHS leader. The owner of this project is expected to ensure the project is specific, measurable, achievable, relevant, and time-bound.

1. A provider may be granted approval for one project per fiscal year.
2. The provider's medical director is responsible for reviewing, modifying, and approving proposals. Approval of projects is at the medical director's and ambulatory ACMO's discretion, based on impact and feasibility. They should provide support and mentorship during the project.
3. Duration of and time needed for project should be included in project proposal and is finalized at the discretion of the medical director.
4. Projects should take no more than 6 months for completion.

5. Projects can take up to a total of 50 hours within the allotted 6 months, with no more than 4 hours per week..
6. Projects should be planned to limit impact on patient access and scheduling.
7. Medical director should evaluate progress during a project via bi-weekly check-ins.
8. Medical director may pause or cancel the project or provider's participation in the project due to superseding clinical needs or performance concerns.

Procedure

A provider should write a proposal using a QI tool (for example, PDSA, A3 Problem Solving, see templates attached) and give it to the medical director. If the provider is invited to join a leader's project, a project plan should be reviewed by the provider and medical director.

The medical director will consider impact and feasibility of projects, along with the clinical impact on access and patient care. Approved projects will have a defined start and end date.

The ambulatory ACMO will give final approval for projects.

Provider time spent on the project shall be backfilled by Services-As-Needed (SAN) providers as much as possible.

Project status should be updated with the medical director on a regular basis.

Upon completion of a project, a presentation of the work is highly encouraged.

ALAMEDA HEALTH SYSTEM

September 24, 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: September 24, 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 Medical Staff:
- Standardized Procedures for Advanced Practice Providers in The Department of Anesthesia
- AHS Medical Staff Committees

AHS & AH Medical Staff:
- Introduction of a New Privilege for a Specific Department of Speciality

Alameda Health System

STANDARDIZED PROCEDURES FOR ADVANCED PRACTICE PROVIDERS IN THE DEPARTMENT OF ANESTHESIA

Department	Anesthesiology	***Effective Date***	9/2025
Campus	Highland and San Leandro	***Date Revised***	
Unit	Inpatient/Outpatient	***Next Scheduled Review***	9/2028
Manual	Interdisciplinary Practice	***Author***	Anesthesia Department Chair
Replaces the following Policies: N/A		***Responsible Person***	Chief of Staff

Procedure Statement

This standardized procedure fulfills Alameda Health System (AHS) 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 Department of Anesthesia 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 provider 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.

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:
   a. Two (2) years of preoperative medicine or primary care clinical experience as an advanced practice provider.
   b. Current Basic Life Support (CPR/BLS) Certification

Conditions and Standards of Practice

1. General Conditions

a. The Advanced Practice Provider (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.
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 his/her 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. Focus Professional Practice Evaluation (FPPE)/Proctoring

The routine FPPE/Proctoring plan is outlined on the NP or PA 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 PA/NP 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 PA/NP 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. During the provision of services by the Advanced Practice Provider a supervising Anesthesiologist will be assigned and available for consultation and escalation per criteria in this standardized procedure. 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

Advanced Practice Providers are authorized to diagnose and treat emergency medical problems according to accepted criteria and management including, but not limited to:

a. Health Care Maintenance and Promotion, all ages
b. Preoperative, intraoperative and postoperative care
c. Patients seen as consultations to the anesthesia service

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;
d. Collect specimens as indicated for additional tests;
c. Perform pertinent laboratory tests in compliance with Clinical Laboratory regulations;
e. Perform any other procedure for which they have been granted privileges;
d. Counsel patients and their families on health promotion, diagnosis and management options;
f. Diagnose and treat conditions listed above;
e. Complete medical records for every patient encounter in the Department of Anesthesia computer based format followed by all providers in the Department of Anesthesia.

3. Protocols

The APP has been granted privileges within the Alameda Health System to perform the requested procedures.

a. 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.
b. The APP is following standard medical technique for the procedures as described in the Resources listed in this document.
c. Appropriate patient consent is obtained, if necessary, before the procedure.
d. Unless otherwise exempt, all biopsied tissue is sent for a pathology report.
e. All other applicable Standardized Procedures in this document are followed during health care management.
f. 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 advanced practice providers authorized to Furnish.
8. No single physician will supervise more than four advance practice providers 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 advanced practice provider 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 reevaluation.

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 advance practice provider.
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 advanced practice provider 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 advance practice provider 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 Advanced Practice Provider 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.

4. 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, Department of Anesthesiology protocols or current texts/articles on care.

5. 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 Anesthesiology 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:

1. Complex Medical Conditions or Optimization
    - Uncontrolled comorbidities such as:
        - Severe heart failure (e.g., NYHA Class III-IV)
        - Unstable angina or recent MI
        - Severe valvular disease (e.g., aortic stenosis)
        - Uncontrolled arrhythmias or recent stroke/TIA
    - Poorly controlled diabetes (e.g., A1c >9 or symptomatic hyperglycemia)
    - Severe pulmonary disease (e.g., oxygen-dependent COPD or new hypoxia)
    - End-stage renal disease on dialysis needing perioperative coordination
    - Complex or unclear medication management, such as:
        - Anticoagulation/antiplatelet bridging
        - Immunosuppressive drugs or biologics
    - Patients needing preoperative cardiac work-up (e.g., stress test, echo) or with conflicting testing results
2. Unclear Surgical Risk or Anesthesia Concerns
    - Ambiguity regarding ASA classification or overall risk
    - Procedures with high-risk of blood loss or fluid shifts in medically fragile patients
    - Potential need for ICU post-op that hasn't been addressed by surgery
    - Patients with airway concerns, such as:
        - Prior difficult intubation
        - Severe obstructive sleep apnea (OSA) without CPAP use or recent testing
    - Concerns about post-op pain management for opioid-tolerant or complex patients
3. Perioperative Planning/Coordination Gaps
    - Incomplete or inconsistent documentation from surgery or referring services
    - Unclear or missing surgical plan or uncertainty about the timing of surgery
    - Missing or abnormal preoperative labs or imaging requiring interpretation
    - Lack of required medical clearance from specialists (e.g., cardiology, pulmonology)
4. Ethical, Legal, or Procedural Uncertainty
    - Cases involving DNR/DNI status or advanced care planning issues
    - Patient refusal of indicated testing or optimization
    - Need to escalate concerns to surgical or medical teams about appropriateness for surgery
    - Unclear decision-making capacity or consent issues
5. Special Populations
    - Pregnant patients or patients of unclear pregnancy status
    - Pediatrics

6. 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.

7. 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.

8. 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.

9. 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:

Interdisciplinary Practice Committee	8/27/25
Credentials Committee	
CPC	9/4/25
Medical Executive Committee	
QPSC	

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

MEDICAL STAFF COMMITTEES

Department	Medical Staff	***Effective Date***	4/2022
Campus	AHS	***Date Revised***	10/2023, 2/2024, 3/2025, 5/2025, 9/2025
Unit	All	***Next Scheduled Review***	9/2028
Manual	Medical Staff	***Author***	Vice President, Physician Services
Replaces the following Policies:		***Responsible Person***	Chief of Staff

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

Purpose: To supplement the Bylaws regarding Medical Staff's committees, including but not limited to committee membership, duties, frequency of meetings and structure.

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

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

Procedures

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

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

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

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

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

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

*The CIDP Committee reports to the Credentials Committee.

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

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

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

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

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

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

Procedure to Propose Additional Medical Staff Standing Committees

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

Procedure to Propose Combined Medical Staff Committees

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

Approvals

		AHS
Medical Executive Committee	**Date:**	**9/17/2025**
QPSC/Board of Trustees	**Date:**	

Alameda Health System Medical Staff Committees
Appendix A

Clinical Practice Council

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

The membership guidelines are as follows:

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

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

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

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

Code Blue Committee

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

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

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

b. Capture data from various sources for process improvement;

c. Approval the crash cart contents and checklists;

d. Review Code Blue documenation;

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

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

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

Committee on Interdisciplinary Practice (CIDP)

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

The duties of the CIDP shall be to:

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

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

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

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

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

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

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

The duties of the CME Committee shall be to:

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

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

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

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

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

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

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

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

Critical Care Committee

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

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

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

b. Develops clinical practice guidelines related to critical care;

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

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

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

Disaster Action Response Team (DART)

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

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

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

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

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

d. Review how system responds to actual mass casualty incidents

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

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

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

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

Ethics Committee

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

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

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

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

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

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

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

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

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

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

Graduate Medical Education Committee

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Infection Prevention and Control Committee

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Interdepartmental Professional Practice Committee (IPPC)

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

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

The duties and responsibilities of the IPPC shall be to:

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

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

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

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

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

f. Provide oversight for the external peer review process.

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

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

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

The Interdepartmental Professional Practice Committee shall meet at minimum quarterly or as needed.

Morbidity & Mortality (M&M) Conference

Each department of the Medical Staff may form a Morbidity and Mortality (M&M) Conference. The M&M Conference Committee may be a combined meeting of the divisions of the department, or the divisions may meet separately.

The M&M Conference shall be a subcommittee of the Quality Review Committee of the department. The chairperson of the M&M Conference shall be the Chair of the Department or the appropriate Division Chief unless the Chair of the Department appoints a chairperson who is a member and holds clinical privileges in the appropriate department/division.

The M&M Conference shall be composed of physician members who hold clinical privileges in the department/division, house staff and other assigned members as may be necessary and appropriate.

The duties shall be to:

a. review patient care activities related to the department/division;

b. develop practice management guidelines related to the department/division;

c. report and recommend practitioner specific cases with significant concerns in patient care to the appropriate departmental QRC;

The M&M Conference shall meet as often as necessary at the call of the Chairperson.

Pharmacy, Therapeutics and Nutritional Care Committee (P&T)

The Pharmacy, Therapeutics and Nutritional Care Committee shall be composed of physicians, nurses, House Staff, administration (including representation from Pharmacy Services, and Nutrition Care) and other assigned members as may be necessary and appropriate.

The duties of the Pharmacy, Therapeutics and Nutritional Care Committee shall be to:

a. develop, implement and assess appropriate quality control and performance improvement measures for professional practices and policies regarding nutrition care and the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures, and all other matters relating to drugs in the Health System, including antibiotic usage;

b. review and recommend to the Medical Executive Committee, relevant

policy, procedures, and protocols that may be necessary for the operation of medication usage and nutritional care programs;

c. evaluate and improve the quality of patient care provided to patients related to medication usage and nutritional care;

d. advise the Medical Staff and Pharmacy Services on matters pertaining to the choice of available drugs;

e. make recommendations concerning drugs to be stocked on the nursing unit floors and by other services;

f. annually review and revise, as necessary, the formulary or drug list for use in the Health System.

g. evaluate clinical data concerning new drugs or preparations requested for use in the Health System;

h. monitor and review adverse drug reactions;

i. to review aggregate data relevant to medication errors;

j. to oversee clinical care related to the nutritional needs of patients; and

k. maintain a permanent record of its proceedings and submit quarterly reports of its activities and recommendations to the Medical Executive Committee

The Pharmacy, Therapeutics and Nutritional Care Committee shall meet quarterly or as often as necessary at the call of its Chairperson.

Operating Room Committee

The Operating Room Committee, a subcommittee of the Medical Executive Committee and shall be composed of physicians, nursing leadership, surgical department representatives, infection control, regulatory affairs, quality, and other assigned members as may be necessary and appropriate.

The duties of the OR Committee shall be to:

a. ratify new policies and procedures and disseminate information to the surgical services;

b. Monitor and assess the quality of care provided in the operating rooms, including tracking and analyzing surgical outcomes, infection rates, and patient satisfaction;

c. monitor the activity and efficiency of services provided;

d. Ensure proper credentialing and privileging process for surgeons, anesthesiologists, and other personnel using the operating rooms. Ensure compliance with hospital bylaws and regulatory requirements;

e. Organize educational programs and training sessions for operating room staff to enhance their skills, knowledge, and awareness of best practices;

f. Evaluate and recommend the purchase, maintenance, and proper usage of surgical equipment, instruments, and technology to ensure the highest quality of care and safety for patients and staff;

g. develop and implement infection control protocols to minimize the risk of surgical site infections and other healthcare-associated infections in the operating rooms;

h. develop and maintain protocols for handling emergency situations in the operating rooms, ensuring staff readiness and patient safety during crises;

i. collaborate with other hospital committees, departments, and external organizations to improve interdisciplinary communication and coordination in the delivery of surgical services.

j. initiate changes necessary to maintain the quality of patient care and to maximize patient safety;

k. maintain a permanent record of its proceedings and submit quarterly reports of its activities and recommendations to the Medical Executive Committee.

The Operating Room Committee shall monthly or as needed at the call of its Chairperson.

Patient Safety Committee

The Patient Safety Committee shall be composed of physicians, nurses, administration (including representation from Risk Management, Quality Services and the Safety Department) and other assigned members as may be necessary and appropriate.

The Patient Safety Committee has been established as an interdisciplinary committee of the Medical Staff to coordinate organization-wide safety and risk management activities and to oversee the development of organizational error reduction programs. The duties of the Patient Safety Committee shall be to:

a. establish measurable objectives for improving patient safety and reducing medical errors;

b. review all sentinel events including the development of a thorough and credible root cause analysis, appropriate plan of correction, and follow-up plan;

c. oversee the organizational safety program;

d. oversee all organizational risk management activities;

e. work with staff in the development of programs to enhance involvement by the patient and the patient's family as a partner in the healthcare process; and

f. maintain a permanent record of its proceedings and submit quarterly reports of its activities and recommendations to the Medical Executive Committee.

The Patient Safety Committee shall meet quarterly or as often as necessary at the call of its chairperson.

Procedural Innovation Committee

Procedural Innovation Committee Duties and responsibilities: The committee will develop and oversee a standardized framework for introducing specialty procedures consistent with existing medical staff policy. This multidisciplinary committee will ensure that appropriate credentialing, proctoring, infrastructure, staffing, resources, quality review, and patient care outcomes are in place before the medical staff privileges for a new procedure. The committee will make recommendations on privileging of a new procedure to the Medical Executive Committee, who holds final approval.

Inclusion Criteria for Procedural Innovation Committee Review: New to a department or specialty AND one of the following:

- Procedures with potential for significant patient harm if not properly implemented
- Low-volume procedures where provider competency and outcomes are difficult to track
- Require new infrastructure, equipment or significant capital investment
- Requires new credentialing or privileging pathways
- Requires significant changes in staffing models
- Lacks established clinical guidelines
- Involves novel technology or devices not yet widely adopted
- Crosses multiple specialties or requires multidisciplinary coordination
- Has significant implications for patient safety, quality, or cost

Exclusion Criteria for Procedural Innovation Committee Review:

- Routine procedures already privileged/credentialed and performed at AHS
- Minor variations of existing procedures that do not have significant quality or infrastructure changes
- Procedures with established pathways and guidelines and previously approved

Membership: The Procedural innovation Committee shall be a multidisciplinary team composed of clinical and operational leaders, including physicians, administrators, nursing, and other designated members. The Chair(s) will be appointed by the Chief of Staff. The Chair will select members based on the expertise required to fulfill the committee's purpose. Physician membership should be selected to ensure representation from procedural specialties and each affected department. The PIC Co-Chairs shall select the appropriate committee members to ensure that the PIC duties are fulfilled. The Co-Chairs may invite additional attendees to ensure the appropriate expertise and experience is available for the meetings. All members shall sign confidentiality agreements and kept in the permanent records.

The PICs voting members shall include the physician members listed in the table below. The PIC chair shall be a member of the medical staff and be appointed by the Chief of Staff. The PICs non-voting members may include representatives from administration and other assigned individuals at the Chief of Staff determines if they are necessary or appropriate for the PIC to fulfill its functions.

Physician Members (Voting)	**Administrative Members (Non-Voting)**
Department Chairs /Designee • Anesthesiology, Perioperative and Pain Medicine • Emergency Medicine • Medicine • Orthopaedic Surgery • Surgery *Division Chiefs/Designee:* • Gastroenterology • Interventional Radiology • Interventional Cardiology • Pulmonary and Critical Care • Vascular Surgery • Chief Medical Officer/ACMO • Chief of Staff/designee	• Associate Chief Nursing Officer / Chief Administrative Officer • Vice President of Patient Care Services • Vice President of Applications/Designee • Vice President Revenue Cycle/Designee • System Vice President Supply Chain Management • System Director of Pharmacy/Designee • Director of Accreditation and Regulatory Affairs • VAT Committee Chairs • Vice President Physician Services • Manager, Medical Staff Services (Credentialing and Privileging)

Additional Ad hoc Physician Specialties:

Departments:

- Ambulatory Care and Preventive Medicine
- Obstetrics, Midwifery and Gynecology
- Pediatrics
- Radiology/Imaging

Divisions:

- Dermatology
- Neurosurgery

Quorum: A quorum requires one committee chair/designee to facilitate the meeting with a minimum of five (5) physicians for voting, including representation from a physician with the expertise required for the proposed privileges or new procedures.

Meeting Frequency: As often as necessary at the call of the chairperson(s). The Procedural Innovation Committee shall maintain a permanent record of its proceedings and shall submit reports and recommendations to the Medial Executive Committee.

Provider Wellbeing Committee

The Provider Wellbeing Committee shall be composed of three (3) physician members of the Medical Staff. Members of the Provider Wellbeing Committee shall not serve as active participants on other peer review or performance improvement committees while serving on the Provider Wellbeing Committee.

The committee shall not have disciplinary function with respect to a physician's staff membership or privileges and shall not be responsible for any investigation leading to disciplinary action against staff membership or privileges/practice prerogatives.

The duties of the Provider Wellbeing Committee shall be to:

a. provide education about physician health, addressing prevention of physical, psychiatric, or emotional illness;

b. facilitate confidential diagnosis, treatment, and rehabilitation of physicians who suffer from potentially impairing conditions;

c. aid the physician regaining or retaining optimal professional functioning consistent with protection of patients;

d. educate the Medical Staff and other organizational staff about illness and impairment recognition issue-specific to physicians;

e. allow for self-referral by physicians and referral by other organizational staff;

f. referral of affected physicians to appropriate professional internal or external resources for diagnosis and treatment of physical, emotional, or drug dependency related conditions;

g. maintenance of the confidentiality of the physician seeking referral or referred for assistance except as limited by law, ethical obligation, or when the safety of a patient is threatened;

h. evaluate the credibility of any complaint, allegation, or concern regarding the physical or emotional health of a physician;

i. monitor impaired physicians during programs of treatment and rehabilitation;

j. report to the appropriate Medical Staff committee, at any time during diagnosis, treatment, or rehabilitation, if it is determined that the physician may be unable to safely perform the privileges he or she has been granted;

k. monitor compliance with any mandatory drug treatment programs; and

l. maintain only such records of its proceedings, as it deems advisable and submit quarterly reports of its activities and recommendations to the Medical Executive Committee.

m. Initiating appropriate actions when a licensed independent practitioner fails to complete the required rehabilitation program.

The Provider Wellbeing Committee shall meet at least quarterly and as often as necessary at the call of its Chairperson.

Procedural Sedation Committee

The Procedural Sedation Committee is a multidisciplinary committee composed of physicians, nurses, pharmacists, operational leaders, and other content experts charged with overseeing the safety and quality of procedural sedation in all AHS locations.

The fundamental responsibilities and duties of the Procedural Sedation Committee shall be to:

a. Create and revise guidelines for clinical practice that are based on current guidelines, evidence-based practice, standards, and recommendations.

b. Create and maintain a comprehensive systemwide policy regarding Procedural Sedation.

c. Monitor compliance with policy and procedures using data derived from retrospective reviews and observation.

d. Perform active case review to monitor outcomes and identify system issues.

e. Assist with the development of multidisciplinary training program and competency for Procedural Sedation.

f. Remain current with regulatory agency and professional organization standards, recommendations and guidelines.

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

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

Quality Steering Committee

The Quality and Steering Committee shall be composed of the Chief of Staff, the Vice Chief of Staff and two (2) at large members of the Medical Staff appointed by the Chief of the Medical Staff. Non-Physician members shall include the Chief Medical Officer, Chief Financial Officer, Chief Operations Officer, Chief Nursing Executive, Vice President of Quality, Ambulatory Quality Services Director, and the Risk Manager. The Committee shall be Co-Chaired by a medical staff member and an administrative member of the committee.

The Quality Steering Committee has a central role in the initiation, performance and maintenance of the organization's performance improvement program. The fundamental responsibilities and duties of the Quality Steering Committee shall be to:

a. set priorities for organizational performance improvement activities that are designed to improve patient care processes and outcomes;

b. develop performance improvement training programs for the organization's staff;

c. foster communication among all departments and services;

d. prioritize and select specific performance improvement team projects;

e. receive aggregate reports related to performance improvement activities from Health System support services, Medical Staff clinical function committees and all organizational performance improvement teams;

f. receive reports from the following:
    i. Code Blue Committee
    ii. Critical Care Committee
    iii. Health Information Management
    iv. Procedural Sedation
    v. Sepsis Committee
    vi. Stroke Committee
    vii. Transfusion Committee

g. have direct oversight of the following functions:
    i. Improving Organizational Performance
    ii. Leadership

h. prepare an annual appraisal of the organization's performance improvement program; and

i. maintain a permanent record of its proceedings and submit quarterly reports of its activities and recommendations to the Medical Executive Committee.

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

Quality Review Committees (QRC)

Each department of the Medical Staff shall have a Quality Review Committee (QRC). Each department's QRC may meet separately or jointly with the QRCs of other departments at the discretion of the Chair of the Department and as approved by the Medical Executive Committee.

Each departmental QRC shall monitor the quality and appropriateness of clinical services provided by those holding clinical privileges in its department related to the divisions represented by the QRC. When requested, the QRC shall also make recommendations to the Credentials and/or Medical Executive Committees related to specific credentialing issues. The Chair of the Department, however, shall have the ultimate duty and responsibility to make recommendations regarding credentialing issues to the Credentials and/or Medical Executive Committees.

The duties and responsibilities of the QRC's shall be to:

a. evaluate and improve the quality of care provided to Health System patients which may include accurate and timely medical record documentation;

b. conduct patient care reviews for the purpose of analyzing and evaluating the quality and appropriateness of care and treatment including practitioner specific data for medication usage, medical records, transfusion review and operative and invasive care, provided by practitioners within the divisions of the departments represented by the QRC;

c. perform peer review and/or other physician specific intensified assessments when indicated or requested by an appropriate Medical Staff committee;

d. identify system problems requiring process improvement activity and make such recommendations to the Quality and Safety Committee;

e. take appropriate actions when important problems in patient care or opportunities to improve patient care are identified;

f. recommend to the Chairperson of the Department, those Medical Staff policies and procedures as may be necessary to conduct patient care and administrative Medical Staff activities;

g. communicate the significant results of peer review and performance improvement activities to relevant practitioners;

h. implement programs that assess compliance with clinical practice guidelines and other recognized standards of care;

i. assume all duties and responsibilities of the departments related to quality assessment, peer review and performance improvement, which have not been otherwise assigned to the Chair of the Department and as may be described in the Bylaws and/or Rules and Regulations; and

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

The Quality Review Committees shall meet quarterly or as often as necessary at the call of its chairperson.

Stroke Committee

The Stroke Committee shall be composed of the Stroke Team which includes physicians, nurses, administration, other representation from the Emergency Department and Neurology Division and EMS and other assigned members as may be necessary or appropriate.

The duties of the Stroke Committee shall be to:

a. develop, implement and assess appropriate quality control and performance improvement measures for the Stroke program;
b. demonstrate conformity with clinical practice guidelines or evidence-based practice
c. maintain a permanent record of its proceedings and submit quarterly reports of its activities and recommendations to the Quality and Safety Council.

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

Transfusion Committee

The Transfusion Committee shall be composed of physicians including representation from pathology, medicine, surgery, anesthesiology, nursing, administration and other assigned members as may be necessary and appropriate.

The duties of the Transfusion Committee shall be to:

a. develop, implement and assess appropriate quality control and performance improvement measures for Blood Bank and transfusion review;

b. monitor standards for transfusion practice, distribution, handling, use and administration to promote appropriate use of blood and blood products;

c. monitor and evaluate the appropriateness of transfusions for blood and blood products, transfusion reactions and physician ordering practices; and

d. maintain a permanent record of its proceedings and submit quarterly reports of its activities and recommendations to the Medical Executive Committee.

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

Tumor Board

The Tumor Board shall be composed of physicians, nurses, administration and other assigned members as may be necessary and appropriate to fulfill the requirements for cancer designation by the American College of Surgeons and the Cancer Commission of the California Medical Association.

The duties of the Tumor Board shall be to:

a. conduct multidisciplinary, patient-oriented treatment planning cancer conferences to improve the care of patients with cancer. Conferences shall focus on:
   i. pretreatment evaluation
   ii. staging
   iii. treatment strategy
   iv. rehabilitation
   v. problem cases

b. provide relevant educational programs related to cancer care to the Medical Staff.

The Tumor Board shall meet as often as required according to the Standards on the Commission of Cancer but at least biannually.

Utilization Management Committee

The Utilization Management Committee shall be composed of physicians, nurses and administration including representation from the Utilization Review Department, Medical Social Services and other assigned members as may be necessary and appropriate.

The duties of the Utilization Management Committee shall be to:

a. develop, implement and assess appropriate quality control and performance improvement measures for the Utilization Review Program;

b. to maintain utilization review and quality control measurements and to conduct utilization review studies designed to evaluate the appropriateness of admissions to the hospital, lengths of stay, discharge practices, use of medical and hospital services and related factors that may contribute to the effective and efficient utilization of resources and services;

c. to obtain, review and evaluate information and data generated by the hospital's case management service;

d. act on recommendations related to utilization review received from the Chief of the Medical Staff, the Medical Executive Committee, the Departments and other committees;

e. maintain a permanent record of its proceedings and submit quarterly reports of its activities and recommendations to the Medical Executive Committee.

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

Alameda Health System

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, 9/2025
Unit	Medical Staff	***Next Scheduled Review***	9/2028
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 from the department shall be submitted to the Procedural Innovative 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 Procedural Innovative Committee 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 Procedural Innovative Committee must assure that a single level of care is maintained relevant to granting of the privilege.

5. The Procedural Innovative Committee shall submit a recommendation to the Medical Executive Committee for action.

Procedural Innovation 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 Procedural Innovation Committee shall complete the Standardized Framework checklist for the Introduction of any New Procedures (Attachment B)**.** The committee shall also 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 for FPPE/proctoring for the new privilege.

c. Whether qualified physicians are available to provide continuous care in the event physicians performing the new privileges are unavailable.
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 Procedural Innovation 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:**	**9/17/2025**	**9/19/2025**
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 : _____

ATTACHMENT B

Alameda Health System Medical Staff
Standardized Framework for the Introduction of New Procedures

The standardized workflow for the Introduction of New Procedures includes a 1) Pre-Approval, 2) Procedural Innovation Committee review, 3) Credentials Committee, Medical Executive Committee and Board approval.

New Procedures Pre-Approval: Physician champions who wish to introduce a new procedure that meets the established inclusion criteria should first engage in discussion with their Division Chief and/or Department Chair. If departmental leadership is in agreement, the Department Chair(s) will then consult with the Chief Medical Officer (CMO) to evaluate whether the proposed procedure aligns with the strategic goals of the organization. In cases where the procedure involves collaboration across multiple departments, the respective Department Chairs will confer in advance to ensure alignment and coordinated support. If the proposed procedure is anticipated to have significant financial impact, a preliminary financial analysis should be conducted under the guidance of the CMO/designee prior to review by the PIC. Once there is approval by the Department Chair(s) and CMO/designee the proposal can be submitted to the Procedural Innovation Committee for review.

The checklist is intended to provide completion of the pre-approval requirements if applicable.

1.	Innovative Procedure Champion	☐ Proposed Procedure
2.	New Innovative Procedure	☐ Does this procedure align with the strategic plan?
3.	Department / Specialty	☐ Does the procedure impact other specialties? Yes/No *If yes, complete a multidisciplinary agreement (Introduction of a New Privilege or a New Privilege for a Specific Department or Speciality - Attachment A)*
4.	Financial Feasibility	☐ Does this need a financial analysis? Yes/No The CMO shall decide if a financial analysis is needed and can be done with their support.
5.	Approvals	☐ Department Chair ☐ Chief Medical Officer

1. **Procedural Innovation Committee:** The committee will review the request based on the elements in the checklist prior to recommending implementation.

The standardized checklist is intended to provide the framework for the items to consider when requesting a new privilege or procedure. The checklist provides milestones for completion of the elements if applicable.

1.	Rationale for New Innovative Procedure	☐ Needs Assessment- What patient care gap needs to be filled? ☐ Review of Evidence- Literature, AHS projected volumes and patient needs
2.	Standardized Workflows	☐ Clinical Protocols ☐ Patient inclusion & exclusion criteria ☐ Documentation templates- nursing, physicians and APPs ☐ Patient flow: example*, ED ----> procedure ----->admission----> discharge (e.g., heart alert protocol)* ☐ Plan for post procedure complications urgent and emergent care ☐ Transfer protocols if applicable
3.	Credentialing	☐ Residency and Fellowship Training ☐ Board Certification ☐ Specialized Training ☐ Continuing Medical Education (CME) relevant to new procedure
4.	Location/Space	☐ Pre-procedure ☐ Intra-procedure ☐ Post procedure and recovery
5.	Quality Assurance	☐ Define Quality Metrics ☐ Ongoing Professional Practice Evaluation (OPPE) ☐ Data Tools: Power BI Epic reports ☐ National Registry/Database Reporting
6.	Staffing	☐ Physician Specialty Support from other departments (e.g., anesthesiology) ☐ Nursing and Ancillary staffing to support procedure ☐ Nursing and Ancillary staff trained/certified to support procedure
7.	Equipment and Supplies	☐ Existing versus new equipment ☐ Capital equipment needs and request submitted ☐ Equipment approved by VAT committee ☐ PAR levels created
8.	Revenue Cycle	☐ Billing and Coding ☐ Charge Capture
9.	EPIC	☐ Clinical Documentation ☐ Order Sets
10.	Accreditation & Regulatory Affairs	☐ Accreditation and Certification ☐ Department and Clinical Scope of Services ☐ Space / Location Licensure
11.	Communication/Education	☐ Announcements and memos ☐ Education and Tip Sheets

		☐ Huddles ☐ Staff Meetings
12.	Privileging	☐ Specific requirements and criteria ☐ Case log number and time frame ☐ Focused Professional Practice Evaluation (FPPE)/Proctoring ☐ Continuing Medical Education (CME)
13.	Reappointment	☐ Clinical Activity and Case logs
14.	Approvals	☐ Procedural Innovation Committee ☐ Credentials and Privileging Committee ☐ Medical Executive Committee ☐ QPSC and Board

Contract Approvals
October 2025

1. New agreement between Hayward Sisters Hospital doing business as St. Rose Hospital and Nelson T. Lewis Construction Co., Inc. for catheterization lab upgrade. The term of this agreement is effective October 15, 2025 through June 15, 2026. The estimated impact of this agreement is $3,197,080.
Mario Harding, Chief Administrative Officer

2. New agreement with ePlus Technology Inc. for provision of data loss protection services. The term of this agreement is effective date last signed for a 3-year term. The estimated impact of this agreement is $1,800,000.
Christine Yang, Chief Information Officer

3. Renewal agreement with Switch, Ltd. for provision of data center services. The term of this agreement is effective February 16, 2026 through February 15, 2031. The estimated impact of this agreement is $1,509,294.
Christine Yang, Chief Information Officer

Contract Approvals
October 2025

4. New agreement with Lescure Company, Inc. for architectural and structural work for the Alameda Hospital HVAC replacement project. The term of this agreement is effective November 1, 2025 through March 31, 2027. The estimated impact of this agreement is $1,668,200.

Mark Fratzke, Chief Operating Officer

5. New agreement with Matrix HG, Inc. for installation of COVID prevention HVAC upgrades at John George Psychiatric Hospital. The term of this agreement is effective November 1, 2025 through October 31, 2026. The estimated impact of this agreement is $1,214,436.

Mark Fratzke, Chief Operating Officer

Recommendation: Motion to Recommend Approval for the above contracts to the Board of Trustees

MONTHLY REPORT
LIFETIME VENDOR SPEND - OCTOBER 2025

Vendor Name	Revised Contract Term	Proposed Contract Spend	Total Lifetime Vendor Spend (including proposed contract)	Proposed Contract Description	Status
Abbott Diabetes Care Sales Corporation	09/05/2025-09/04/2028	$376,823.34	$1,632,519.45	AHS currently utilizes the Abbott Precision Xceed Pro across multiple hospitals and wellness centers for bedside glucose testing. This system supports rapid glucose measurement critical for managing diabetic and critically ill patients. 3-year renewal for continuing services	Executed
Microsoft-Nuance Healthcare	08/15/2025-08/14/2028	$117,396.00	$1,431,067.35	This is a quote for implementation of an online web portal for image exchange between AHS and outside facilities. Also included is the integration between powershare and our AHS Epic E.H.R. This quote also includes 3-years of licensing and support.	Executed
Press Ganey	04/01/2021-06/30/2027	$5,723	$5,081,447.52	Amendment #5 removes Behavioral Health Inpatient Service and Replaces it with Psychiatric Inpatient (PIX) service at Highland Hospital. This includes modifying Attachment A & B to line up with this new change in verbiage and cost.	Executed
Press Ganey	04/01/2021-06/30/2027	$0	$5,075,724.52	Amendment #6 moves existing Ambulatory Surgery with OASCAHPS service from Alameda Hospital to a new service of Outpatient mail/eSurvey/Text at AHS Wellness Centers. Attachment A Section 1(a) and Attachment B shall both be modified to include Outpatient Services	Executed
United Systems Fire and Security	05/01/2025-04/30/2026	$67,136.67	$1,751,400.79	5-year Sprinkler Test JGPH & FMT	Executed

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
5	Entisys Solutions, Inc. dba E360	$1,499,410	9/29/2025	9/28/2028	FC - 9-3-25 BOT Approved 9-17-25	Citrix virtual access platform		Chief Information Officer
6	GuidePoint Security LLC	$1,457,310	9/30/2025	6/30/2028	FC - 9-3-25 BOT Approved 9-17-25	Arctic Wolf cybersecurity monitoring and recovery services		Chief Information Officer
7	Xerox, Inc.	$3,983,160	11/1/2025	10/31/1930	FC - 9-3-25 BOT Approved 9-17-25	Printer equipment and services.		Chief Information Officer
8	Anthem Blue Cross Life and Health Insurance Company	$5,930,739	1/1/2025	12/31/2027	FC - 9-3-25 BOT Approved 9-17-25	Third-party administrator services for AHS employee health insurance plan.		Chief Human Resources Officer
9	Cardea Health	$6,394,800	10/1/2025	9/30/2028	FC - 9-3-25 BOT Approved 9-17-25	Respite housing services.		Chief Clinical Officer
10	Lifepoint Rehabilitation of California, LLC	$4,211,233	10/1/2025	9/30/2028	FC - 9-3-25 BOT Approved 9-17-25	Inpatient rehabilitation management services.		Chief Operating Officer
11	McKesson Corporation	$447,180,000	4/1/2026	3/31/1931	FC - 9-3-25 BOT Approved 9-17-25	Wholesale pharmaceutical supply services.		Chief Clinical Officer
12	Quest Diagnostics	$13,280,743	3/1/2022	2/28/2026	FC - 9-3-25 BOT Approved 9-17-25	Reference laboratory services.		Chief Clinical Officer
	Total Amount for FY 25 year to date	$503,664,410						

Board of Directors Contract Summary | October 2025

<table>
<tr><td>Contractor/ Vendor Name:</td><td>Nelson T. Lewis Construction Co., Inc. (“NT Lewis”)</td></tr>
<tr><td>Description:</td><td>St. Rose Hospital (“SRH”) is a STEMI Receiving Center and operates a cardiac catheterization laboratory (“Cardiac Cath Lab”) that provides interventional cardiology services on an emergency and non-emergency basis. The current equipment in the Cardiac Cath Lab is at the end of its life and must be replaced. Replacing the equipment in the current location of the Cardiac Cath Lab would require shutting down the current Cardiac Cath Lab for 6-9 months and such a closure would have a materially adverse effect on patient care and SRH’s revenue. In order to avoid closing the current Cardiac Cath Lab and to allow for a back-up cath lab, plans were submitted to the California Department of Health Care Access and Information (“HCAI”) to develop a new Cardiac Cath Lab in empty space next to the ED. These plans have been approved by HCAI and SRH is ready to proceed.

As part of the Cardiac Cath Lab Project, the radiology department access points (doors), which are adjacent to the new Cardiac Cath Lab, will be modified to accommodate new technology with a larger footprint and improve patient flow. New larger doors will be automated to allow hands free activation for safer, more efficient patient transportation.

SRH solicited proposals for the work approved by HCAI from three qualified contractors including NT Lewis. The proposal submitted by NT Lewis was found to be the most competitive and qualified proposal. NT Lewis also has a history of successfully performing and completing work at SRH including the recent conversion of the 3rd Floor Medical/Surgical Unit into a Sub-Acute Unit.

The proposed contract is a fixed price contract whereby NT Lewis has agreed to perform the required work for a fixed price of $3,197,080 in 210 calendar days. The timeline may be subject to adjustment based on discovery of unknown conditions or delays in delivery of certain HVAC and other similar equipment.

The proposed contract with NT Lewis does not include the costs of the Cardiac Cath Lab equipment being purchased from GE.</td></tr>
<tr><td>Contract Type and Term:</td><td>New Contract – Standard Form of Agreement between Owner and Contractor
Term: October 15, 2025 – June 15, 2026</td></tr>
<tr><td>Termination Clause:</td><td>SRH may terminate the contract for convenience at any time. If terminated for convenience, SRH is required to pay NT Lewis an amount equal to cost of the work completed plus office overhead plus 15% profit.</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>Fixed Contract Sum</td><td></td><td>$3,197,080</td></tr>
<tr><td>Total Estimated Spend:</td><td>Approval Requested</td><td>$3,197,080</td></tr>
</table>
</td></tr>
<tr><td>Estimated Cost Savings:</td><td>N/A</td></tr>
</table>

Fiscal Implications:	Alameda Alliance has graciously provided a grant of $3,500,000 to fund the costs associated with the Cardiac Cath Lab Project and such funds are being held by AHS Foundation. In addition, the St. Rose Hospital Foundation has committed $1,000,000 towards the project. Discussions are ongoing with Fremont Bank Foundation for additional funding to cover the estimated remaining costs of $775,000. The AHS Foundation is also working to identify a donor if St. Rose is not able to secure funding from the Fremont Bank Foundation.
Reasons for Recommendation:	The current Cardiac Cath Lab equipment is out of date and must be replaced and the development of the new Cardiac Cath Lab will avoid the closure of the current Cardiac Cath Lab for 6-9 months and the adverse impact of such closure. SRH is a STEMI receiving center and the availability of interventional cardiology procedures is essential to meeting healthcare needs of community.
Coordination with Medical Staff:	The Interventional Cardiologists have been briefed regarding the development of the new Cardiac Cath Lab and the timelines associated with the construction.
Administrative Review:	Primary: SRH Director of Facilities Secondary: SRH Chief Administrative Officer
Prior BOT Review/Action:	None.
Executive Sponsor:	SRH Chief Administrative Officer

<table>
<tr><td>Contractor/Vendor Name:</td><td>ePlus Technology Inc. (“ePlus”)</td></tr>
<tr><td>Description:</td><td>ePlus is a U.S.-based digital security services provider infrastructure company founded in 2007. ePlus provides the Zscaler platform providing data and cyberthreat protection services. Alameda Health System (“AHS”) leadership is requesting Board approval to enter a data loss protection (“DLP”) and Cloud Access Security Broker (“CASB”) agreement (“Agreement”) with ePlus using the Zscaler solution (“Solution”) to provide the following services:

1. Prevent unauthorized disclosure of Protected Health Information (“PHI”) via email and cloud-based applications
2. Identify and mitigate unauthorized PHI access via the AHS Virtual Personal Network (“VPN”), Bring Your Own Devices (“BYOD”)
3. Provide surveillance and enforcement across the internet and remote work environments

Implementation of the Solution will enable AHS to deploy the full suite of technical safeguards required to extend robust data protection measures to remote and out of network users.</td></tr>
<tr><td>Contract Type and Term:</td><td>Services Agreement
Effective date last signed for a 3-years term.</td></tr>
<tr><td>Termination Clause:</td><td>A party may terminate if the other party is in breach and does not cure the breach within thirty (30) days after notice of 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>Subscription Services</td><td></td><td>$998,980</td></tr>
<tr><td>Implementation Services</td><td></td><td>$200,000</td></tr>
<tr><td>Additional Cybersecurity features</td><td></td><td>$601,020</td></tr>
<tr><td>Total Requested Amount:</td><td>Approval Requested</td><td>$1,800,000</td></tr>
</table>
</td></tr>
<tr><td>Cost Savings</td><td>AHS negotiated a $3,251,020 discount for the services contemplated under the proposed arrangement. In addition, AHS will experience additional cost savings of $400,000 when an incumbent application is replaced when the future upgrades are implemented during Year 2 of the new Agreement.</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>Zscaler is an established provider of cloud cybersecurity and data loss protection services. Acquisition of the Zscaler Solution will enhance AHS’ remote and out-of-network user data protection coverage improving our information security profile and ensure compliance with regulatory and legal requirements. Solution will also reduce the largest and potentially costliest risk maintained at AHS. By way of example, a $65M dollar court settlement was recently awarded to 135,000 patients whose</td></tr>
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<tr><td></td><td>patient data was stolen by a malicious actor who hacked LeHigh Valley Health Network.</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 Information Security 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:	Switch, Ltd. ("Switch")
Description:	Switch is a U.S.-based digital infrastructure company founded in 2000. The company designs, develops, and operates highly secure, sustainable, and large-scale data center ecosystems. Switch is recognized as an industry leader in: • Data Center Design & Operations – Facilities engineered for high-density workloads, advanced redundancy, and mission-critical performance. • Sustainability – Commitment to renewable energy and energy-efficient operations, supporting client environmental goals. • Carrier-Neutral Connectivity – Access to a broad network of carriers and cloud providers for flexibility and scalability. • Security – Multi-layered facility protections, including biometric access controls, 24/7 monitoring, and strict physical safeguards. Switch maintains data center campuses in Las Vegas, Reno, Grand Rapids, and Atlanta. These facilities serve enterprise, healthcare, government, and technology clients who require maximum reliability and data protection. **Current AHS Engagement** AHS has been under contract with Switch since October 14, 2022, with the agreement set to expire on February 15, 2026. Under the current agreement, Switch provides: • 10 Dedicated Cabinets – Housing AHS servers, storage arrays, and networking equipment within Switch's Las Vegas facility. • Redundant Power and Cooling – Dual-powered infrastructure and cooling systems to ensure system uptime and business continuity. • Secure Environment – Temperature-controlled colocation with multi-layered access controls and 24/7 monitoring. • Operational Independence – Switch does not access AHS devices, servers, or the data stored on them, ensuring complete control and confidentiality remains with AHS. This infrastructure supports AHS's critical business applications and data services, providing off-site resiliency and disaster recovery capability. **Proposed Renewal & Extension** Management recommends renewal and extension of the existing agreement to maintain uninterrupted services. Key details include: • Term: Renewal will extend the agreement for five (5) years, through February 15, 2031. • Scope of Services: Continuation of 10 dedicated cabinets at Switch's Las Vegas facility, inclusive of redundant power, cooling, and secure colocation. • Service Benefits: Sustains uninterrupted system reliability, operational security, and support for AHS's disaster recovery posture.

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<tr><td></td><td>Given the above, approval of this renewal is recommended to ensure the continuity of AHS's off-site data hosting capabilities, maintain system reliability, and support long-term operational security. This agreement allows AHS to continue leveraging Switch's industry-leading infrastructure without disruption through 2031.</td></tr>
<tr><td>Contract Type and Term:</td><td>Agreement Renewal
February 16, 2026 through February 15, 2031 (February 16, 2026 will be the commencement date).</td></tr>
<tr><td>Termination Clause:</td><td>A party may terminate if the other party breaches the Service Order and does not cure the breach within thirty (30) days after notice of 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>Switch Service Order</td><td>$1,509,294</td><td>$1,509,294</td></tr>
<tr><td>Total Requested Amount:</td><td>Approval Requested</td><td>$ 1,509,294</td></tr>
</table>
</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>We recommend Switch as AHS's vendor due to their proven track record of providing secure, reliable, and scalable colocation services since 2022. Renewing with Switch allows AHS to maintain existing infrastructure without costly migrations, while ensuring stability and predictability of costs through 2031.</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>
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</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>
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Contractor/Vendor Name:	Lescure Company, Inc. (“Lescure”)

Description:	Lescure is a Concord, California based construction company that was founded in 1947. Alameda Health System (“AHS”) has had a good working relationship with Lescure for several years now. In the course of past engagements, Lescure has helped AHS replace several steam generators at San Leandro Hospital (“SLH”), replace medical air compressors at Alameda Hospital (“AH”), and most recently the replacement of the SLH end-of-life underground emergency generator fuel tank. Lescure has a reliable track-record and is a trusted vendor for construction-based projects.
	
	AHS now seeks to partner with Lescure to help update the AH HVAC system to ensure future sustainability and a comfortable hospital environment. The existing HVAC system at Alameda is + 25 years past its useful life and experiencing repeated mechanical failures resulting in unacceptably high system downtime and unstable temperature and humidity levels in patient care areas. HVAC system disruptions can also increase the risk of airborne contaminants and bacteria adding urgency to the need to address this issue.
	
	To address this issue, AHS leadership has engaged Lescure under a prior arrangement arranged with Lescure to provide the following services under the following statement of work contingent on Board approval:
	
	• Statement of Work #7: Alameda Hospital Pumps ET-AS System Replacement–
	  ○ Architectural and structural work:
	  ▪ Partner with sub-contractors to ensure timely and accurate completion of all required paperwork, including permitting and regulatory approvals.
	  ▪ Safely remove any hazardous materials identified in the work area.
	  ▪ Demolish end-of-life equipment, concrete pads, and structural supports to prepare area for new installation.
	  ▪ Install 10 new replacement pumps (9 in central plant, 1 on roof) in conjunction with new concrete pads, piping, and supporting electrical and structural components.
	  ▪ Install new building management system (“BMS”) to manage new equipment, including variable frequency drives (“VFD”) for all 10 pumps. This will automate the system for improved efficiency.
	  ▪ Integrate new equipment with existing infrastructure, including flushing and treating new systems followed by testing and inspections to ensure all systems are fully operational.
	
	AHS leadership is requesting Board approval to enter the statement of work (“SOW #7”) with Lescure to complete above.

Contract Type and Term:	Statement of Work #7 Term: 11/01/2025 through 03/31/2027

<table>
<tr><td>Termination Clause:</td><td>Without Cause Termination: AHS may terminate without cause and without further liability by providing 30 days' notice, in writing, to the other party</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>Statement of Work #7 (11/01/2025 through 03/31/2027)</td><td></td><td>$1,668,200</td></tr>
<tr><td>Total Requested Amount:</td><td>Approval Requested</td><td>$1,668,200</td></tr>
</table>
</td></tr>
<tr><td>Estimated Cost Savings:</td><td>Installation of new energy efficient HVAC equipment will result in up to $20,000 in annual savings on energy costs.</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's HVAC system must be updated as soon as possible as the system is past its end of useful life, which has caused system failures and disruptions at Alameda Hospital.</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></td><td></td><td></td><td></td><td>X</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: System Director Facilities
Secondary: Vice President Supply Chain and Materials Management</td></tr>
<tr><td>Prior BOT Review/Action:</td><td>Statements of Work 5 and 6 (Temporary HVAC and Phase I Legacy HVAC Repair and Upgrade) approved by Board of Trustees January 8, 2025.</td></tr>
<tr><td>Executive Sponsor</td><td>Chief Operating Officer</td></tr>
</table>

Board of Trustees Contract Summary | October 2025

<table>
<tr><td>Contractor/Vendor Name:</td><td>Matrix HG, Inc. (“Matrix”)</td></tr>
<tr><td>Description:</td><td>Matrix is a Concord, California-based full-service HVAC company that performed HVAC repairs at John George Psychiatric Hospital (“JGPH”) under a prior arrangement.

AHS now seeks to partner with Matrix to lead the JGPH Covid Mitigation Project under which AHS will implement HVAC upgrades to comply with Covid prevention requirements. Services provided by Matrix under the proposed agreement (“Agreement”) include planning, permitting, and execution necessary to complete the work in compliance with operational and safety standards. This will be a multi-phase project divided as follows:

1. Initial Review – Will perform site inspection of current HVAC system and cross-reference with blue-prints and applicable regulatory and/or safety codes.
2. Design & Meetings – Generate detailed plans for the upgraded HVAC system and review with JGHP staff for feedback.
3. Documentation – Compile all required documents and drawings for the project.
4. Construction & Closeout –
a. Permits & Approvals – Obtain all necessary permits and regulatory approvals.
b. Construction – Installation of upgraded HVAC system, including HEPA filter units in 4 designated rooms. Will ensure system has ability to bring in 100% outside air when required.
c. Final Inspections - Manage inspections, address any issues, and obtain all required approvals from responsible authorities to ensure compliant project completion.
d. Completion – Upon project completion, compile final list of any pending issues and prepare close-out documents.</td></tr>
<tr><td>Contract Type and Term:</td><td>Standard Agreement
11/01/2025-10/31/2026</td></tr>
<tr><td>Termination Clause:</td><td>Without Cause Termination: AHS may terminate without cause and without further liability by providing 30 days’ notice, in writing, to the other party</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>Phase A & Phase B, Contingency, Professional Fees, and Taxes</td><td></td><td>$1,214,436</td></tr>
<tr><td>Total Requested Amount:</td><td>Approval Requested</td><td>$1,214,436</td></tr>
</table>
</td></tr>
<tr><td>Estimated Cost Savings:</td><td>N/A</td></tr>
<tr><td>Fiscal Implications:</td><td>Cost has been included in FY 26 budget.</td></tr>
</table>

<table>
<tr><td>Reasons for Recommendation:</td><td>John George’s HVAC system must be repaired to fall into compliance with operational and safety standards for Covid Mitigation.</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></td><td></td><td></td><td></td><td></td></tr>
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</td></tr>
<tr><td>Coordination with Medical Staff:</td><td>N/A</td></tr>
<tr><td>Administrative Review:</td><td>Primary: System Director Facilities
Secondary: Vice President Supply Chain and Materials Management</td></tr>
<tr><td>Prior BOT Review/Action:</td><td>N/A</td></tr>
<tr><td>Executive Sponsor</td><td>Chief Operating Officer</td></tr>
</table>

Center for Operational Transformation

ALAMEDA HEALTH SYSTEM

Center for Operational Transformation

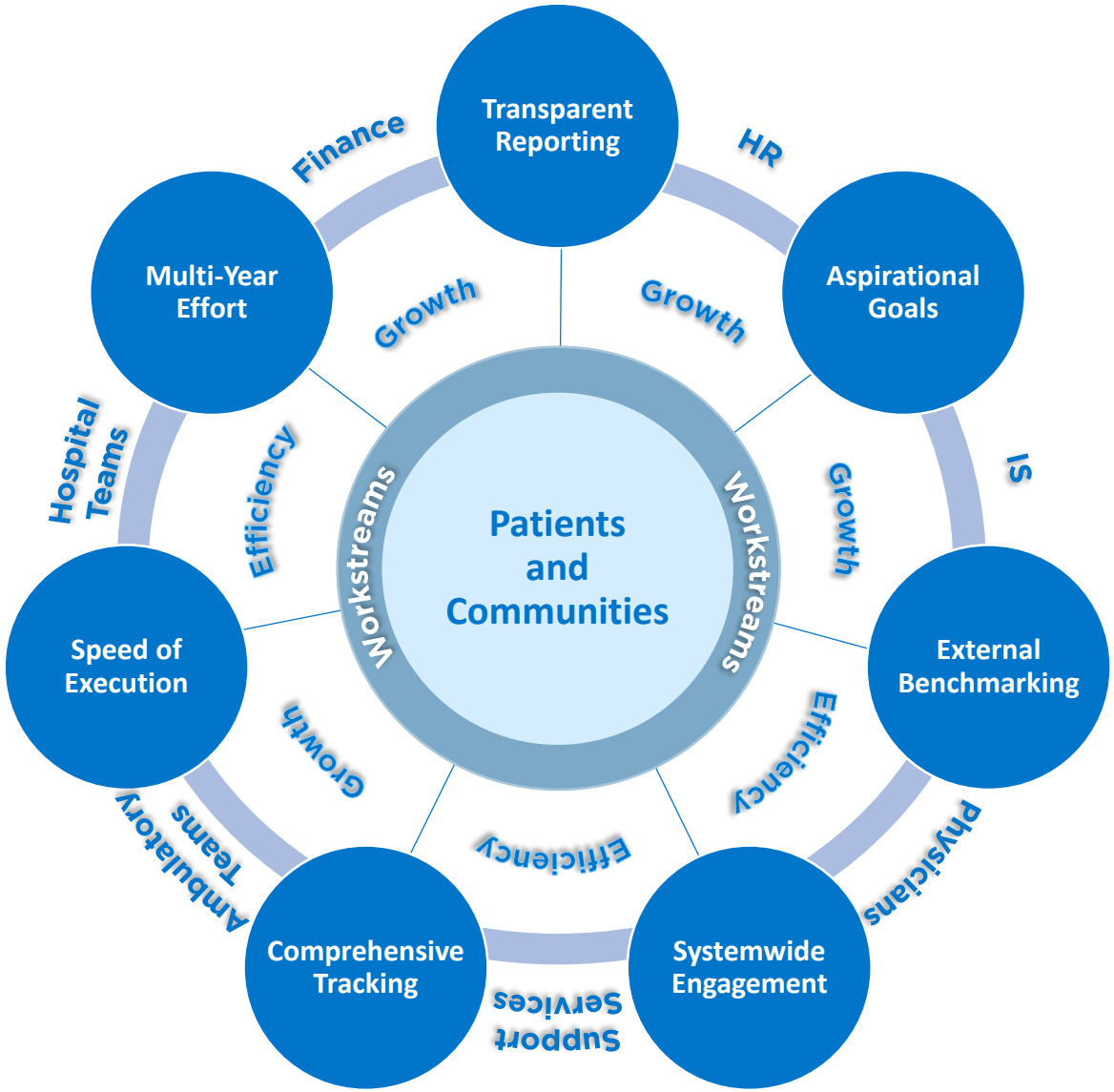
Overview / Update

10.08.2025
Board of Trustees

ACHIEVE AHS

Vision:

'Achieving Excellence through Transformation'



Tenets to Ensure Success:

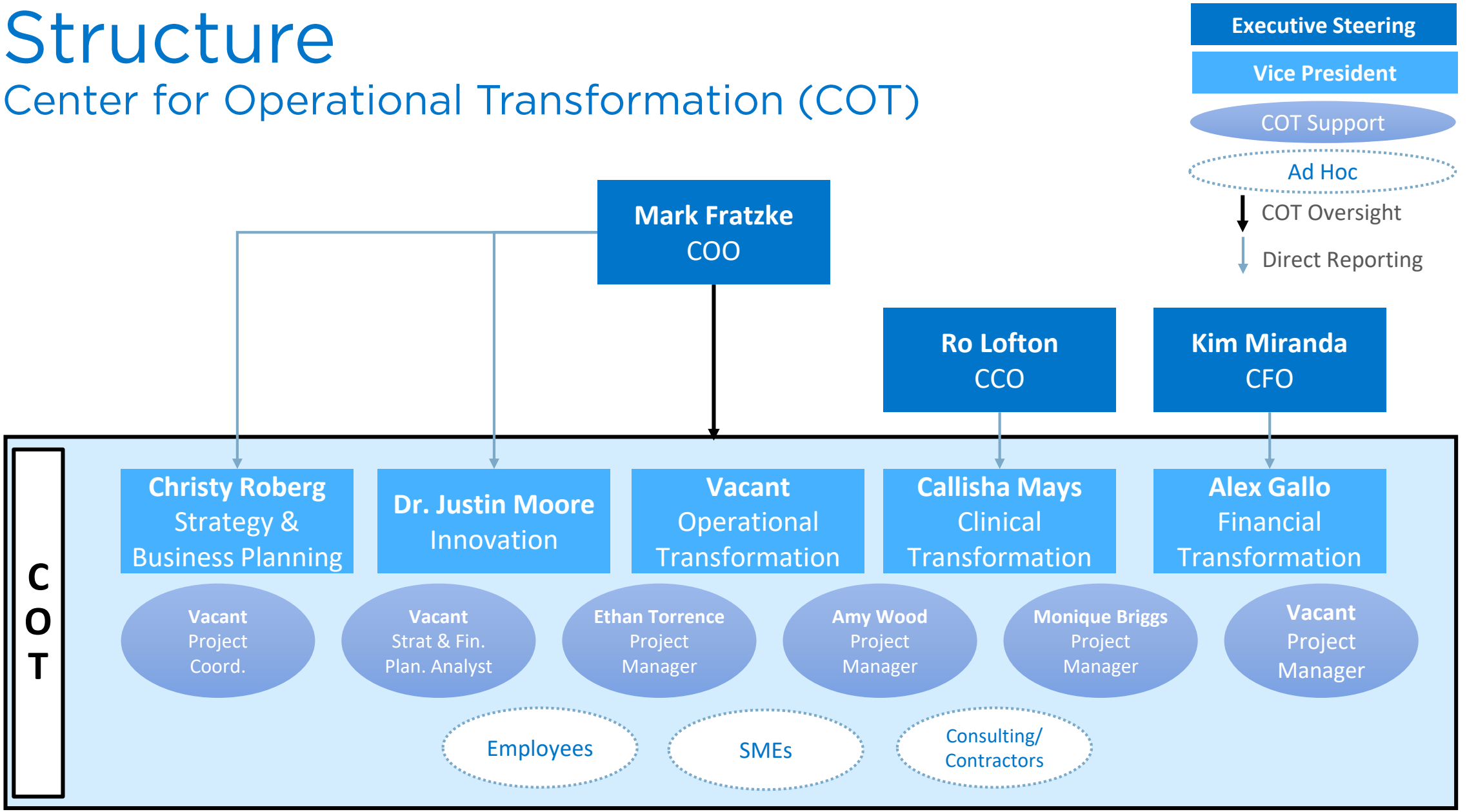
- Identify and implement bold change within AHS and Affiliates
- Ensure improvements are measurable and address immediate and long-term financial opportunities
- All levels of the organization are empowered to identify and implement needed improvements

ACHIEVE AHS & Center for Operational Transformation

- **ACHIEVE AHS** is a system-led, aspirational effort focused on transforming operations within Alameda Health System and Affiliates.
- Efforts are guided through **The Center for Operational Transformation (COT)**:
  - COT is a lean, cross-functional hub of resources with optimized expertise;
  - Members of COT assist the organization with focus, discipline, and consistency.

Structure

Center for Operational Transformation (COT)



How We Built the Initiative Portfolio

Influence of the Big Bill
Initiatives were prioritized based on alignment with the major financial challenges facing AHS, with emphasis on driving material impact to system sustainability.

Roll-Up of Top Initiatives by Group
Each functional and clinical group identified its highest-value opportunities. We first developed an inventory of all initiatives – both planned and in progress. The initiatives were then consolidated into a system-wide portfolio to ensure balance across growth and efficiency.

No Initiatives Cancelled
All previously identified projects remain in motion; prioritization clarified focus on the most impactful initiatives while preserving momentum on existing work.

Optimized Resources, Intentional Growth

Consolidated Initiatives:

- Transition of Operations Projects from ePMO
- Existing Capital Improvement Projects
- Existing Departmental Projects/Initiatives
- Operational Plan Initiatives
- Efficiency Opportunity Initiatives

Prioritization:

	L1: Enterprise Critical	L2: Strategic	L3: Department-Level
Financial Impact	>$10M annually	$500K–$10M	<$500K
Resource Support	Dedicated PM, exec sponsorship	Consultative support	Self-managed, tools on request
Visibility	CEO/Board dashboards	Monthly COT updates	Quarterly aggregate reporting, Reported at MORs, Quality
COT Approval Required	Yes	Yes	No
Alignment	– Aligned with AHS operational business plan – Objectives and efficiencies required to absorb legislative reimbursement reductions.	– Aligned with AHS operational business plan – Objectives and efficiencies required to absorb legislative reimbursement reductions.	– Aligns with unit/department-based improvements

Transformation Mandate

- Ensure execution of critical L1/L2 projects
- Create systematic, transparent project intake & prioritization
- Build long-term financial plan tied to initiatives
- Enable self-sustaining transformation culture

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Growth and Efficiency Initiatives Impact

- We will ensure that initiatives address access, quality, and sustainability priorities.
- The L1 initiatives are expected to deliver **$285M in cumulative savings** from FY26–FY29.
- The initiatives will provide both short-term relief and long-term financial resiliency.

The portfolio of initiatives blends Efficiency projects (cost control, rightsizing, process redesign) with Growth projects (service expansion, fundraising, clinical partnerships) to ensure transformation efforts reduce costs while fueling future revenue.

L1 Growth Initiatives

($ in thousands)

#	Name	Description	Total Spend	Yr 1 Savings	Yr 2 Savings	Yr 3 Savings	Total Savings
01	BCHIP Inpatient medical detox unit at SLH	Multiyear project capitalized via BHCIP funds. This project is to develop an inpatient detox unit at San Leandro Hospital	15,000				
02	Consolidation of Ortho at San Leandro	Multiyear project starting in FY26 with devoted capital. Moving ortho outpatient practice from Alameda to San Leandro. Consideration of outpatient ortho physical therapy.	8,500				
03	HCP-3 Dental/OMFS Relocation	Relocation of dental services at WCHHC from Wings to HCP	7,000				

L1 Efficiency Initiatives

($ in thousands)

#	Name	Description	Total Spend	Yr 1 Savings	Yr 2 Savings	Yr 3 Savings	Total Savings
04	Rightsizing	Better align organizational resources with current and future service demand and metric ratios, ensuring long-term efficiency and sustainability.		95,000	60,000		155,000
05	Program/Department Elim / Consolid.	Streamline operations, eliminate redundancy.		10,000	10,000		20,000
06	Headcount/Labor Planning Revamp	Redesign hiring and workforce planning processes to align with financial performance goals. Establish a three-year forecast that sets headcount as a percentage of operating income, with approval authority streamlined down to CAO levels. Introduce forecasting and tracking to ensure staffing levels remain within defined targets.			20,000	60,000	80,000
07	Contracts - go through all contracts, pursue savings and implement sustainable process (much less than six months to finalize contract).	Review contracts to identify savings opportunity. Setup a sustainable and effective process.		2,500	2,500	2,500	7,500
08	Mid-level optimization	Ensure mid level providers are working at the top of their license and AHS is optimizing charge capture.					
09	Compensation and Benefits Optimization	Negotiate a system-wide adjustment to employee compensation and/or benefits to achieve near-term labor cost savings.		45,394			45,394
10	Portfolio Mix	Develop a service mix roadmap that positions each site for financial and strategic sustainability. Align clinical services, staffing, and community needs to optimize performance across the portfolio.			2,000	5,000	7,000

L2 Initiatives (1 of 2)

($ in thousands)

Name	Description
Non-Essential Travel Freeze	All travel requires approval of C-Suite
Alameda Seismic work	Multiyear project running thru 2030. $55 million in capital investment secured via Alameda Hospital parcel tax dollars.
CMS TEAM Payment Bundle Opportunity	AHS has the opportunity to participate in the CMS TEAM payment bundle, leveraging a 100% Medicare claims file analysis. A tailored data and analytics solution would support execution and position the organization to achieve measurable financial impact, while providing actionable insights for care delivery and cost efficiency.
San Leandro Sterile Processing	Multiyear buildout of SPD at San Leandro to support surgery. Capital approved. Completion date November 2027.
Alameda SNF	Multiyear project capitalized via parcel tax funds from Alameda Hospital.
Medicare Advantage and Dual Eligibles (Medi-Medi) Contracts	Ensure Alameda Health System is contracted to participate in Medicare Advantage and dual eligible (dual coverage Medicare and Medicaid) health plan networks.
ED Remodel – BHCIP	This is a BCHIP application slated to be submitted by 10/28/25 for Improvements to patient flow, quality of care, and the physical environment at the WCHHC ED to better support behavioral health and substance abuse patients. Current ED space is not operationally equipped or appropriately designed to meet the needs of this growing patient population.
Primary Care Expansion / Urgent Care Clinic	This initiative is assessing whether we need to expand Primary Care outside of WCHHC, defining a PC strategy at the system level which includes assessment for an external Urgent Care clinic
OR Staffing Efficiency	Adjust staffing levels to match operating hours, which will require union negotiations to modify shift lengths.
Clinic Staffing Efficiency	Address "no shows" proactively with same day appointments, over booking, and developing standardized process for filling in last minute pts in clinics -Implement call center open scheduling, eliminate screening processes -Build provider trust to allow patients
Alameda Hospital HVAC Replacement Project	HVAC construction project at ALH as part of Seismic work to ensure compliance with regulation and replace end of life equipment
HGH Outpatient Pharmacy Relocation	Per CA State Board of Pharmacy, regulatory requirement to separate HGH's Inpatient and Outpatient pharmacies.
Transition of Alameda Health Medical Group	As Alameda Health System (AHS) moves toward a more unified physician workforce, we want to transition all SEIU-represented physicians from Alameda Health Medical Group (AHMG) to direct employment with AHS, effective March 1, 2025. Physicians will continue to see AHMG on their wage statements during the transition period. Thereafter, AHMG will be dissolving, moving AHS into its next chapter of creating one shared identity among all physicians and Advanced Practice Providers (APP) across the system.

L2 Initiatives (2 of 2)

($ in thousands)

Name	Description
Code Critical Transfers	Code Critical' Transfer for emergent transfers from AH/SLH to HGH for life saving procedures and inpatient care
Office Space Strategy	As part of Facilities Consolidation, make decision on relocating staff from HGH, SSC, JLS to one facility.
Invasive Vascular move to Cupid	Project Objective and Goal: Transition from Radiant to Cupid Software in the Cardiac Cath Lab Objective: The primary objective of this project is to streamline operations and address interface challenges by transitioning from the Radiant software program to the Cupid software program in the Cardiac Cath Lab. Goal: The goal of this project is to enhance operational efficiencies and standardize processes for both staff and physicians, ultimately improving workflow, reducing errors, and facilitating better patient care.
Revamp Capital Spending Process	The current capital approval process often allows projects to move forward without clear alignment to strategic priorities. This initiative will redesign the governance framework for capital spending.
L3 Tracking	This initiative will establish a structured program to track, manage, and report financial savings from all L3 projects. It includes site-level training, ongoing education, and a consistent monitoring process to ensure initiatives deliver measurable and sustained results.
Outsource	Outsource functions or portion of departments for efficiency, expertise & technology at lower FTE price point. Consider benefits, recruiting, call center, help desk, billing follow up etc
Replace AHS ERP System	AHS will undertake a comprehensive project to select and implement a new enterprise resource planning (ERP) system that integrates finance, supply chain, and human resources. The initiative will modernize core business processes, improve data accuracy and transparency, and enable more efficient, strategic decision-making across the organization.
Fairmont SNF / SNF Strategy	Long term strategy for SNF across AHS system. Specifically, looking at increasing SNF beds at SRH, via partnership with Stanford, or at BLDG H at FMT
Focus Growth: Ortho, Onc, Gen Surgery, GI, Cardiology	Focus growth efforts on top growing service lines within Alameda County/AHS and Affiliate hospital service areas.
OP Imaging/Ancillary	Desire to grow specialty Pharmacy and Outpatient Rx. Proposal from Huron Consulting.
Peds and Women's South County	Assessment currently in process by Birth Center Equity regarding OB services provided in South County.
SLH & HGH DaVinci Surgical Robot	Capital & other items cost ($3.1mil/HGH, $2.5mil SLH) total $6,425,000 (includes table, instruments, accessories, unplanned cost).

Key Enablers

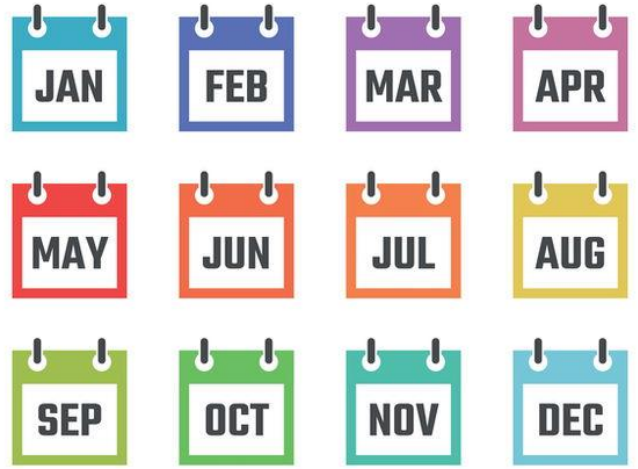
- Centralized portfolio management, repository of information, standardized processes and tools
- Frequent and consistent progress reporting
- Quarterly town halls, newsletters, intranet site
- Cascading expertise
- Best-practice implementation

First 90 Days

- Align on top L1/L2 priorities; suspend under-resourced projects
- Draft Long-Term Financial Plan tied to initiatives
- Identify projects/initiatives already in motion; pause low-value efforts
- Baseline supply chain, HR, IT support projects for resource alignment
- Stand up COT project intake & tracking processes
- Launch idea intake framework and define criteria for vetting pilots
- Launch communication modalities, channels, and cadence

First 12 Months

- Activate new growth projects after Q1 reprioritization
- Finalize COT systems architecture and portfolio dashboard
- Redesign capital approval & monitoring processes
- Demonstrate measurable savings to justify growth posture
- Stand up innovation pipeline and select 2–3 priority pilots to test
- Begin scaling successful pilots into broader transformation portfolio
- Conduct portfolio review; prepare Year 2 transformation roadmap



Year 1 Success

Process:

- L1/L2 initiatives on track and on time
- Savings and revenue tracked
- % Departments with transformation plans in place

Outcome:

- AHS achieving improvements with growth and efficiency
- Performing on track to budget with contingency funds to absorb legislative funding cuts
- Embedded culture of process/performance improvement and innovation

Questions / Discussion

Thank you.

AHS AI Program Review

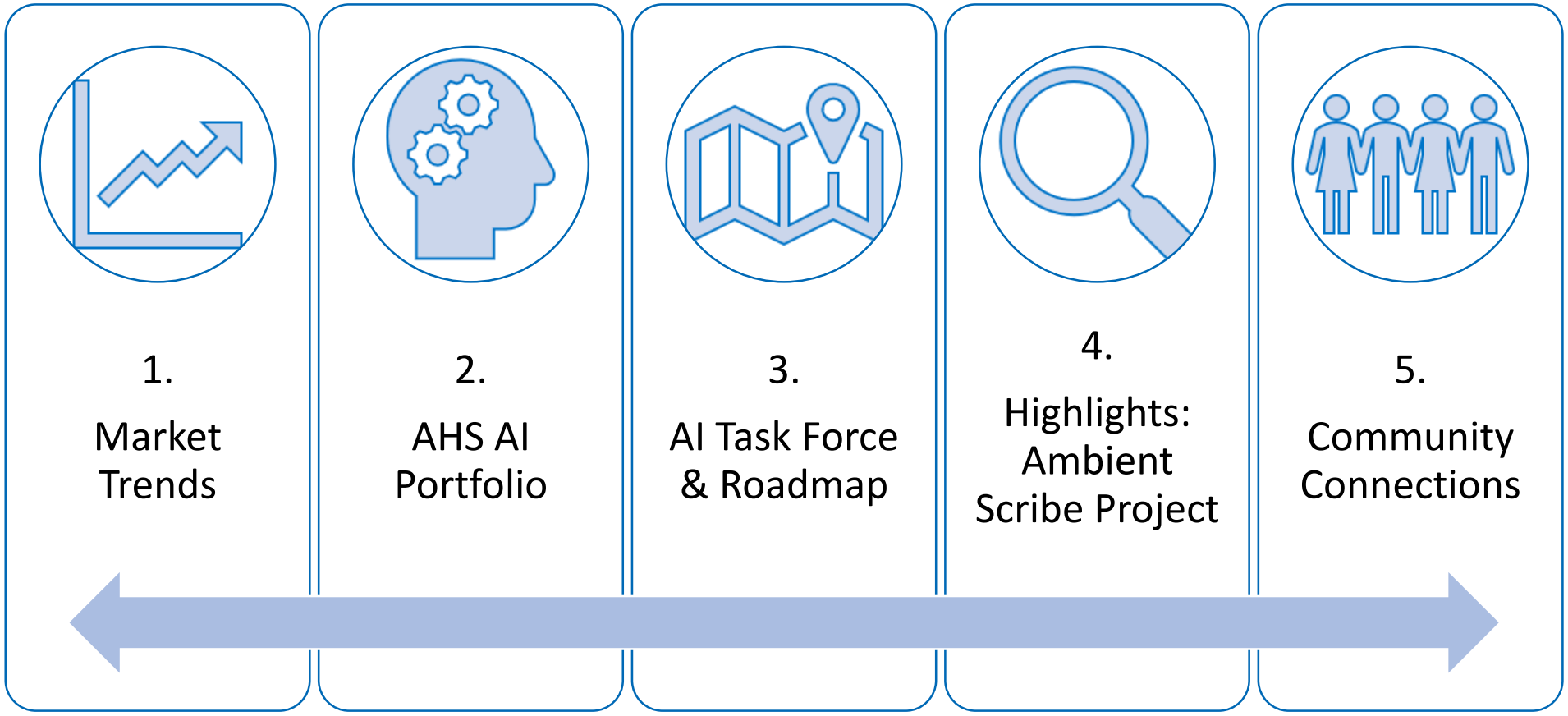
ALAMEDA HEALTH SYSTEM

AI Task Force & Roadmap

Sarah Rahman, MD MPH
ACMIO

10/8/25

Agenda

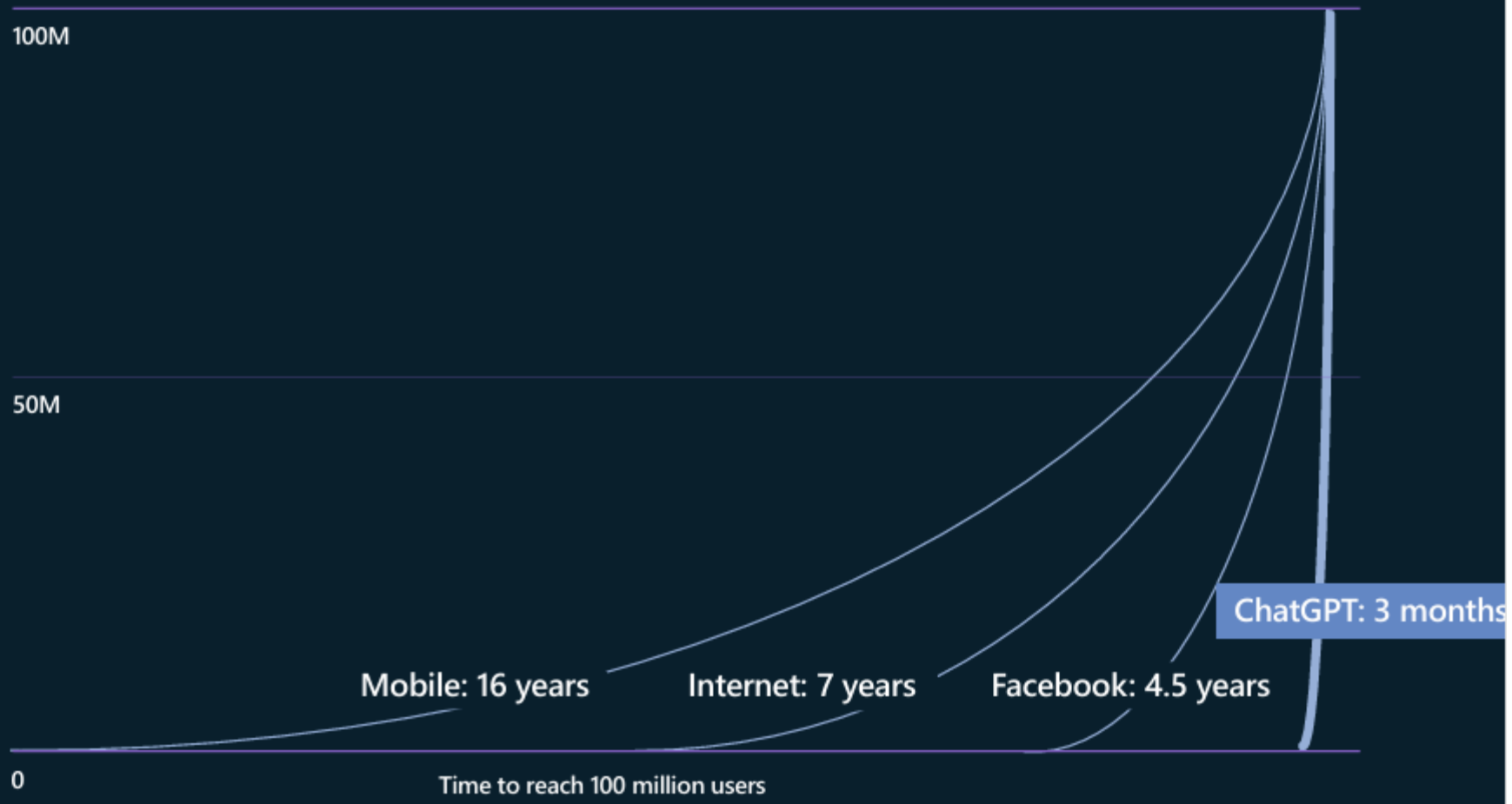

1.
Market Trends
2.
AHS AI Portfolio
3.
AI Task Force & Roadmap
4.
Highlights: Ambient Scribe Project
5.
Community Connections

How is AI Different?

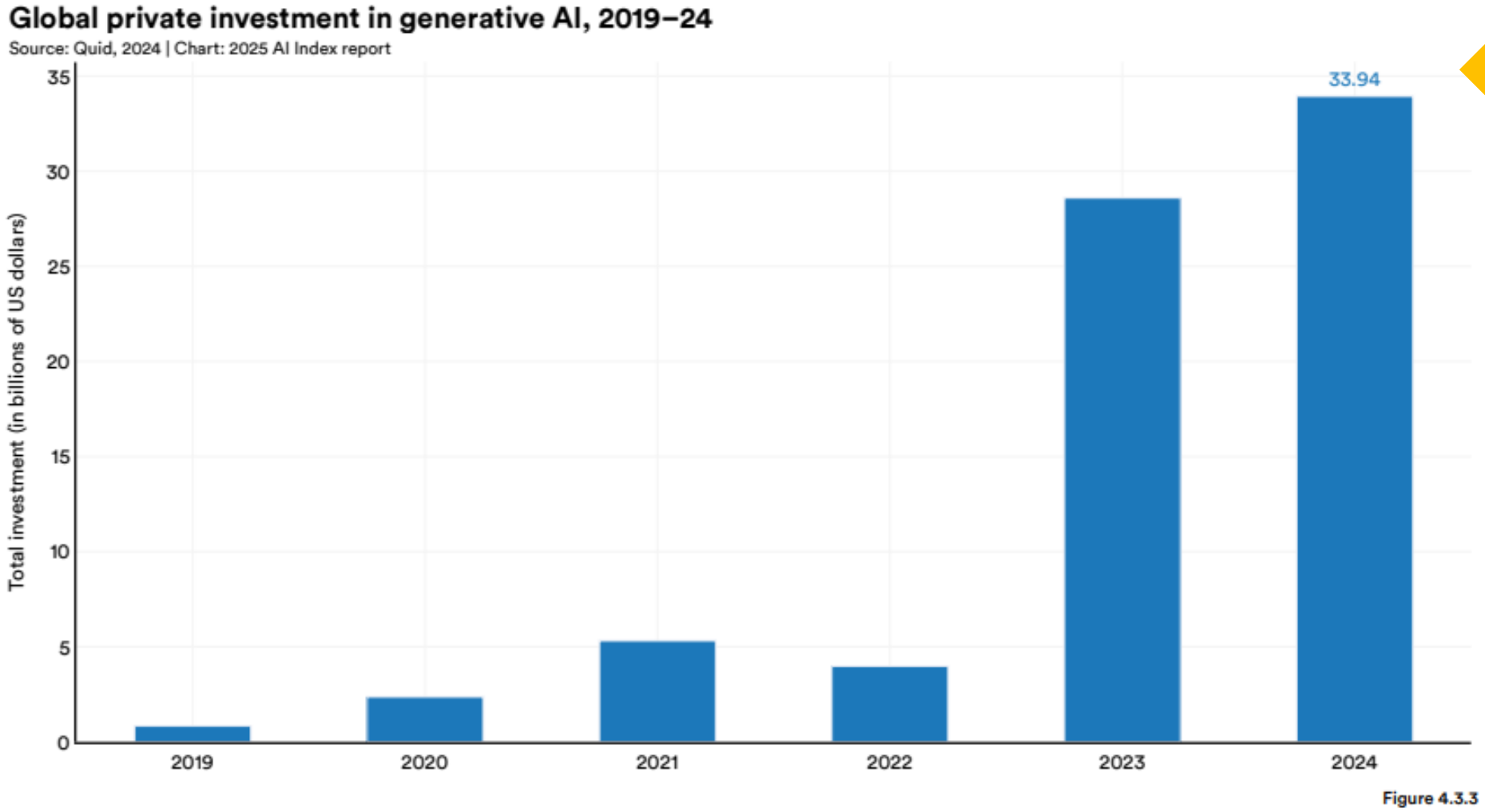
Generative AI Is Rapidly Gaining Momentum

The use of generative AI has expanded at a pace and scale that is unprecedented in the tech industry. Although it can take time to adopt a new technology, government agencies need a strategy to realize value.

Source: Microsoft, TK Study Name. TK Month 2024.
Survey Question: TK



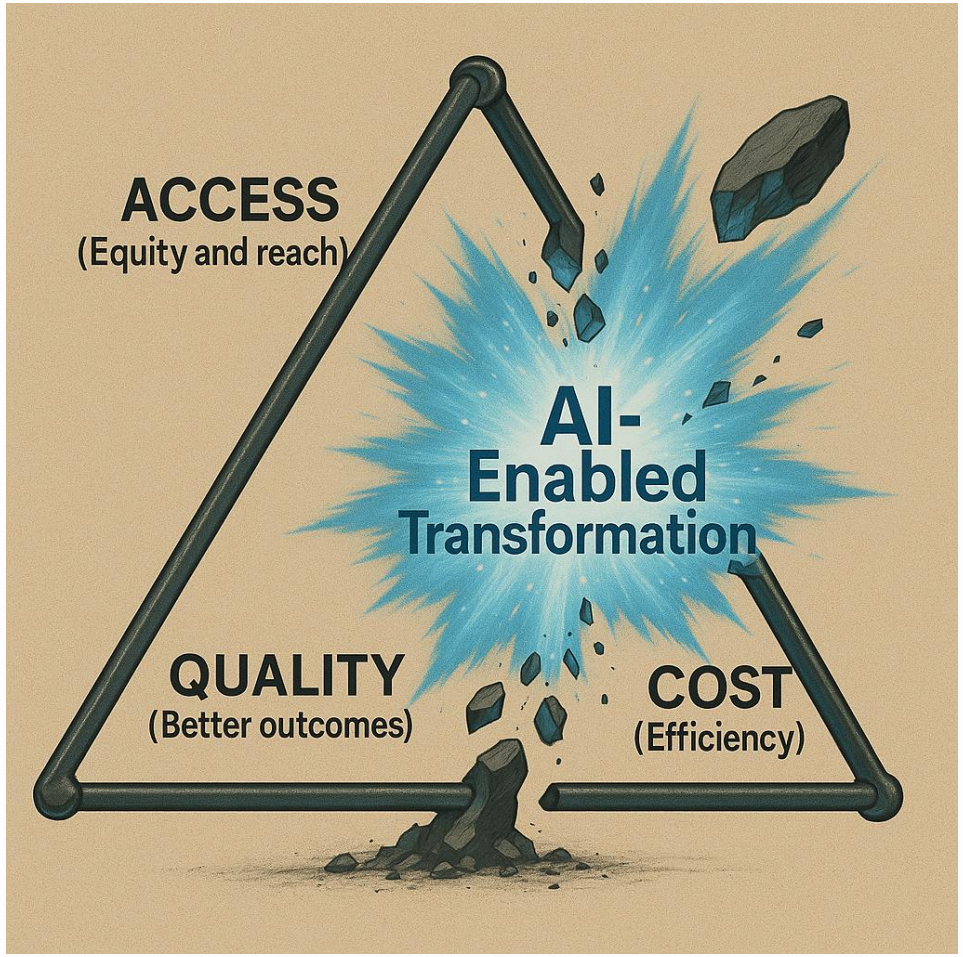
Market Trends:
Exponential Growth of AI Global Investment



$34 Billion

Maslei et al. “The AI Index 2025 Annual Report,” Stanford University Human-Centered Artificial Intelligence.

The Promise of AI:
Breaking the Healthcare Iron Triangle



AHS AI Portfolio: The Future is Now: The AHS AI Portfolio

Mature

- Amplifire- Epic Nursing education
- Doximity- Provider AI search tool
- Arctic Wolf and CrowdStrike- Security tools
- Protenus- Compliance auditing tool
- Zoom meeting AI Companion scribe
- DM Digital Retinal Screening

Early Progress

AI Ambient Scribe Pilot (May-July)

ServiceNow Human Resources Service Delivery (+ AI)

AI Benefits Assistance (July 1)

Epic Launchpad (July 14)

- Chart Summary
- Discharge Draft
- AI Text Assistant
- SlicerDicer SideKick
- Denial Appeal Letter

Future & Scoping

Ambient Note Scribe for AMB + ED(Oct)

Radiology tools

Epic Launchpad (Oct 13)

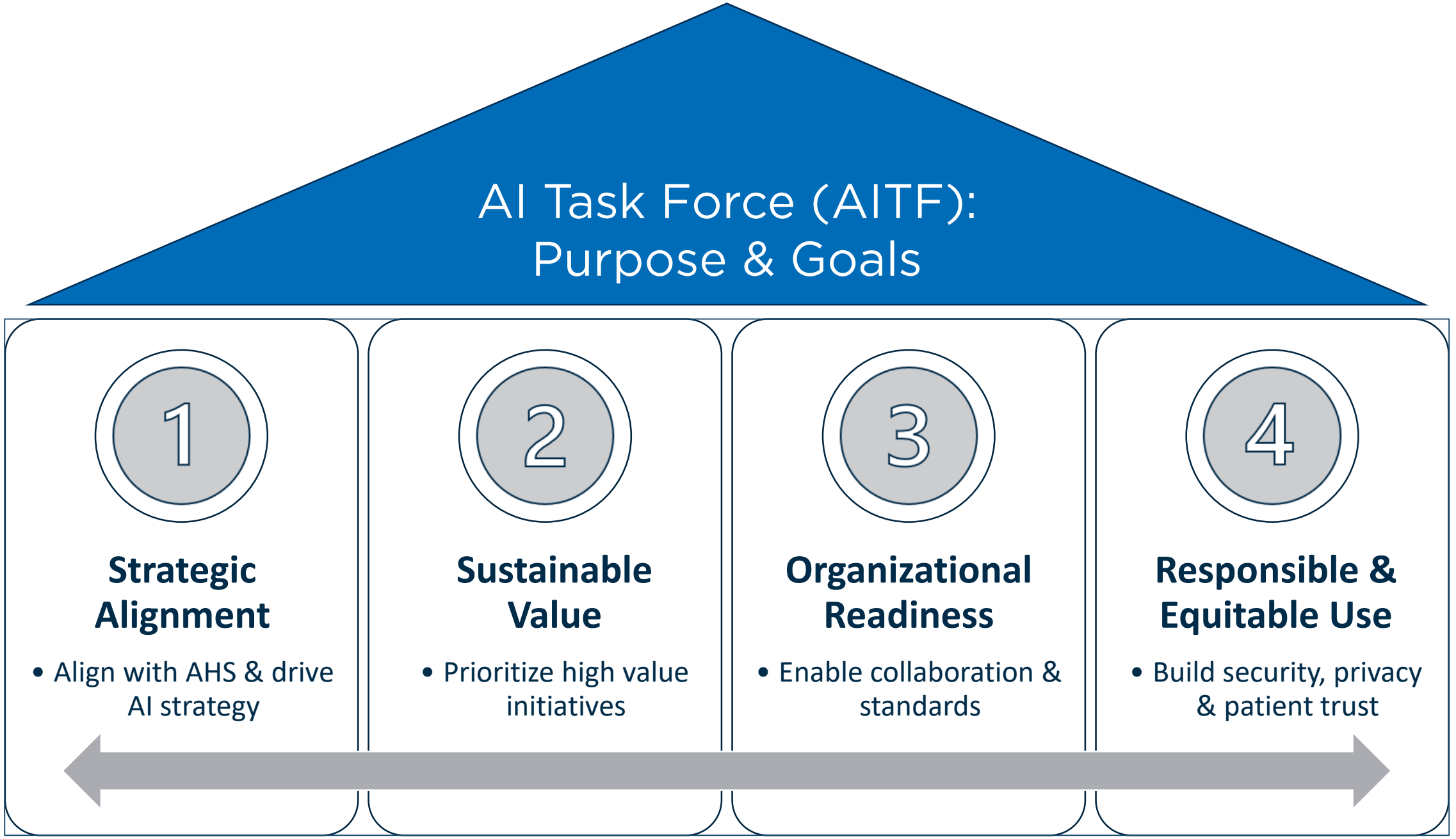
- Nursing Care Plan Notes
- PB Coding Assistant
- Dashboard Insights

Safety and Risk Management – Event Reporting and RCA

Epic AI Starter Kit- Generative AI in Epic

Epic Roadmap- Artificial Intelligence

AI Task Force (AITF): Purpose & Goals



1

Strategic Alignment

AI Task Force (AITF) Launched May 14, 2025

- **Mission:** To champion responsible, equitable and innovative use of artificial intelligence at Alameda Health System
- **Vision:** AITF will lead in the safe, equitable, and innovative use of AI to transform the healthcare experience for the communities we serve

Multi-Disciplinary Team	
Co-Chairs	Christine Yang (Co-Chair) - CIO Sarah Rahman MD, MPH-(Co-Chair) - ACMIO
CMO & ACMO's	Lisa Laurent, MD- CMO Porshia Mack, MD, MBA- ACMO, Amb Services Andrea Wu, MD- ACMO, Acute Care
Chief Clinical Officer	Romoanetia Lofton, DNP, MSN, MBA, FNP- BC, NE-BC
VP Patient Care	Dana Littlepage RN
Chief Financial Officer	Kimberly Miranda
Chief Revenue Cycle Officer	Shari Johnson
Chief Human Resources Officer **VP of HR**	Jet Chapman Arleen Gomez
CMIO	David English, MD
Chief Administrative Officers	Richard Espinoza, LNHA- Post Acute Services Patricia Espeseth, LMFT- John George Psychiatric Hospital

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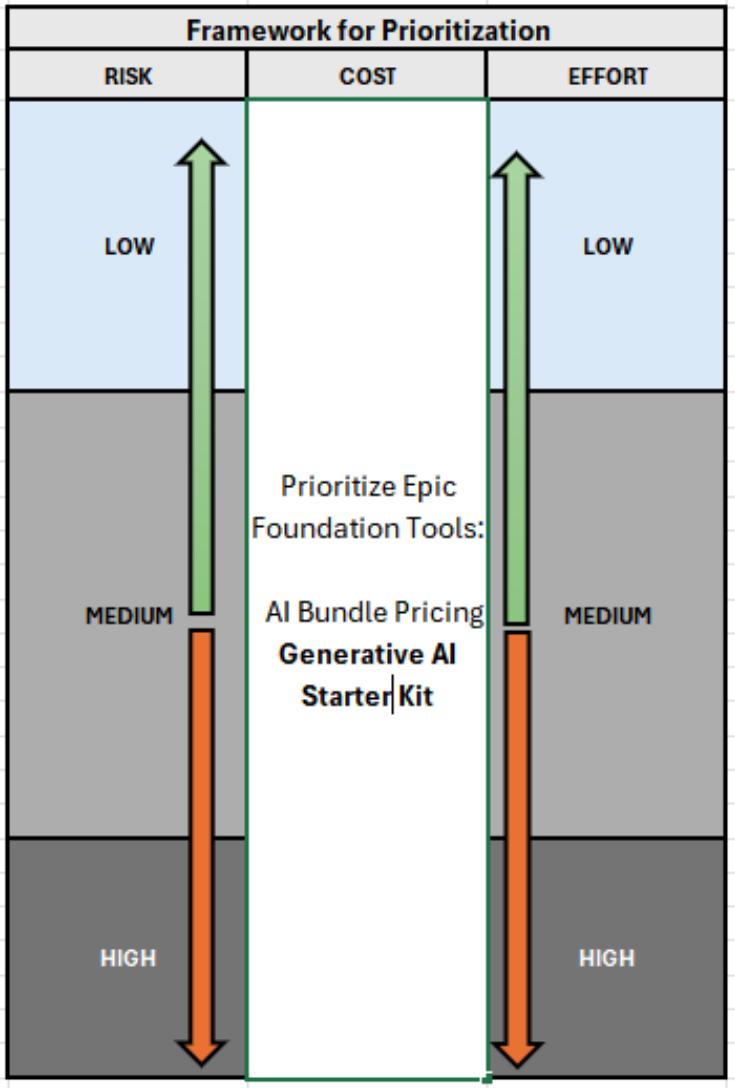
Healthcare Risk & Prioritization Framework

2

Sustainable Value

AI Scorecard	Impact
Admin Tools	INFORM Management
Revenue Integrity and Financial Performance	
Reporting	
Health Equity and Access	DRIVE Management
Operational Efficiency	
Patient Experience and Engagement	
Regulatory and Compliance	
Quality and Patient Safety	TREAT or DIAGNOSE Clinical Care
Predictive Models	



Examples:
SlicerDicer SideKick & Denial Appeals Letter

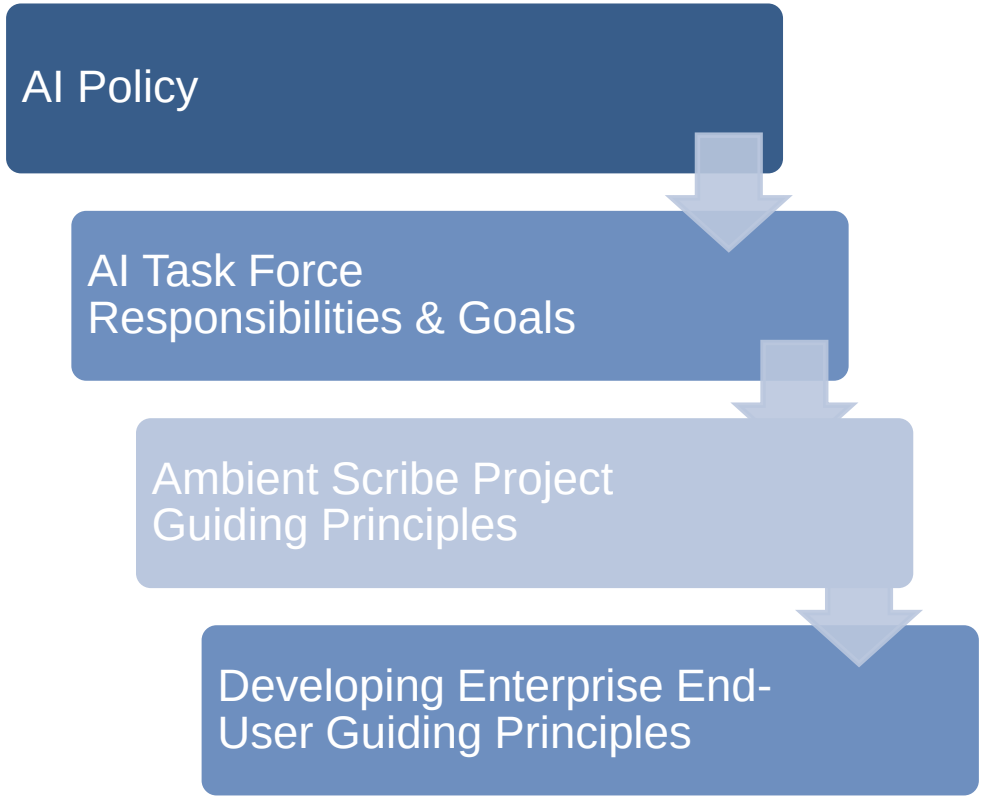
Example:
Ambient Note Scribe

Example:
Inpatient Falls Risk Predictive Model

3

Organizational Readiness

Organizational Readiness: AI Guiding Principles

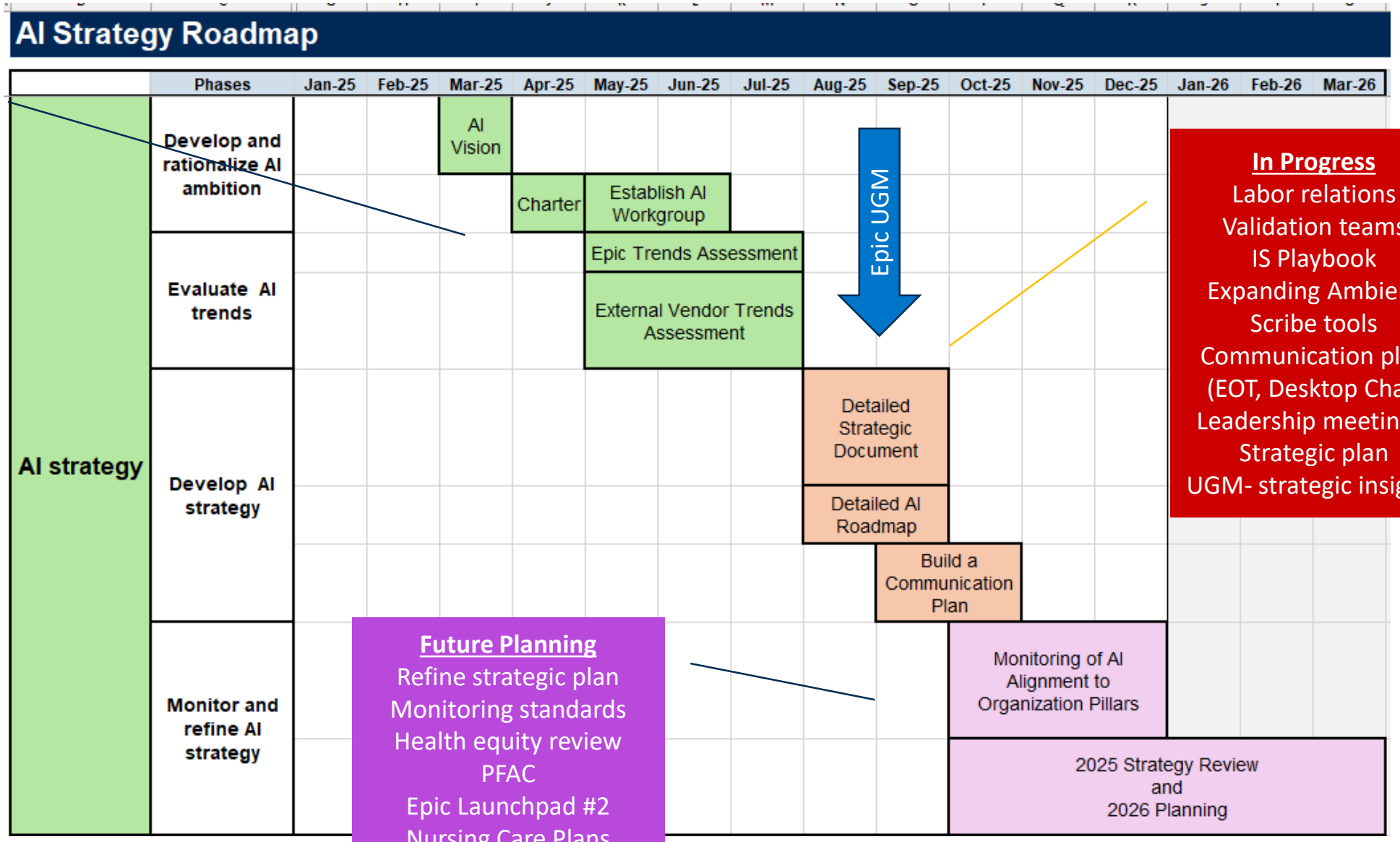


What's Important for AHS End Users?

- Patient Safety First
- Transparency & Accountability
- Human Oversight
- Stakeholder Collaboration
- Data Integrity
- Privacy & Security

AI Strategic Roadmap

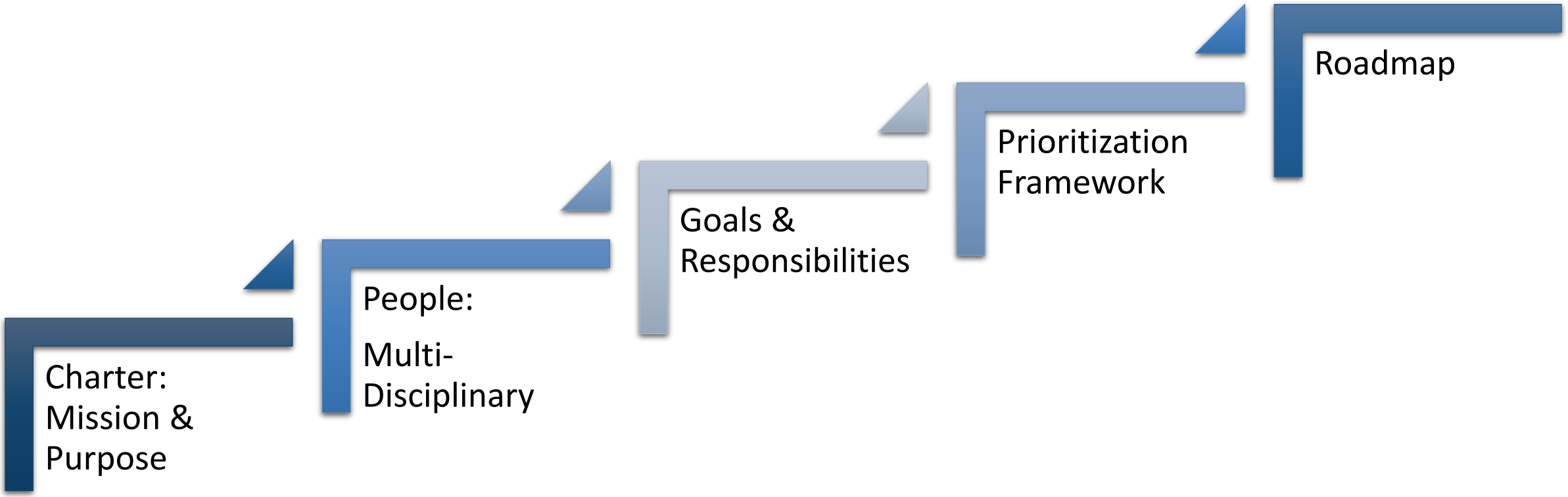
Accomplishments
AITF Kick-Off 5/14
Charter approval
Policy approval 6/18 MEC
Ambient Scribe pilot 5/7
Epic Launchpad 7/14
Align with Chief Strategy and Mission Officers



In Progress
Labor relations
Validation teams
IS Playbook
Expanding Ambient Scribe tools
Communication plan (EOT, Desktop Chat, Leadership meetings)
Strategic plan
UGM- strategic insights

Future Planning
Refine strategic plan
Monitoring standards
Health equity review
PFAC
Epic Launchpad #2
Nursing Care Plans

Building the Infrastructure: AI Taskforce (AITF) & Governance



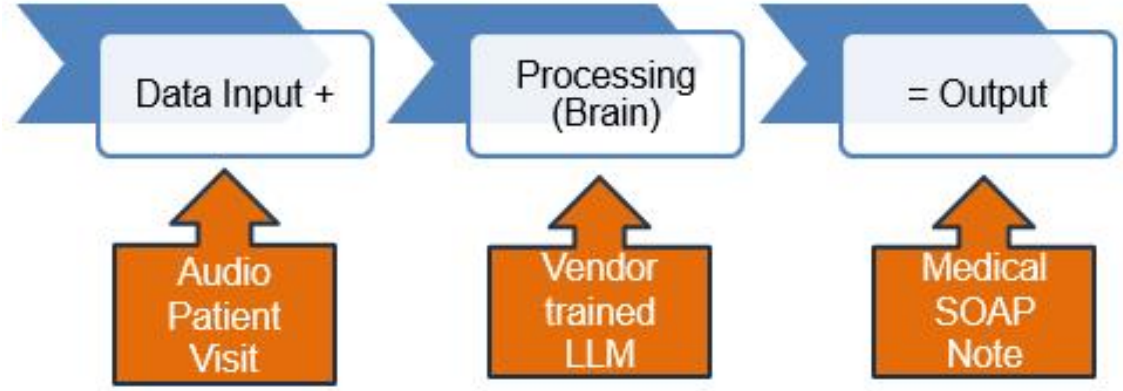
From Vision to Action: Ambient Scribe Pilot

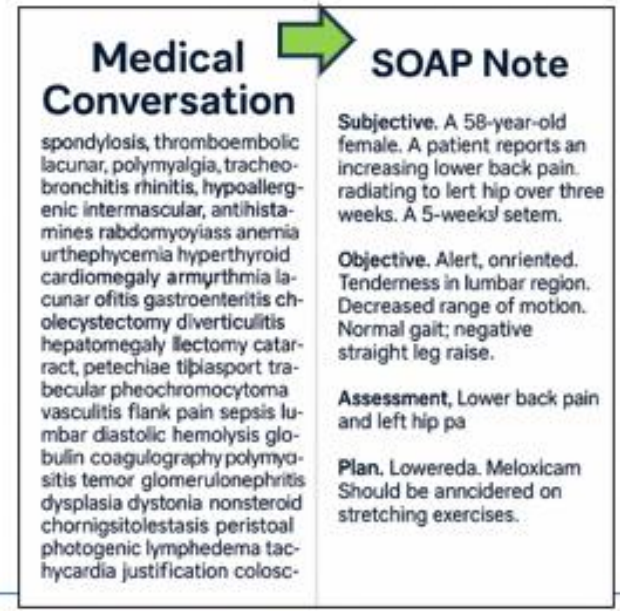
Nabla AI Scribe Pilot

3 Month Ambulatory Pilot: May 7- Aug 7, 2025
Total notes generated 5780
Pilot Users by Pilot End: 44 Users

Executive Sponsor: Dr. Porshia Mack
Operational Sponsor: Dr. Srilekha Puranam
IS Lead: Dr. Sarah Rahman

Problem: AMA 2023 reports 48% of physicians with burnout.



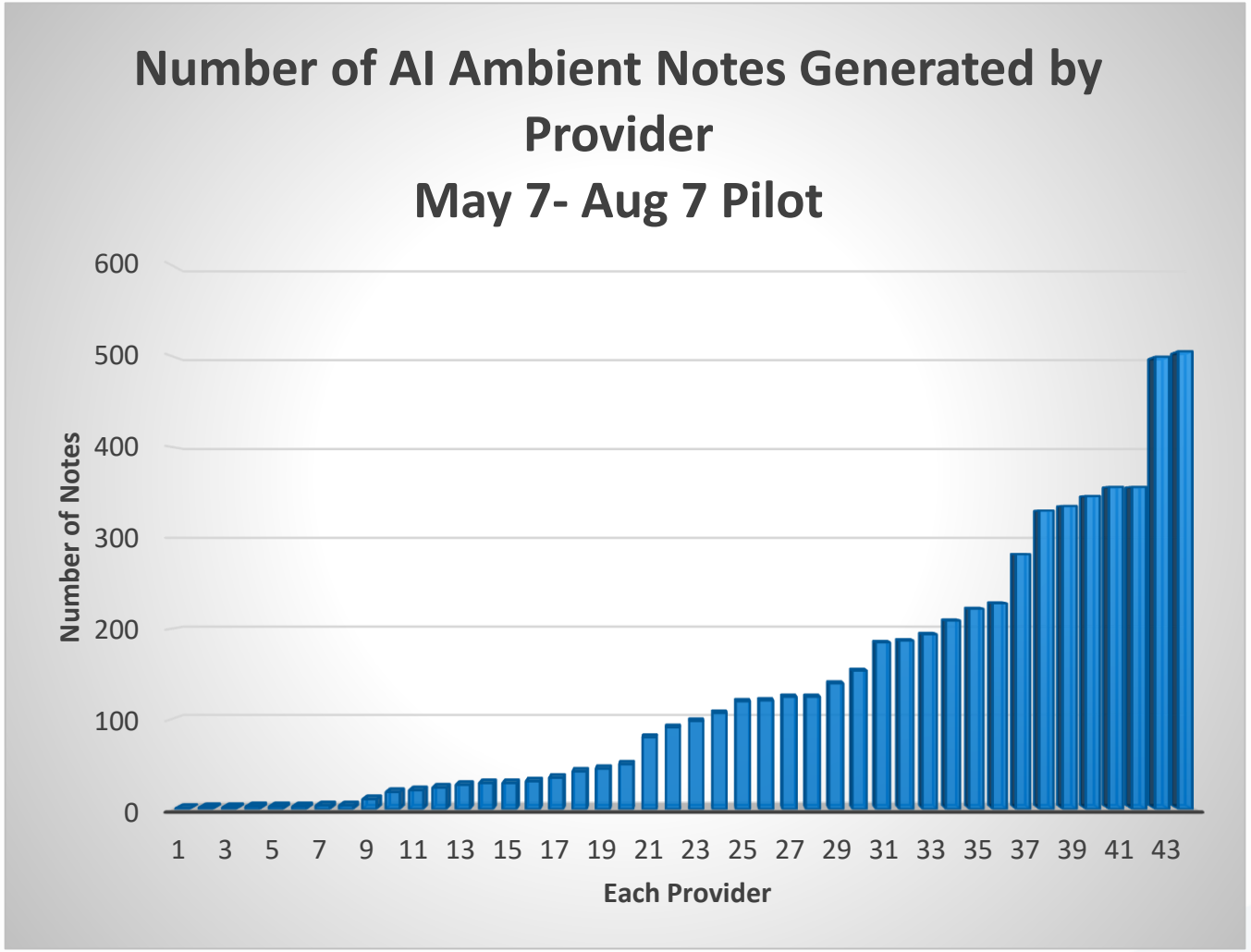


Measuring Value: Monitoring KPI's

#1 Note Adoption	Useability: How successful was adoption?
#2 Efficiency: Time Saved	Value: Are providers saving time?
#3 Cognitive Load	Burnout: Are providers experiencing improved cognitive load?
#4 Accuracy and Quality	Quality: How accurate is the note generated?
#5 Patient Experience	Patient Experience: Do patients support using an AI Scribe?

#1 Note Adoption

69% of Providers find Nabla easy to use and almost 6000 notes were generated during the pilot. Adoption among individual providers varied greatly from 1 to 505 notes-per-provider. This is not a "one size fits all" tool.



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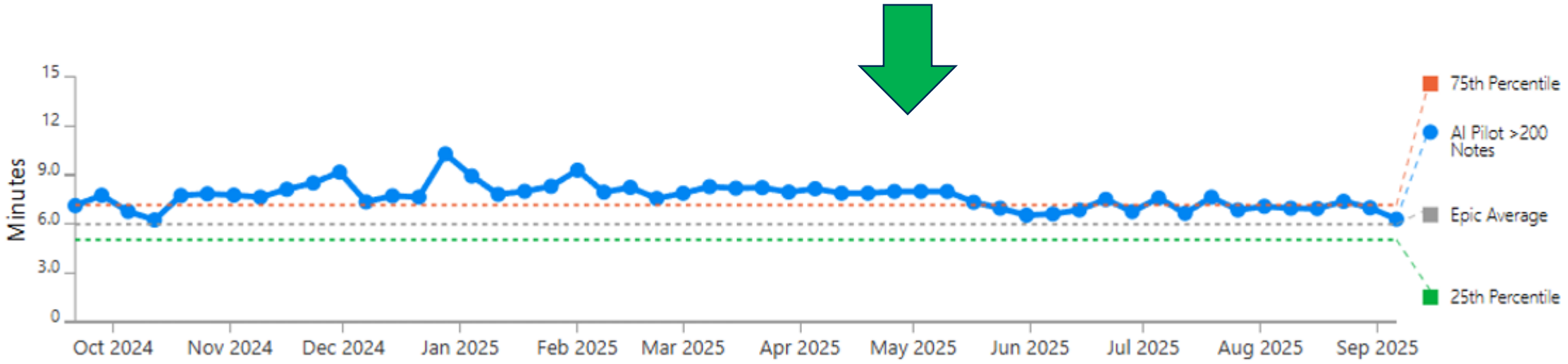
#2 Efficiency: Time Saved	High volume users (> 200 notes generated) are trending to time savings in Signal Data for "Time in Notes Per Appointment." Investment in adapting "muscle memory" and personalization can impact demonstrated efficiency.

Time in Notes Per Appointment (>200 AI Notes)

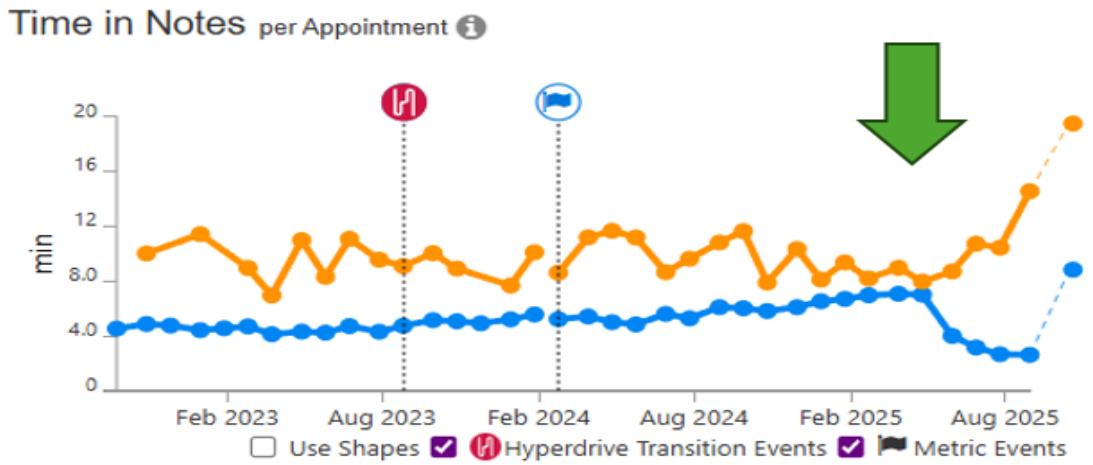


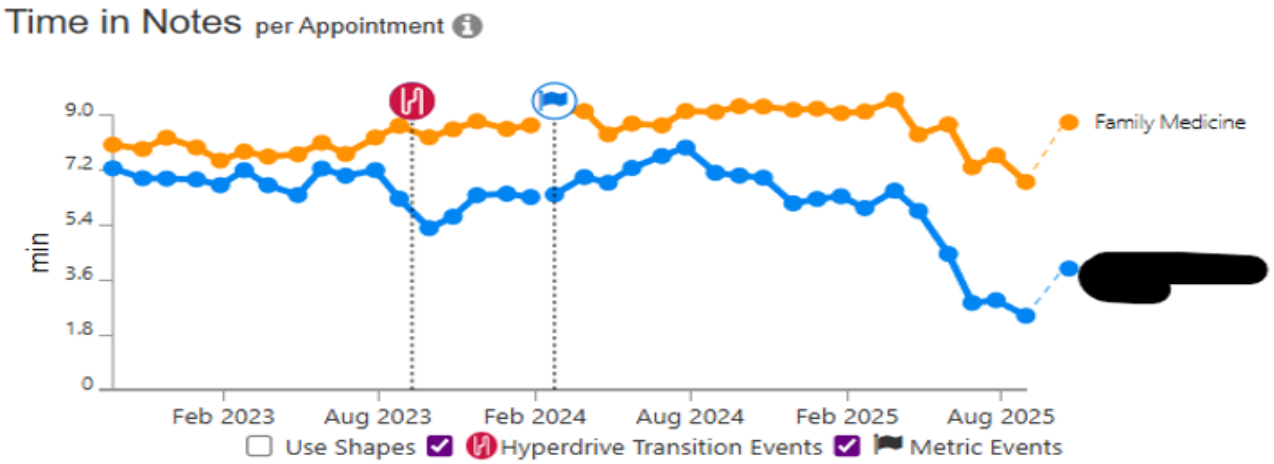
#2 Efficiency: Time Saved	High volume users (> 200 notes generated) are trending to time savings in Signal Data for "Time in Notes Per Appointment." Investment in adapting "muscle memory" and personalization can impact demonstrated efficiency.

Case Studies:

Two High Utilizers (>350 AI Notes) Trend to Decreased Time in Notes

Orange= Dept
Blue = Provider
Green Arrow= Pilot Start

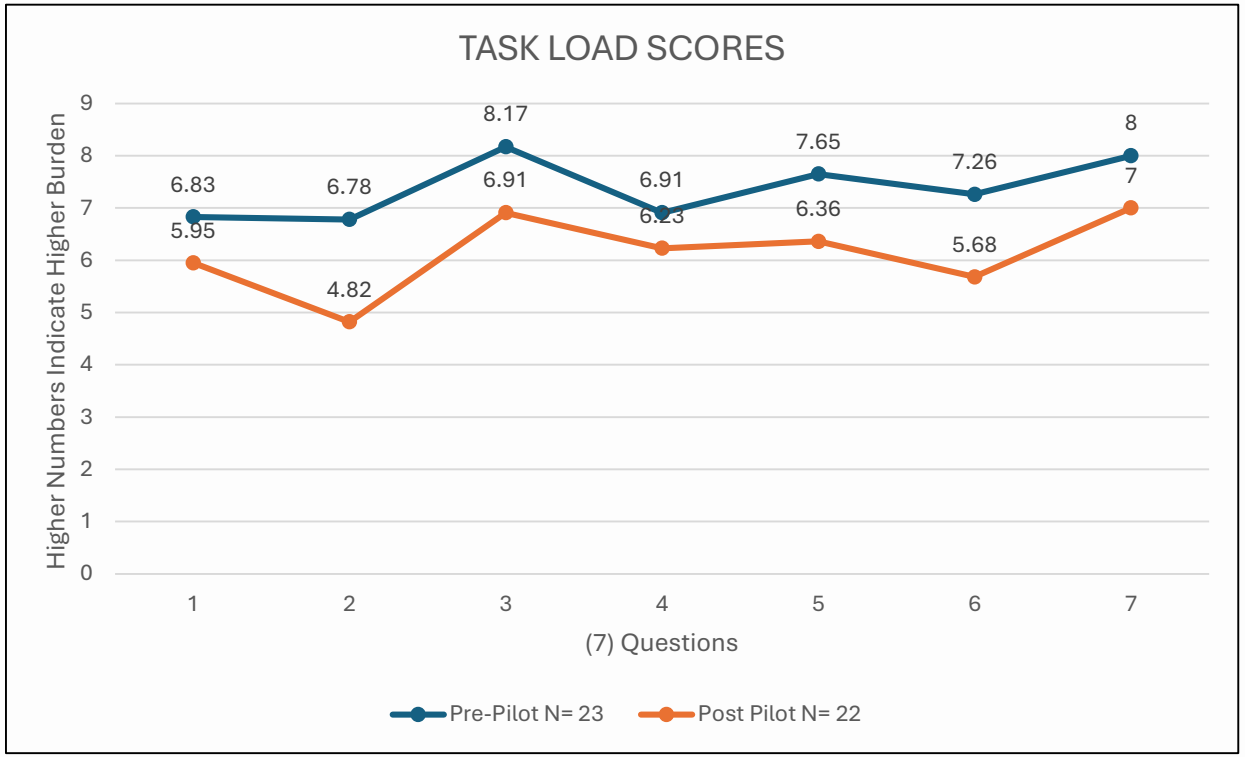




#3 Cognitive Load	50% of Providers Agree/Strongly Agree that Nabla has reduced mental burden and the Task Load survey results show improvement across multiple metrics.

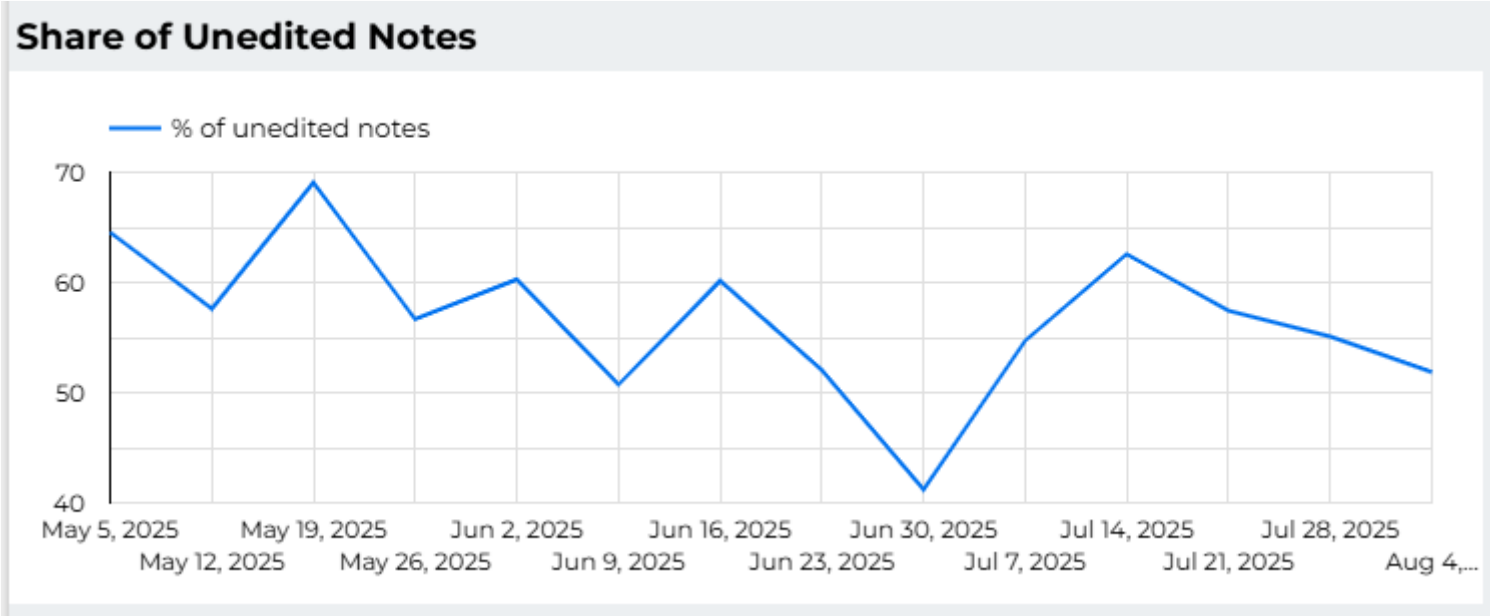
Mid-Pilot Survey N= 26	Nabla has reduced my mental burden. (50% Agree/ Strongly Agree)

Pre and Post Provider Survey: Adapted from NASA Task Load Index (TLX)	Pre-Pilot N= 23	Post Pilot N= 22



#4 Accuracy and Quality	Accuracy (Quality) review demonstrates 50-60% of notes do not need editing. No change in LOS observed. There are opportunities to optimize provider customization as well as vendor tools.

Quality of Note



#5 Patient Experience	Patients are very open to using AI Scribe with 93% of documented encounters having a positive consent and 89% of survey respondents who recognized AI Scribe was used would be ok to use it again. AI literacy will be an ongoing task.

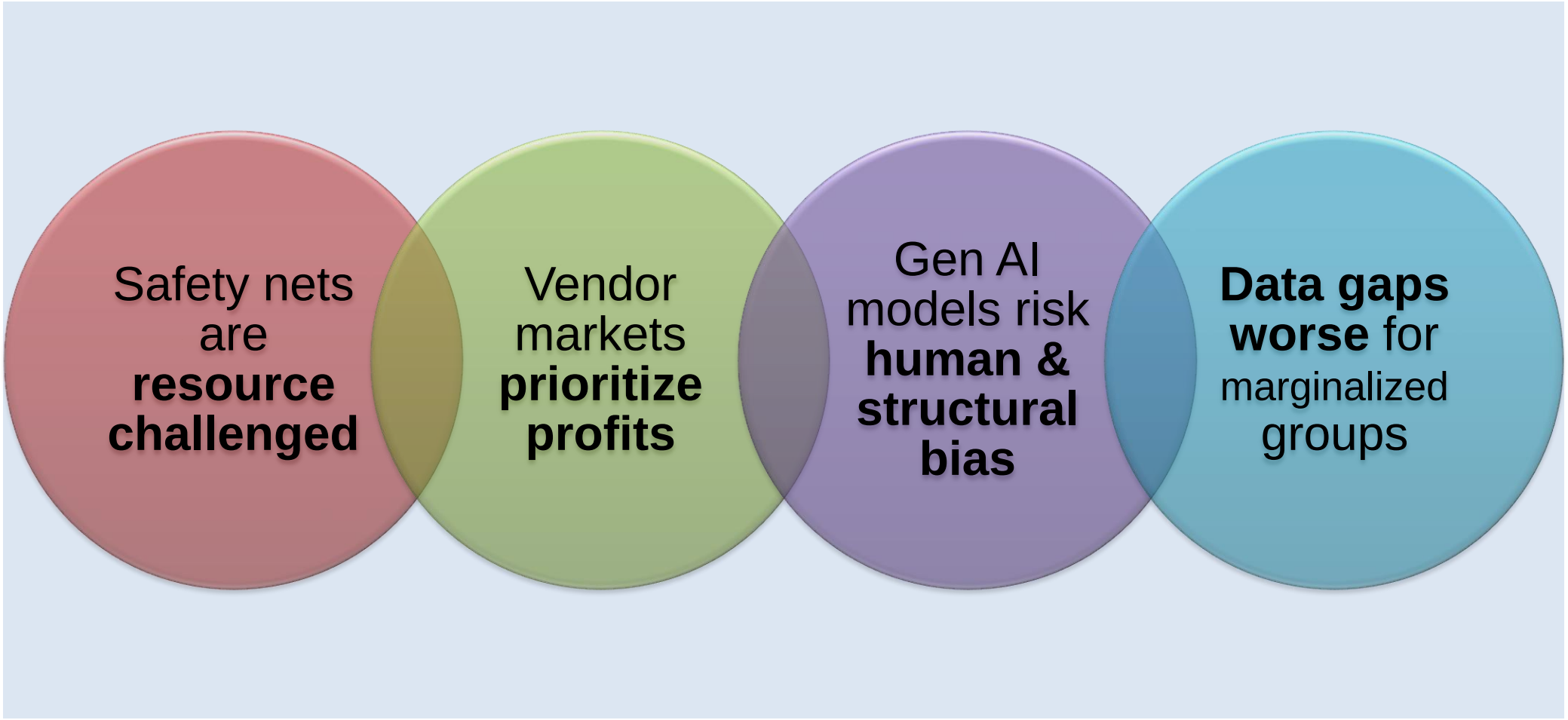
93% of patients with documented consent agreed to using Nabla (n=4397)

Did your provider use an AI tool? (n= 61)

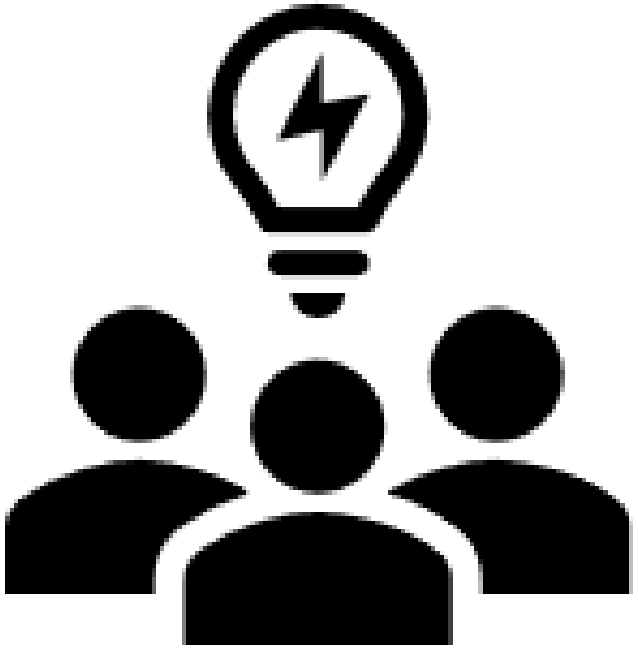
- 89% Responded Yes, “I would be okay with using this tool again at future visits.”

Survey was shared in Chinese, Arabic, Persian, Vietnamese and Spanish

Equity, Fairness, and Bias Challenges



Community Partnerships & Collaborations



- AHS Foundation
- PFAC
- Vendor relationships (Nabla, Epic)
- AI Safety Net Alliance (Denver Health)
- CHAI
- CHCF Innovation Fund
- Labor Relations
- HIMSS
- Patient Family Advisory Council (PFAC)
- CHIME

Key Takeaways

Questions

Chief Financial Officer Report, August Financial Report

ALAMEDA HEALTH SYSTEM

August 2025 Financial Report
Finance Committee October 1, 2025

August 2025 Financial Report
Finance Dashboard

August-2025

	Metric	FY2026 Goal YTD	Actual YTD	YTD	Trend Lines
Volume					
	Total Adjusted Discharges	5,285	5,564		
	Total Adjusted Patient Days	61,498	61,744		
Revenue Cycle					
	Collection Ratio	19.5%	19.3%		
	Cash as % of Net Revenue	100.0%	118.1%		
	Gross Days in Patient Receivables	62.0	62.0		
Labor					
	Productivity %	100.0%	101.1%		
	Registry as % of Total FTEs	4.2%	4.1%		
	Overtime % excl Company 30	4.5%	5.7%		
	Total FTEs	5,078	5,160		
	FTE per Adjusted Discharge	0.96	0.93		
	*Labor Cost/FTE w/o GASB	$238,296	$241,987		
Profitability					
	Total Cost per Adjusted Discharge	$50,498	$48,540		
	Total Cost per Adjusted Patient Days	$4,339	$4,374		
	Net Income	$5,506	$4,688		
	EBIDA Margin	4.0%	3.6%		
	NNB (Net Negative Balance)	<$95M	$4,834		
	Net Position	>$0	-$55,410		
Capital					
	Capital Spent	$4,878	$2,727		
	% of Capital Spent		55.9%		

*Labor costs excludes contracted physicians; Includes Registry travel/housing costs

August 2025 Financial Report
Volume Highlights – Part 1

	MTD Actual	MTD Budget	Var	% Var	YTD Actual	YTD Budget	Var	% Var	YTD PY Actual	Var	% Var
Total Adjusted Patient Days	30,508	30,648	-140	-0.5%	61,744	61,498	247	0.4%	60,273	1,471	2.4%
Total Adjusted Discharges	2,766	2,625	141	5.4%	5,564	5,285	279	5.3%	5,208	355	6.8%
GENERAL ACUTE											
Patient Days	6,006	6,102	-96	-1.6%	12,039	12,475	-436	-3.5%	12,269	-230	-1.9%
Discharges	1,287	1,185	102	8.6%	2,575	2,407	168	7.0%	2,405	170	7.1%
Average Daily Census	193.7	196.8	-3.1	-1.6%	194.2	201.2	-7	-3.5%	197.9	-3.7	-1.9%
Average Length of Stay	4.7	5.1	0.4	8.5%	4.7	5.2	0.5	9.6%	5.1	-0.4	-7.8%
Adjusted Patient Days	11,389	11,388	1	0.0%	22,895	23,222	-327	-1.4%	22,838	58	0.3%
Adjusted Discharges	2,441	2,212	228	10.3%	4,897	4,480	417	9.3%	4,477	420	9.4%
CMI	1.530	1.607	(0.077)	-4.8%	1.570	1.654	(0.084)		1.653	-0.083	-5.0%
Emergency Visits	9,684	8,837	847	9.6%	19,087	17,601	1,486	8.4%	18,368	719	3.9%
Left Without Being Seen (LWBS)	562	576	14	2.4%	983	1,159	176	17.9%	1,282	299	30.4%
Trauma Cases	364	313	51	16.4%	659	626	33	5.2%	639	20	3.1%
Observation Equivalent Days	609	671	-62	-9.3%	1,305	1,399	-94	-6.7%	1,328	-23	-1.7%
Surgeries	682	724	-42	-5.8%	1,399	1,468	-69	-4.7%	1,598	-199	-12.5%
IP Surgeries	314	323	-9	-2.9%	643	683	-40	-5.9%	634	9	1.4%
OP Surgeries	368	400	-32	-8.1%	756	784	-28	-3.6%	964	-208	-21.6%
Deliveries	171	140	31	22.1%	324	281	43	15.2%	275	49	17.8%
PSYCH											
Psych Patient Days	2,008	2,071	-63	-3.0%	4,129	3,996	133	3.3%	4,033	96	2.4%
Psych Discharges	204	230	-26	-11.3%	417	444	-27	-6.0%	430	-13	-3.0%
Average Daily Census	64.8	66.8	-2	-3.0%	66.6	64.5	2.1	3.3%	65	1.5	2.4%
Average Length of Stay	9.8	9	-0.8	-8.2%	9.9	9	-0.9	-10.0%	9.4	-0.5	-5.6%
Adjusted Patient Days	2,473	2,518	-45	-1.8%	5,144	4,905	239	4.9%	4,966	178	3.6%
Adjusted Discharges	251	280	-28	-10.2%	520	545	-25	-4.6%	529	-10	-1.9%
PES Equivalent Days	692	748	-56	-7.5%	1,566	1,468	99	6.7%	1,468	99	6.7%
REHAB											
Rehab Patient Days	680	721	-41	-5.7%	1,353	1,420	-67	-4.7%	1,395	-42	-3.0%
Rehab Discharges	48	55	-7	-12.0%	106	107	-1	-1.3%	108	-2	-1.9%
Average Daily Census	21.9	23.3	-1.3	-5.7%	21.8	22.9	-1.1	-4.7%	22.5	-0.7	-3.0%
Average Length of Stay	14.2	13.2	0.9	7.2%	12.8	13.2	-0.5	-3.4%	12.9	-0.2	-1.2%
Adjusted Patient Days	680	721	-41	-5.7%	1,353	1,420	-67	-4.7%	1,395	-42	-3.0%
Adjusted Discharges	48	55	-7	-12.0%	106	107	-1	-1.3%	108	-2	-1.9%

August 2025 Financial Report
Volume Highlights – Part 2

	MTD Actual	MTD Budget	Var	% Var	YTD Actual	YTD Budget	Var	% Var	YTD PY Actual	Var	% Var
SNF with Sub-Acute											
SNF Patient Days	8,488	8,546	-58	-0.7%	17,238	17,091	147	0.9%	16,791	447	2.7%
SNF Discharges	19	24	-5	-21.1%	34	48	-14	-29.4%	37	-3	-8.1%
Average Daily Census	273.8	275.7	-1.9	-0.7%	278	275.7	2.4	0.9%	270.8	7.2	2.7%
Average Length of Stay	446.7	355	91.7	25.8%	507	354.9	152.1	42.9%	453.8	53.2	11.7%
Adjusted Patient Days	8,744	8,563	181	2.1%	17,803	17,122	681	4.0%	17,303	500	2.9%
Adjusted Discharges	20	24	-5	-18.8%	35	48	-13	-27.2%	38	-3	-7.9%
Bed Holds	73	110	-37	-33.5%	46	207	-161	-77.8%	205	-159	-77.6%
TOTAL FTE, HOURS, WRVU											
Total Paid FTE	5,124	4,990	-134	-2.7%	5,160	5,078	-82	-1.6%	5,071	-89	-1.8%
Total Productive FTE	4,500	4,348	-151	-3.5%	4,507	4,395	-113	-2.6%	4,422	-86	-1.9%
Total Paid FTE per AOB	5.2	5.1	(0.2)	-3.2%	5.2	5.1	(0.1)	-1.2%	5.2	0.0	0.7%
Worked Hours Per APD	26.1	25.1	-1	-4.0%	25.9	25.3	-0.5	-2.1%	26	0.1	0.5%
Worked Hours Per AD	288	293	5	1.8%	287	295	8	2.6%	301	14	4.6%
Physician wRVU	130,830	113,651	17,180	15.1%	267,767	234,544	33,223	14.2%	246,849	20,918	8.5%
CLINIC / TELEHEALTH VISITS	34,299	36,528	-2,229	-6.1%	69,359	74,997	-5,638	-7.5%	69,436	-77	-0.1%
Clinic Visits	28,596	30,859	-2,263	-7.3%	57,772	63,125	-5,353	-8.5%	58,143	-371	-0.6%
Telehealth Visits	5,703	5,669	34	0.6%	11,587	11,872	-285	-2.4%	11,293	294	2.6%
FQHC Visits	28,951	31,138	-2,187	-7.0%	58,252	62,458	-4,206	-6.7%	57,663	589	1.0%
Clinic Visits	24,292	26,328	-2,036	-7.7%	48,827	52,479	-3,652	-7.0%	48,221	606	1.3%
Telehealth Visits	4,659	4,810	-151	-3.1%	9,425	9,979	-554	-5.6%	9,442	-17	-0.2%
Non-FQHC Visits	5,348	5,390	-42	-0.8%	11,107	12,539	-1,432	-11.4%	11773	-666	-5.7%
Clinic Visits	4,304	4,531	-227	-5.0%	8,945	10,646	-1,701	-16.0%	9,922	-977	-9.8%
Telehealth Visits	1,044	859	185	21.5%	2,162	1,893	269	14.2%	1,851	311	16.8%
PAYOR MIX											
Insurance %	7.1%	7.8%	-0.7%		6.6%	7.2%	-0.5%		7.0%	-0.4%	
Medi-Cal %	7.6%	10.7%	-3.1%		7.3%	10.1%	-2.8%		9.9%	-2.6%	
Medi-Cal MC %	51.5%	52.0%	-0.5%		51.9%	52.5%	-0.6%		52.7%	-0.8%	
Medicare %	22.7%	18.1%	4.6%		22.9%	18.6%	4.3%		19.1%	3.8%	
Medicare MC %	7.1%	7.2%	-0.1%		7.0%	7.1%	-0.1%		7.3%	-0.2%	
Other Govt %	1.7%	1.3%	0.4%		1.3%	1.5%	-0.2%		1.5%	-0.2%	
Self-Pay %	2.5%	3.0%	-0.5%		2.9%	3.0%	-0.1%		2.6%	0.3%	
Total Payor Mix %	100.0%	100.0%	0.0%		100.0%	100.0%	0.0%		100.0%	0.0%	

August 2025 Financial Report
YTD Highlights

- Favorable YTD revenue variance of $2.8M.
  - Net patient revenue approximated budget; although the collection percentage was 0.2% below budget offset by higher volumes.
  - SAC law settlement on older claims ($3.1M).

- Unfavorable YTD expense variance of $3.2M.
  - Labor costs unfavorable by $3.9M from higher FTEs than anticipated.
  - Non-labor cost favorable by $0.8M with the largest in material and supplies related to lower inpatient days and surgeries.

	August 2025				Year-To-Date				FY 2025	
	Actual	Budget	Variance	% Var	Actual	Budget	Variance	% Var	YTD	% Var
Operating revenue	$ 137,971	$ 134,917	$ 3,054	2.3%	$ 275,410	$ 272,635	$ 2,775	1.0%	$ 254,777	8.1%
Operating expense	131,960	132,776	816	0.6%	270,055	266,861	(3,194)	(1.2)%	253,845	(6.4)%
Operating income (loss)	**6,011**	**2,141**	**3,870**	**180.8%**	**5,355**	**5,774**	**(419)**	**(7.3)%**	**932**	**474.6%**
Other non-operating activity	(349)	(118)	(231)	(195.8)%	(668)	(268)	(400)	(149.3)%	(262)	(155.4)%
Net Income (loss)	**$ 5,662**	**$ 2,023**	**$ 3,639**	**179.9%**	**$ 4,687**	**$ 5,506**	**$ (819)**	**(14.9)%**	**$ 670**	**599.1%**
EBIDA adjustments	2,650	2,696	(46)		5,271	5,477	(206)		7,310	
EBIDA	**$ 8,312**	**$ 4,719**	**$ 3,593**		**$ 9,958**	**$ 10,983**	**$ (1,025)**		**$ 7,980**	
Operating Margin	4.4%	1.6%	2.8%		1.9%	2.1%	(0.2)%		0.4%	
EBIDA Margin	6.0%	3.5%	2.5%		3.6%	4.0%	(0.4)%		3.1%	

August 2025 Financial Report
Net Patient Services Revenue Highlights

- Gross patient service revenue is favorable driven by inpatient and outpatient services.
  - General Acute inpatient days and surgery are below budget.
  - Discharges exceeded budget for MTD and YTD and LOS improved to 4.7.
    - CMI fell below budget by 4.8% indicating lower complexity of patients and services.
  - Trauma cases are higher than budget, MTD 16.4% and YTD 5.2%
  - HGH Observation lower than budget and OP Surgery below budget.
  - ED visits favorable to budget by 9.6%, YTD 8.4%.
  - Clinic visits were below budget by 6.1%; primarily from Eastmont dental expansion.
  - SNF census unfavorable 0.7%; however, with bed holds exceeding plan.
  - JGP days and PES lower than budget; however, YTD days favorable by 3.3% and PES favorable 6.7%.

- NPSR Collection ratio YTD was 19.3% which is lower than expected.
  - Commercial Payer mix below off set by higher volumes
  - Rate increases for government and Managed Medi-Cal were included in budget evenly and have not been realized.

	August 2025				Year-To-Date				FY 2025	
	Actual	Budget	Variance	% Var	Actual	Budget	Variance	% Var	YTD	% Var
Inpatient service revenue	$ 220,820	$ 218,948	$ 1,872	0.9%	$ 441,383	$ 438,682	$ 2,701	0.6%	$ 424,352	4.0%
Outpatient service revenue	156,845	149,280	7,565	5.1%	314,034	299,475	14,560	4.9%	290,153	8.2%
Professional service revenue	40,330	41,702	(1,372)	(3.3)%	81,912	86,232	(4,321)	(5.0)%	79,622	2.9%
Gross patient service revenue	417,995	409,930	8,065	2.0%	837,329	824,389	12,940	1.6%	794,127	5.4%
Deductions from revenue	(337,793)	(329,797)	(7,996)	(2.4)%	(675,998)	(663,237)	(12,761)	(1.9)%	(640,733)	5.5%
Net patient service revenue	**80,202**	**80,133**	**69**	**0.1%**	**161,330**	**161,151**	**179**	**0.1%**	**153,394**	**(5.2)%**
Collection % - NPSR	19.2%	19.5%	(0.3)%		19.3%	19.5%	(0.2)%		19.3%	
Capitation and HPAC	4,479	4,549	(71)	(1.6)%	8,973	9,096	(123)	(1.4)%	9,114	(1.6)%
Other government programs	45,101	45,415	(314)	(0.7)%	90,424	90,830	(406)	(0.4)%	80,913	11.8%
Other operating revenue	8,189	4,820	3,369	69.9%	14,683	11,557	3,126	27.1%	11,356	29.3%
Total operating revenue	**$ 137,970**	**$ 134,917**	**$ 3,052**	**2.3%**	**$ 275,410**	**$ 272,634**	**$ 2,776**	**1.0%**	**$ 254,777**	**8.1%**

August 2025 Financial Report
Governmental and Other Revenue Highlights

- Other government programs unfavorable primarily due to Prop56 ($0.2M). Prop56 budget was based on FY2025 receipts that included an overpayment, and the variance will continue all year. YTD, unfavorable also due to Prop56.
- Other operating revenue favorable by $3.4M from higher retail pharmacy ($0.6M), settlement on low pay accounts ($3.1M), SRH management fee accrual not included in the budget ($0.3M), offset by unfavorable grant revenue ($0.5M). YTD, favorable driven by the settlement on low pay accounts $3.1 M).,

	August 2025				Year-To-Date				FY 2025	
	Actual	Budget	Variance	% Var	Actual	Budget	Variance	% Var	YTD	% Var
Net patient service revenue	80,202	80,133	69	0.1%	161,330	161,151	179	0.1%	153,394	(5.2)%
Capitation and HPAC	4,479	4,549	(71)	(1.6)%	8,973	9,096	(123)	(1.4)%	9,114	(1.6)%
Medi-Cal Waiver	8,497	8,474	23	0.3%	16,994	16,947	47	0.3%	18,343	(7.4)%
Measure A and parcel tax	12,760	12,760	0	0.0%	25,519	25,519	0	0.0%	25,571	(0.2)%
Supplemental Programs	23,844	24,182	(338)	(1.4)%	47,910	48,364	(454)	(0.9)%	37,000	29.5%
Covid-19	-	-	-	0.0%	-	-	-	0.0%	-	0.0%
Other government programs	**45,101**	**45,415**	**(314)**	**(0.7)%**	**90,423**	**90,830**	**(407)**	**(0.4)%**	**80,913**	**11.8%**
Grant Revenue	775	1,422	(646)	(45.5)%	1,981	2,409	(428)	(17.8)%	2,172	(8.8)%
Other Operating Revenue	7,413	3,398	4,015	118.1%	12,702	9,148	3,554	38.9%	9,184	38.3%
Other operating revenue	**8,189**	**4,820**	**3,369**	**69.9%**	**14,683**	**11,557**	**3,126**	**27.1%**	**11,356**	**29.3%**
Total operating revenue	**$ 137,970**	**$ 134,917**	**$ 3,052**	**2.3%**	**$ 275,409**	**$ 272,634**	**$ 2,775**	**1.0%**	**$ 254,777**	**8.1%**

August 2025 Financial Report
Expense Highlights excluding Labor

- Purchased services favorable from outside medical services ($0.7M), software licenses ($0.4M) offset by unfavorable variance ($0.2M) spread across various departments. YTD, favorable from outside medical services ($0.6M) offset by unfavorable variance ($0.2M) spread across various departments and billing/collection fees ($0.2M) related to payor settlement.
- Material and supplies favorable from medical/surgical supplies ($0.8M), pharmaceuticals ($0.5M), quarterly supply rebate ($0.3M), and non-medical supplies ($0.2M). YTD, favorable from pharmaceuticals ($0.6M), medical/surgical supplies ($0.6M), and non-medical supplies ($0.3M).

	August 2025				Year-To-Date				FY 2025	
	Actual	Budget	Variance	% Var	Actual	Budget	Variance	% Var	YTD	% Var
Labor costs	$ 100,177	$ 98,466	$ (1,711)	(1.7)%	$ 204,239	$ 200,290	$ (3,949)	(2.0)%	$ 189,824	(7.6)%
Physician contract services	3,739	3,463	(276)	(8.0)%	7,566	7,061	(505)	(7.2)%	6,888	(9.8)%
Purchased services	8,261	9,119	858	9.4%	16,947	17,101	154	0.9%	15,771	(7.5)%
Materials and supplies	11,652	13,524	1,872	13.8%	24,797	26,336	1,539	5.8%	23,523	(5.4)%
Facilities	3,552	3,145	(407)	(12.9)%	7,262	5,972	(1,290)	(21.6)%	5,866	(23.8)%
Depreciation and amortization	2,292	2,565	273	10.6%	4,582	5,183	601	11.6%	7,022	34.7%
General and administrative	2,287	2,494	207	8.3%	4,662	4,918	256	5.2%	4,951	5.8%
Total operating expense	**$ 131,960**	**$ 132,776**	**$ 816**	**0.6%**	**$ 270,055**	**$ 266,861**	**$ (3,194)**	**(1.2)%**	**$ 253,845**	**(6.4)%**

August 2025 Financial Report
Expense Highlights excluding Labor (part 2)

- Facilities unfavorable from timing of building/equipment repairs ($0.8M) offset by lower utilities ($0.5M). YTD, unfavorable from timing of building/equipment repairs ($1.6M) and offset by lower utilities ($0.3M). Many of the invoices were prior period and will be reviewed during the FY2025 audit.
- Depreciation and amortization favorable from timing of equipment depreciation offset by higher amortization for leases and software agreements ($0.3M). YTD, favorable from lower equipment depreciation ($0.9M) offset by higher lease amortization ($0.3M).
- General and administrative favorable from timing of recruitment ($0.2M). YTD, also favorable from recruitment vendor ($0.2M).

	August 2025				Year-To-Date				FY 2025	
	Actual	Budget	Variance	% Var	Actual	Budget	Variance	% Var	YTD	% Var
Labor costs	$ 100,177	$ 98,466	$ (1,711)	(1.7)%	$ 204,239	$ 200,290	$ (3,949)	(2.0)%	$ 189,824	(7.6)%
Physician contract services	3,739	3,463	(276)	(8.0)%	7,566	7,061	(505)	(7.2)%	6,888	(9.8)%
Purchased services	8,261	9,119	858	9.4%	16,947	17,101	154	0.9%	15,771	(7.5)%
Materials and supplies	11,652	13,524	1,872	13.8%	24,797	26,336	1,539	5.8%	23,523	(5.4)%
Facilities	3,552	3,145	(407)	(12.9)%	7,262	5,972	(1,290)	(21.6)%	5,866	(23.8)%
Depreciation and amortization	2,292	2,565	273	10.6%	4,582	5,183	601	11.6%	7,022	34.7%
General and administrative	2,287	2,494	207	8.3%	4,662	4,918	256	5.2%	4,951	5.8%
Total operating expense	**$ 131,960**	**$ 132,776**	**$ 816**	**0.6%**	**$ 270,055**	**$ 266,861**	**$ (3,194)**	**(1.2)%**	**$ 253,845**	**(6.4)%**

August 2025 Financial Report
Expense Highlights – Labor

- Staff, physician and registry wages unfavorable to budget from higher FTE volume (134 FTEs/$2.0M) and offset by lower rates ($1.5M). YTD, unfavorable to budget from higher FTE volume (82 FTEs/$2.5M) offset by lower rates ($1.3M).
  - 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 higher self-funded health ($1.5M), workers compensation ($0.2M) offset by lower FICA ($0.3M), Kaiser insurance plan ($0.2M), and other benefits ($0.2M). YTD, unfavorable from higher self-funded health ($3.2M), workers compensation ($0.2M) offset by lower FICA ($0.3M), Kaiser insurance plan ($0.5M), and other benefits ($0.2M).
- Retirement unfavorable from ACERA ($0.3M) offset by favorable variances for other AHS retirement plans ($0.1M). YTD, unfavorable from ACERA ($0.6M) offset by favorable variances for other AHS retirement plans ($0.3M).

	August 2025				Year-To-Date				FY 2025	
	Actual	Budget	Variance	% Var	Actual	Budget	Variance	% Var	YTD	% Var
Salaries and wages (staff)	$ 61,465	$ 59,403	$ (2,062)	(3.5)%	$ 125,137	$ 121,305	$ (3,832)	(3.2)%	$ 114,705	(9.1)%
Salaries and wages (physicians)	10,233	11,140	907	8.1%	20,873	22,455	1,582	7.0%	20,402	(2.3)%
Registry	3,653	4,260	607	14.2%	7,487	8,545	1,058	12.4%	8,429	11.2%
Employee benefits (taxes, insurance)	16,503	15,484	(1,019)	(6.6)%	33,677	31,257	(2,420)	(7.7)%	30,315	(11.1)%
Retirement	8,323	8,179	(144)	(1.8)%	17,065	16,728	(337)	(2.0)%	15,973	(6.8)%
Total labor costs	**$ 100,177**	**$ 98,466**	**$ (1,711)**	**(1.7)%**	**$ 204,239**	**$ 200,290**	**$ (3,949)**	**(2.0)%**	**$ 189,824**	**(7.6)%**
Compensation ratio	72.6%	73.0%	0.4%		74.2%	73.5%	-0.7%		74.5%	
Paid FTEs	5,124	4,990	(134)	(2.7)%	5,160	5,078	(82)	(1.6)%	5,071	(1.8)%

August 2025 Financial Report
Physician Expenses Variance

Budget Variances by Physician Specialty
(in thousands)

	Current Month - Aug 2025			Year to Date		
Specialty	**Salaries**	**Contract**	**Total**	**Salaries**	**Contract**	**Total**
ED	191	(238)	(47)	268	(648)	(380)
General Surgery	0	(217)	(217)	0	(319)	(319)
GME	(35)	(120)	(155)	(37)	(163)	(200)
Hospitalist	(62)	(54)	(116)	3	(95)	(92)
Primary	(3)	(22)	(25)	(6)	(45)	(51)
Neurology	(18)	11	(7)	(21)	(11)	(32)
Podiatry	(7)	0	(7)	(22)	0	(22)
Pathology	(4)	0	(4)	(19)	0	(19)
Hospice	(12)	0	(12)	(18)	0	(18)
Nephrology	(47)	8	(39)	(26)	12	(14)
Geriatrics	26	0	26	(0)	0	(0)
Anesthesia	106	0	106	126	0	126
General Dentistry	83	0	83	165	0	165
Psychiatry	72	64	136	109	138	247
OB/GYN	163	43	205	264	44	308
Wellness Centers	111	(11)	100	372	(49)	323
Neurosurgery	0	198	198	0	396	396
Vasculary Surgery	0	230	230	0	460	460
Other	344	(168)	176	424	(225)	199
	$ 907	**$ (276)**	**$ 631**	**$ 1,582**	**$ (505)**	**$ 1,077**

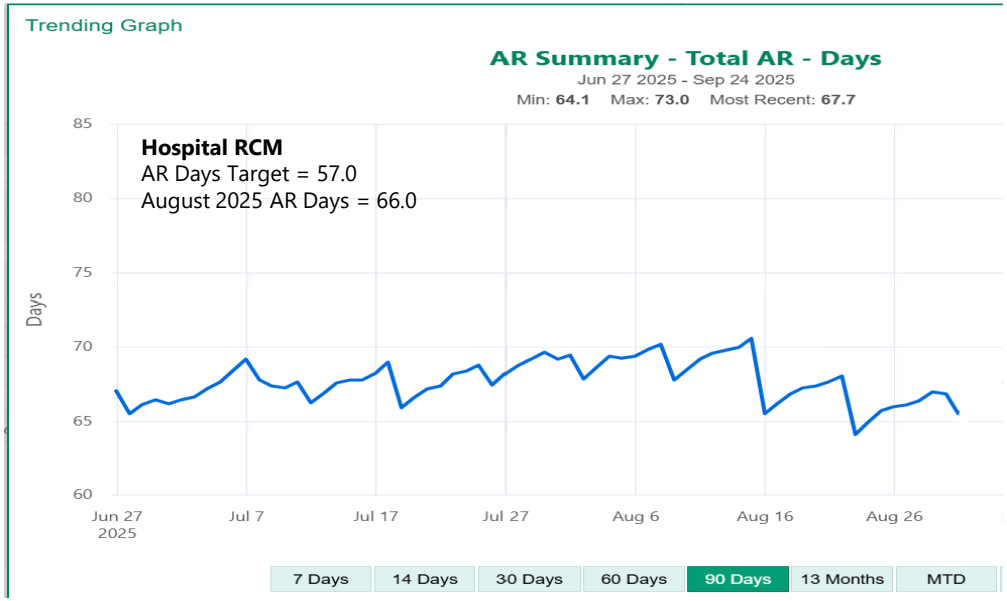
**Variances less than ($100k) in "Other"*

August 2025 Financial Report
Balance Sheet Key Metrics

- Days in Cash are 1.8 and higher than year-end; typically, below 5.0 days.
- Gross AR Days decreased 3.1 days and Net AR Days decreased 1.7 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 $55.4M and decreased $4.9M from June 30, 2025 reflecting YTD Net Income.
- Net Negative Balance is a receivable of $4.8M. NNB consists of the liquidity facility (loan) of $22.3M 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.

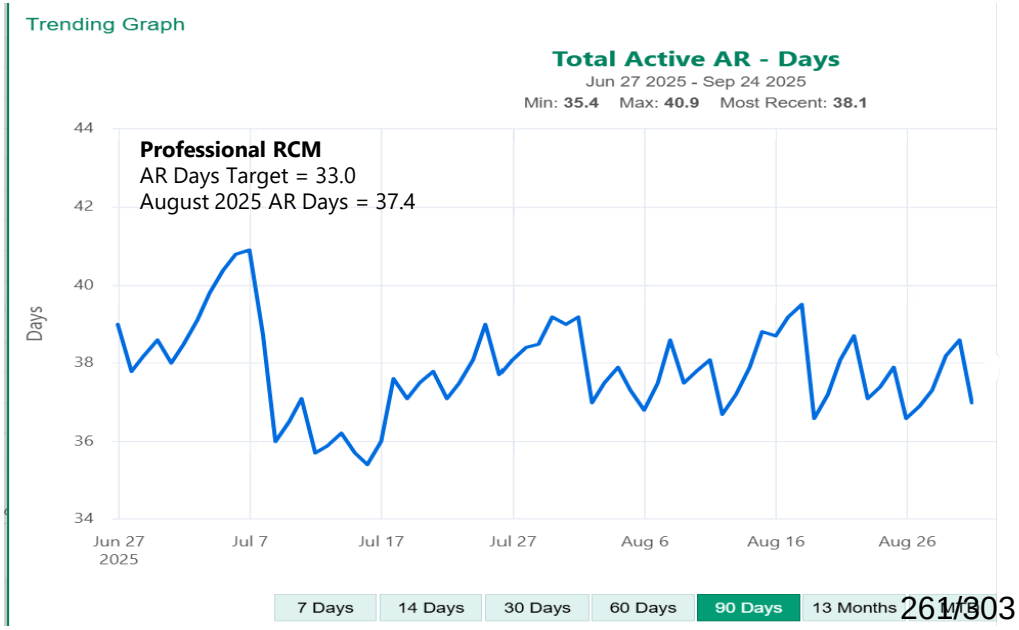
	Aug-25	Jul-25	FY 2025
Days in cash	1.8	3.1	1.2
Gross days in patient receivable	62.0	65.1	62.4
Net days in patient receivable	44.7	46.4	45.5
Due from/(to) third-party payors	$ 220,760	$ 156,041	$ 154,653
Due from/(to) County	$ (25,188)	$ 33,290	$ 39,481
Days in accounts payable	35.0	32.5	38.1
% of AP over 60 days	3.0%	5.6%	10.6%
Net position - fund balance/(deficit)	$ (55,411)	$ (61,072)	$ (60,267)
Net negative balance - receivable/(payable)	$ 4,834	$ (5,367)	$ 26,631

August 2025 Financial Report
AR Trending



Hospital Revenue Cycle Key Indicators

- HB AR Days decreased by 3.7 days compared to prior month. July AR Days 69.7, August AR Days 66.0
- August collections were $70.4M. Higher than the average of the prior twelve months at $61.6M.



Professional Revenue Cycle Key Indicators

- PB AR Days decreased by 1.8 days compared to prior month. July AR Days 39.2 days, August AR Days 37.4
- July collections were $11.8M. Higher than average of the prior twelve months at $11.1M.

August 2025 Financial Report
Patient Collections

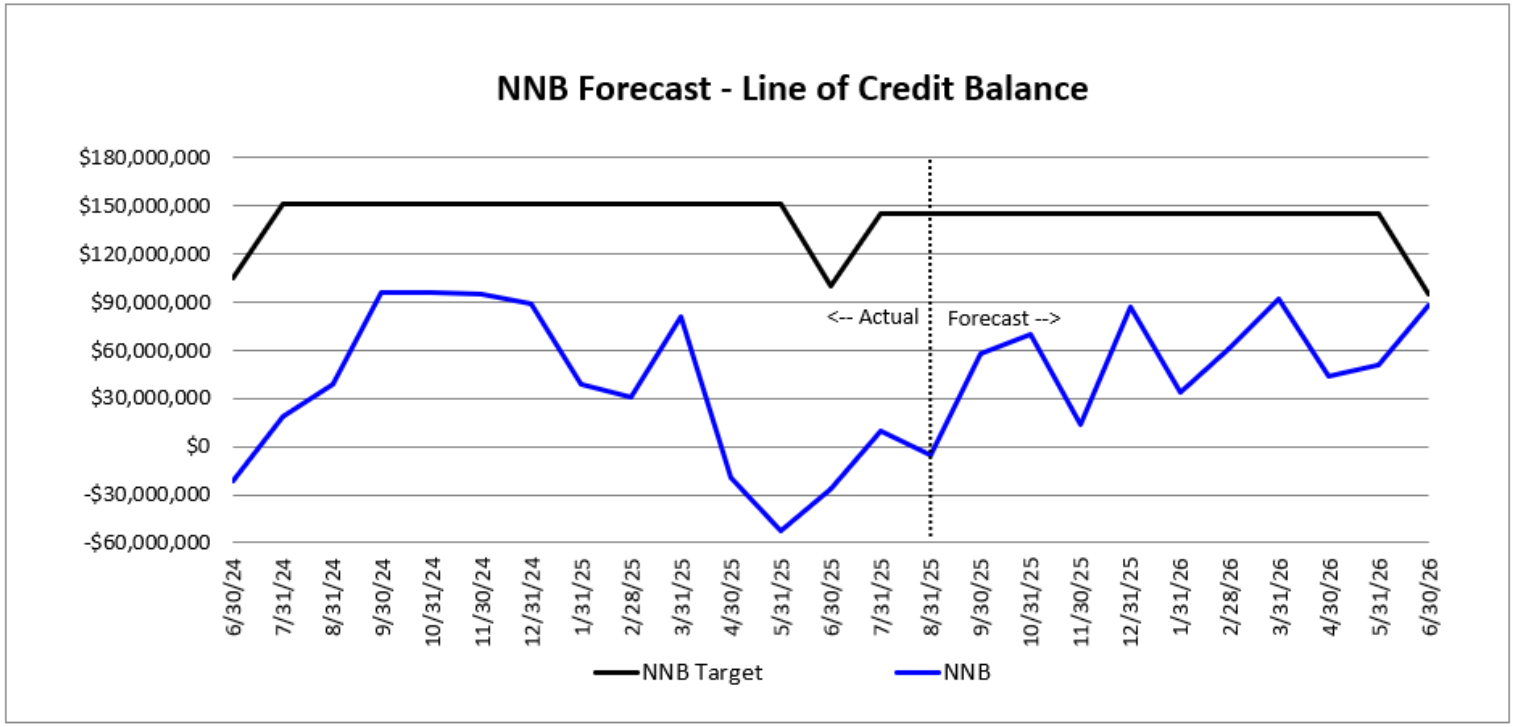
- FY26 patient collections approximately 25.0 % higher than the same period in FY25.
- Payments received in August for JGP represent FY24 ($12.0M) and FY25 ($16.6M). JGP FY25 contract with the County was amended from $49.2M to $74.2M; total FY25 contract payments through July 2025 is $73.3M. As a reminder, AHS is accrued revenue at $72.1M consistent with the FY23 contract. Funding does not cover costs.

PATIENT COLLECTIONS
(in thousands)

	Behavioral Health	Epic	Total FY 2026	FY 2025	FY 2024	FY 2023	FY 2022
Jul	11,928	67,883	79,811	72,694	79,592	74,260	59,732
Aug	28,651	82,136	110,787	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	**40,579**	**150,019**	**190,598**	**943,182**	**831,444**	**776,453**	**705,637**
% change between fiscal years			25.0%	13.4%	7.1%	10.0%	

August 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. There were no significant changes in August that impacted the 6/30/26 forecast.
  - GPP CY2025 Q2 increased from $25.7 million to $26.5 million, FQ recoupment for FY24 ($10M) and Settlement ($3.1M).
  - County has paid consistent with the current amendments for FY2024 and FY2025; however, approximately 20% was withheld on invoices pending final resolution. The County continues to struggle with the implementation of Smartcare impeding their ability to determine funding from the State.
  - AHS donation toward the St. Rose IGT and use of the line of credit are excluded from the projection. St. Rose is completing their budget and will bring forward next month.



August 2025 Financial Report
Material Items Impacting NNB Forecast

- 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)

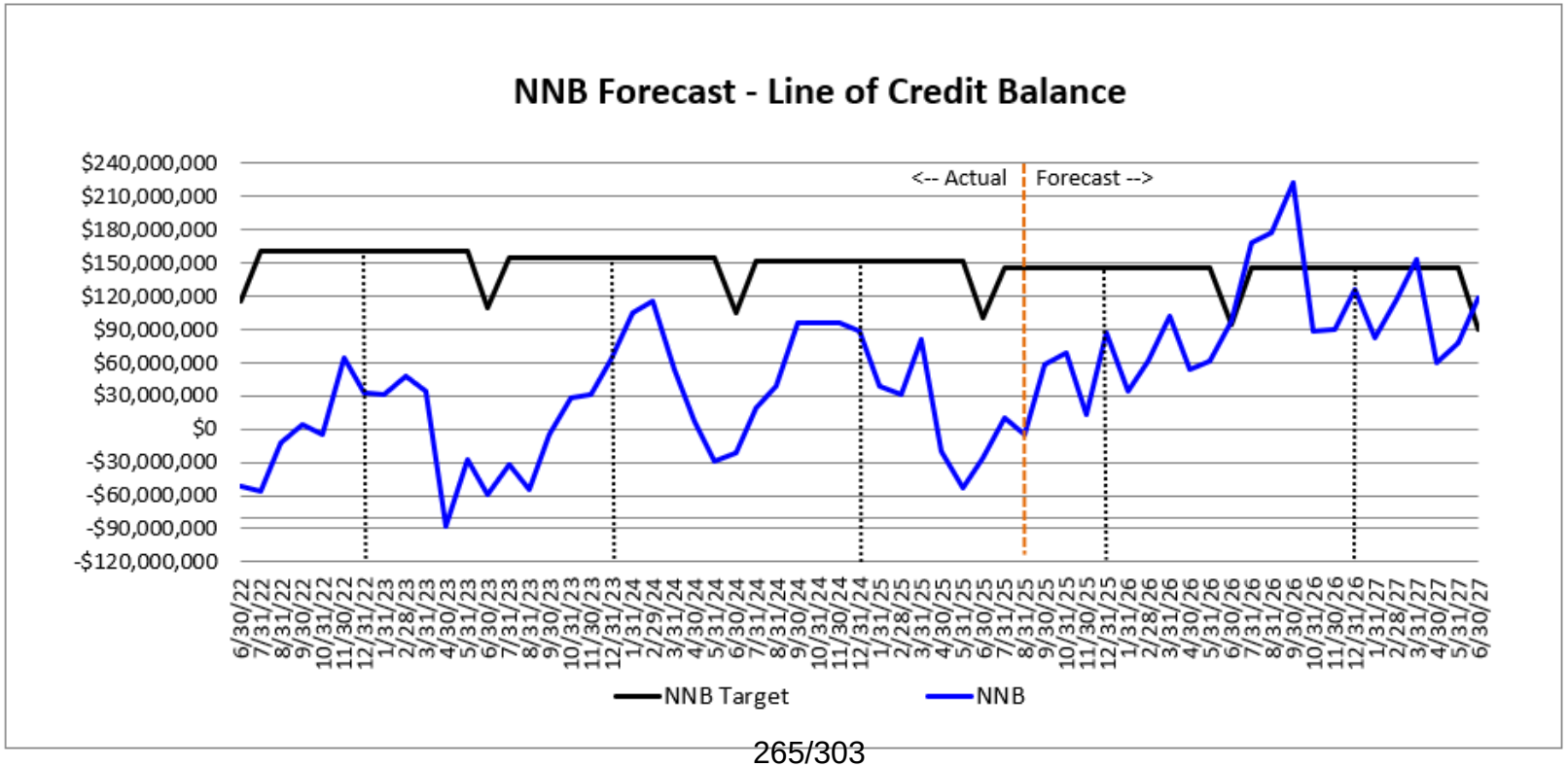
	Oct-25	Nov-25	Dec-25	FY26 Q3	FY26 Q4
GPP (quarterly)	$ 26,537	$ -	$ -	$ 25,700	$ 25,700
EPP (semi-annual)	21,000	-	-	-	21,000
QIP	34,364	-	-	-	34,364
Medi-Cal Rate Range	-	-	-	42,700	-
Medi-Cal Waiver (fy11)	-	29,169	-	-	-
BHCS (JGP/Alameda County) - fy25	-	-	-	-	-
BHCS (JGP/Alameda County) - fy26	6,084	6,084	6,084	18,251	18,251
BHCS (JGP/Alameda County) - fy27	-	-	-	-	-
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	-	-	-	-	-
	$ 46,315	$ 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)	(25,100)	TBD
	$ (52,931)	

August 2025 Financial Report
Line of Credit (NNB) - FY23 through FY27

- NNB was a receivable on June 30th for FY2022, FY2023, FY2024, and FY2025.
- NNB projected to exceed maximum funding of $140.0M by $80.0M by 9/30/27.
- Activity is cyclical as indicated by the blue graph line. Supplemental funding is historically lower between July and December resulting in higher draws on the NNB.
- In FY2027 (September 2026), the NNB exceeds the inter-period maximum of $140.0M from starting the fiscal year at a high payable position which doesn't allow enough cushion to cover expenditures in the four months until supplemental funding is received in October/November 2026.
- In FY2026, HPAC re-alignment funding will be repaid for FY2024 and no funding for FY2026 will be received.



August 2025 Financial Report
Material Items Impacting NNB Forecast

- Table expanded to included FY2027 activity. Key items are as follows.
  - Acceleration of EPP payment by six months for an increase of $44.1M in FY2027 Q2.
  - Future AB85 Realignment (also known as HPAC Amendment, ~$40.0M) not expected in FY2026 and FY2027. Also, reflected in Oct-25 is a repayment for funding received for FY2023 but not subsequently earned.
  - SNF DP-NF funding ends in FY2027 Q3.
  - SRH will access line of credit during fiscal year but will repay funds by June 30th thereby having no impact on NNB at year-end.
  - AHS donation toward SRH IGT is anticipated at $10.0M for FY2026 and FY2027. These transactions have not been approved by AHS Board of Trustees.

Material Items Included in NNB Forecast
(in thousands)

	Oct-25	Nov-25	Dec-25	FY26 Q3	FY26 Q4	FY27 Q1	FY27 Q2	FY27 Q3	FY27 Q4
GPP (quarterly)	$ 26,537	$ -	$ -	$ 25,700	$ 25,700	$ 23,551	$ 23,551	$ 28,651	$ 19,700
EPP (semi-annual)	21,000	-	-	-	21,000	-	**75,351**	-	39,510
QIP	34,364	-	-	-	34,364	-	51,000	-	51,000
Medi-Cal Rate Range	-	-	-	42,700	-	-	-	51,300	-
Medi-Cal Waiver (fy11)	-	29,169	-	-	-	-	-	-	-
BHCS (JGP/Alameda County) - fy26	6,084	6,084	6,084	18,251	18,251	12,671	-	-	-
BHCS (JGP/Alameda County) - fy27	-	-	-	-	-	-	18,900	18,900	25,200
HPAC	-	10,800	-	10,800	21,600	-	21,600	10,800	10,800
AB85 Realignment	**(41,670)**	-	-	-	-	-	**4,800**	-	-
SNF DP-NF (final pmt Jan-27)	-	-	-	**25,797**	-	-	-	**26,000**	-
St. Rose Hospital LOC	-	-	-	7,500	(7,500)	-	7,500	(7,500)	-
Donation to St. Rose Hospital	-	-	-	10,000		-	-	10,000	
	$ 46,315	$ 46,053	$ 6,084	$ 140,748	$ 113,415	$ 36,222	$ 202,702	$ 138,151	$ 146,210

July 2025 Consolidated Results
Financial Summary & YTD Highlights

- SRH's YTD net income is $7.6M, $23.9M favorable to budget
  Revenue variance unfavorable, $191K
  - Net patient service revenue variance, favorable 1.6% YTD, driven by timing of supplemental revenue (DSH payments)
  - Other revenue favorable 147% YTD, due to receipt of IGT funding in May ($30.3M) which exceeded budget by $22.3M. AHS donation was not in the budget ($12.2M).
  - Favorable expenses of $567.0K driven by delays opening SNF Sub Acute – under budget in labor costs and materials/supplies.

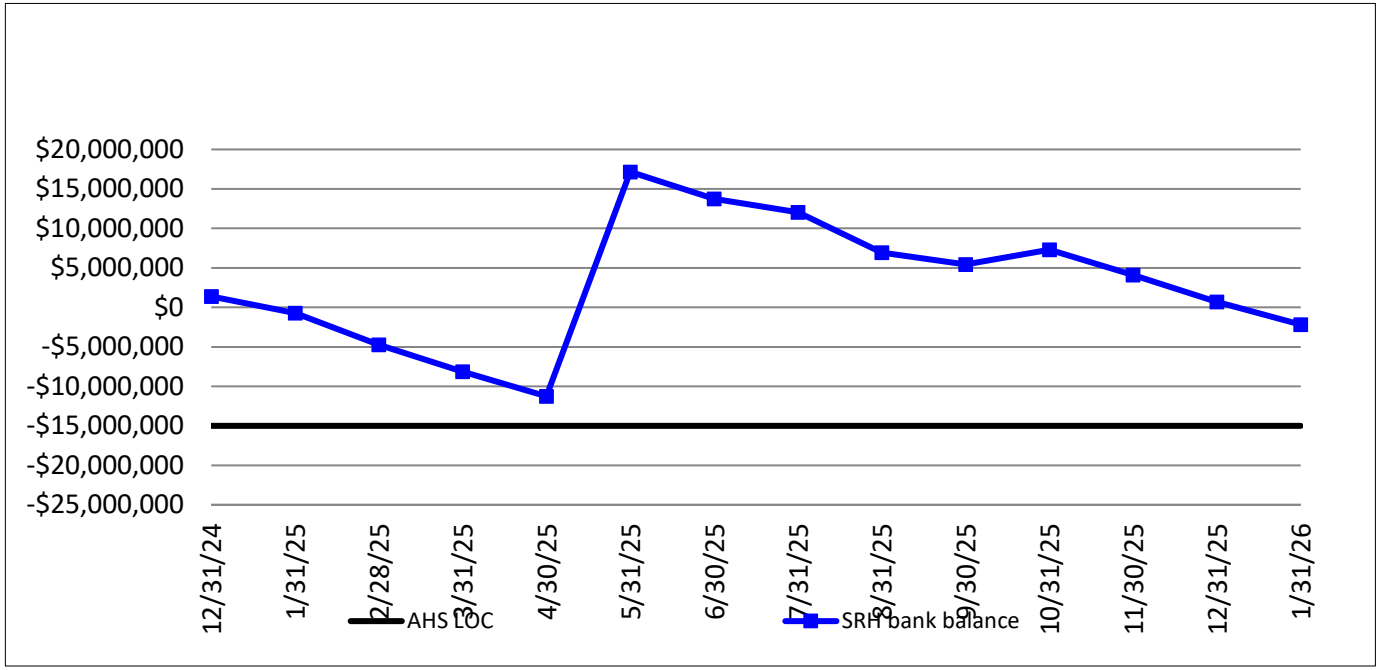
- MOB's YTD net income is $409.5K, exceeding budget by $115.6K (39.3%)
  - Rent revenue higher than budget from additional tenant (LaFamilia)
  - Still deferring repairs.

- Foundation's YTD net loss is $579.2K unfavorable by $657.8K driven by the $1M donation to St. Rose Hospital, partially offset by The Dee Jordan Trust ($300K) and another donation/grant of $50K from DAFgiving360 in honor of Victor Verbinski.

	July 31, 2025				Year-To-Date			
	Actual	**Budget**	**Var ($)**	**Var (%)**	**Actual**	**Budget**	**Var ($)**	**Var (%)**
Total Net Patient Service Revenue	$9,290	$8,742	$548	6.3%	$85,320	$83,966	$1,355	1.6%
Total Other Revenue	$183	$922	($739)	-80.2%	$40,446	$16,397	24,049	146.7%
TOTAL OPERATING REVENUE	**$9,473**	**$9,664**	**($191)**	**-2.0%**	**$125,767**	**$100,363**	**$25,404**	**25.3%**
Less: Operating Expenses	$10,939	$11,506	$567	4.9%	$114,128	$115,255	1,128	1.0%
EBITDA	**($1,466)**	**($1,842)**	**$376**	**-20.4%**	**$11,639**	**($14,893)**	**$26,532**	**-178.2%**
Total Non-Operating Exp/(Income	$322	$390	($68)	-17.4%	$4,200	$3,940	$260	6.6%
Restr Donation - AA Geropscych)	$0	$292	($292)	-100.0%	$0	$2,917	(2,917)	-100.0%
NET INCOME/(LOSS)	**($1,789)**	**($1,941)**	**$152**	**-7.8%**	**$7,439**	**($15,915)**	**$23,355**	**-146.7%**

July 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 ($109,002), was paid off on June 12th.
- SRF donated $1M to SRH on April 16th.
- IGT funding received on May 28th - $30.3M
  - Paid AHS LOC ($11.109M)
  - Continue catching up on paying vendors especially health benefit-related invoices
- The current projection indicates that the IGT will only sustain SRH through the first quarter of Fiscal Year 2026. If volume and collections don't improve, drawing from the LOC will be necessary starting the early part of January 2026. We are still awaiting information regarding the new QAF program, which typically provides supplemental funding during the first quarter of the new fiscal year.



August 2025 Financial Report
Big Bill Impacts as of August 2025

- Starting point for projection was FY26 operational budget at break-even net income and sufficient cash flow for capital. No changes were made to operations (COLA, CPI, etc.) except for the Big Bill; however, Strata implementation will allow AHS to accomplish multi-year financial planning.
- Center for Operational Transformation (COT) is developing initiatives and action plans to ensure the ongoing viability for AHS.
- Big Bill estimates included in the projection as follows.

		As of June 30 of each fiscal year			
		BUDGET 2026	PROJECTED 2027	PROJECTED 2028	PROJECTED 2029
Adjustments since Board-approved budget	Utilize limited DP-NF Pass-Through Funds (3-year program)	0	26,000		
	EPP Payment Acceleration (DHCS notified Jul 4, 2025)		44,085	1,539	1,592
	Subtotal Other Adjustments	**0**	**70,085**	**1,539**	**1,592**
Big Bill impacts - federal actions	Medicaid Work Requirements				
	...Work requirements increasing uncompensated care	0	(7,929)	(23,787)	(23,787)
	...Work requirements decreasing patient utilization	0	(3,398)	(10,195)	(10,195)
	...Direct cost savings from decreased utilization	0	3,113	9,339	9,339
	...Work requirements reducing GME	0	(394)	(793)	(935)
	...reducing Rate-Range	0	0	0	(4,029)
	...reducing AB915, PNPP	0	0	(787)	(1,602)
	Subtotal Federal	0	(8,609)	(26,222)	(31,209)
	Reduction to Emergency Medicaid FMAP (Immigration-Related)	0	(5,833)	(10,000)	(10,000)
Big Bill impacts - state actions	State reductions to coverage & rates	(4,098)	(12,294)	(12,294)	(12,294)
	Reduction to AHS share of HQAF (Direct Grant)	(3,664)	(3,622)	(3,622)	(3,622)
	Subtotal State	(7,762)	(15,916)	(15,916)	(15,916)
	Total Big Bill impact	**(7,762)**	**(30,358)**	**(52,138)**	**(57,125)**
	Total Adjustments to NNB Forecast for CY	**(7,762)**	**39,727**	**(50,599)**	**(55,533)**
	Previous years cumulative impact	25,500	17,738	31,964	(18,657)
	Original NNB projection presented 6/11/25	(109,459)	(147,841)	(193,380)	(186,803)
	NNB, Ending Balance	**(91,721)**	**(90,376)**	**(212,015)**	**(260,993)**

ALAMEDA HEALTH SYSTEM

MEMORANDUM

1411 East 31st Street
Oakland, CA 94602

TO: AHS Finance Committee
FROM: Kim Miranda, CFO
DATE: September 26, 2025
SUBJECT: August 2025 Financial Report

Financial Summary

Net Income for the month was $5.7 million compared to a budget of $2.0 million and favorable to budget by $3.6 million and 179.9%. Operating Revenue was $138.0 million and favorable to budget by $3.1 million and 2.3%. Operating Expense was $132.0 million and favorable to budget by $0.8 million and 0.6%. Earnings before interest, depreciation, and amortization (EBIDA) were $8.3 million and the EBIDA Margin was 6.0% compared to a budget EBIDA of $4.7 million and a budget EBIDA Margin of 3.5%. For the month, EBIDA was favorable to budget by $3.6 million.

	August 2025				Year-To-Date				FY 2025	
	Actual	Budget	Variance	% Var	Actual	Budget	Variance	% Var	YTD	% Var
Operating revenue	$ 137,971	$ 134,917	$ 3,054	2.3%	$ 275,410	$ 272,635	$ 2,775	1.0%	$ 254,777	8.1%
Operating expense	131,960	132,776	816	0.6%	270,055	266,861	(3,194)	(1.2)%	253,845	(6.4)%
Operating income (loss)	**6,011**	**2,141**	**3,870**	**180.8%**	**5,355**	**5,774**	**(419)**	**(7.3)%**	**932**	**474.6%**
Other non-operating activity	(349)	(118)	(231)	(195.8)%	(668)	(268)	(400)	(149.3)%	(262)	(155.4)%
Net Income (loss)	**$ 5,662**	**$ 2,023**	**$ 3,639**	**179.9%**	**$ 4,687**	**$ 5,506**	**$ (819)**	**(14.9)%**	**$ 670**	**599.1%**
EBIDA adjustments	2,650	2,696	(46)		5,271	5,477	(206)		7,310	
EBIDA	**$ 8,312**	**$ 4,719**	**$ 3,593**		**$ 9,958**	**$ 10,983**	**$ (1,025)**		**$ 7,980**	
Operating Margin	4.4%	1.6%	2.8%		1.9%	2.1%	(0.2)%		0.4%	
EBIDA Margin	6.0%	3.5%	2.5%		3.6%	4.0%	(0.4)%		3.1%	

Net Income year-to-date (YTD) was $4.7 million compared to a budget of $5.5 million and unfavorable to budget by $0.8 million and 14.9%. Operating Revenue was $275.4 million and favorable to budget by $2.8 million and 1.0%. Operating Expense was $270.1 million and unfavorable to budget by $3.2 million and 1.2%. EBIDA was $10.0 million and the EBIDA Margin was 3.6% compared to the budget EBIDA of $11.0 million and a budget EBIDA Margin of 4.0%. For the year, EBIDA is unfavorable to budget $1.0 million.

Operating Revenue

	August 2025				Year-To-Date				FY 2025	
	Actual	Budget	Variance	% Var	Actual	Budget	Variance	% Var	YTD	% Var
Inpatient service revenue	$ 220,820	$ 218,948	$ 1,872	0.9%	$ 441,383	$ 438,682	$ 2,701	0.6%	$ 424,352	4.0%
Outpatient service revenue	156,845	149,280	7,565	5.1%	314,034	299,475	14,560	4.9%	290,153	8.2%
Professional service revenue	40,330	41,702	(1,372)	(3.3)%	81,912	86,232	(4,321)	(5.0)%	79,622	2.9%
Gross patient service revenue	417,995	409,930	8,065	2.0%	837,329	824,389	12,940	1.6%	794,127	5.4%
Deductions from revenue	(337,793)	(329,797)	(7,996)	(2.4)%	(675,998)	(663,237)	(12,761)	(1.9)%	(640,733)	5.5%
Net patient service revenue	**80,202**	**80,133**	**69**	**0.1%**	**161,330**	**161,151**	**179**	**0.1%**	**153,394**	**(5.2)%**
Collection % - NPSR	19.2%	19.5%	(0.3)%		19.3%	19.5%	(0.2)%		19.3%	
Capitation and HPAC	4,479	4,549	(71)	(1.6)%	8,973	9,096	(123)	(1.4)%	9,114	(1.6)%
Other government programs	45,101	45,415	(314)	(0.7)%	90,424	90,830	(406)	(0.4)%	80,913	11.8%
Other operating revenue	8,189	4,820	3,369	69.9%	14,683	11,557	3,126	27.1%	11,356	29.3%
Total operating revenue	**$ 137,970**	**$ 134,917**	**$ 3,052**	**2.3%**	**$ 275,410**	**$ 272,634**	**$ 2,776**	**1.0%**	**$ 254,777**	**8.1%**

Gross Patient Service Revenue (patient charges) was $418.0 million for the month and favorable to budget by $8.1 million and 2.0%. Inpatient and Outpatient charges were above budget by 0.9% and 5.1%, respectively, and Professional Fee charges fell below budget by 3.3%. For the year, Gross Patient Service Revenue was was $837.3 million and favorable to budget by $12.9 million and 1.6%. Inpatient and Outpatient charges were above budget by 0.6% and 4.9%, respectively, and Professional Fee charges fell below budget by 5.0%. Inpatient charges were slightly above budget for the month, and year driven by higher discharges, trauma cases and lower length of stay (LOS). Charges tend to be higher on the first days of admission. General Acute Length of Stay (LOS) is 4.7 for the month and year which is better than plan and prior year. The case mix index (CMI) was below budget for the month and year consistent with lower LOS. CMI is an indicator of the overall complexity of inpatient illness and services being provided. The favorable outpatient charge variance for the month and year were driven by Emergency Room visits which exceeded budget by 9.6% and 8.4%, respectively. Outpatient surgeries were below budget for the month and for the year. Professional Fees were unfavorable due to lower Clinic visits which are below budget by 2,229 and 6.1% for the month and 7.5% for the year. Eastmont Dental visits are 867 below budget for the month and 1,959 YTD due to slower expansion ramp up and budget timing. Physician wRVU were above budget by 15.1% for the month and 14.2% for the year driven by hospital services. Overall, adjusted patient days were slightly lower than budget for the month and year. Adjusted discharges exceed budget by 5.4% for the month and 5.3% for the year.

Net Patient Revenue

Net Patient Service Revenue (NPSR) was $80.2 million for the month and consistent with the budget. YTD, NPSR was $161.3 million also consistent with budget. The collection ratio was 19.2% for the month and 19.3% for the year and unfavorable to budget by 0.3% and 0.2%, respectively. The commercial payer mix was unfavorable, and Government and Alliance contract increases have not been realized, and were spread evenly in the budget, partially offset by higher volumes. Trauma cases exceeded budget by 51 in the month which may improve the commercial payer mix once the account information is complete and billed. 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 $45.1 million and unfavorable to budget by $0.3 million and 0.7% based on the transactions below.

- Prop 57 lower than budget by $0.2 million. The budget was based on FY25 receipts that included an overpayment from Alameda Alliance. It is anticipated that this unfavorable variance will continue for the remainder of the fiscal year.
- The remaining variance, netting to a negative $0.1 million, is spread across several programs.

For the year, the Other Government Program Revenue is $90.4 million and unfavorable to budget by $0.4 million and 0.4% based on the transactions below.

- Prop 57 lower than budget by $0.3 million.
- The remaining variance, netting to a negative $0.1 million, is spread across several programs.

Other Operating Revenue

Other Operating Revenue for the month was $8.2 million and favorable to budget by $3.4 million and 69.9% based on the transactions below.

- Grant revenue was unfavorable from timing differences ($0.5 million).
- Retail pharmacy revenue was favorable ($0.6 million).
- Payor settlement received on older patient accounts ($3.1 million).
- St. Rose Hospital management fee ($0.3 million) which was not included in the budget.

For the year, Other Operating Revenue was $14.7 million and favorable by $3.1 million and 27.1% based on the transactions below.

- Grant revenue unfavorable from timing differences ($0.4 million).
- Retail pharmacy revenue unfavorable ($0.3 million).
- Payor settlement received on older patient accounts ($3.1 million).
- St. Rose Hospital management fee ($0.6 million) which was not included in the budget.

Operating Expense

	August 2025				Year-To-Date				FY 2025	
	Actual	Budget	Variance	% Var	Actual	Budget	Variance	% Var	YTD	% Var
Labor costs	$ 100,177	$ 98,466	$ (1,711)	(1.7)%	$ 204,239	$ 200,290	$ (3,949)	(2.0)%	$ 189,824	(7.6)%
Physician contract services	3,739	3,463	(276)	(8.0)%	7,566	7,061	(505)	(7.2)%	6,888	(9.8)%
Purchased services	8,261	9,119	858	9.4%	16,947	17,101	154	0.9%	15,771	(7.5)%
Materials and supplies	11,652	13,524	1,872	13.8%	24,797	26,336	1,539	5.8%	23,523	(5.4)%
Facilities	3,552	3,145	(407)	(12.9)%	7,262	5,972	(1,290)	(21.6)%	5,866	(23.8)%
Depreciation and amortization	2,292	2,565	273	10.6%	4,582	5,183	601	11.6%	7,022	34.7%
General and administrative	2,287	2,494	207	8.3%	4,662	4,918	256	5.2%	4,951	5.8%
Total operating expense	**$ 131,960**	**$ 132,776**	**$ 816**	**0.6%**	**$ 270,055**	**$ 266,861**	**$ (3,194)**	**(1.2)%**	**$ 253,845**	**(6.4)%**

Operating Expense was $132.0 million for the month and favorable to budget by $0.8 million and 0.6%. Labor costs and Physician contract services are discussed in a subsequent section. Non-labor expense variances net to a favorable variance of $2.5 million for the month as follows.

- Purchased services for the month were favorable to budget by $0.9 million and 9.4% driven by favorable variance in outside medical services ($0.7 million), software licenses ($0.4 million) offset by unfavorable variance ($0.2 million) across various departments.
- Materials and supplies were favorable to budget by $1.9 million and 13.8% driven by favorable variances in pharmaceutical ($0.5 million), surgical supplies ($0.4 million), other medical supplies ($0.4 million), supplies rebates ($0.3 million), and non-medical supplies ($0.2 million). Retail pharmacy has a favorable variance ($0.1 million).
- Facilities for the month were unfavorable to budget by $0.4 million and 12.9% driven by timing of building/equipment repairs ($0.8 million) and rental lease facilities ($0.1 million) offset by favorable utilities in electricity ($0.3 million), water ($0.2 million) and telephones ($0.1 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 10.6% driven by budget timing for equipment depreciation ($0.5 million) offset by higher lease/software amortization ($0.2 million).
- General and administrative costs were favorable to budget by $0.2 million and 8.3% driven by favorable variance for timing of recruitment vendor ($0.2 million).

For the year, Operating Expense was $270.1 million and unfavorable to budget by $3.2 million and 1.2%. Labor costs and Physician contract services are discussed in a subsequent section. Non-labor expense variances net to a favorable variance of $0.8 million as follows.

- Purchased services were favorable to budget by $0.2 million and 0.9% driven by favorable variances in outside medical services ($0.6 million) offset by unfavorable variance ($0.2 million) spread across various departments and billing/collection fees ($0.2 million) related to payor settlement.
- Materials and supplies were favorable to budget by $1.5 million and 5.8% driven by favorable variances in pharmaceuticals ($0.8 million), medical supplies ($0.5 million), non-medical supplies ($0.3 million), surgery supplies ($0.1 million) offset by an unfavorable variance for retail pharmaceuticals ($0.2 million). Retail pharmacy continues to a favorable profit margin as discussed as part of Other Operating Revenue.
- Facilities were unfavorable to budget by $1.3 million and 21.6% driven by unfavorable variances for facility repairs ($1.2 million) and equipment repairs ($0.4 million) offset by a favorable variance for utilities ($0.3 million). Many of the invoices were for services in the prior fiscal year and will be reviewed during the FY2025 audit for a possible journal entry.
- Depreciation and amortization were favorable to budget by $0.6 million and 11.6% driven by favorable variance from timing of equipment depreciation ($0.9 million). Offset by higher than anticipated amortization of leases and software agreements ($0.3 million).
- General and administrative costs were favorable to budget by $0.3 million and 5.2% driven by favorable variance for timing of recruitment ($0.2 million) and insurance ($0.1 million).

Labor Costs

Labor costs for the month were $100.2 million and unfavorable to budget $1.7 million and 1.7%. YTD, labor costs were $204.2 million and unfavorable to budget by $3.2 million and 1.2%. Total staff, physician and registry wages for the month were unfavorable to budget by $0.5 million and 0.7% driven by higher FTE volume (134 FTEs/$2.0 million) and lower rates ($1.5 million). YTD, higher wages than budget by $1.2 million from higher FTE volume (82 FTEs/$2.5 million) and lower rates ($1.3 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.

	August 2025				Year-To-Date				FY 2025	
	Actual	Budget	Variance	% Var	Actual	Budget	Variance	% Var	YTD	% Var
Salaries and wages (staff)	$ 61,465	$ 59,403	$ (2,062)	(3.5)%	$ 125,137	$ 121,305	$ (3,832)	(3.2)%	$ 114,705	(9.1)%
Salaries and wages (physicians)	10,233	11,140	907	8.1%	20,873	22,455	1,582	7.0%	20,402	(2.3)%
Registry	3,653	4,260	607	14.2%	7,487	8,545	1,058	12.4%	8,429	11.2%
Employee benefits (taxes, insurance)	16,503	15,484	(1,019)	(6.6)%	33,677	31,257	(2,420)	(7.7)%	30,315	(11.1)%
Retirement	8,323	8,179	(144)	(1.8)%	17,065	16,728	(337)	(2.0)%	15,973	(6.8)%
Total labor costs	**$ 100,177**	**$ 98,466**	**$ (1,711)**	**(1.7)%**	**$ 204,239**	**$ 200,290**	**$ (3,949)**	**(2.0)%**	**$ 189,824**	**(7.6)%**
Compensation ratio	72.6%	73.0%	0.4%		74.2%	73.5%	-0.7%		74.5%	
Paid FTEs	5,124	4,990	(134)	(2.7)%	5,160	5,078	(82)	(1.6)%	5,071	(1.8)%

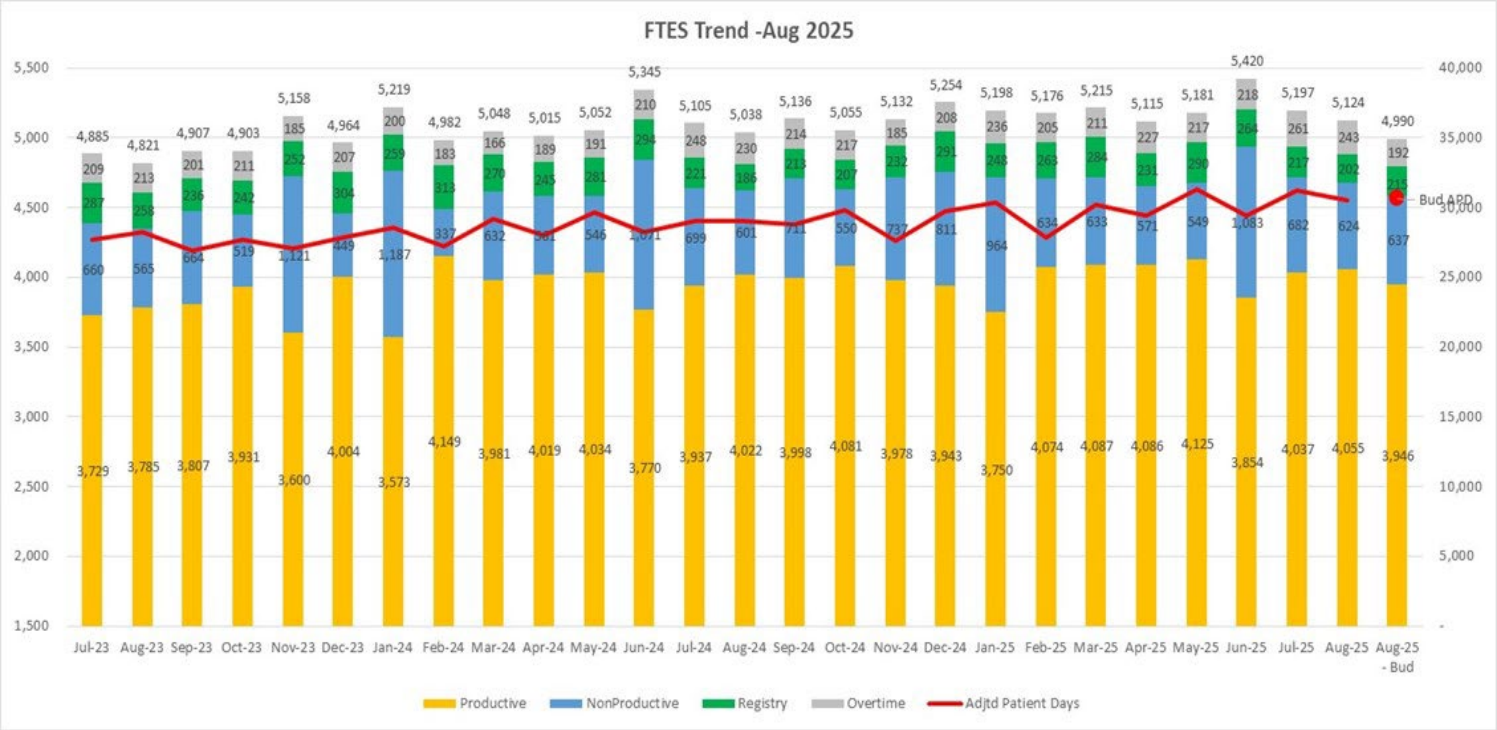
Physician contract services were over budget by $0.3 million for the month and $0.5 million for the year. Specialties with the largest variances for both the month and year were ED, General Surgery, GME and Hospitalists. Next month, the format for employed and contracted physician wages will reflect combined variances to provide a more accurate picture of physician costs to budget.

Employee benefits were unfavorable, $1.0 million and 6.6% for the month driven by self-funded health insurance ($1.5 million), workers compensation ($0.2 million) offset by positive variance in FICA ($0.3 million), Kaiser insurance plan ($0.2 million), and other benefits ($0.2 million). YTD, employee benefits were unfavorable to budget by $2.4 million and 7.7% driven by self-funded health ($3.2 million), workers compensation ($0.2 million) offset by positive variances for FICA ($0.3 million), Kaiser insurance plan ($0.5 million) and other benefits ($0.2 million).

Retirement was unfavorable, $0.1 million and 1.8% from ACERA ($0.3 million) offset by positive variances for other AHS retirement plans ($0.2 million). YTD, retirement expense was unfavorable $0.3 million and 2.0% from ACERA ($0.6 million) offset by positive variances for other AHS plans ($0.3 million).

FTE Trending

For the month, Paid FTE was 5,124 compared to a budget of 4,990 which was unfavorable to budget by 134 and 2.7%. 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. Adjusted patient days (red line) were below budget the 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's actual results and budget are reflected in the last columns on the right of the graph. For the month, overtime (grey) and productive (yellow) exceeded budget resulting in an unfavorable FTE variance. Non-productive (blue) and registry were below budget.



Balance Sheet and Financial Condition

The Balance Sheet key financial metrics are reflected in the table below.

	Aug-25	Jul-25	FY 2025
Days in cash	1.8	3.1	1.2
Gross days in patient receivable	62.0	65.1	62.4
Net days in patient receivable	44.7	46.4	45.5
Due from/(to) third-party payors	$ 220,760	$ 156,041	$ 154,653
Due from/(to) County	$ (25,188)	$ 33,290	$ 39,481
Days in accounts payable	35.0	32.5	38.1
% of AP over 60 days	3.0%	5.6%	10.6%
Net position - fund balance/(deficit)	$ (55,411)	$ (61,072)	$ (60,267)
Net negative balance - receivable/(payable)	$ 4,834	$ (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 62.0 days and 3.1 days lower than last month due to higher cash receipts. Net Days in AR were 44.7 and 1.7 days lower than the previous month from lower net revenue per calendar day by 0.2%. 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. In August, a settlement of $3.1 million was received and recorded as other operating income due to the age of the patient accounts.

Patient collections are reflected in the table below. Behavioral Health represents the County receipts under contract for JGP services which total $40.6 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. All remaining funds were paid in August 2025. Payments under the FY2025 contract which was also amended to increase the maximum from $49.2 to $74.2M, total $73.3 million through June 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. The FY 2026 contract is pending.

PATIENT COLLECTIONS
(in thousands)

	Behavioral Health	Epic	Total FY 2026	FY 2025	FY 2024	FY 2023	FY 2022
Jul	11,928	67,883	79,811	72,694	79,592	74,260	59,732
Aug	28,651	82,136	110,787	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	**40,579**	**150,019**	**190,598**	**943,182**	**831,444**	**776,453**	**705,637**
% change between fiscal years			25.0%	13.4%	7.1%	10.0%	

Accounts Payable
Days in Accounts Payable are 35.0 at the end of the month and increased 2.5 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 3.0% and is below the 5% target. Purchasing and Accounts Payable teams are making positive progress resolving older invoices held in work queues.

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 $220.8 million, which increased $64.7 million over last month. Key items are noted below.

- Payment received for GME FY2026 Q1 ($8.8 million).
- Payment for Medi-Cal P14 FY2019 Final Settlement recoupment ($3.2 million).
- IGT funded for EPP CY2023 July-December ($18.2 million).
- IGT funded for QIP CY2024 ($21.6 million).
- Minor cost report adjustments and monthly accruals ($30.5 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 8/31/2025

Programs	FY97-20	FY21-25	FY26	Net Balance	Comments
Medicare Cost Report	(1,617)	(4,676)	(111)	(6,403)	Older years pending disputed SSI ratio and outlier holds for both OPPS/IPPS services from CMS.
Medi-Cal P14 Waiver	4,225	(1,680)	(1,477)	1,069	P14 audits are in various stages of completion. Currently DHCS has finalized up to FY19.
Current Waiver (GPP & CalAIM)	-	(5,618)	16,807	11,188	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	1,890	(268)	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)	(833)	(24,161)	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 FQ billing in March 2022.
Medi-Cal Managed Care EPP	0	129,173	11,288	140,462	EPP (Enhanced Payment Program). New supplemental program for services provided to Medi-Cal Managed Care.
Medi-Cal Managed Care QIP	0	128,177	13,283	141,461	QIP (Quality Incentive Program). New supplemental program for services provided to Medi-Cal Managed Care.
Medi-Cal Managed Care Rate Range	(0)	74,117	4,317	78,433	Subsidize rates for Medi-Cal Managed Care members in Alameda County.
Medi-Cal Managed Care GME	0	5,935	(744)	5,191	CMS approved in March 2020. GME is paying concurrently with fiscal year.
Medi-Cal Managed Care DP-NF Pass-Through	-	4,299	-	4,299	New payment program assisting AHS with LTC carve-in from FFS to managed care, time-limited CY2023 through CY2025. CY2023 disclosed and received Jan 2025.
Medi-Cal SNF Cost Settlement	0	1,967	70	2,037	The State began their reconciliation.
AB915	-	2,353	1,468	3,821	AB915/Medi-Cal Hospital OP cost settlement. DHCS began reconciling older years during FY23.
All Other Supplemental Programs	0	3,643	1,240	4,883	Hospital Fee, NDPH & P4P programs
Subtotal	**$ (11,313)**	**$ 239,311**	**$ 47,198**	**$ 275,195**	
Old Waiver (FY11 & FY12)	27,565	0	0	27,565	FY11 & FY12 will be finalized by December 2025.
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	**$ (65,749)**	**$ 239,311**	**$ 47,198**	**$ 220,760**	

Net County Receivable and Payable

Due To/From County of Alameda	Aug-25	Jul-25	FY 2025
Due from County of Alameda	$ 24,799	$ 45,740	$ 45,740
Capital designation receivable	7,000	7,000	7,000
Due from County of Alameda	**31,799**	**52,740**	**52,740**
Due to County of Alameda	(2,879)	(2,379)	(2,379)
County IGT funding	(43,229)	-	-
Capital cost payable	(10,880)	(10,880)	(10,880)
Due to County of Alameda	**(56,988)**	**(13,259)**	**(13,259)**
Net due from/(to) County	**$ (25,189)**	**$ 39,481**	**$ 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 once they have received the funds are returned 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 August 31, 2025, is negative $55.4 million, which improved $5.7 million over last month reflecting the net income for the month.

Net Negative Balance

The Net Negative Balance (NNB) or Line of Credit with the County is $4.8 million receivable on August 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 ($22.3 million payable) decreased by the County Restricted Cash Fund ($27.1 million) which is included in Cash.

Contingencies

John George Pavilion (JGP)

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. The County is paying claims consistently with the FY2023 maximum contract amount of $72.1 million; however, they are withholding approximately 20% pending resolution with the State. AHS has no information on the status of these claims or if more adequate funding will happen. AHS and the County are currently working to execute the FY2026 contract which is expected to increase funding.

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.

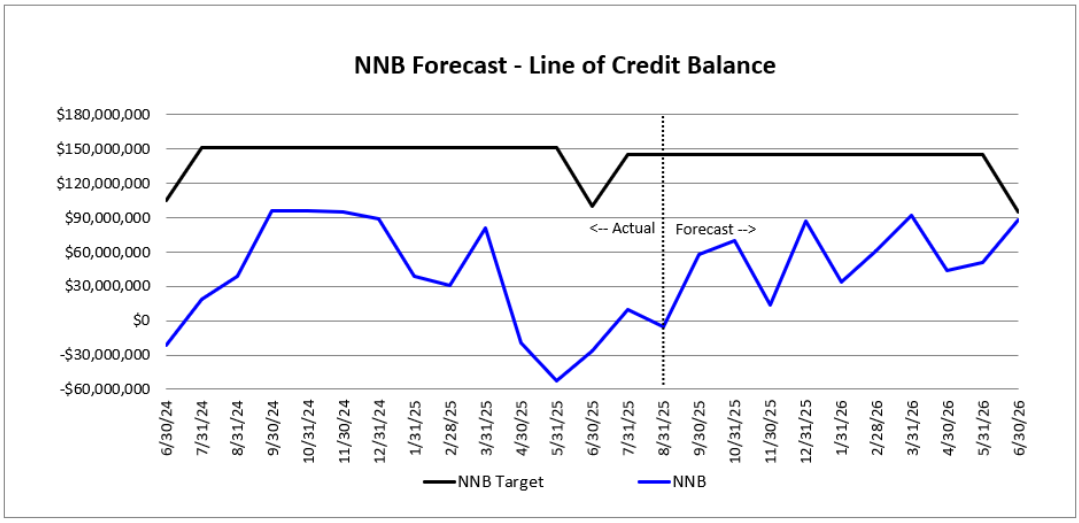
Line of Credit (Net Negative Balance) Forecast

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 August 31, 2025 was consistent with previous month's forecast.

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 expected June 30, 2026 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.

- GPP CY2025 Q2 increased from $25.7 million to $26.5 million.
- SRH use of the line of credit is excluded from 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)

	Oct-25	Nov-25	Dec-25	FY26 Q3	FY26 Q4
GPP (quarterly)	$ 26,537	$ -	$ -	$ 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	-	-	-	-	-
BHCS (JGP/Alameda County) - fy26	6,084	6,084	6,084	18,251	18,251
BHCS (JGP/Alameda County) - fy27	-	-	-	-	-
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	-	-	-	-	-
	$ 46,315	$ 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)	(25,100)	TBD
	$ (52,931)	

ALAMEDA HEALTH SYSTEM (consolidated)
Statement of Revenues and Expenses
For the Period Ended August 31, 2025
(In Thousands)

	August 2025				Year-To-Date				FY 2025		
	Actual	Budget	Variance	% Variance	Actual	Budget	Variance	% Variance	YTD	Variance	% Variance
Operating revenue											
Net patient service revenue	$ 80,202	$ 80,133	$ 69	0.1%	$ 161,330	$ 161,152	$ 178	0.1%	$ 153,394	$ 7,936	5.2%
Capitation revenue	4,479	4,549	(70)	(1.5)%	8,973	9,096	(123)	(1.4)%	9,114	(141)	(1.5)%
Other government programs	45,101	45,415	(314)	(0.7)%	90,424	90,830	(406)	(0.4)%	80,913	9,511	11.8%
Other operating revenue	8,189	4,820	3,369	69.9%	14,683	11,557	3,126	27.0%	11,356	3,327	29.3%
Total operating revenue	**137,971**	**134,917**	**3,054**	**2.3%**	**275,410**	**272,635**	**2,775**	**1.0%**	**254,777**	**20,633**	**8.1%**
Operating expense											
Labor costs	100,177	98,466	(1,711)	(1.7)%	204,239	200,290	(3,949)	(2.0)%	189,824	(14,415)	(7.6)%
Physician contract services	3,739	3,463	(276)	(8.0)%	7,566	7,061	(505)	(7.2)%	6,888	(678)	(9.8)%
Purchased services	8,261	9,119	858	9.4%	16,947	17,101	154	0.9%	15,771	(1,176)	(7.5)%
Materials and supplies	11,652	13,524	1,872	13.8%	24,797	26,336	1,539	5.8%	23,523	(1,274)	(5.4)%
Facilities	3,552	3,145	(407)	(12.9)%	7,262	5,972	(1,290)	(21.6)%	5,866	(1,396)	(23.8)%
Depreciation and amortization	2,292	2,565	273	10.6%	4,582	5,183	601	11.6%	7,022	2,440	34.7%
General and administrative	2,287	2,494	207	8.3%	4,662	4,918	256	5.2%	4,951	289	5.8%
Total operating expense	**131,960**	**132,776**	**816**	**0.6%**	**270,055**	**266,861**	**(3,194)**	**(1.2)%**	**253,845**	**(16,210)**	**(6.4)%**
Operating income (loss)	**6,011**	**2,141**	**3,870**	**180.8%**	**5,355**	**5,774**	**(419)**	**(7.3)%**	**932**	**4,423**	**474.6%**
Non-operating activity											
Interest income (expense)	(358)	(131)	(227)	(173.3)%	(689)	(294)	(395)	(134.4)%	(288)	(401)	(139.6)%
Other nonoperating revenue	9	13	(4)	(30.8)%	21	26	(5)	(19.2)%	26	(5)	(19.2)%
Total non-operating activity	**(349)**	**(118)**	**(231)**	**(195.8)%**	**(668)**	**(268)**	**(400)**	**(149.3)%**	**(262)**	**(406)**	**(155.4)%**
Net income (loss)	**$ 5,662**	**$ 2,023**	**$ 3,639**	**179.9%**	**$ 4,687**	**$ 5,506**	**$ (819)**	**(14.9)%**	**$ 670**	**$ 4,017**	**599.1%**
EBIDA adjustments											
Interest income (expense)	358	131	227		689	294	395		288	401	
Depreciation and amortization	2,292	2,565	(273)		4,582	5,183	(601)		7,022	(2,440)	
Total EBIDA adjustments	2,650	2,696	(46)		5,271	5,477	(206)		7,310	(2,039)	
EBIDA	**$ 8,312**	**$ 4,719**	**$ 3,593**		**$ 9,958**	**$ 10,983**	**$ (1,025)**		**$ 7,980**	**$ 1,978**	

ALAMEDA HEALTH SYSTEM (consolidated)
Balance Sheet
As of August 31, 2025
(In Thousands)

	Current Month	Prior Month	FYE 2025
ASSETS			
Cash & cash equivalents	$ 7,430	$ 13,538	$ 14,556
Patient account receivables, net	102,855	107,502	101,401
Due from third-party payors	409,009	347,867	346,479
Due from County of Alameda	31,799	50,672	52,740
Due from State of California	25,711	26,018	25,635
Inventories	12,545	12,506	12,267
Other current assets	24,414	22,433	17,592
TOTAL CURRENT ASSETS	**613,763**	**580,536**	**570,670**
Restricted cash equivalents	27,133	27,133	27,133
Right-to-use lease assets, net	30,358	30,981	31,604
Right-of-use subscription assets, net	4,655	4,853	5,050
Capital assets - nondepreciable	9,021	9,021	9,021
Capital assets - depreciable, net	128,745	128,918	129,675
TOTAL NONCURRENT ASSETS	**199,912**	**200,906**	**202,483**
DEFERRED OUTFLOWS OF RESOURCES	**105,415**	**105,415**	**105,415**
TOTAL ASSETS & DEFERRED OUTFLOWS	**$ 919,090**	**$ 886,857**	**$ 878,568**
LIABILITIES & NET ASSETS			
Accounts payable and accrued expenses	$ 75,862	$ 69,428	$ 79,162
Accrued compensation	42,223	46,287	63,953
Due to third-party payors	188,249	191,826	191,826
Due to County of Alameda	56,987	17,382	13,259
Other Payables	41,887	42,892	37,834
TOTAL CURRENT LIABILITIES	**405,208**	**367,815**	**386,034**
Liquidity facility - County of Alameda	22,299	32,500	502
Net pension obligation	369,662	369,662	369,662
Post employment benefit asset	43,255	43,255	43,255
Accrued compensated absences, net of current portion	22,604	22,604	26,667
Self-insurance liabilities, net of current portion	39,820	39,820	39,820
Lease obligations, net of current portion	28,647	29,192	29,739
Subscription obligations, net of current portion	1,843	1,918	1,993
Other long-term liabilities	0	0	0
TOTAL LONG TERM LIABILITIES	**528,130**	**538,951**	**511,638**
DEFERRED INFLOWS OF RESOURCES	**41,163**	**41,163**	**41,163**
Fund balance - capital contribution	86,635	86,635	86,466
Fund balance - prior years	(146,733)	(146,733)	(166,072)
Current year income/(loss)	4,687	(974)	19,339
FUND BALANCE	**(55,411)**	**(61,072)**	**(60,267)**
TOTAL LIABILITIES, DEFERRED INFLOWS, & FUND BALANCE	**$ 919,090**	**$ 886,857**	**$ 878,568**

ALAMEDA HEALTH SYSTEM (consolidated)
Statement of Cash Flows
For the Period Ended August 31, 2025
(in thousands)

	Current Month	Year-to Date	FYE 2025
CASH FLOWS FROM OPERATING ACTIVITIES			
Operating income (loss)	$ 6,011	$ 5,355	$ 23,794
Depreciation and amortization	2,292	4,582	36,849
Net changes in operating assets and liabilities:			
Patient account receivables, net	4,647	(1,454)	4,695
Due from/to third-party payors	(64,719)	(66,107)	(9,320)
Due from/to County	58,478	64,669	(14,681)
Due from State	307	(76)	(1,371)
Inventory	(39)	(278)	(280)
Other current assets	(1,981)	(6,822)	30
Accounts payable and accrued expenses	6,433	(3,300)	(6,325)
Accrued compensation	(4,064)	(21,730)	7,686
Other current payables	(1,005)	4,053	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	**6,360**	**(25,171)**	**51,751**
CASH FLOWS FROM NONCAPITAL FINANCING ACTIVITIES			
Change in liquidity facility	(10,201)	21,797	(4,599)
Interest payments on working capital loan	370	741	4,402
Receipts of rental income	9	21	(253)
Net cash provided by (used in) noncapital financing activities	**(9,822)**	**22,559**	**(450)**
CASH FLOWS FROM CAPITAL AND FINANCING ACTIVITIES			
Purchase and construction of capital assets	(1,215)	(1,926)	(19,936)
Proceeds from disposals of capital assets	0	0	0
Repayment of other long-term liabilities	0	0	(2,783)
Payments of lease liabilies	(628)	(1,176)	(6,730)
Interest payments on lease liabilities	92	186	1,232
Payments of subscription obligations	(75)	(151)	(4,532)
Interest payments on subscription obligations	10	21	128
Capital contributions and transfers	-	169	1,015
Net cash provided by (used in) capital and financing activities	**(1,816)**	**(2,877)**	**(31,606)**
CASH FLOWS FROM INVESTING ACTIVITIES			
Interest and investment income	(830)	(1,637)	(9,964)
Net cash provided by (used in) investing activities	**(830)**	**(1,637)**	**(9,964)**
CHANGES IN CASH AND CASH EQUIVALENTS	**(6,108)**	**(7,126)**	**9,731**
CASH AND CASH EQUIVALENTS, beginning of period	40,671	41,689	31,958
CASH AND CASH EQUIVALENTS, end of period	**$ 34,563**	**$ 34,563**	**$ 41,689**

ALAMEDA HEALTH SYSTEMS Volume Reports

Month: August

	MTD Actual	MTD Budget	Var	% Var	YTD Actual	YTD Budget	Var	% Var	YTD PY Actual	Var	% Var
Total Adjusted Patient Days	30,508	30,648	-140	-0.5%	61,744	61,498	247	0.4%	60,273	1,471	2.4%
Total Adjusted Discharges	2,766	2,625	141	5.4%	5,564	5,285	279	5.3%	5,208	355	6.8%
GENERAL ACUTE											
Patient Days	6,006	6,102	-96	-1.6%	12,039	12,475	-436	-3.5%	12,269	-230	-1.9%
Discharges	1,287	1,185	102	8.6%	2,575	2,407	168	7.0%	2,405	170	7.1%
Average Daily Census	193.7	196.8	-3.1	-1.6%	194.2	201.2	-7	-3.5%	197.9	-3.7	-1.9%
Average Length of Stay	4.7	5.1	0.4	8.5%	4.7	5.2	0.5	9.6%	5.1	-0.4	-7.8%
Adjusted Patient Days	11,389	11,388	1	0.0%	22,895	23,222	-327	-1.4%	22,838	58	0.3%
Adjusted Discharges	2,441	2,212	228	10.3%	4,897	4,480	417	9.3%	4,477	420	9.4%
CMI	1.530	1.607	(0.077)	-4.8%	1.570	1.654	(0.084)		1.653	-0.083	-5.0%
Emergency Visits	9,684	8,837	847	9.6%	19,087	17,601	1,486	8.4%	18,368	719	3.9%
Left Without Being Seen (LWBS)	562	576	14	2.4%	983	1,159	176	17.9%	1,282	299	30.4%
Trauma Cases	364	313	51	16.4%	659	626	33	5.2%	639	20	3.1%
Observation Equivalent Days	609	671	-62	-9.3%	1,305	1,399	-94	-6.7%	1,328	-23	-1.7%
Surgeries	682	724	-42	-5.8%	1,399	1,468	-69	-4.7%	1,598	-199	-12.5%
IP Surgeries	314	323	-9	-2.9%	643	683	-40	-5.9%	634	9	1.4%
OP Surgeries	368	400	-32	-8.1%	756	784	-28	-3.6%	964	-208	-21.6%
Deliveries	171	140	31	22.1%	324	281	43	15.2%	275	49	17.8%
PSYCH											
Psych Patient Days	2,008	2,071	-63	-3.0%	4,129	3,996	133	3.3%	4,033	96	2.4%
Psych Discharges	204	230	-26	-11.3%	417	444	-27	-6.0%	430	-13	-3.0%
Average Daily Census	64.8	66.8	-2	-3.0%	66.6	64.5	2.1	3.3%	65	1.5	2.4%
Average Length of Stay	9.8	9	-0.8	-8.2%	9.9	9	-0.9	-10.0%	9.4	-0.5	-5.6%
Adjusted Patient Days	2,473	2,518	-45	-1.8%	5,144	4,905	239	4.9%	4,966	178	3.6%
Adjusted Discharges	251	280	-28	-10.2%	520	545	-25	-4.6%	529	-10	-1.9%
PES Equivalent Days	692	748	-56	-7.5%	1,566	1,468	99	6.7%	1,468	99	6.7%
REHAB											
Rehab Patient Days	680	721	-41	-5.7%	1,353	1,420	-67	-4.7%	1,395	-42	-3.0%
Rehab Discharges	48	55	-7	-12.0%	106	107	-1	-1.3%	108	-2	-1.9%
Average Daily Census	21.9	23.3	-1.3	-5.7%	21.8	22.9	-1.1	-4.7%	22.5	-0.7	-3.0%
Average Length of Stay	14.2	13.2	0.9	7.2%	12.8	13.2	-0.5	-3.4%	12.9	-0.2	-1.2%
Adjusted Patient Days	680	721	-41	-5.7%	1,353	1,420	-67	-4.7%	1,395	-42	-3.0%
Adjusted Discharges	48	55	-7	-12.0%	106	107	-1	-1.3%	108	-2	-1.9%
Occupancy %	78%	83%	0%		78%	82%	0%		80%	0%	
Bed Holds	2	2	0	-7.0%	2	2	0	-7.0%	2	0	0.0%
Paid FTE	68	72	4	5.8%	69	72	2	3.1%	70	1	0.8%
Productive FTE	56	62	6	9.8%	59	61	2	3.1%	62	3	4.6%
Paid FTE per AOB	3.08	3.08	0	0.1%	3.18	3.12	-0.05	-1.7%	3.11	-0.07	-2.2%
Worked Hours per APD	14.5	15.1	0.7	4.3%	15.4	15.1	-0.3	-1.7%	15.6	0.3	1.6%
Worked Hours per AD	205	200	-5	-2.5%	196	200	4	1.8%	202	6	2.8%
SNF with Sub-Acute											
SNF Patient Days	8,488	8,546	-58	-0.7%	17,238	17,091	147	0.9%	16,791	447	2.7%
SNF Discharges	19	24	-5	-21.1%	34	48	-14	-29.4%	37	-3	-8.1%
Average Daily Census	273.8	275.7	-1.9	-0.7%	278	275.7	2.4	0.9%	270.8	7.2	2.7%
Average Length of Stay	446.7	355	91.7	25.8%	507	354.9	152.1	42.9%	453.8	53.2	11.7%
Adjusted Patient Days	8,744	8,563	181	2.1%	17,803	17,122	681	4.0%	17,303	500	2.9%
Adjusted Discharges	20	24	-5	-18.8%	35	48	-13	-27.2%	38	-3	-7.9%
Bed Holds	73	110	-37	-33.5%	46	207	-161	-77.8%	205	-159	-77.6%
TOTAL FTE, HOURS, WRVU											
Total Paid FTE	5,124	4,990	-134	-2.7%	5,160	5,078	-82	-1.6%	5,071	-89	-1.8%
Total Productive FTE	4,500	4,348	-151	-3.5%	4,507	4,395	-113	-2.6%	4,422	-86	-1.9%
Total Paid FTE per AOB	5.2	5.1	(0.2)	-3.2%	5.2	5.1	(0.1)	-1.2%	5.2	0.0	0.7%
Worked Hours Per APD	26.1	25.1	-1	-4.0%	25.9	25.3	-0.5	-2.1%	26	0.1	0.5%
Worked Hours Per AD	288	293	5	1.8%	287	295	8	2.6%	301	14	4.6%
Physician wRVU	130,830	113,651	17,180	15.1%	267,767	234,544	33,223	14.2%	246,849	20,918	8.5%
CLINIC / TELEHEALTH VISITS	34,299	36,528	-2,229	-6.1%	69,359	74,997	-5,638	-7.5%	69,436	-77	-0.1%
Clinic Visits	28,596	30,859	-2,263	-7.3%	57,772	63,125	-5,353	-8.5%	58,143	-371	-0.6%
Telehealth Visits	5,703	5,669	34	0.6%	11,587	11,872	-285	-2.4%	11,293	294	2.6%
FQHC Visits	28,951	31,138	-2,187	-7.0%	58,252	62,458	-4,206	-6.7%	57,663	589	1.0%
Clinic Visits	24,292	26,328	-2,036	-7.7%	48,827	52,479	-3,652	-7.0%	48,221	606	1.3%
Telehealth Visits	4,659	4,810	-151	-3.1%	9,425	9,979	-554	-5.6%	9,442	-17	-0.2%
Non-FQHC Visits	5,348	5,390	-42	-0.8%	11,107	12,539	-1,432	-11.4%	11773	-666	-5.7%
Clinic Visits	4,304	4,531	-227	-5.0%	8,945	10,646	-1,701	-16.0%	9,922	-977	-9.8%
Telehealth Visits	1,044	859	185	21.5%	2,162	1,893	269	14.2%	1,851	311	16.8%
PAYOR MIX											
Insurance %	7.1%	7.8%	-0.7%		6.6%	7.2%	-0.5%		7.0%	-0.4%	
Medi-Cal %	7.6%	10.7%	-3.1%		7.3%	10.1%	-2.8%		9.9%	-2.6%	
Medi-Cal MC %	51.5%	52.0%	-0.5%		51.9%	52.5%	-0.6%		52.7%	-0.8%	
Medicare %	22.7%	18.1%	4.6%		22.9%	18.6%	4.3%		19.1%	3.8%	
Medicare MC %	7.1%	7.2%	-0.1%		7.0%	7.1%	-0.1%		7.3%	-0.2%	
Other Govt %	1.7%	1.3%	0.4%		1.3%	1.5%	-0.2%		1.5%	-0.2%	
Self-Pay %	2.5%	3.0%	-0.5%		2.9%	3.0%	-0.1%		2.6%	0.3%	
Total Payor Mix %	100.0%	100.0%	0.0%		100.0%	100.0%	0.0%		100.0%	0.0%	

ALAMEDA HEALTH SYSTEMS Volume Reports

Month: August

	MONTH				YEAR-TO-DATE				PRIOR YEAR-TO-DATE		
	MTD Actual	MTD Budget	Var	% Var	YTD Actual	YTD Budget	Var	% Var	YTD PY Actual	Var	% Var
Campus: HIGHLAND											
Total Patient Days	4,240	4,113	127	3.1%	8,513	8,625	-112	-1.3%	8,438	75	0.9%
Total Discharges	839	714	125	17.6%	1,647	1,497	150	10.0%	1,494	153	10.2%
Total Adjusted Patient Days	7,521	7,362	159	2.2%	15,236	15,280	-44	-0.3%	14,853	384	2.6%
Total Adjusted Discharges	1,488	1,278	211	16.5%	2,948	2,652	296	11.2%	2,630	318	12.1%
GENERAL ACUTE											
GA Patient Days	4,240	4,113	127	3.1%	8,513	8,625	-112	-1.3%	8,438	75	0.9%
GA Discharges	839	714	125	17.6%	1,647	1,497	150	10.0%	1,494	153	10.2%
GA OP Factor	1.7808	1.7968	0.016	0.9%	1.7964	1.7781	-0.0183	-1.0%	1.7663	-0.0301	-1.7%
Average Daily Census	136.8	132.7	4.1	3.1%	137.3	139.1	-1.8	-1.3%	136.1	1.2	0.9%
Average Length of Stay	5.1	5.8	-0.7	-12.3%	5.2	5.8	-0.6	-10.3%	5.6	-0.5	-8.5%
Adjusted Patient Days	7,551	7,390	161	2.2%	15,293	15,337	-44	-0.3%	14,904	389	2.6%
Adjusted Discharges	1,494	1,282	212	16.5%	2,959	2,661	297	11.2%	2,639	320	12.1%
Occupancy %	81.0%	79.0%	2.0%		81.0%	82.0%	-1.0%		81.0%	1.0%	
Emergency Visits	4,957	4,349	608	14.0%	9,792	8,729	1,063	12.2%	9,156	636	6.9%
Left Without Being Seen (LWBS)	397	515	118	29.7%	662	1,055	393	59.4%	1,037	375	56.6%
Trauma Cases	364	313	51	16.4%	659	626	33	5.2%	639	20	3.1%
Observation Equivalent Days	258	319	-61	-19.1%	487	661	-174	-26.4%	558	-71	-12.8%
IP Surgeries	267	256	11	4.3%	533	541	-8	-1.4%	502	31	6.2%
OP Surgeries	204	222	-18	-7.9%	444	418	26	6.2%	428	16	3.7%
Total Surgeries	471	478	-7	-1.4%	977	959	18	1.9%	930	47	5.1%
Deliveries	171	140	31	22.1%	324	281	43	15.2%	275	49	17.8%
TOTAL FTE, HOURS, WRVU											
Total Paid FTE	1,788	1,668	-120	-7.2%	1,807	1,748	-59	-3.4%	1,763	-43	-2.5%
Total Productive FTE	1,568	1,447	-121	-8.4%	1,583	1,510	-73	-4.8%	1,538	-45	-2.9%
Total Paid FTE per AOB	7.37	7.02	-0.35	-4.9%	7.35	7.09	-0.26	-3.7%	7.36	0.01	0.1%
Worked Hours Per APD	36.9	34.8	-2.1	-6.1%	36.8	35	-1.8	-5.1%	36.7	-0.1	-0.3%
Worked Hours Per AD	187	201	14	7.0%	190	202	11	5.7%	207	17	8.2%
Physician wRVU	3	7	-4	-57.5%	6	8	-3	-31.7%	8	-2	-28.6%
OTHER STATS											
GI Procedures	335	368	-33	-9.0%	688	718	-30	-4.1%	692	-4	-0.6%
Cardiac Procedures	126	69	57	83.1%	265	127	138	109.2%	121	144	119.0%
HGH Cath Lab and IR	689	617	72	11.7%	1,476	875	601	68.8%	977	499	51.1%
CLINIC / TELEHEALTH											
Specialty	667	504	163	32.5%	1,373	1,033	340	32.9%	1,178	195	16.6%
Behavioral Health	627	521	106	20.3%	1,279	2,327	-1,048	-45.0%	1,878	-599	-31.9%
Clinic Visits	1,294	1,025	269	26.3%	2,652	3,360	-708	-21.1%	3,056	-404	-13.2%
Telehealth Specialty	854	702	152	21.6%	1,739	1,441	298	20.7%	1,493	246	16.5%
Telehealth Behavioral Health	78	78	0	-0.5%	190	265	-75	-28.4%	200	-10	-5.0%
Telehealth Visits	932	781	151	19.4%	1,929	1,707	222	13.0%	1,693	236	13.9%
TOTAL CLINIC VISITS	2,226	1,806	420	23.3%	4,581	5,067	-486	-9.6%	4,749	-168	-3.5%
PAYOR MIX											
Insurance %	8.5%	9.9%	-1.4%		7.2%	8.6%	-1.4%		8.4%	-1.1%	
Medi-Cal %	6.2%	11.3%	-5.1%		7.1%	10.8%	-3.7%		10.4%	-3.4%	
Medi-Cal MC %	51.0%	51.7%	-0.7%		50.7%	52.4%	-1.7%		52.8%	-2.1%	
Medicare %	21.8%	14.6%	7.1%		22.2%	16.2%	6.0%		16.7%	5.5%	
Medicare MC %	8.0%	7.6%	0.4%		7.9%	7.0%	0.9%		7.3%	0.6%	
Other Govt %	1.8%	1.6%	0.1%		1.5%	2.0%	-0.5%		1.9%	-0.4%	
Self-Pay %	2.7%	3.3%	-0.6%		3.5%	3.0%	0.5%		2.6%	0.9%	
Total Payor Mix %	100.0%	100.0%	0.0%		100.0%	100.0%	0.0%		100.0%	0.0%	
CAMPUS CMI											
CMI Highland	1.583	1.692	-0.109	-6.4%	1.636	1.744	-0.108	-6.2%	1.744	-0.108	-6.2%

ALAMEDA HEALTH SYSTEMS Volume Reports

Month: August

	MONTH				YEAR-TO-DATE				PRIOR YEAR-TO-DATE		
	MTD Actual	MTD Budget	Var	% Var	YTD Actual	YTD Budget	Var	% Var	YTD PY Actual	Var	% Var
Campus: ALAMEDA											
Total Patient Days	6,245	6,223	22	0.4%	12,520	12,488	32	0.3%	12,203	317	2.6%
Total Discharges	241	219	22	9.8%	477	448	29	6.4%	425	52	12.2%
Total Adjusted Patient Days	9,439	9,215	225	2.4%	18,983	18,413	570	3.1%	18,464	519	2.8%
Total Adjusted Discharges	364	325	39	12.1%	723	661	62	9.4%	643	80	12.5%
GENERAL ACUTE											
Patient Days	1,007	932	75	8.0%	1,874	1,907	-33	-1.7%	1,966	-92	-4.7%
Discharges	232	207	25	11.9%	462	424	38	9.0%	410	52	12.7%
Average Daily Census	32.5	30.1	2.4	8.0%	30.2	30.8	-0.5	-1.7%	31.7	-1.5	-4.7%
Average Length of Stay	4.3	4.5	-0.2	-3.5%	4.1	4.5	-0.4	-9.8%	4.8	-0.7	-15.4%
Adjusted Patient Days	1,858	1,693	164	9.7%	3,512	3,449	64	1.8%	3,641	-128	-3.5%
Adjusted Discharges	428	377	51	13.7%	866	767	99	12.9%	759	107	14.0%
Occupancy %	49%	46%	4%	8.0%	46%	47%	-1%	-1.7%	48%	-2%	-4.7%
Emergency Visits	1,809	1,672	137	8.2%	3,543	3,235	308	9.5%	3,375	168	5.0%
Left Without Being Seen (LWBS)	58	0	-58	-100.0%	121	0	-121	-100.0%	82	-39	-32.2%
Observation Equivalent Days	169	174	-5	-3.0%	385	349	36	10.4%	382	3	0.9%
IP Surgeries	12	22	-10	-45.6%	25	40	-15	-37.1%	39	-14	-35.9%
OP Surgeries	5	0	5	0.0%	6	0	6	0.0%	167	-161	-96.4%
Total Surgeries	17	22	-5	-22.9%	31	40	-9	-22.0%	206	-175	-85.0%
SNF with Sub-Acute											
SNF Patient Days	5,238	5,290	-52	-1.0%	10,646	10,581	65	0.6%	10,237	409	4.0%
SNF Discharges	9	12	-3	-26.3%	15	24	-9	-38.6%	15	0	0.0%
SNF OP Factor	1.0045	1.0018	-0.0028	-0.3%	1.0075	1.0016	-0.0058	-0.6%	1.0049	-0.0025	-0.3%
Average Daily Census	169	170.7	-1.7	-1.0%	171.7	170.7	1	0.6%	165.1	6.6	4.0%
Average Length of Stay	582	433.3	148.7	34.3%	709.7	433.3	276.4	63.8%	682.5	27.3	4.0%
Adjusted Patient Days	5,262	5,300	-38	-0.7%	10,726	10,598	127	1.2%	10,288	438	4.3%
Adjusted Discharges	9	12	-3	-26.1%	15	24	-9	-38.2%	15	0	0.3%
Occupancy %	93.0%	94.0%	-1.0%		95.0%	94.0%	1.0%		91.0%	4.0%	
Bed Holds	37	70	-33	-47.4%	-12	138	-150	-108.7%	135	-147	-108.9%
TOTAL FTE, HOURS, WRVU											
Total Paid FTE	638	612	-26	-4.2%	628	611	-17	-2.8%	599	-28	-4.8%
Total Productive FTE	568	535	-33	-6.1%	551	530	-20	-3.9%	521	-29	-5.6%
Total Paid FTE per AOB	2.09	2.06	-0.04	-1.7%	2.05	2.06	0.01	0.3%	2.01	-0.04	-1.9%
Worked Hours Per APD	10.7	10.3	-0.4	-3.6%	10.3	10.2	-0.1	-0.7%	10	-0.3	-2.8%
Worked Hours Per AD	276	292	16	5.3%	270	284	14	5.1%	287	17	6.1%
CLINIC / TELEHEALTH											
Specialty	1,361	1,233	128	10.4%	2,887	2,508	379	15.1%	2,514	373	14.8%
Clinic Visits	1,361	1,233	128	10.4%	2,887	2,508	379	15.1%	2,514	373	14.8%
Telehealth Specialty	15	14	1	7.1%	33	42	-9	-21.4%	42	-9	-21.4%
Telehealth Visits	15	14	1	7.1%	33	42	-9	-21.4%	42	-9	-21.4%
TOTAL CLINIC VISITS	1,376	1,247	129	10.3%	2,920	2,550	370	14.5%	2,556	364	14.2%
PAYOR MIX											
Insurance %	7.2%	7.4%	-0.2%		7.5%	7.3%	0.3%		7.4%	0.1%	
Medi-Cal %	5.8%	8.0%	-2.2%		5.7%	6.9%	-1.3%		8.3%	-2.6%	
Medi-Cal MC %	49.7%	49.5%	0.2%		51.2%	49.8%	1.4%		49.7%	1.5%	
Medicare %	26.1%	23.4%	2.7%		25.0%	22.6%	2.4%		22.8%	2.2%	
Medicare MC %	7.7%	8.9%	-1.2%		7.3%	10.1%	-2.7%		9.7%	-2.4%	
Other Govt %	1.4%	0.8%	0.5%		1.4%	1.2%	0.2%		1.2%	0.2%	
Self-Pay %	2.3%	2.1%	0.2%		1.9%	2.3%	-0.4%		0.9%	1.0%	
Total Payor Mix %	100.0%	100.0%	0.0%		100.0%	100.0%	0.0%		100.0%	0.0%	
CAMPUS CMI											
CMI Alameda	1.467	1.496	-0.029	-1.9%	1.415	1.496	-0.081	-5.4%	1.494	-0.079	-5.3%

ALAMEDA HEALTH SYSTEMS Volume Reports

Month: August

	MONTH				YEAR-TO-DATE				PRIOR YEAR-TO-DATE		
	MTD Actual	MTD Budget	Var	% Var	YTD Actual	YTD Budget	Var	% Var	YTD PY Actual	Var	% Var
Campus: SAN LEANDRO											
Total Patient Days	1,439	1,778	-339	-19.1%	3,005	3,362	-357	-10.6%	3,260	-255	-7.8%
Total Discharges	264	319	-55	-17.2%	572	593	-21	-3.6%	609	-37	-6.1%
Total Adjusted Patient Days	3,239	3,479	-240	-6.9%	6,482	6,796	-315	-4.6%	6,652	-171	-2.6%
Total Adjusted Discharges	594	624	-30	-4.8%	1,234	1,199	35	2.9%	1,243	-9	-0.7%
GENERAL ACUTE											
GA Patient Days	759	1,057	-298	-28.2%	1,652	1,942	-290	-14.9%	1,865	-213	-11.4%
GA Discharges	216	264	-48	-18.3%	466	486	-20	-4.1%	501	-35	-7.0%
GA OP Factor	2.6914	2.2466	-0.4449	-19.8%	2.527	2.3433	-0.1837	-7.8%	2.3692	-0.1578	-6.7%
Average Daily Census	24.5	34.1	-9.6	-28.2%	26.6	31.3	-4.7	-14.9%	30.1	-3.4	-11.4%
Average Length of Stay	3.5	4	-0.5	-12.1%	3.5	4	-0.5	-11.3%	3.7	-0.2	-4.8%
Adjusted Patient Days	2,043	2,374	-331	-14.0%	4,175	4,551	-376	-8.3%	4,419	-244	-5.5%
Adjusted Discharges	581	594	-13	-2.1%	1,178	1,138	39	3.4%	1,187	-9	-0.8%
Occupancy %	39.0%	54.0%	-15.0%		42.0%	50.0%	-7.0%		48.0%	-5.0%	
Emergency Visits	2,918	2,815	103	3.7%	5,752	5,637	115	2.0%	5,837	-85	-1.5%
Left Without Being Seen (LWBS)	107	61	-46	-43.2%	200	104	-96	-48.0%	163	-37	-18.5%
Observation Equivalent Days	183	179	4	2.2%	433	389	44	11.3%	388	45	11.6%
IP Surgeries	35	45	-10	-22.6%	85	103	-18	-17.5%	93	-8	-8.6%
OP Surgeries	159	179	-20	-11.0%	306	366	-60	-16.4%	369	-63	-17.1%
Total Surgeries	194	224	-30	-13.4%	391	469	-78	-16.7%	462	-71	-15.4%
REHAB											
Rehab Patient Days	680	721	-41	-5.7%	1,353	1,420	-67	-4.7%	1,395	-42	-3.0%
Rehab Discharges	48	55	-7	-12.0%	106	107	-1	-1.3%	108	-2	-1.9%
Rehab OP Factor	1	1	0	0.0%	1	1	0	0.0%	1	0	0.0%
Average Daily Census	21.9	23.3	-1.3	-5.7%	21.8	22.9	-1.1	-4.7%	22.5	-0.7	-3.0%
Average Length of Stay	14.2	13.2	0.9	7.2%	12.8	13.2	-0.5	-3.4%	12.9	-0.2	-1.2%
Adjusted Patient Days	680	721	-41	-5.7%	1,353	1,420	-67	-4.7%	1,395	-42	-3.0%
Adjusted Discharges	48	55	-7	-12.0%	106	107	-1	-1.3%	108	-2	-1.9%
Occupancy %	78%	83%	0%	0.0%	78%	82%	0%	0.0%	80%	0%	0.0%
Bed Holds	2	2	0	-7.0%	2	2	0	-7.0%	2	0	0.0%
TOTAL FTE, HOURS, WRVU											
Total Paid FTE	470	470	0	-0.1%	481	463	-18	-3.8%	463	-18	-3.8%
Total Productive FTE	394	402	8	1.9%	408	393	-15	-3.9%	401	-7	-1.7%
Total Paid FTE per AOB	4.5	4.19	-0.31	-7.5%	4.6	4.23	-0.37	-8.8%	4.32	-0.28	-6.6%
Worked Hours Per APD	21.5	20.5	-1.1	-5.3%	22.3	20.5	-1.8	-9.0%	21.4	-0.9	-4.4%
Worked Hours Per AD	117	114	-3	-3.0%	117	116	-1	-1.0%	114	-3	-2.4%
PAYOR MIX											
Insurance %	5.5%	5.3%	0.1%		5.8%	5.8%	0.0%		5.8%	0.0%	
Medi-Cal %	10.5%	10.3%	0.2%		8.4%	9.6%	-1.3%		9.6%	-1.3%	
Medi-Cal MC %	46.0%	48.6%	-2.6%		45.8%	48.8%	-3.0%		48.5%	-2.7%	
Medicare %	25.5%	23.6%	1.9%		27.3%	22.9%	4.4%		23.4%	3.9%	
Medicare MC %	7.9%	8.6%	-0.7%		8.3%	8.8%	-0.5%		9.0%	-0.7%	
Other Govt %	1.7%	0.9%	0.9%		1.9%	1.1%	0.8%		1.1%	0.8%	
Self-Pay %	2.9%	2.7%	0.2%		2.6%	3.1%	-0.5%		2.8%	-0.2%	
Total Payor Mix %	100.0%	100.0%	0.0%		100.0%	100.0%	0.0%		100.0%	0.0%	
CAMPUS CMI											
CMI San Leandro	1.356	1.38	-0.024	-1.7%	1.454	1.451	0.003	0.2%	1.449	0.005	0.3%

ALAMEDA HEALTH SYSTEMS Volume Reports

Month: August

	MONTH				YEAR-TO-DATE				PRIOR YEAR-TO-DATE		
	MTD Actual	MTD Budget	Var	% Var	YTD Actual	YTD Budget	Var	% Var	YTD PY Actual	Var	% Var
Campus: JOHN GEORGE											
Total Patient Days	2,008	2,071	-63	-3.0%	4,129	3,996	133	3.3%	4,033	96	2.4%
Total Discharges	204	230	-26	-11.3%	417	444	-27	-6.0%	430	-13	-3.0%
Total Adjusted Patient Days	2,399	2,446	-48	-2.0%	4,971	4,762	208	4.4%	4,811	160	3.3%
Total Adjusted Discharges	244	272	-28	-10.3%	502	529	-27	-5.1%	513	-11	-2.1%
PSYCH											
Psych Patient Days	2,008	2,071	-63	-3.0%	4,129	3,996	133	3.3%	4,033	96	2.4%
Psych Discharges	204	230	-26	-11.3%	417	444	-27	-6.0%	430	-13	-3.0%
Average Daily Census	64.8	66.8	-2	-3.0%	66.6	64.5	2.1	3.3%	65	1.5	2.4%
Average Length of Stay	9.8	9	-0.8	-9.3%	9.9	9	-0.9	-10.0%	9.4	-0.5	-5.6%
Adjusted Patient Days	2,473	2,518	-45	-1.8%	5,144	4,905	239	4.9%	4,966	178	3.6%
Adjusted Discharges	251	280	-28	-10.2%	520	545	-25	-4.6%	529	-10	-1.9%
PES Equivalent Days	692	748	-56	-7.5%	1,566	1,468	99	6.7%	1,468	99	6.7%
PES Visits	773	841	-68	-8.1%	1,653	1,732	-79	-4.6%	1,730	-77	-4.5%
PES Hours	16,614	16,123	491	3.0%	37,592	32,707	4,885	14.9%	35,222	2,370	6.7%
PES Hours per Visit	21	19	-2	-12.1%	23	19	-4	-20.4%	20	-2	-11.7%
TOTAL FTE, HOURS, WRVU											
Total Paid FTE	387	369	-18	-4.9%	391	364	-27	-7.5%	379	-12	-3.2%
Total Productive FTE	339	321	-18	-5.5%	341	313	-28	-9.1%	332	-9	-2.9%
Total Paid FTE per AOB	5	4.67	-0.32	-6.9%	4.88	4.74	-0.14	-3.0%	4.89	0.01	0.2%
Worked Hours Per APD	25	23.3	-1.8	-7.6%	24.3	23.3	-1	-4.5%	24.4	0.1	0.4%
Worked Hours Per AD	246	209	-37	-17.7%	241	209	-31	-14.9%	229	-12	-5.1%
Physician wRVU	7,617	8,377	-760	-9.1%	16,355	18,480	-2,125	-11.5%	18,401	-2,045	-11.1%
PAYOR MIX											
Insurance %	2.3%	5.0%	-2.6%		3.9%	4.1%	-0.2%		3.5%	0.4%	
Medi-Cal %	14.3%	12.8%	1.5%		10.5%	12.0%	-1.5%		11.9%	-1.4%	
Medi-Cal MC %	52.8%	53.0%	-0.1%		57.5%	53.2%	4.3%		52.2%	5.3%	
Medicare %	25.8%	22.9%	3.0%		23.8%	21.6%	2.2%		23.8%	0.0%	
Medicare MC %	2.7%	3.2%	-0.6%		3.5%	3.2%	0.3%		3.2%	0.3%	
Other Govt %	1.9%	-0.1%	1.9%		-1.1%	0.2%	-1.3%		0.2%	-1.3%	
Self-Pay %	0.2%	3.3%	-3.0%		1.9%	5.7%	-3.8%		5.3%	-3.3%	
Total Payor Mix %	100.0%	100.0%	0.0%		100.0%	100.0%	0.0%		100.0%	0.0%	
CAMPUS CMI											
CMI Behavioral Health	1.399	1.345	0.054	4.0%	1.391	1.337	0.054	4.0%	1.336	0.055	4.1%

ALAMEDA HEALTH SYSTEMS Volume Reports

Month: August

	MONTH				YEAR-TO-DATE				PRIOR YEAR-TO-DATE		
	MTD Actual	MTD Budget	Var	% Var	YTD Actual	YTD Budget	Var	% Var	YTD PY Actual	Var	% Var
Campus: FAIRMONT											
Total Patient Days	3,250	3,255	-5	-0.2%	6,592	6,511	82	1.3%	6,554	38	0.6%
Total Discharges	10	12	-2	-15.7%	19	24	-5	-20.0%	22	-3	-13.6%
OP Factor	1.2838	1.3515	0.0677	5.0%	1.2938	1.3671	0.0733	5.4%	1.3489	0.0551	4.1%
Total Adjusted Patient Days	4,172	4,399	-227	-5.2%	8,529	8,901	-372	-4.2%	8,841	-312	-3.5%
Total Adjusted Discharges	13	16	-3	-19.9%	25	32	-8	-24.3%	30	-5	-17.2%
SNF with Sub-Acute											
SNF Patient Days	3,250	3,255	-5	-0.2%	6,592	6,511	82	1.3%	6,554	38	0.6%
SNF Discharges	10	12	-2	-15.7%	19	24	-5	-20.0%	22	-3	-13.6%
SNF OP Factor	1.072	1.0023	-0.0697	-7.0%	1.0756	1.0021	-0.0735	-7.3%	1.071	-0.0046	-0.4%
Average Daily Census	104.8	105	-0.2	-0.2%	106.3	105	1.3	1.3%	105.7	0.6	0.6%
Average Length of Stay	325	274.5	50.5	18.4%	346.9	274.2	72.7	26.5%	297.9	49	16.5%
Adjusted Patient Days	3,484	3,263	221	6.8%	7,090	6,524	566	8.7%	7,019	71	1.0%
Adjusted Discharges	11	12	-1	-9.8%	20	24	-3	-14.1%	24	-3	-13.3%
Occupancy %	96%	96%	0%		98%	96%	2%		97%	1%	
Bed Holds	36	39	-3	-8.7%	58	69	-11	-15.9%	70	-12	-17.1%
TOTAL FTE, HOURS, WRVU											
Total Paid FTE	292	282	(10)	-3.6%	293	294	1	0.4%	294	2	0.5%
Total Productive FTE	256	246	(10)	-4.2%	255	254	-1	-0.3%	257	2	0.7%
Total Paid FTE per AOB	2.17	1.99	-0.18	-9.3%	2.13	2.05	-0.08	-4.0%	2.06	-0.06	-3.1%
Worked Hours Per APD	10.9	9.9	-1	-9.8%	10.6	10.1	-0.5	-4.6%	10.3	-0.3	-3.0%
Worked Hours Per AD	3530	2715	-815	-30.0%	3676	2777	-899	-32.4%	3066	-610	-19.9%
CLINIC / TELEHEALTH											
Behavioral Health	1,640	2,264	-624	-27.6%	3,383	4,763	-1,380	-29.0%	4,334	-951	-21.9%
Rehab	9	9	0	-1.0%	23	15	8	56.8%	18	5	27.8%
Clinic Visits	1,649	2,273	-624	-27.5%	3,406	4,778	-1,372	-28.7%	4,352	-946	-21.7%
Telehealth Behavioral Health	97	65	32	50.2%	200	144	56	38.9%	116	84	72.4%
Telehealth Visits	97	65	32	50.2%	200	144	56	38.9%	116	84	72.4%
TOTAL CLINIC VISITS	1,746	2,338	-592	-25.3%	3,606	4,922	-1,316	-26.7%	4,468	-862	-19.3%
PAYOR MIX											
Insurance %	1.48%	1.18%	0.30%		2.11%	0.93%	1.19%		1.21%	0.90%	
Medi-Cal %	6.05%	6.88%	-0.83%		3.83%	6.63%	-2.80%		6.92%	-3.09%	
Medi-Cal MC %	75.95%	68.58%	7.38%		77.97%	68.85%	9.12%		68.41%	9.56%	
Medicare %	15.20%	20.19%	-4.99%		15.42%	20.12%	-4.70%		19.23%	-3.81%	
Medicare MC %	1.30%	2.54%	-1.24%		0.84%	2.82%	-1.97%		2.94%	-2.10%	
Other Govt %	0.17%	0.21%	-0.04%		0.10%	0.16%	-0.07%		0.21%	-0.12%	
Self-Pay %	-0.16%	0.42%	-0.58%		-0.26%	0.50%	-0.76%		1.07%	-1.34%	
Total Payor Mix %	100.00%	100.00%	0.00%		100.00%	100.00%	0.00%		100.00%	0.00%	

ALAMEDA HEALTH SYSTEMS Volume Reports

Month: August

	MONTH				YEAR-TO-DATE				PRIOR YEAR-TO-DATE		
	MTD Actual	MTD Budget	Var	% Var	YTD Actual	YTD Budget	Var	% Var	YTD PY Actual	Var	% Var
Campus: FQ CLINIC											
TOTAL FTE, HOURS, WRVU											
Total Paid FTE	511	519	8	1.5%	504	527	23	4.4%	505	1	0.1%
Total Productive FTE	434	443	9	2.1%	426	444	18	4.1%	426	(1)	-0.2%
Physician wRVU	39,435	36,120	3,315	9.2%	77,827	72,786	5,040	6.9%	72,680	5,147	7.1%
OTHER STATS ----------											
Covid Immunization	219	218	1	0.5%	429	661	(232)	-35.1%	661	(232)	-35.1%
CLINIC / TELEHEALTH VISITS --											
Primary Care	13,693	13,952	(259)	-1.9%	27,207	27,796	(589)	-2.1%	27,883	(676)	-2.4%
Specialty	10,578	12,376	(1,798)	-14.5%	21,579	24,683	(3,104)	-12.6%	20,338	1,241	6.1%
Behavioral Health	21	0	21	0.0%	41	0	41	0.0%	0	41	0.0%
Clinic Visits	24,292	26,328	(2,036)	-7.7%	48,827	52,479	(3,652)	-7.0%	48,221	606	1.3%
Telehealth Primary Care	2,531	2,711	(180)	-6.6%	4,970	5,665	(695)	-12.3%	5,145	(175)	-3.4%
Telehealth Specialty	2,095	2,064	31	1.5%	4,395	4,238	157	3.7%	4,247	148	3.5%
Telehealth Behavioral Health	33	35	(2)	-5.7%	60	76	(16)	-21.1%	50	10	20.0%
Telehealth Visits	4,659	4,810	(151)	-3.1%	9,425	9,979	(554)	-5.6%	9,442	(17)	-0.2%
TOTAL CLINIC VISITS	28,951	31,138	(2,187)	-7.0%	58,252	62,458	(4,206)	-6.7%	57,663	589	1.0%
PAYOR MIX ----------											
Insurance %	2.7%	2.5%	0.3%		2.7%	2.5%	0.2%		2.4%	0.3%	
Medi-Cal %	14.7%	17.7%	-3.0%		13.8%	17.7%	-3.9%		11.4%	2.4%	
Medi-Cal MC %	63.7%	62.2%	1.5%		64.8%	62.3%	2.5%		67.5%	-2.8%	
Medicare %	12.7%	12.0%	0.7%		12.8%	11.8%	1.0%		12.6%	0.3%	
Medicare MC %	1.0%	1.2%	-0.2%		1.0%	1.2%	-0.2%		1.4%	-0.4%	
Other Govt %	1.7%	1.7%	0.0%		1.7%	1.7%	0.0%		2.1%	-0.4%	
Self-Pay %	3.5%	2.9%	0.6%		3.3%	2.9%	0.4%		2.7%	0.6%	
Total Payor Mix %	100.0%	100.0%	0.0%		100.0%	100.0%	0.0%		100.0%	0.0%	

Public Affairs and Community Engagement Report

ALAMEDA HEALTH SYSTEM

TO: Board of Trustees

FROM: Jeanette Dong, Chief, Public Affairs & Community Engagement

DATE: September 29, 2025

SUBJECT: Public Affairs and Community Engagement Report

Public Affairs and Community Engagement (PACE) provides collaborative and integrated strategic communications and meaningful engagement with stakeholders that support, promote, and amplify AHS' 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.

The California State Legislature concluded its regular session on September 13, extending adjournment by one day to pass a package of environmental and wildfire fund bills. As a result, the governor’s deadline to sign bills has also been extended by one day, to October 13. Appendix A includes a list of state bills AHS is currently tracking.

At the federal level, government funding is scheduled to lapse at midnight on September 30 unless Congress acts. The House of Representatives passed a continuing resolution (CR) that extends government funding at current levels until November 21. The Senate, however, failed to advance it. In addition, an alternative short-term funding bill offered by Senate Democrats, which included a repeal of the Medicaid cuts from the Big Bill, also failed by a 47-45 vote. Lawmakers have now reached an impasse. House and Senate leaders are expected to meet with the president on Monday, September 29. Congress has until September 30 to pass a funding proposal to avert a government shutdown.

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 September 2025 and a preview of activities for October 2025.

*Contact Louise Nakada, LNakada@alamedahealthsystem.org for more information.

Date	Location	Event	Description
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, over 35 members of the AHS family participated in the AHS contingent, which celebrated the community's inclusiveness and diversity. In addition, the AHS Internal Medicine Department/residents offered 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 participated in a health fair for City of Newark employees. Health screenings were offered.
September 20, 2025 8:30 a.m. – 11:30 a.m.	Alameda County Community Food Bank, Oakland	AHS Employee Volunteer Event	Over 30 members of the AHS family joined CEO James Jackson at this volunteer event that supported the Alameda County Community Food Bank. More than 20,000 pounds of produce, which is nearly 17,000 meals, were packaged for those in need. ACCFB is an important community partner.
September 21, 2025 7:30 a.m.	Alameda Point, Alameda	Alameda Running Festival	AHS / Alameda Hospital sponsored the Wellness Expo for this annual running event, which includes a 5k, 10k, and half-marathon. Health and wellness tips and information about AHS services were provided to over 1,000 participants.
September 25, 2025 9:00 a.m. – 2:00 p.m.	Oakland Zoo, Oakland	22nd Annual Healthy Living Festival	AHS sponsored and participated in this annual event that promoted health and wellness for Alameda County residents 55 and older. The event was hosted by Alameda County Supervisor Nate Miley and the United Seniors of Oakland and Alameda County. Over 1,000 seniors attend this event each year.
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 attended this annual event hosted by the Alameda Chamber & Economic Alliance. The event featured elected officials, economic experts, and business leaders.

September 25, 2025 5:00 p.m. – 7:30 p.m.	Casa Peralta, San Leandro	San Leandro Chamber Multicultural Mixer	AHS participated 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 were provided.
October 2025	AHS Cafes, Oakland, San Leandro, Alameda	"Soctober" Sock Drive	AHS Food and Nutrition Services is hosting a "Socktober" sock drive to support local shelters in Alameda County. New pairs of socks will be collected in AHS cafes at the Highland, Alameda, San Leandro, and Fairmont café locations.
October 3, 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 will host a community blood drive to help save lives and alleviate the blood supply shortage.
October 4, 2025 9:00 a.m. – 12:00 p.m.	Dublin Senior Center, Dublin	Dublin Senior Health Fair	AHS will participate in this community event for seniors. Health and wellness tips and information about AHS services will be provided.
October 4, 2025 11:00 a.m. – 7:00 p.m.	Alameda Point Waterfront Park, Alameda	Filipino Island Fest	AHS / Internal Medicine Department will offer health screenings and health and wellness information at this festival celebrating Filipino culture.
October 18, 2025 9:00 a.m. – 12:00 p.m.	Alameda Hospital Parking Lot, Alameda	Alameda Hospital Community Health Fair	This community health fair will offer free flu shots, health screenings, and information about AHS services and programs. Community organizations will also provide information about their programs that impact the health and well-being of the community.
October 18, 2024 10:00 a.m. – 2:30 p.m.	San Leandro Public Library, San Leandro	Alameda County District 3 Emergency Preparedness Event	AHS will join other community organizations at this event, which focuses on keeping families safe during natural disasters and emergencies. The event is hosted by Alameda County Supervisor Lena Tam.

COMMUNICATIONS

The PACE Communications Team develops and implements communication strategies and plans for key organizational initiatives. Updates are provided as of September 1, 2025

Unique Stories

From September 1 to September 29, 2025, PACE created 27 unique stories to spotlight AHS programs and departments. These stories were shared via the AHS intranet, the internet, CEO Chronicles and social media.

CEO Chronicles Newsletter

The CEO Chronicles is a monthly newsletter sent to nearly 6,000 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 September 2025 issue.

The September 2025 newsletter's open rate was 51% for AHS staff distribution, 37% for St. Rose Hospital distribution and 55% for external distribution. The benchmark for open rate (i.e., the percentage of newsletter emails that are opened) is 27%.

The September 2025 CEO Chronicles CEO video shared the expected impacts to AHS from the Big Bill. The Real People, Real Care (RPRC) Spotlight video featured Andrea Zomora, employee relations consultant.

This newsletter included a back-to-school piece to highlight MyChart and scheduling pediatric appointments, a respiratory illness and vaccine reminder and information on open enrollment and what steps to take now to prepare. Additionally, we had recaps of our participation in the Oakland Pride Parade and Festival, as well as activities for Community Health Worker Awareness Week. We also highlighted Alameda and St. Rose Hospitals for their recognition from the American Heart Association for improving patient outcomes in heart disease and stroke. The AHS Index featured Medicaid statistics, and our *In the News* section featured the East Bay Times article on Medicaid cuts. A calendar of events providing community engagement events for September and October was included as we do in every edition of the CEO Chronicles.

For the AHS staff distribution, the CEO video was the most viewed, and the RPRC spotlight and open enrollment tied for the second most viewed. For the St. Rose Hospital distribution, the Alameda and St. Rose Hospitals recognition from the American Heart Association was number one, followed by the CEO video. For the external distribution, the CEO video was the number one watched, followed by the American Heart Association recognition.

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, 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 September 2025, staff received a finance update and presentations on flu vaccines, suicide prevention, breast cancer awareness and we announced the employees of the quarter. In addition, we shared a video from KPIX recognizing Sambo Ly, manager of Interpreter Services, with the Icon Award for her decades of service to refugees and community members in Alameda County.

For September 2025, the Chat averaged 516 total participants every Wednesday. Total participants include all panelists and attendees.

Social Media Report
Date Range of Report: September 1 to September 29, 2025

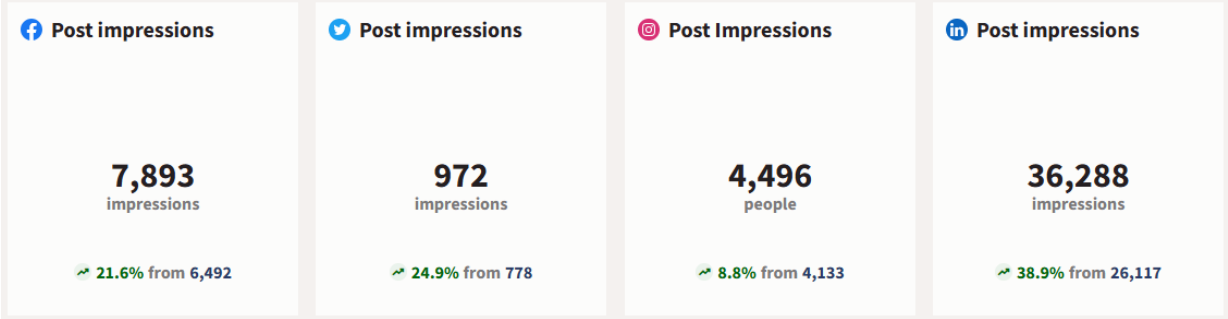
Number of Followers/Fans Compared to Previous 30 Days

Facebook	**X** (formerly Twitter)	**Instagram**	**LinkedIn**
Followers: 2,369 followers; 0.1% from 2,366	Followers: 2,053 followers; 0.2% from 2,057	Followers: 1,019 followers; 0.6% from 1,013	Followers: 29,625 followers; 1% from 29,337
Page new followers: 11 new followers; 31.3% from 16	Page new followers: -4 followers; 100% from -2	Page new followers: 11 followers; 54.2% from 24	Page new followers: 289 new followers; 17.2% from 349

Engagement Report Compared to 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.

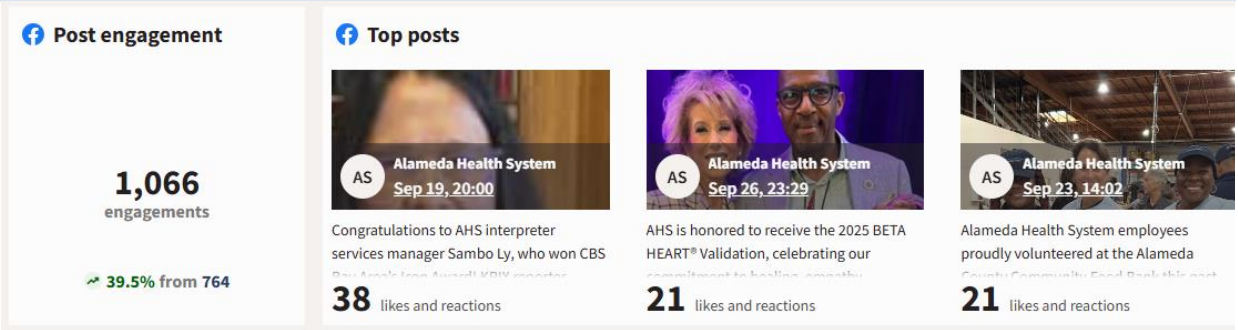
Facebook **X** (formerly Twitter) **Instagram** **LinkedIn**



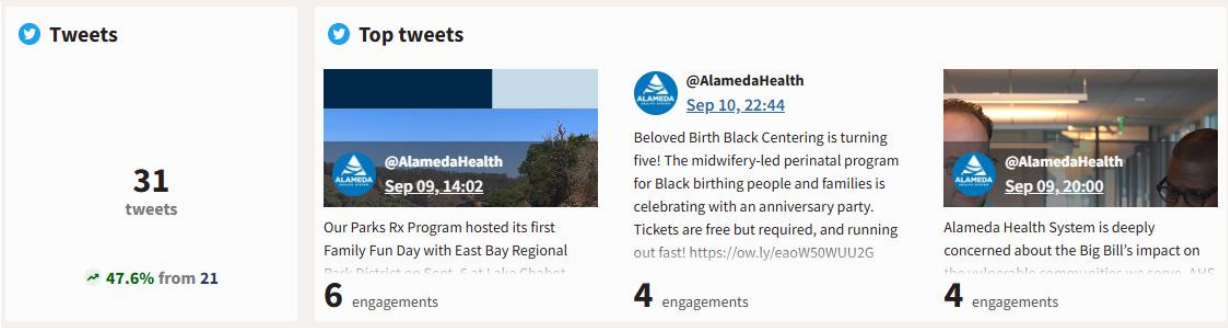
Social media engagement is the measure of interactions - comments, likes, shares, posts, etc. that our audience has with the content AHS posts.

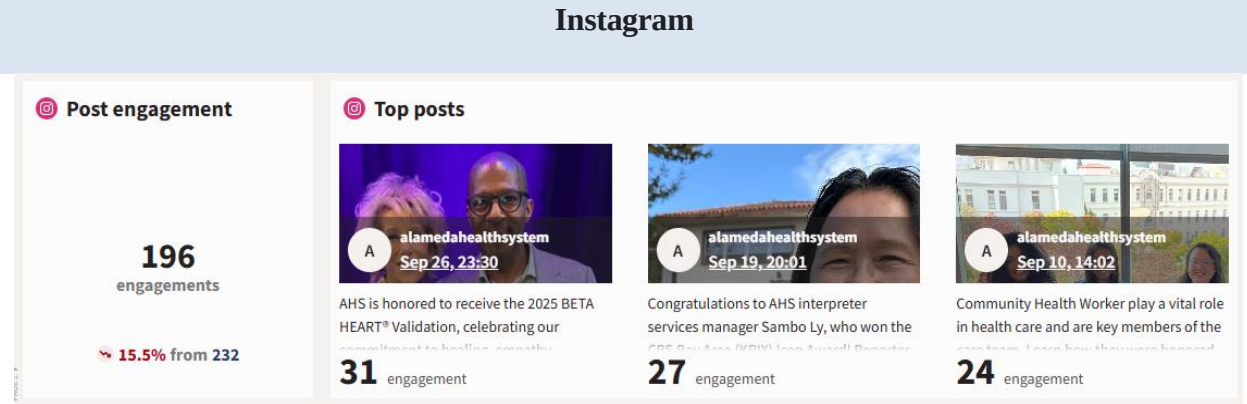
Top 3 Social Media Posts Based on Engagement On All Social Media Platforms September 1 to September 29, 2025 Compared to Previous 30 Days

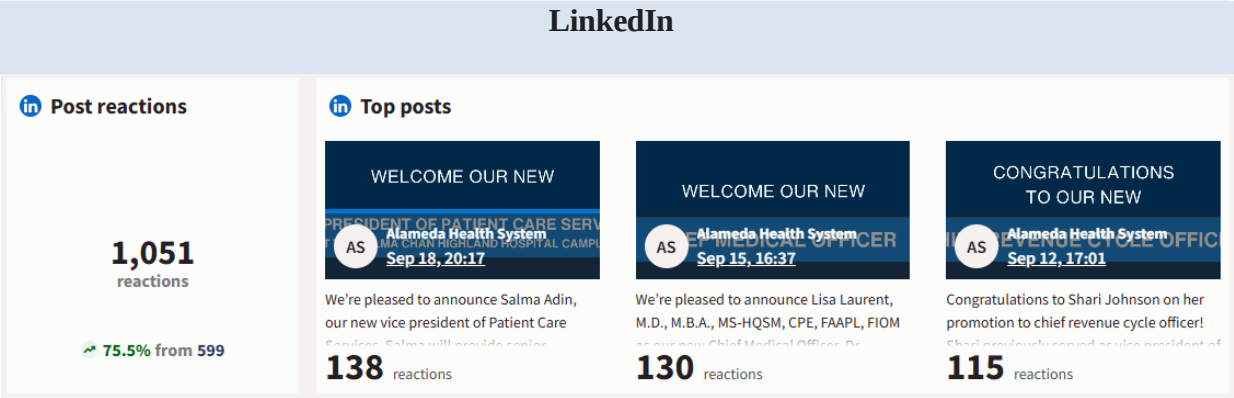
Facebook



X (formerly Twitter)







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
Sep. 1- 29, 2025	222	94,583,916	$1,717,738

[Alameda Post: Five tips for choosing a nursing home]

Finding a nursing home is emotionally and financially stressful — and not many know where to start. Learn about five tips that may help in this month's Healthy Alameda column, published in the Alameda Post.

[CBS News: East Bay refugee from Cambodia devotes life to serving newcomers at Alameda Health System]

Sambo Ly, AHS manager of interpreter services, has won the Icon Award from CBS News Bay Area (KPIX) in recognition of her decades of service to refugees and community members in Alameda County.

[Alameda Health System is recognized for responsible sourcing and sustainable procurement]

"AHS is a pillar organization in our community. We prioritize keeping our dollars local whenever possible, as well as sourcing and distributing resources directly within the communities we serve. This includes responsible supply chain practices that build regenerative prosperity with vendors whose practices and values align with our mission of caring, healing, teaching and serving all," said AHS CEO James Jackson.

[Alameda Health System is recognized as one of Newsweek's America's Best Nursing Homes 2026]

All four AHS skilled nursing and sub-acute facilities, commonly referred to as nursing homes, have been recognized on Newsweek's America's Best Nursing Homes 2026 list.

"We believe that health care is a human right that everyone should have access to, regardless of their ability to pay for services. This recognition affirms our belief that the public, safety-net health system can and does provide exceptional care on par with for profit institutions. This recognition is a reflection of our highly skilled and compassionate team members who care for our residents like family, and our facilities that have strong and consistent processes," said Richard Espinoza, chief administrative officer of post-acute services at AHS.

Appendix A – AHS Activities on Key State Bills – 9/26/2025

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.	Governor's desk	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 screen 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, and presume financial assistance eligibility upon verification. 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 a patient to complete a financial assistance application 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.	Governor's desk	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.	Chaptered	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 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.	Governor's desk	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