BOARD OF TRUSTEES MEETING

WEDNESDAY, NOVEMBER 12, 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
Teleconference Location: 4501 Pleasanton Avenue, Pleasanton, CA 94566

ZOOM Meeting Link:[1]
https://alamedahealthsystem.zoom.us/j/9361457125?pwd=4JnAmhDnBaLqY4GWf4PQBwp3w0Puy2.1&omn=88679995373
Meeting ID: 936 145 7125
Meeting Password: 20200513

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

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

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

MEMBERS

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

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[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. Human Resources Committee: October 15, 2025
David Sayen, Chair

C2. Quality Professional Services Committee: October 22, 2025
Lilavati Indulkar, MD, Chair

C3. Finance Committee: November 5, 2025
Alan Fox, Committee Chair

D. CONSENT AGENDA: ACTION

D1. Approval of the System Wide Policies and Standardized Procedures listed below

- Personal Appliance Policy

Recommendation from the Quality Professional Services Committee on October 22, 2025 to approve the policies listed below.

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

- Medication Aerosolized Epoprostenol Sodium (Flolan® OR Veletri®) Continuous Administration Policy
- Medication Administration Chemotherapy Antidotes for Extravasation Management
- Medication carts, Kits and Transport Boxes for Specific Depts. and Divisions
- Procedural Sedation Policy
- Patient Complaints and Grievances Policy
- 2026 Quality Assurance and Performance Improvement Plan (QAPI)
- Against Medical Advice Policy (AMA)
- School of Nursing and Paraprofessional Affiliation Requirements Policy
- PCP Assignment and Panel Size Policy
- Responsible Use of AI Policy
- Patient Non-Discrimination to Access Health Care Services

Recommendation from the Quality Professional Services Committee on October 22, 2025 to approve the policies listed below.

D3. Approval of the AHS Medical Staff Policies and Procedures listed below:

AHS and AH Medical Staff:

- Standardized Procedures for Advanced Practice Providers in The Department of Orthopaedic Surgery

Recommendation from the Finance Committee on November 5, 2025 to approve the contracts listed below.

D4. Contracts

D4a. Renewal agreement with Symplr Care Management LLC for provision of patient safety and quality reporting software applications. The term of this agreement is effective January 1, 2026 through December 31, 2028. The estimated impact of this agreement is $1,112,847.
Christine Yang, Chief Information Officer

D4b. New agreement with LAZ Parking California, LLC for provision of parking services. The term of this agreement is effective January 1, 2026 through December 31, 2028. The estimated impact of this agreement is $6,937,194.
Mark Fratzke, Chief Operating Officer

Recommendation from the Finance Committee on November 5, 2025 to approve the St. Rose Budget listed below.

D5. St. Rose Budget FY 26

E. ACTION/DISCUSSION

E1. DISCUSSION: Department of Medicine Overview
Indhu Subramanian, Vice Chair Medicine and Program Director Internal Medicine Residency

E2. ACTION/DISCUSSION: Labor Efficiencies to Address Budget Shortfalls
Kim Miranda, Chief Financial Officer
Alexander Gallo, Vice President Financial Transformation

F. DISCUSSION: Board Calendar and Tracking

G. STAFF REPORTS (Written)

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

CLOSED SESSION

1. THREAT TO PUBLIC SERVICES OR FACILITIES
(Gov. Code § 54957)
Consultation with Ian Rodriguez, Deputy Director of Security

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

3. Labor Negotiation
[Government Code Section 54957.6]
AHS Designated Representatives: David Sayen, Board President
Unrepresented Employee: Chief Executive Officer

4. Conference with Labor Negotiators
[Government Code Section 54957.6]
AHS Designated Representatives: Ulysses Madison, Director of People Operations
Employee Organization: UAPD, ILWU, ACMEA, SEIU, CNA, SEIU-UHW

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

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

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

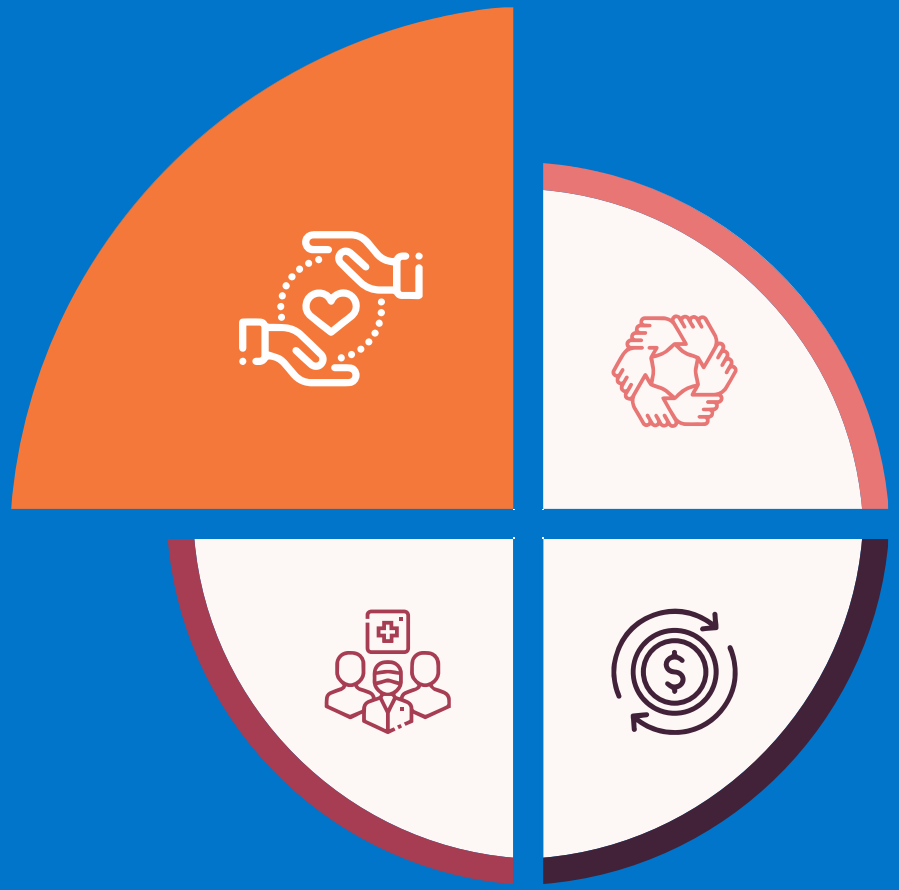
AHS CEO Board Report

James Jackson
11/12/2025
Board of Trustee Meeting

AHS Pillars

Quality Care

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



DOC OF THE DAY

ALAMEDA HEALTH SYSTEM

1411 East 31st Street
Oakland, CA 94602

October 28, 2025

To: All AHS Staff and Medical Staff

From: Lily Indulkar, MD, Vice Chair, Dept. of Medicine & Division Chief, Hospital Medicine
Indhu Subramanian, MD, Chair, Department of Medicine

Re: DOC OF THE DAY

We are pleased to announce that the **Division of Hospital Medicine, Highland Hospital** within the **Department of Internal Medicine** will be launching a new **"Doc of the Day" shift**, beginning **this Wednesday**, **October 29, 2025.**

This dedicated role will operate **daily from 9:00 AM to 5:00 PM**, **seven days a week, year-round**.

Purpose and Function

The "Doc of the Day" (DoD) physician will serve as a central point of coordination—a clinical "air traffic controller"—to help manage patient flow across the acute care hospitals. This role is designed to enhance communication, streamline decision-making, and improve throughput from the emergency department to inpatient units and beyond.

Key Benefits

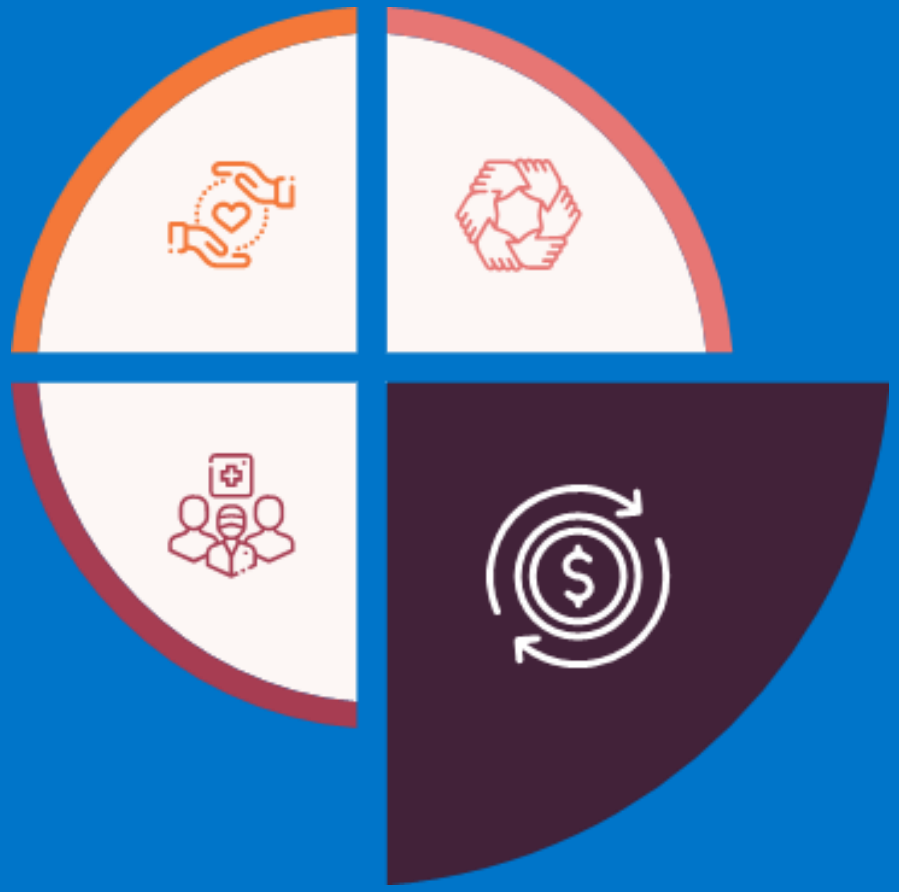
- **Improved System Throughput:** A dedicated physician overseeing admissions and transfers, will reduce delays and optimize bed utilization.
- **Enhanced Communication:** The DoD will facilitate real-time coordination among hospital medicine teams, nursing units, and the emergency department.
- **Consistent Oversight:** Having a single point of contact ensures consistency in decision-making and operational flow throughout the day.
- **Better Patient Experience:** Smoother transitions of care translate into shorter wait times and improved satisfaction for patients and their families.

We are excited to learn about the impact this initiative will have on hospital efficiency, interdisciplinary collaboration, and patient-centered care.

We believe this new operational model will continue to advance our mission of delivering high-quality, timely, and coordinated care.

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.

Acute

Performance Scores and Comparison*

Level: 8
1—10 scale

Score: 76
1—100 scale

Percentile: 80
1—100 scale; against peer group

Ambulatory

Level: 8
1—10 scale

Score: 77.8
1—100 scale

Percentile: 66.6
1—100 scale; against peer group

LTPAC

Level: 8
1—10 scale

Score: 76
1—100 scale

Percentile: 83.3
1—100 scale; against peer group

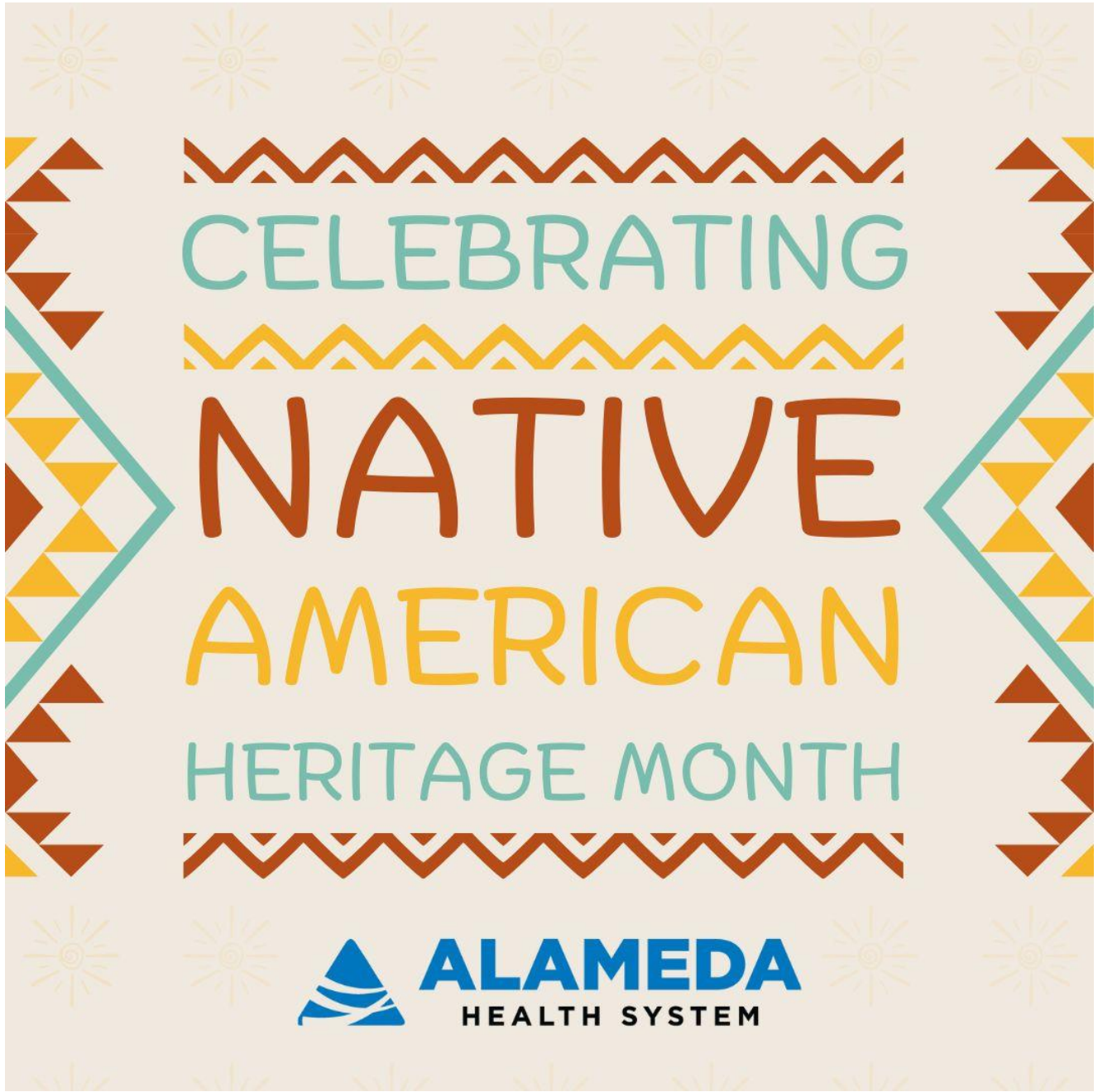
***Scoring Methodology Note:** Dimension scores are based on percent of possible points earned in each dimension; section score adds all dimensions together, with each dimension weighted based on respondent organization's size; section scores are converted to a 1—10 scale and rounded up to determine section level.*

AHS Pillars

Staff & Physician Experience

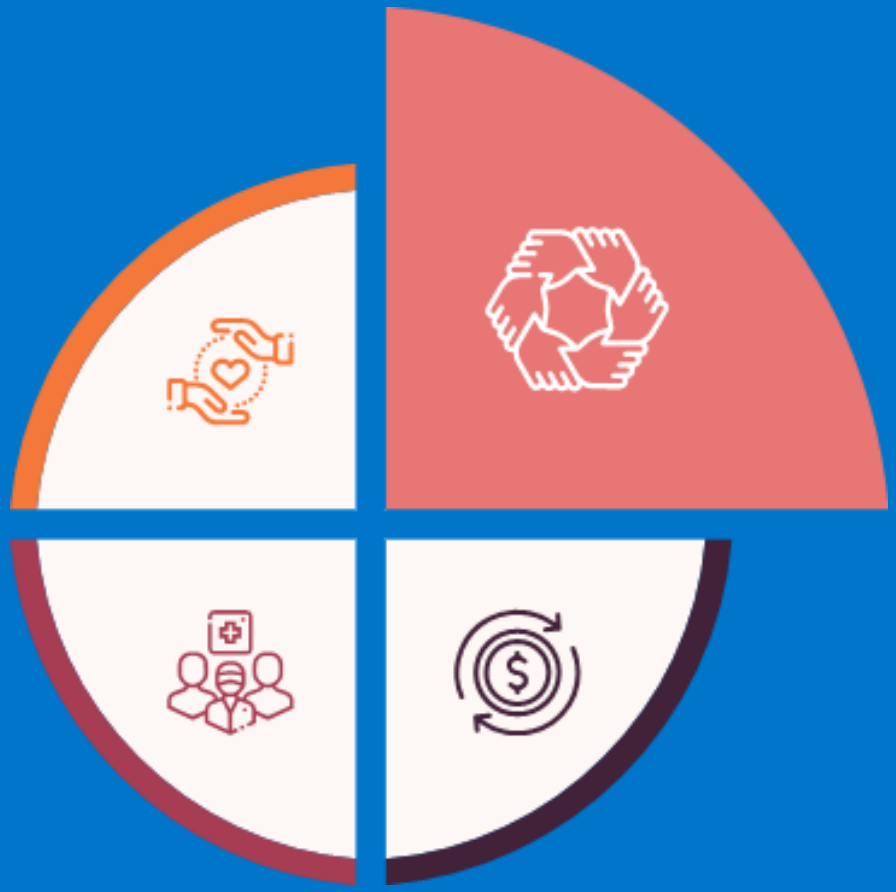
AHS values its physicians, clinicians, and staff and seeks to grow, engage, retain, and empower them to serve all.

CAPH Health Systems Operating Committee Nominee: Aemal Aminy, VP of Support Services


CELEBRATING
NATIVE
AMERICAN
HERITAGE MONTH
ALAMEDA
HEALTH SYSTEM

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.




FREEDOM FUND
gala
NAACP
Oakland Branch
CIVIL RIGHTS PRESIDENTIAL AWARD RECIPIENTS:
The Honorable ROB BONTA
JOHN L. BURRIS, ESQ.
KEYNOTE SPEAKER:
DR. DAVID FRANKLIN
Join us as we celebrate the 2025 Freedom Fund Gala Award Recipients
Special Honorees- Amy Tharpe, Merlin Edwards, Dan Kerman, Paul Cobb, Maximus Simmons, Sonya Simril, Mike Thomas, James Jackson, Tyler Waugh, Douglas Hollie, and Darren White
November 7, 2025 at 6 PM
Oakland Marriott City Center
For more information & to purchase tickets:
naacpoakland.org/gala

Alameda Health System was honored to receive the 2025 Global Citizen Award for its Refugee Health Program, recognizing AHS' unwavering commitment to compassionate, culturally responsive care for immigrants and refugees across Alameda County.

ALAMEDA HEALTH SYSTEM

Join us Nov 15 for Cafecito in Nature at Tilden Nature Area! Explore with critter hunts, enjoy coffee, snacks, and outdoor fun.

ALAMEDA HEALTH SYSTEM

Wilma Chan Highland Hospital Campus Neighborhood Clean-up

Let's keep our neighborhood clean!

Saturday, November 15, 2025

9 a.m. – 11 a.m.

In partnership with the City of Oakland's Adopt-a-Spot program, AHS has "ADOPTED" the perimeter around the Wilma Chan Highland Hospital Campus and the surrounding neighborhood.

Meet us under the AHS canopy located at the entrance to the Highland Care Pavilion (HCP) parking structure!

Wear your AHS blue caps or t-shirts (we'll have a supply of baseball caps on hand). Cleaning tools and refreshments are provided. Bring along your co-workers, family, and friends!

Clean-up will be canceled if it rains.

Please RSVP by November 12, 2025 | PACE@alamedahealthsystem.org

Questions

James Jackson
11/12/2025
Board of Trustee Meeting

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

November 12, 2025

Berenice Perez, MD, AHS Chief of Staff

Cathy Pyun, DO, AH Chief of Staff

Guiding Principles

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

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

- Credentials Committee
- Education: Curbside Consults Best Practices
- Committee Reports
  - Clinical Practice Council
  - Quality Steering Committee
  - Operating Room Committee
- Resources and Enterprise After Care in the Hospital REACH (3.0)
- Peer Review Redesign Update
- Department Reports
  - Radiology and Imaging
  - Medicine

Credentials Committee

Policies:

- Standardized Procedures for Advanced Practice Providers in the Department of Orthopaedic Surgery

Privileges:

- Orthopaedic Surgery – Advanced Practice Provider (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.

Curbside Consults: Best Practices

Goal: Develop Physician Guidelines on Curbside Consultations

Medical Executive Committee Educational Topic

- What is a Curbside Consult
  - Informal physician to physician advice
  - No chart review or patient exam
  - Based only on information from requesting doctor
  - Best for simple, non-complex questions
- Legal Implications
  - Low risk if done properly
  - Risk increases if a physician-patient relationship is established
- Best Practices to Reduce Risk
  - Clearly state advice is informal
  - Avoid documenting or billing if advice was informal
  - Recommend formal consults when indicated
  - Share general guidance—not treatment decisions

Clinical Practice Council

Reviews all protocols, policies, plans that affect the delivery of patient care

- 13 medication protocols, policies and plans
- Approved
  - Medication Aerosolized Epoprostenol Sodium (Flolan® OR Veletri®) Continuous Administration Policy
  - Medication Administration Chemotherapy Antidotes for Extravasation Management
  - Medication carts, Kits and Transport Boxes for Specific Depts. and Divisions
  - Procedural Sedation Policy
  - Patient Complaints and Grievances Policy
  - 2026 Quality Assurance and Performance Improvement Plan (QAPI)
  - Against Medical Advice Policy (AMA)
  - School of Nursing and Paraprofessional Affiliation Requirements Policy
  - PCP Assignment and Panel Size Policy

Quality Steering Committee

Oversees implementation, review, & evaluation of QAPI program & performance improvement activities

- September 2025 Report
- QAPI Plan 2026 Approved
  - Planned projects will focus on surgical site infections, falls, HAPI and readmissions
  - Monitoring
    - OKR/KPI Dashboards
    - Performance Improvement Team Reporting

Resources and Engagement After Care in the Hospital (REACH) 3.0

Project Scope: Telehealth visit within 2-3 days post inpatient discharge

- MD/DO, RN, CHW each randomly assigned patients vs. control
- Daytime hours Mon-Fri during Sept 8-Oct 3

Reductions in high-cost acute care utilization:

- Repeat ED visits (-44%)
- Readmissions (-50%)
- Hospital days (-36%)

Category	Total
Program Cost	-$1,291,892
Revenue	$256,414
Cost Avoidance (Median)	$16,615,178
Quality (Minimum)	$4,500,000
Total	**$20,079,700**

ALAMEDA HEALTH SYSTEM

Medical Staff Peer Review Redesign Taskforce

Assessment Report – Summary of Findings

- Identified a strong commitment to quality and Just Culture; however, there was limited prioritization and role clarity
- The distinction between Peer Review and M&M processes appeared unclear
- A perception of mistrust was highlighted among staff

Taskforce Goals and Timeline

- Current process relies too heavily on case review as the main approach; the taskforce needs to clarify which cases belong in case review versus M&M
- Consistent approach for peer review across all departments
- Emphasis was placed on fairness, credibility, consistency, and efficiency as guiding principles

Framework Discussion

- Focused discussion on structure and process improvements
- Current number of QRCs across AHS seems excessive and complicated
- Most supported a multi-specialty peer review model to encourage shared learning and avoid silos; specialty departments may still maintain focused QRCs
- Identified the need to move away from voting toward consensus-based decisions in peer review outcomes

Case Review Indicators

- Indicators should be valid, reliable, and relevant to physician performance
- Competency should reflect both activity (volume of work) and quality of outcomes
- Standardized indicators across all departments would promote consistency
- Physicians should be given the opportunity to provide input before final peer review determinations

Next Steps

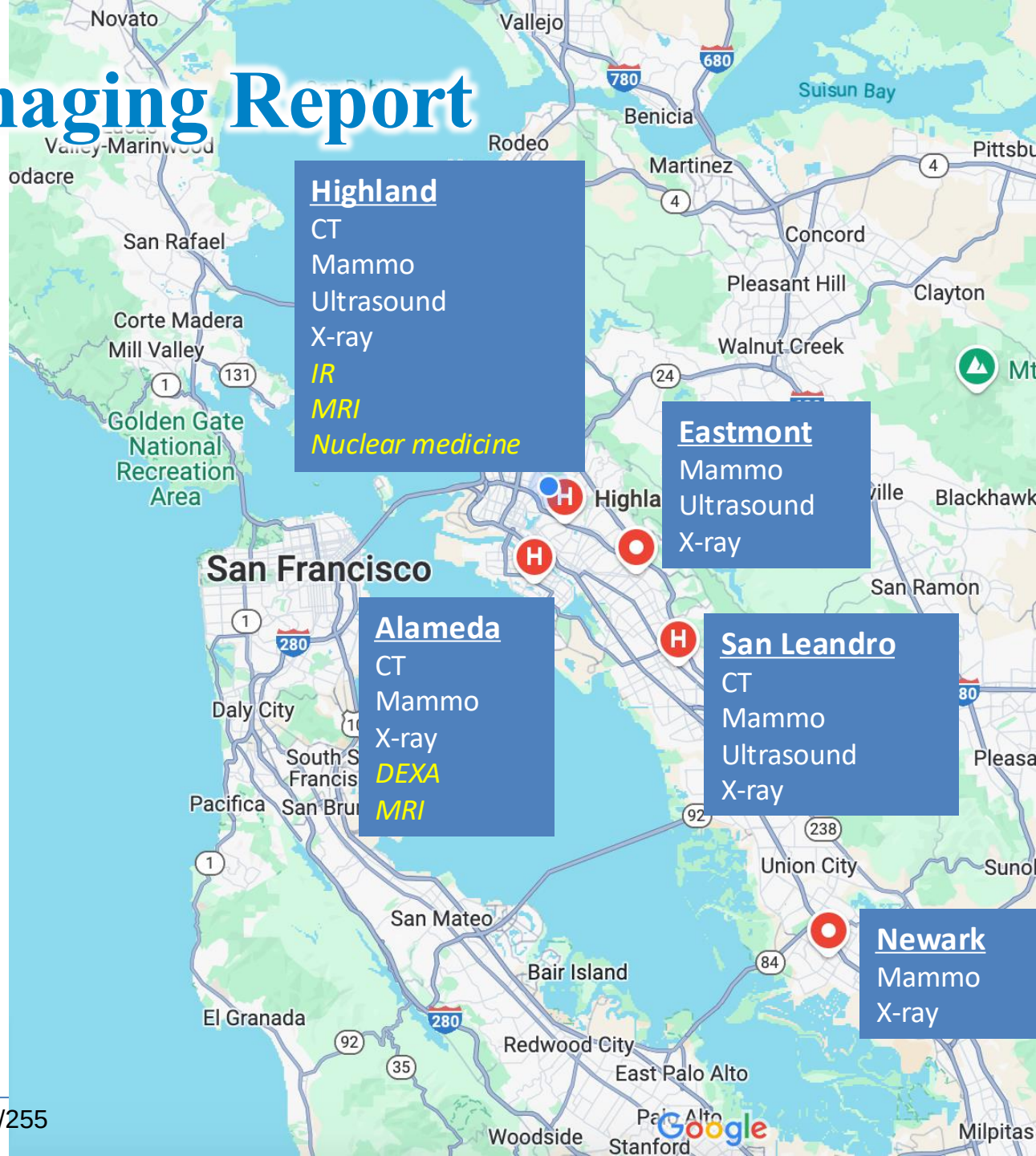
- Integrate Quality Department and Medical Staff feedback to develop a unified peer review framework; develop core set of department case review indicators
- Develop Peer Review Policy & Procedure

Radiology/Imaging Report

Services

- Multiple sites across AHS
- Multiple imaging modalities

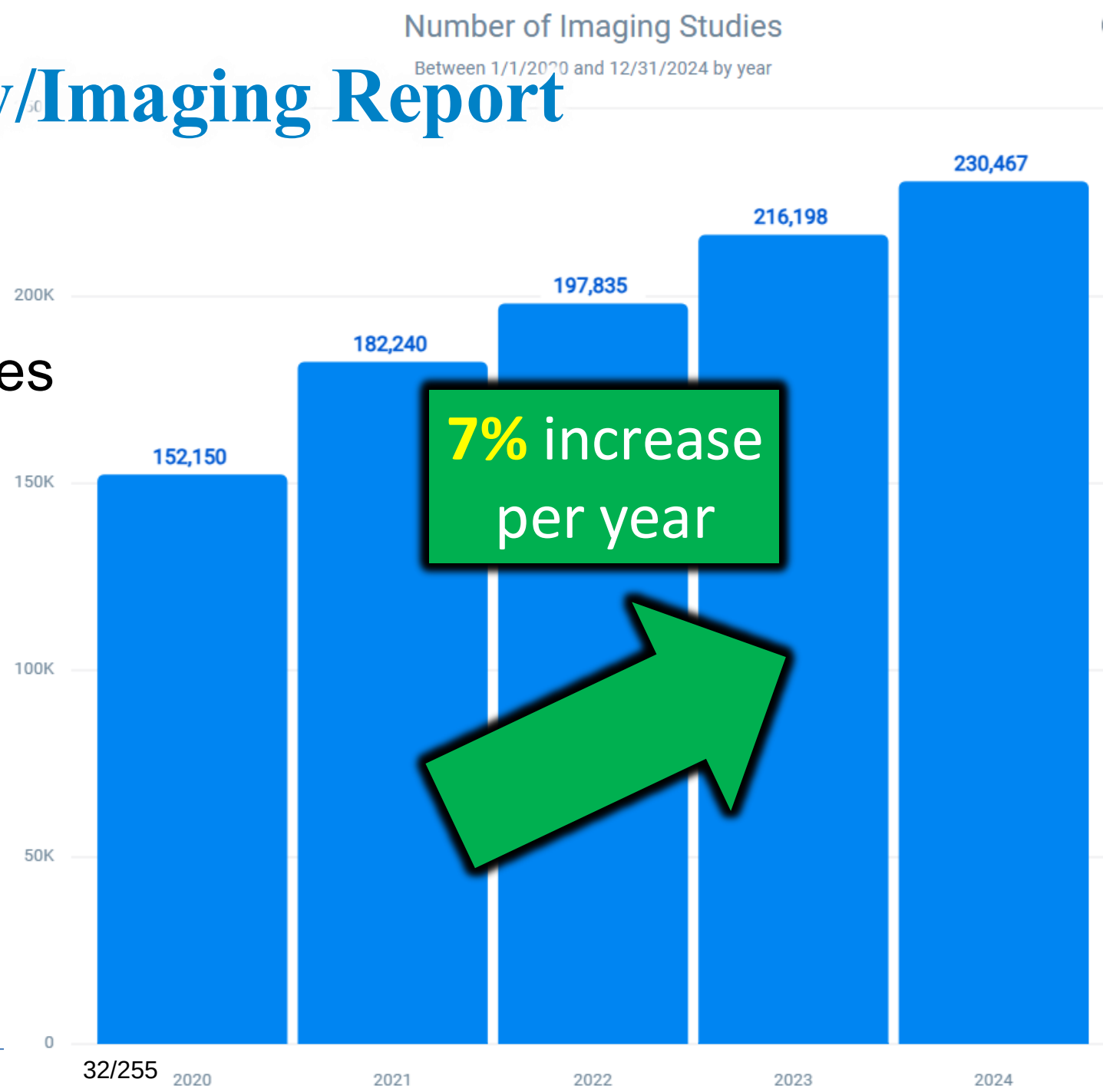
	IT	Clerks	Techs	Nurses	Radiologists
Highland	4 analysts and 2 consultants	13	56	31	11 (+vRad,UCSF)
Alameda		3	25		
San Leandro		4	22		



Radiology/Imaging Report

Strengths

- Increasing imaging volumes



ALAMEDA HEALTH SYSTEM

Radiology/Imaging Report

Strengths

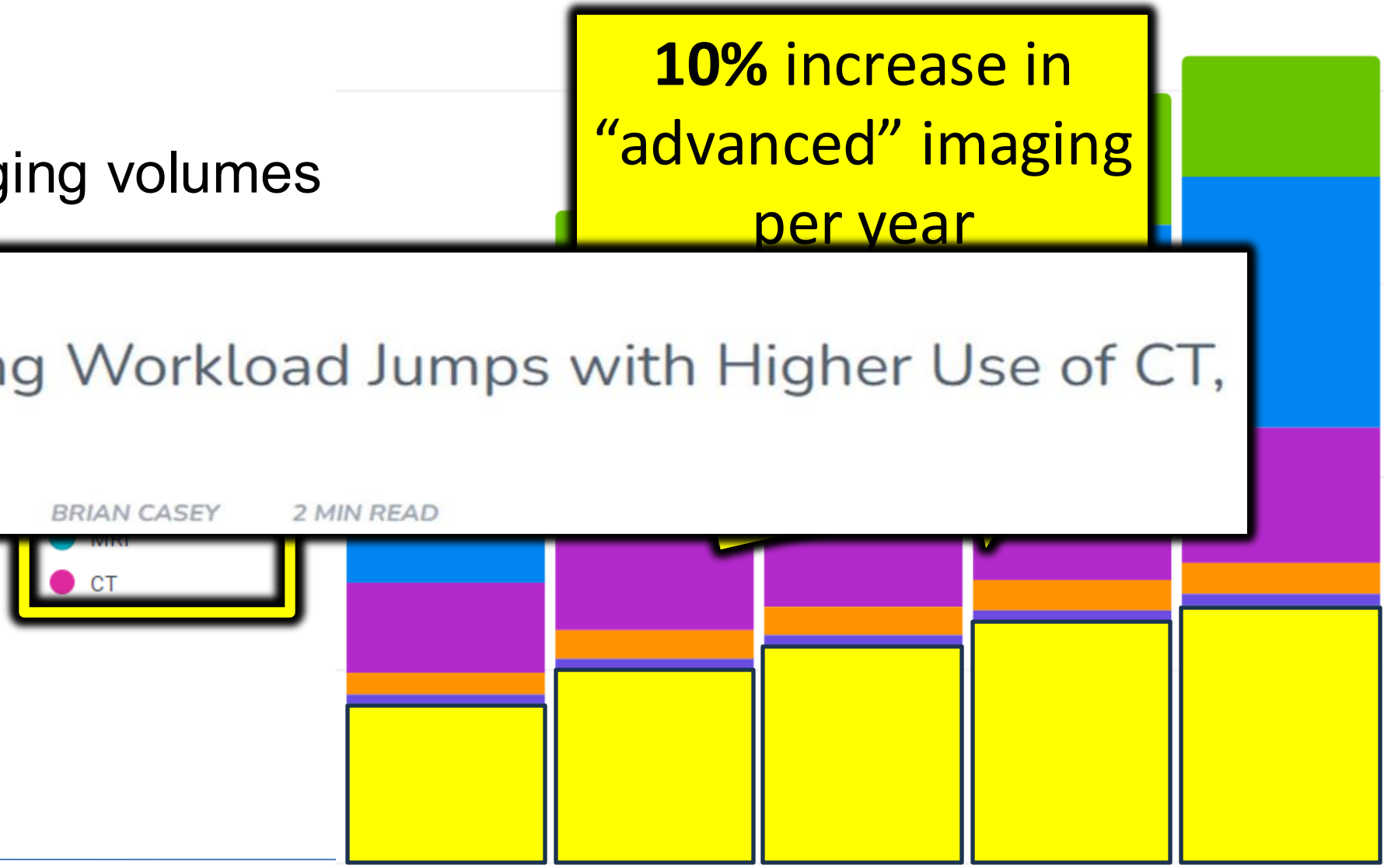
- Increasing imaging volumes

10% increase in "advanced" imaging per year

RADIOLOGY

Imaging Workload Jumps with Higher Use of CT, MRI

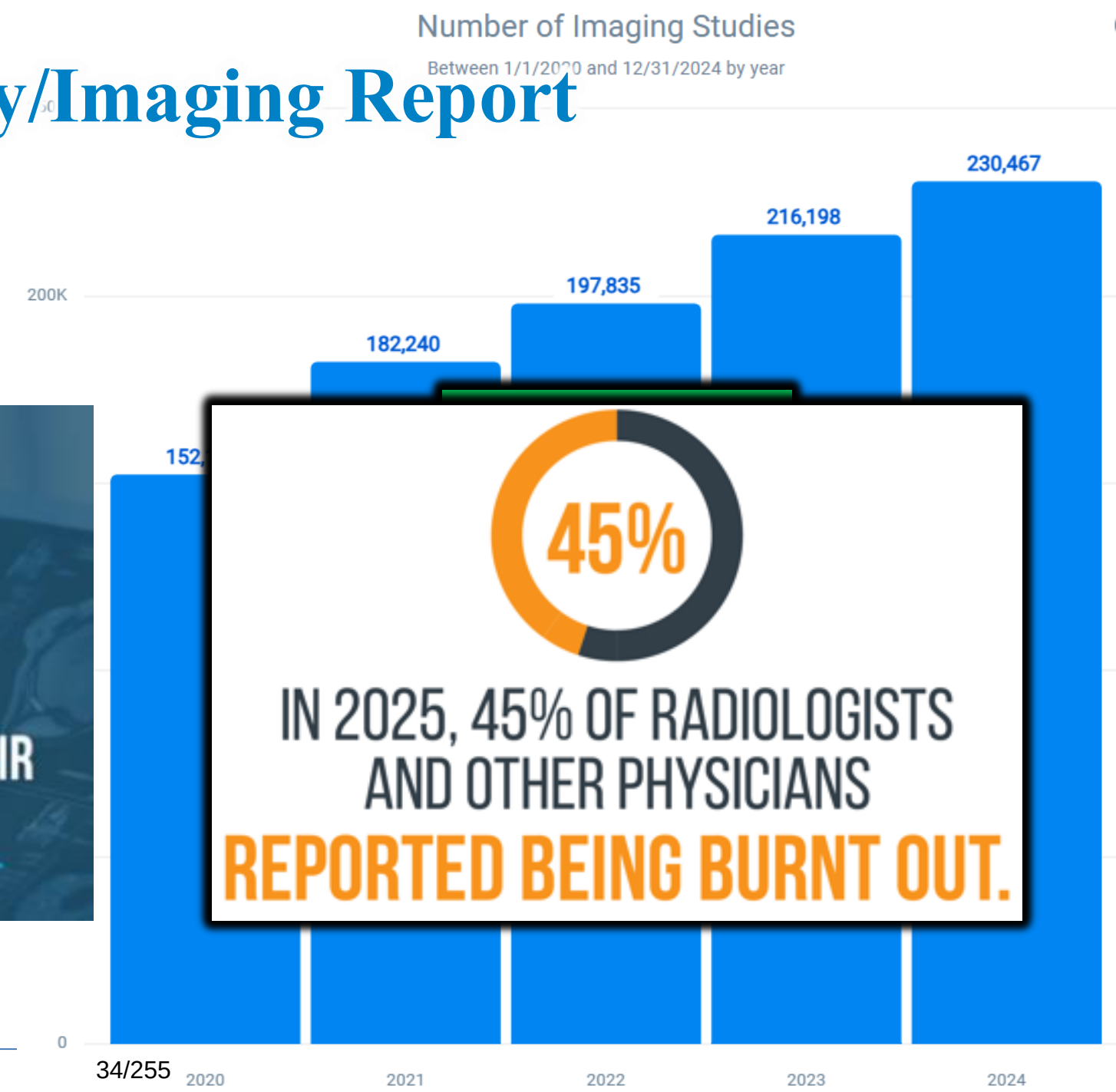
MAY 19, 2025 BRIAN CASEY 2 MIN READ



Radiology/Imaging Report

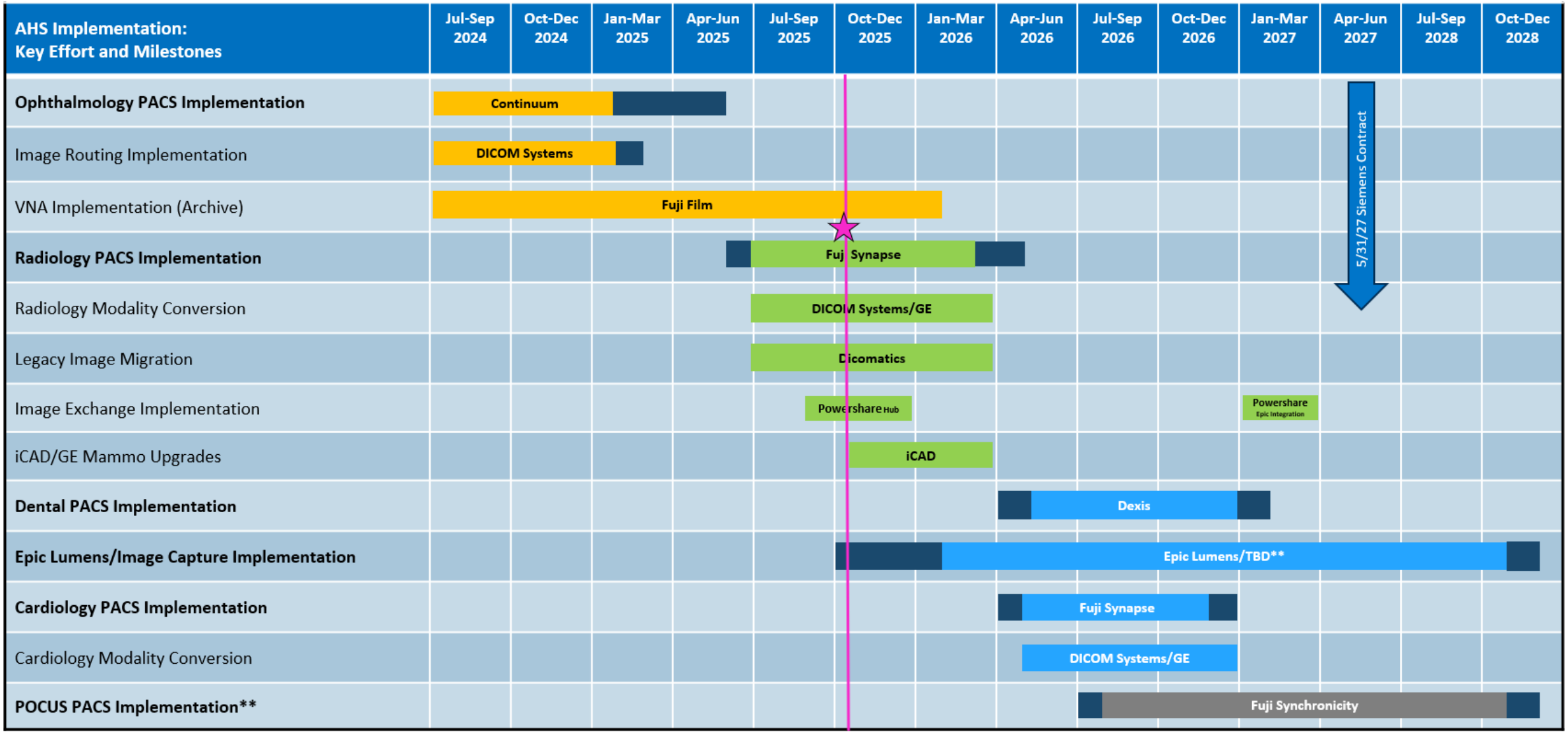
Threats

- Recruitment/retention



ALAMEDA HEALTH SYSTEM

Enterprise Imaging Program (Updated 10/8/25)



Note: Project start dates contingent on contract process and are subject to revision over time as project durations are estimated.
***Vendor Image Capture solution TBD, POCUS timeline TBD*

Alameda Hospital Medical Staff

- The Medical Executive Committee met in October to discuss local operational items and for credentialing and privileging which is reported at this meeting in closed session.

ALAMEDA HEALTH SYSTEM

CARING, HEALING, TEACHING, SERVING ALL

COMMITTEE AND TRUSTEE REPORTS

No Written Materials

Agenda Item C Committee 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

ALAMEDA HEALTH SYSTEM	Policy and Scope	
	Personal Appliance Use	**Version #1**
	LEVEL X☐ System ☐ Site	EFFECTIVE DATE: 11 15 2025 LAST REVIEW DATE: 11 15 2025

POLICY STATEMENT

PURPOSE

The purpose of the policy is to ensure safety, regulatory compliance, and air quality within hospital facilities. The use of personal electrical appliances (including scent diffusers, heaters, and other non-approved devices) is restricted in all clinical and administrative areas. This policy applies to all hospital staff, including employees, contracted personnel, volunteers, and medical staff, in all hospital-owned or -leased facilities.

SCOPE THIS POLICY GOVERNS THE USE OF PERSONAL ELECTRICAL APPLIANCES BY ALL HOSPITAL PERSONNEL AND ALL HOSPITAL OWNED OR LEASED FACILITIES, INCLUDING BOTH CLINICAL AND ADMINISTRATIVE AREAS.

DEFINITIONS

Personal Appliance: Any employee-owned, non-hospital-issued electrical device such as space heaters, diffusers, humidifiers, fans, plug-in air fresheners, mini-refrigerators, microwaves, coffee makers, or similar equipment.

RESPONSIBILITIES

Employee Responsibilities

Understand and follow all applicable safety measures and restrictions associated with the use of employee-owned devices.

Engineering/Facilities Responsibilities

Upon notification, the Engineering and Human Resources Department will evaluate on a case-by-case basis the medical need for personal appliances and their approval.

Accountability

Failure to follow these guidelines may result in the removal of the item and may be subject to further review under hospital safety and HR policies.

Enforcement

Upon review, unauthorized appliances are subject to immediate removal by Facilities or Safety personnel. Repeated violations may result in disciplinary action under Human Resources policies.

POLICY

Prohibited Appliances (Examples include but are not limited to):

- Essential oil diffusers or humidifiers
- Plug-in air fresheners or scented devices
- Space heaters
- Toasters and toaster ovens
- Any unapproved appliances not issued or reviewed by Facilities

Guidance for hospital issued & approved devices.
Any equipment or device issues by Engineering/Facilities must be plugged directly into a wall outlet (no extension cords or daisy-chained power strips)

REFERENCES
Cal/OSHA Title 8, Section 3362 (General Workplace Safety)
Joint Commission Environment of Care Standards
NFPA 99 – Health Care Facilities Code
Human Resources policies

Alameda Health System			CPC Executive Summary to AHS and AH Medical Executive Committee(s) – October 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 Aerosolized Epoprostenol Sodium (Flolan® OR Veletri®) Continuous Administration Policy	Tina Yoo, PharmD	• JC Triennial review, no changes • System P&T approved 9/2025 • Consent Item – Policy		10/2028		• System P&T 9/2025 • CPC 10/02/2025 • MEC 10/15/2025
Medication Administration Chemotherapy Antidotes for Extravasation Management	Natalie Fan, PharmD/Vivian Phan, PharmD	• Revise language on Chemotherapy/Biotherapy Extravasation Kit • System P&T approved 9/2025 • Consent Item – Policy		10/2028		• System P&T 9/2025 • CPC 10/02/2025 • MEC 10/15/2025
Medication carts, Kits and Transport Boxes for Specific Depts. and Divisions	Natalie Fan, PharmD/Vivian Phan, PharmD	• Remove Heme/Onc Chemotherapy/Biotherapy Extravasation Kit • System P&T approved 9/2025 • Consent Item – Policy		10/2028		• System P&T 9/2025 • CPC 10/02/2025 • MEC 10/15/2025
Procedural Sedation Policy	Dr. Michael Wu Janice Borelli	• Revised		10/2028		• CPC 10/02/2025 • MEC 10/15/2025
Patient Complaints and Grievances Policy	Darshan Grewal Jan Robertson	• Revised ; Follow up returning to CPC • To comply with new CMS language for the definitions around complaints and grievances • To comply with AHS's contractual agreements with payors. (rather than AAH) • To provide patients with one single phone number to call to file a complaint rather than facility wide numbers; Patient Safety Department will handle all incoming calls regarding complaints and grievances		10/2028		• CPC 10/02/2025 • MEC 10/15/2025

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**
2026 Quality Assurance and Performance Improvement Plan (QAPI)	Christian Rieta , MS-HCA, BSN, RN-BC, CPHQ	• Revised • Consolidated information to be more succinct. Updated OKR Dashboard metrics, updates PI Activities, updated Governing Structure (committees and workgroups focused on Quality)		10/2028		• CPC 10/02/2025 • MEC 10/15/2025
Against Medical Advice Policy (AMA)	Dawn Anderson, MSN, MBA, HCM	• Revised		10/2028		• CPC 10/02/2025 • MEC 10/15/2025
School of Nursing and Paraprofessional Affiliation Requirements Policy	Wacheera Davis, DNP, MSN, BSN, RN, MBA	• Revised document with updated clinical placement definitions and guidelines		10/2028		• CPC 10/02/2025 • MEC 10/15/2025
PCP Assignment and Panel Size Policy	Porshia Mack, MD, MBA	• Revised Summary of the revisions: • On page 3- change CAO to ACMO • On page 3- Add same exception from #4 to #5: • 5. The maximum amount of FTE allowed for Targeted Need clinic time is 0.1 FTE per provider. Only empaneled primary care providers are eligible to have a Targeted Need clinic. Special circumstances outside of this require the approval of the clinic medical director and the ACMO.		10/2028		• CPC 10/02/2025 • MEC 10/15/2025
Responsible Use of AI Policy	E'Jaaz Ali	• New • To govern the proper, secure, and safe use of artificial intelligence.		10/2028		• CPC 6/05/2025 • MEC 6/18/2025

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**
Patient Non-Discrimination to Access Health Care Services	Akemi Renn	• New • To comply with the Federal non-discrimination regulation of the Affordable Care Act (ACA), section 1557 that prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs or activities.		10/2028		• CPC 6/05/2025 • MEC 6/18/2025

MEDICATION: Aerosolized Epoprostenol Sodium (Flolan® or Veletri®) Continuous Administration Policy

Site	Alameda Health System	***Previous Revision Dates***	
Effective Date	10/2025	***Date Revised***	9/2025
Document Owner	MGR SYS MED SAFETY-CLIN PHARM	***Next Scheduled Review***	9/2028
Approvals	BOT, QPSC		

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

PURPOSE

Purpose:

To provide a guideline for the safe administration of Aerosolized Epoprostenol Sodium (Flolan® or Veletri®) Continuous Administration Guideline for Patients with Acute Respiratory Distress Syndrome (ARDS) or pulmonary arterial hypertension in which other therapies have not been effective or tolerated.

This policy applies to the following indication: Acute Respiratory Distress Syndrome (ARDS) or pulmonary arterial hypertension.

Policy

1. Aerosolized epoprostenol (Flolan® or Veletri®) will be administered by Respiratory Care Services in collaboration with an ER or ICU nurse.

2. Respiratory Care Services is responsible for the setup and administration of aerosolized epoprostenol (Flolan® or Veletri®)

3. Pharmacy is responsible for the reconstitution and preparation of aerosolized epoprostenol (Flolan® or Veletri®)

4. Please refer to the Aerosolized Epoprostenol Sodium (Flolan® or Veltri®) Continuous Administration Guideline for Patients with Acute Respiratory Distress Syndrome (ARDS) or Pulmonary Arterial Hypertension protocol for detailed instructions.

APPROVALS

		HH/SLH	AH
System Pharmacy & Therapeutics	Date:	9/2025	
Clinical Practice Committee	Date:	10/2025	
Medical Executive Committee	Date:	10/2025	
Board of Trustees	Date:	11/2025	

ALAMEDA HEALTH SYSTEM	**Policy**	
	Medication Administration: Chemotherapy Antidotes for Extravasation Management	**29926 1**
	LEVEL ☐ System ☐ Site	EFFECTIVE DATE: 10/2025 NEXT REVIEW DATE: 10/2028

Purpose

To provide guidance on the appropriate management of cytotoxic chemotherapy extravasation. This policy aims to minimize tissue damage at the extravasation site, based on evidence and best practices.

Note: The guideline is not a substitute for clinical judgment**.**

Policy

In the event that an extravasation of a cytotoxic agent occurs, timely and appropriate management should be taken in order to minimize tissue damage at the extravasation site.

Definitions

1. Extravasation: An antineoplastic cytotoxic drug that infiltrates into the surrounding tissues during intravenous administration. Particular drugs may cause extensive necrosis and the damage can continue for several weeks or months after the infusion.

2. Intravenous chemotherapy agents are classified into 5 categories according to their damage potential for extravasation
   a. Vesicants: Drugs that can cause tissue necrosis and blister formation if the drug extends into the tissue surrounding the vein.
      i. Non-DNA binding vesicants: when extravasated, these agents are inactivated or quickly metabolized and resume the normal healing process.
      ii. DNA binding vesicants: remain in the tissues resulting in long-term or more severe injury.
   b. Exfoliants: Drugs of low vesicant potential, as much injury are determined to be superficial. Extravasation may present as blistering, inflammation and skin shedding without tissue death.
   c. Irritants: Drugs that can cause inflammation, irritation, and pain at the site of extravasation. Patients often complain of a "burning sensation" in the vein during infusion.
   d. Inflammitants: Drugs that can cause mild to moderate inflammation and painless erythema.
   e. Neutrals: Drugs that do not cause inflammation or damage upon extravasation.

Common Reactions & Associated Drugs[1]

Vesicants (Tissue necrosis & blister formation)		**Exfoliants** (Blistering, inflammation, & skin shedding)	**Irritants** (Inflammation, pain, or irritation)	**Inflammitants** (Inflammation, painless skin erythema, & flares)	**Neutrals** (No inflammation/ damage)
DNA BINDING	Dactinomycin Daunorubicin Doxorubicin Epirubicin Idarubicin Mitomycin	Cisplatin Docetaxel Liposomal Daunorubicin Liposomal Doxorubicin Mitoxantrone Oxaliplatin Paclitaxel	Bendamustine Bleomycin Carboplatin Etoposide Topotecan	5-Fluorouracil Methotrexate	Asparaginase Bevacizumab Bleomycin Bortezomib Cetuximab Cyclophosphamide Cytarabine Eribulin Fludarabine Gemcitabine Ifosfamide Melphalan Rituximab
NON-DNA BINDING	Vinblastine Vincristine Vinorelbine				

					Trastuzumab

Note: These are common antineoplastic agents, NOT an all inclusive list

Signs and Symptoms Associated with Extravasation and Venous Irritation

Assessment Parameter	Extravasation		Spasm/Irritation of the Vein
	Immediate Manifestations of Extravasation	Delayed Manifestations of Extravasation	
Pain	Severe pain or burning that lasts minutes or hours eventually subsides; usually occurs while the drug is being given around the needle site	Up to 48 hours after infusion	Aching and tightness along the vein
Redness	Blotchy redness around the needle site; it is not always present at the time of extravasation	May intensify over time	Vein may be reddened or darkened
Ulceration	Develops insidiously; usually occurs 48-96 hours later	Late occurrence	Not likely
Swelling	Severe swelling; usually occurs immediately	Up to 48 hours after infusion	Not likely
Blood return	Inability to obtain blood return	N/A	Blood return usually present
Other	Change in the quality of infusion	Local tingling and sensory deficits	Possibility resistance felt in injection

Modified from Avon, Somerset, and Wiltshire NHS Cancer Services Policy4

Prevention of extravasation

1. Assessment of venous access
    a. The quality of venous access should be assessed by RN during infusion center orientation or prior to administration of cycle 1 day 1 of chemotherapy treatment.
    b. Patients who have risk factors for extravasation (small and fragile veins, lymphoedema, previous treatment, long-term treatment, previous extravasation, etc.) should be counseled on the possibility of port placement.
2. Cannulation site/Administration
    a. Large veins in the forearm are recommended for peripheral administration.
    b. If a cannulation attempt fails, further attempts must be above the previous site to prevent vesicant seepage below the site of recent venipuncture.
    c. Venous access should be assessed and tested immediately prior to and frequently during the infusion of cytotoxic agents. This includes checking for blood return and resistance during administration.
3. Patient Education

a. Patients should receive education on the signs and symptoms of extravasation. The importance of immediate reporting of any changes in sensation, stinging or burning during the administration of chemotherapy should be discussed prior to the first treatment.

Procedure

1. Extravasation involving a PERIPHERAL LINE: At the first sign of infiltration:
    a. Stop injection/infusion immediately.
    b. Disconnect the IV tubing from the IV device but leave the needle/catheter in place.
    c. With a 1-3 mL syringe, slowly aspirate as much of the residual drug as possible. Do not apply pressure to the area.
    d. Remove IV access. Do not use this site for IV access any longer.
        i. If extravasation of cisplatin is suspected, IV access is kept until provider has assessed for need of sodium thiosulfate administration.
    e. Assess the site of the suspected extravasation and mark the extravasated area with a pen. Observe region for pain, induration or necrosis, and assess symptoms reported by the patient (e.g. pain, impairment of range of motion)
    f. Notify the physician. Physician to place order for the antidote
    g. Initiate substance-specific (antidote) measures as shown in Appendix A, if applicable,
    h. Document all procedures.
    i. RN should set up heme/onc clinic appointment for 1-week follow up prior to discharge from infusion center
        i. Patients with extravasation during inpatient admission will be evaluated by the medical team during the hospital stay. Follow up will be scheduled as necessary by the medical team
    j. Provide patient education.
        i. Continue warm or cold therapy for 24 to 48 hours.
        ii. Elevate area for 48 hours to minimize swelling.
        iii. Resume activity with affected limb as tolerated.
    k. Consider surgical evaluation and wound consult for persistent or worsening symptoms.

2. Extravasation involving a **CENTRAL LINE**: If the patient report changes in sensation, pain, burning, or swelling at the central venous catheter (CVC) site or in the ipsilateral chest, if a change occurs, or if no blood returns:
    a. Stop chemotherapy and IV fluids. Do not remove the cannula.
    b. If the patient has an implanted port, assess the site for proper needle placement.
    c. If extravasation is a result of needle dislodgement in a port, leave the needle in place and attempt to aspirate the residual drug.
    d. If possible, aspirate the residual from the area of suspected infiltration at the port pocket or at the exit site of the tunneled or percutaneous catheter. Do not apply pressure to the area.
    e. If aspiration is unsuccessful, remove the needle from the port and attempt to aspirate the drug subcutaneously, from the pocket and surrounding tissue.
    f. Assess the site of the suspected extravasation. Observe region for pain, induration or necrosis, and assess symptoms reported by the patient (e.g. pain, impairment of range of motion)
    g. Notify the physician. Physician to place order for the antidote
    h. Initiate substance-specific (antidote) measures as shown in Appendix A, if applicable
    i. If the patient has an implanted port, remove the port needle after instilling the antidote. Inject the antidote into subcutaneous tissue as appropriate.
    j. Document all procedures.
    k. RN should set up heme/onc clinic appointment for 1-week follow up prior to discharge from infusion center.

i. Patients with extravasation during inpatient admission will be evaluated by the medical team during the hospital stay. Follow up will be scheduled as necessary by the medical team

l. Provide patient education.
   i. Continue warm or cold therapy for 24 to 48 hours.

m. Collaborate with the physician regarding
   i. The need for a radiographic flow study to determine the cause of extravasation.
   ii. Future plans for IV access and patient management

3. Antidotes for Extravasation
   a. a. Antidotes will be stored in and compounded by pharmacy
   b. Antidotes to be kept in pharmacy
      i. Sodium thiosulfate 25% (12.5gm/50mL)
      ii. Hyaluronidase 150 units/1mLvial (stored in refrigerator)
      iii. Topical DMSO 50% - 50mL vial

Dexrazoxane 500mg vial (at least 4 vials)

Appendix A: TABLE OF APPROVED SUBSTANCE-SPECIFIC MEASURES/ANTIDOTES FOR EXTRAVASATION MANAGEMENT

DRUG	ANTIDOTE	ICE/HEAT

Anthracycline Agents
• Daunorubicin (Cerubidine□)
• Doxorubicin (Adriamycin□)
• Epirubicin (Ellence□)
• Idarubicin (Idamycin□)
	Dexrazoxane (Totect):
	Dose to be given for 3 consecutive days, starting within 6 hours after extravasation.
	Day 1: 1000mg/m^2 IV (max dose: 2000mg)
	Day 2: 1000mg/m^2 IV (max dose2000mg)
	Day 3: 500mg/m^2 IV (max daily dose: 1000mg)
	**reduce dose by 50% if Crcl <40 ml/min
	Mixing & Final Dilution
	• Mix each vial with provided 50ml diluent
	  ○ final [ ] = 10mg/ml
	  ○ use within 2 hours
	• Withdraw needed dose and further dilute into infusion bag containing 1000ml of NaCl (use within 4 hours)
	Infusion
	• Infuse over 1-2 hours in large vein remote from site of extravasation
		ICE compress for 15-20 minutes at least four times a day for 24 to 48 hours
		
		Do not ice 15 minutes before and after dexrazoxane administration.

	• Remove ice packs from extravasation site 15 minutes before dexrazoxane administration to allow adequate blood flow to site • Day 2 & 3 should start at the same hours (±3 hours) as Day 1 • Do not use with DMSO **Dimethyl Sulfoxide (DMSO) (Rimso-50□)** • Using a sterile gauze pad, apply 1.5mL *topically* to cover twice the size of infiltration. • Begin within 10 minutes of extravasation • Apply every 8 hours for 7 days • Allow to air dry. Do not cover with dressing • Do not use with Dexrazoxane *for **peripheral line** extravasation IF dexrazoxane unavailable OR cannot be started within 6 hours*	
Bendamustine (Bendeka□, Treanda□)	**Sodium Thiosulfate:** • Prepare 1/6 molar solution: Mix 1.6 mL of 25% sodium thiosulfate with 8.4 mL sterile water for injection. • Inject 2 ml subcutaneously into site for each mg of bendamustine extravasated • Use 25-gauge or smaller needle • Change needed with each injection	**ICE** compress for 15-20 minutes at least four times a day for 6-12 hours following sodium thiosulfate
Daunorubicin, Liposomal (DaunoXome□) Doxorubicin, Liposomal (Doxil□)	None recommended	**ICE** compress for 15-20 minutes at least four times a day for 24 hours
Carboplatin (Paraplatin)	**Sodium Thiosulfate:** • Prepare 1/6 molar solution: Mix 1.6 mL of 25% sodium thiosulfate with 8.4 mL sterile water for injection. • Inject 5 ml subcutaneously using a 25-gauge needle, changing needles between each injection into affected area in a pinwheel fashion.	**ICE** compress for 15-20 minutes at least four times a day for 6-12 hours following sodium thiosulfate

Cisplatin (Platinol□) (> 20 mL and conc. □ 0.5 mg/mL)	**Sodium Thiosulfate:** • Prepare 1/6 molar solution: Mix 1.6 mL of 25% sodium thiosulfate with 8.4 mL sterile water for injection. • Inject 2 ml into site for each 100 mg cisplatin extravasated through an existing IV line. • Then 1 ml (as multiple 0.1 ml injections clockwise around the area of extravasation) subcutaneously into extravasation site. Use 25-gauge or smaller needle • Subcutaneous injections can be repeated several times over the next 3 to 4 hours.	**ICE** compress for 15-20 minutes at least four times a day for 6-12 hours following sodium thiosulfate
Etoposide (VePesid□)(VP-16)	None recommended	**WARM** compresses for 15- 20 minutes at least four times a day
Mechlorethamine (Mustargen□)(Nitrogen Mustard)	**Sodium Thiosulfate:** • Prepare 1/6 molar solution: Mix 1.6 mL of 25% sodium thiosulfate with 8.4 mL sterile water for injection. • Inject 2 ml subcutaneously into site for each mg of mechlorethamine extravasated • Use 25-gauge or smaller needle • Change needed with each injection	**ICE** compress for 15-20 minutes at least four times a day for 6-12 hours following sodium thiosulfate
Mitomycin C (Mutamycin□)	**Dimethyl Sulfoxide (DMSO) (Rimso-50□)** • Using a sterile gauze pad, apply 1.5mL *topically* to cover twice the size of infiltration. • Begin within 10 minutes of extravasation • Apply every 8 hours for 7 days • Allow to air dry. Do not cover with dressing	**ICE** compress for 15-20 minutes at least four times a day for 24-48 hours
Oxaliplatin (Eloxatin□)	None recommended May consider for extravastion > 40 mg: Dexamethasone 8mg orally BID for up to 14 days	**WARM** compresses for 15- 20 minutes at least four times a day for 24-48 hours
Taxane Agents • Docetaxel (Taxotere) • Paclitaxel (Taxol)	No known antidotes or treatments May Consider: Hyaluronidase (Amphadase□): • Inject subcutaneously into the extravasation site using a 25-gauge needle or smaller. • Dosage: 150 units (1 mL) given as five 0.2 mL injections into the extravasation site at the leading edge Change the needle after each injection.	**ICE** compress for 15-20 minutes at least four times a day

Vinca Alkaloids • Vinblastine (Velban□) • Vincristine (Oncovin□) • Vinorelbine (Navelbine□)	**Hyaluronidase (Amphadase□):** • Inject subcutaneously into the extravasation site using a 25-gauge needle or smaller. • Dosage: 150 units (1 mL) given as five 0.2 mL injections into the extravasation site at the leading edge • Change the needle after each injection.	**WARM** compresses for 15- 20 minutes at least four times a day
All other cytotoxic drugs	None Recommended	**ICE** compress for 15-20 minutes at least four times a day for 24-48 hours

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APPROVALS

		System	Alameda	AHS/Highland/John George/San Leandro
Department	**Date:**	8/2024		
Pharmacy and Therapeutics (P&T)	**Date:**	9/2024, 3/2024, 9/2025		
Clinical Practice Council (CPC)	**Date:**	10/2024, 4/2024, 10/2025		
Medical Executive Committee	**Date:**	4/2024 10/2025		
Board of Trustees	**Date:**	4/2024 11/2025		

ALAMEDA HEALTH SYSTEM	Policy	
	MEDICATION CARTS, KITS AND TRANSPORT BOXES FOR SPECIFIC DEPTS. AND DIVISIONS	**29923 2**
	LEVEL ☐ System ☐ Site	EFFECTIVE DATE: 6/2025

Policy

To provide access and storage to medications in boxes or kits to specific areas where Automated Dispensing Machines (ADM, e.g. Pyxis) are not accessible and/or certain specific drugs are not included in crash carts. These departments/divisions may include however not limited to Allergy Clinic, Anesthesiology, Cardiology, Diagnostics, Oral Surgery, Operating Room, Emergency Department, and Radiology.

Other medication kits are assembled and put in ADM by pharmacy for the ease of removal under specific situations.

Procedures

A. Preparation

1. Pharmacy staff fills medications listed in the boxes and kits. Non-medicinal supplies in oral surgery boxes are filled by the Oral Surgery division.
2. Pharmacy staff records expiration dates of mediations on the content list.
3. Pharmacy staff who prepares the box or kit will sign and date on the content list.
4. Pharmacist will check all medications against the content list for correct quantity and expiration.
5. Pharmacist will sign and date the content list after checking the box or kit.
6. The signed and dated content list will be put inside the box or kit.
7. A copy of this content list can be put outside the box or kit. Or a sticker with the name of earliest expired drug and expiration date will be put outside the box or kit. This is to identify when to replace the content of the box or kit.
8. Pharmacy will put a tamper resistance lock on the checked box or kit to ensure the box or kit is secured before being dispensed.

B. Dispensing

1. When a box or kit is needed for a procedure by a department/division, the department/division staff will come to pharmacy to pick up the specific box or kit.
2. Pharmacy staff, before dispensing the box or kit, will make sure the lock is secured and medications are not expired.
3. Pharmacy staff fills out the dispensing log to indicate when and where the box/kit is dispensed.

C. Storage

1. Each department/division is responsible for storing the box/kit in an area where direct supervision of its usage is allowed until the procedure is complete.
2. Anesthesia department, oral surgery division and radiology department will store the boxes/kits in their areas until replacement.
3. Such storage areas should be easily monitored by the department or division staff to prevent unauthorized usage.

D. Administering and Returning
   1. When a medication is needed, the department staff will break the lock to open the box or kit.
   2. The department/division staff will put the patient addressograph sticker on the content list for subsequent billing by pharmacy.
   3. The department/division staff will return the used box or kit with the patient stamped content list to pharmacy for replacement.
   4. In the situation where the lock is found broken in the department/division, but medications are not used, the box or kit should be returned to pharmacy for checking.

E. Replacement
   1. Pharmacy will follow the procedures under "Preparation" in this policy to replace and refill any medications used in the box or kit that is returned from the department/division.

F. Medication kits stored in Automated Dispensing Machine (ADM, e.g. Pyxis)
   1. These kits are assembled in pharmacy and checked by pharmacist before putting in ADM.
   2. Kits are removed from ADM according to the ADM procedure.
   3. A refill or stock out report will be printed in the pharmacy to prompt for replacement.
   4. Used kits should be placed in the "return to pharmacy" bin for pick up and return to pharmacy.

APPROVALS

		System	Alameda	AHS/Highland/John George/San Leandro
Pharmacy and Therapeutics (P&T)	**Date:**	6/2025		
Clinical Practice Council (CPC)	**Date:**	7/2025		
Medical Executive Committee	**Date:**	7/2025		
Board of Trustees	**Date:**	8/2025		

ALL Acute Care Medication Carts and Kits

Radiology Contrast Allergic Reaction Kit

Medication	Quantity	Expiration
Diphenhydramine Inj. 50 mg/ml 1 ml Vial	1	
Epinephrine Inj. 1 mg/ml (1:1000) 1 ml Vial (in light protection bags)	2	
Methylprednisolone Inj.125 mg Vial	1	

Epinephrine Dosing: Hypersensitivity Reaction (e.g. anaphylaxis):
IM administration in the anterolateral aspect of the middle third of the thigh is preferred in the setting of anaphylaxis. Subcutaneous administration results in slower absorption and is less reliable.

IM (preferred anterior thigh): **Adults:** 0.3 to 0.5 mg (0.3 to 0.5 ml) of 1 mg/ml solution every 5 to 15 minutes. **Peds:** 0.01 mg/kg (Max 0.3 mg) of 1 mg/ml solution (AAAAI [Lieberman 2015]; AHA [Vanden Hoek 2010]; WAO [Kemp 2008])

Rapid Sequence Intubation (RSI) Kit

Quantity	Medication	Expiration
1	Etomidate 2 mg/ml vial (total 10 mL)	
1	Rocuronium 10 mg/ml vial (total 10 mL)	
2	Succinylcholine 20 mg/ml inj (total 10 mL)	

Employee Health Adult Anaphylaxis Kit

Quantity	Medication	Expiration date
2	Diphenhydraime 25mg caps	
1	EpiPen 0.3mg/0.3mL prefilled syringe	
1	BD syringe, Leur-lok (1 ml syringe)	
1	BD Eclipse 25G needle	
2	Isopropyl alcohol 70% prep pads	

Anesthesia Support Kit

Quantity	Medication	Expiration
1	Ephedrine 50 mg/ml (1 ml) vial/ampule	
1	Etomidate 2 mg/ml (10 ml) vial	
1	Norepinephrine 1 mg/ml (4 ml) ampule	
1	Propofol 10 mg/ml (20 ml) vial	
1	Rocuronium 10 mg/ml (10 ml) vial	
1	Succinylcholine 20 mg/ml (5 ml) syringe	

Back up medications for situations like power outage and Pyxis failure. The kit is stored in a locked box.

Wilma Chan Highland Hospital Medication Carts and Kits

Anesthesia Intubation Kit (to be put in Anesthesia Airway Backpack)

Drug	Quantity	Expiration
Atropine Inj. 0.1 mg/ml 10 ml syringe	1	
Epinephrine Inj. 0.1 mg/ml (1:10,000) 10 ml syringe	1	
Etomidate Inj. 2 mg/ml 10 ml vial	1	
Phenylephrine Inj. 100 mcg/ml 10 ml syringe	1	
Propofol Inj. 10 mg/ml 20 ml vial	2	
Rocuronium Inj. 10 mg/ml 10 ml vial	1	
Succinylcholine Inj. 20 mg/ml 5 ml syringe	1	
Sugammadex 100 mg/ml 5 ml vials	3	

Cardiac CT Scan/Nuclear Medicine Box

Drug	Quantity	Expiration
Albuterol Inhaler 90 mcg/puff 8 gm inhaler	1	
Aminophylline Inj. 25mg/ml 10 ml vial	2	
Caffeine inj 60mg/3mL	1	

Electrocardiography (EKG) Kit

Medication	Strength	Quantity	Expiration
Atropine inj	1mg/1mL Vial	1	
Diphenhydramine inj.	50 mg/1 ml Vial	1	
Metoprolol inj.	5 mg/5 ml Vial	1	
Nitroglycerin SL tablet	0.4 mg	2 bottles (25 tabs/bottle)	

HEART ALERT (STEMI) Kit

(STEMI = ST-Elevation Myocardial Infarction)

Medication Name	Dose Given	Time	Route	Documented in MAR	Quantity in Kit	Exp. Date	Quantity Used
Atropine Inj 1mg (0.1 mg/ml) 10 ml prefilled syringe				☐	1		
Epinephrine Inj 1mg (1:10,000) 10 ml prefilled syringe				☐	1		
Amiodarone Inj 150mg (50mg/ml) 3 ml vial				☐	2		
Diphenhydramine Inj 50mg/ml 1 ml vial				☐	1		
Nitroglycerin 0.4 mg sublingual tablets				☐	1 bottle		

ADULT TRANSPORT/CODE BOX

Generic drug name	Quantity
Atropine 1mg/10mL syringe	1
Dextrose 50% 25g/50mL syringe	1
Dextrose 10% 100mg/mL (250mL bag)	1
Epinephrine 1:10000 1mg/10mL syringe	1
Oral glucose gel 15g	1
Normal saline 10mL flush	3
Angiocath starter kit*	1
Empty syringe 3mL	1
Empty syringe 10mL	3
18 gauge eclipse needle	4
25 gauge eclipse needle for IM inj	1

Generic drug name	Quantity
RSI meds grouped together	
Etomidate 2mg/mL (10mL)	1
Rocuronium 10mg/mL (10mL)	2
Succinylcholine 20mg/mL (5 ml) syringe	2
Midazolam 10mg/2mL (Versed)	1
Naloxone 2mg/2mL syr	1

*20G 1 ¼" Catheter x2, 18G 1 ¼" catheter x2, IV starter kit with ChloraPrep (DYND74260) x2

*20G 1 ¼" Catheter x2, 18G 1 ¼" catheter x2, IV starter kit with ChloraPrep (DYND74260) x2

Neonatal Transport Box- Pharmacy Section

Pharmacy Section ONLY

Epinephrine 1:10,000 (0.1 mg/mL) 10mL Syringe- 1 ea____ (√)

(Dose of Epinephrine= 0.1 to 0.3 mL/KG of Epinephrine 1:10,000 IV)

Pharmacist Code Stroke Kit

Quantity	Medication	Expiration Date
2	30mL syringe	
2	10mL syringe	
5	5mL syringe	
1	BD Alaris Pump Infusion Set (REF 2426-0500)	
6	18G Eclipse Needles	
6	Saline Flush 10mL	
1	Nicardipine 25mg in 100mL (either NS or D5)	
1	Tenecteplase 50mg kit	
1	Labetalol hydrochloride 100mg / 20mL vial	
N/A	Miscellaneous: labels, tapes, and dosing sheet	

Non-Cytotoxic Vesicant Medication and Fluids Extravasation Kit

Quantity	Medications	Expiration Dates
2	Phentolamine mesylate for injection 5 mg/vial	
2	Hyaluronidase (Amphadase®) 150 units/ml, 1 ml vial (Hyaluronidase is STORED IN PYXIS REFRIGERATOR)	
2	0.9% Sodium chloride for injection, preservative free, 10 ml	
3	Nitroglycerin Ointment USP, 2% (NITRO-BID®) 1 inch (1 gram) foilpac®	

Operation OB – MEDICATION BOX

Quantity	Drug	Expiration Date
2	Oxytocin (Pitocin) 10 units/ml 1 ml vial	
5	Misoprostol (Cytotec) 100 mcg tablet	

OB Procedure Cart

Nursing:
Stamp with patient's name, place in medication box and return to pharmacy

Quantity	Medication	Expiration
2	Calcium gluconate 1g vials	
1	Hydralazine 20mg/mL vial	
1	Labetalol100mg/20mL (5mg/mL) vial	
1	Magnesium sulfate 20g/500mL bag	
2	Magnesium sulfate 50%, 5gm/10mL, 10mL vials	
5	Misoprostol 200mcg tab	
1	Naloxone 2mg/2mL syringe	
1	Nitroglycerin spray 0.4mg/spray	
2	Oxytocin 30 units/500mL bag	
4	Oxytocin 10 units/mL, 1mL vial	
3	Nifedipine 10mg, Immediate Release tabs	
1	Terbutaline1mg/mL vial	
1	Tranexamic Acid 1000mg/10ml	

The following medications are in the **9W** Pyxis Refrigerator under "**OB PPH Emergency Kit**", to access:

- Log in to pyxis
- Hit "remove meds" button
- Hit "kit" button at the bottom of the screen
- Choose the "**OB PPH Emergency Kit**"
- Remove the below meds

Pyxis items in the OB Code Kit	
Quantity	**Medication**
1	Hemabate 250mcg ampule (refrigerator in zip-lock bag)
2	Methergine 0.2mg/mL ampule (refrigerator in zip-lock bag)
5	Misoprostol 200mcg tab

****Diazepam inj** must be **removed separately from Pyxis** when needed

Oral Surgery Box

Supplies	Qty.
Alcohol Pads	8
BD 10ml Syringe w/ Luer Lock Tip Blunt Fill Needles	2
BD 5 ml Syringe	3
BD Eclipse 18G x1½" Needles	4
BD Eclipse 3 ml Syringe w/ 21G x1½" Needle	3
CPR Mask	1
Extension Set w/ y-site	1
IV Catheter 18G x1¼"	2
IV Catheter 20G x1¼"	2
IV Catheter 22G x1"	2
IV Start Kit w/Chloral Prep	2
Oxygen Mask	1
Regular IV Set	1

Drugs	Qty.	Expiration Date
Albuterol Inhaler	1	
Aspirin 325mg	2	
Atropine Inj. 0.4 mg/ml 1 ml Vial	2	
Dextrose 50% Inj. 0.5 gm/ml 50 ml Syringe	1	
Diphenhydramine Inj. 50 mg/ml 1 ml Vial	1	
Ephedrine Inj. 50 mg/ml 1 ml Ampule w/ Filter needle	1	
Epinephrine 1:1000 Inj. 1 mg/ml 1 ml Ampule (For anaphylaxis: Adults: 0.3 to 0.5 mg (0.3 to 0.5 ml) of 1 mg/ml solution given IM, preferred anterior thigh)	1	
Esmolol 100mg/10ml	1	
Flumazenil Inj. 0.1 mg/ml 5 ml Vial	1	
Hydralazine 20mg/mL (1mL) vial	1	
Labetalol Inj. 5 mg/ml 20 ml vial	1	
Lidocaine Gel 2% 5 ml Tube	1	
Methylprednisolone Inj. 125 mg Vial	1	
Naloxone Inj. 0.4 mg/ml 1 ml Vial	2	
Nitroglycerin SL Tablet 0.4 mg/tab #25 tab Bottle	1	
Normal saline 10ml vial	2	
Normal Saline 250 ml Bag	1	
RSI Kit	1	
Sterile Water Inj. 10 ml Vial	1	

Drugs are replaced by pharmacy. Supplies are replaced by dental dept. oral surgery staff

Hypersensitivity Reaction Kit for Infusion Center

Medication	Quantity	Expiration
Diphenhydramine Inj. 50 mg/ml 1 ml Vial	1	
Methylprednisolone Inj.125 mg Vial	1	
Epinephrine 1mg/mL vial (Refer to "MANAGEMENT OF ACUTE ADVERSE REACTIONS (ADR) POLICY: CHEMOTHERAPY/BIOTHERAPY/IMMUNOTHERAPY: policy for dosing)	1	

Famotidine inj. 20 mg/2ml vials are in Pyxis Refrigerator.

- Atropine vial and/or syringe are in the pyxis machine
- Kit will include one 3mL syringe, one 18-gauge needle and one 21-gauge needle.

ED Block Cart

Quantity	Medication
Rescue/LAST Treatment	
12	Preferred choice: Intralipid (Fat Emulsion) 20% inj 200 - 250 ml bag with 1.2 micron filter tubing OR 2nd choice: SMOFlipid 20% - 100mL bags x2 with 1.2micron filter tubing

	+ ASRA checklist for treatment of local anesthetic systemic toxicity (LAST) [both original and simplified versions]
2	16 gauge needles
2	50mL syringes

ED Code Bag

Generic drug name	Quantity
Atropine 1mg/10mL syringe	1
Dextrose 50% 25g/50mL syringe	1
Dextrose 10% 100mg/mL (250mL bag) **during D50W shortage only**	1
Epinephrine 1:10000 1mg/10mL syringe	1
Etomidate 2mg/mL (10mL)	1
Glucose gel (oral) 15g	1
Midazolam 10mg/2mL (Versed)	1
Naloxone 2mg/2mL syr	1
Rocuronium 10mg/mL (10mL)	2
Succinylcholine 20mg/mL (5 ml) syringe	2
Tenecteplase kit	1
Supplies	**Quantity**
Normal saline 10mL flush	4
Angiocath starter kit*	1
Empty syringe 3mL	2
Empty syringe 10mL	2
18 gauge eclipse needle	4
25 gauge eclipse needle for IM inj	1

Alameda Hospital Only Medication Carts and Kits

ANAPHYLAXIS KIT

KEEP AT BEDSIDE FOR PACLITAXEL (TAXOL), L-ASPARAGINASE, PEPASPARAGINE INJECTION

PATIENT NAME
RN NAME

Quantity	Generic Name	Trade Name	Strength	Size	Form
1	Diphenhydramine	Benadryl	50mg/ml	1ml	SDV
1	Epinephrine (1:1000) (For anaphylaxis: Adults: 0.3 to 0.5 mg (0.3 to 0.5 ml) of 1 mg/ml solution given IM, preferred anterior thigh)	Adrenalin	1mg/ml	1ml	Ampule
1	Filter Needle			19G	Needle
1	Methylprednisolone	Solu-Medrol	125mg/2ml	2ml	SDV
1	Albuterol Solution	Proventil	2.5mg/3ml	3ml	SDV
3	Syringe			3ml	Syringe
3	Needle 18G			18G	Needle
3	Alcohol Prep Pad			Each	Pad

RETURN TO PHARMACY AFTER INFUSION.

FIRST EXPIRING DRUG:	**EXPIRATION DATE:**

TECH/RPH /

CCU Difficult Airway Cart Drug List

Patient Addressograph

Drugs	Quantity	Quantity Used
Lidocaine 2% Jelly 30ml	2	
Lidocaine 2% 50 ml Multiple Dose Vial	1	
Hurricaine Topical Spray	1	
Phenylephrine Nasal Decongestant Spray	1	

First Drug(s) to Expire:_____ Expiration Date:_____

Filled/Checked By:_____/_____ Date:_____

***Return entire kit to pharmacy for replacement after each use**

Kcentra® Kit Content

(Prothrombin Complex Concentrate, 4 Factor Unactivated)

Item Name	Quantity	Expiration Date
Kcentra Reconstitution Instructions	1	x
Orange "Medication Added" sticker	6	x
60 mL luer lok syringe	2	x
20 mL luer lok syringe	4	x
16 gauge needles	6	x
Empty 100mL IVPB bags	6	
Alcohol swabs	10	x
Kcentra 1000 unit manufacturer box	4	
Kcentra 500 unit manufacturer box	2	

Filled by: _____ Checked by: _____ Date checked: _____

Lock Number: _____

Date Used: _____

PATIENT HOSPITAL LABEL STICKER

***Return entire kit to pharmacy for replacement after each use**

TNKase® Kit Content

Item Name	Quantity	Expiration Date
TNKase 50mg	1	
AIS bag: dose chart, Orange "Medication Added" sticker, 5cc luer lok syringe, AIS flyer	1	
STEMI bag: dose chart, Orange "Medication Added" sticker, STEMI flyer	1	x

Filled by: _____ Checked by: _____ Date checked: _____

Lock Number: _____ Kit #: _____

NURSE: Return to Pharmacy when used

NURSE:

Place Patient Hospital Sticker

Pain Medications Tray List

Drugs	Exp Date	QTY	QTY Used
Lidocaine 1% P.F. (10 mg/mL) – 5 mL		25	
Lidocaine 2% P.F. (20 mg/mL) – 5 mL		10	
Bupivacaine 0.25% P.F. (2.5 mg/mL) – 10 mL		10	
Dexamethasone P.F. 10 mg/mL – 1 mL		25	
Kenalog (Triamcinolone Acetonide) 40 mg/mL – 1 mL		12	
Bupivacaine 0.5% P.F. (5 mg/mL) – 30 mL		9	
MethylPREDNISolone acetatae injectable suspension (Depo-medrol) 80mg		4	

San Leandro Only Medication Carts and Kits

Cardiology Drug Kit

Cardiology Drug Kit	Aminophylline 500mg vial	1
Cardiology Drug Kit	Atropine 1mg/10ml	1
Cardiology Drug Kit	Esmolol 100mg/10ml	1
Cardiology Drug Kit	Nitroglycerin 0.4mg tabs	25
Cardiology Drug Kit	Verapamil 5mg/2ml	1
Cardiology Drug Kit	22ga x1.5” safety needle	1
Cardiology Drug Kit	Diltiazem 5mg/ml 10 ml vial	1

Dobutamine Stress Test Kit (prepared upon order)

Dobutamine stress test kit (prepared upon order)	Dobutamine 250mg/d50w 250ml
Dobutamine stress test kit (prepared upon order)	d5w 500ml
Dobutamine stress test kit (prepared upon order)	esomolol 100mg/10ml
Dobutamine stress test kit (prepared upon order)	atropine 1mg/10ml inj

Rapid Response Kit

Rapid Response Kit	Ipatroprium/Albuterol 0.5mg/3mg amp	1
Rapid Response Kit	Nitroglycerin 0.4mg	1
Rapid Response Kit	Aspirin 325mg tab	1
Rapid Response Kit	Dextrose 50% 50ml	1
Rapid Response Kit	Naloxone 0.4mg	1
Rapid Response Kit	NS 1000ml IV	1

Ancillary ICU Code Box

Ancillary ICU Code Box	Amiodarone 150mg/3ml inj.	3
Ancillary ICU Code Box	Dextrose 5% 100ml bag	1
Ancillary ICU Code Box	Filter - 0.2 Micron	1
Ancillary ICU Code Box	Adenosine 6mg/2ml inj	3
Ancillary ICU Code Box	Atropine 1mg/10ml syringe	3
Ancillary ICU Code Box	Calcium Chloride 10% syringe	1
Ancillary ICU Code Box	Dextrose 50% 50ml syringe	1
Ancillary ICU Code Box	Dopamine 800mg/250ml D5W IV drip	1
Ancillary ICU Code Box	Epinephrine 1mg/10ml syringe	4
Ancillary ICU Code Box	Lidocaine 0.4% 250ml IV drip	1
Ancillary ICU Code Box	Lidocaine 100mg syringe	2
Ancillary ICU Code Box	Magnesium 1gm/2ml vial (Dilute with 9ml NS)	2
Ancillary ICU Code Box	Naloxone 2mg/2ml syringe	2
Ancillary ICU Code Box	Sodium Bicarbonate 8.4% syringe	2
Ancillary ICU Code Box	Sodium chloride flush 10ml syringe	4
Ancillary ICU Code Box	Sterile water 10ml	2
Ancillary ICU Code Box	Vasopressin 20 units/1 ml inj.	2

Kcentra® Kit Content

(Prothrombin Complex Concentrate, 4 Factor Unactivated)

Item Name	Quantity	Expiration Date
Kcentra Reconstitution Instructions	1	x
Orange "Medication Added" sticker	6	x
60 mL luer lok syringe	2	x
20 mL luer lok syringe	4	x
16 gauge needles	6	x
Empty 100mL IVPB bags	6	
Alcohol swabs	10	x
Kcentra 1000 unit manufacturer box	4	
Kcentra 500 unit manufacturer box	2	

Filled by: _____ Checked by: _____ Date checked: _____

Lock Number: _____

Date Used: _____

PATIENT HOSPITAL LABEL STICKER

TNKase® Kit Content

Item Name	Quantity	Expiration Date
TNKase 50mg	1	
AIS bag: dose chart, Orange "Medication Added" sticker, 5cc luer lok syringe, AIS flyer	1	
STEMI bag: dose chart, Orange "Medication Added" sticker, STEMI flyer	1	x

Filled by: _____ Checked by: _____ Date checked: _____

Lock Number: _____ Kit #: _____

NURSE: Return to Pharmacy when used

NURSE:

Place Patient Hospital Sticker

SLH OR Eye Medication Tray 1 Drug List

Drugs	Exp Date	QTY	QTY Used
Cyclopentolate (Cyclogyl) Soln 2% - 2 mL		1	
Cyclopentolate (Cyclogyl) Soln 1% - 2 mL		1	
Tropicamide 1% - 3 mL		1	
Phenylephrine (AK-Dilate) Soln 10% - 5 mL		2	
Sulfacet/Pred (Blephamide) Oint 3.5gm		1	
Gentamicin Soln 5 mL		2	
Gentamicin Oint 3.5 gm		1	
Erythromycin Oint 3.5 gm		2	
Ciprofloxacin (Cipro) Soln 0.3% - 2.5 mL		1	
Neo/Poly B/Dex (Maxitrol) Oint 3.5 gm		10	
Atropine Soln 1% - 2 mL		2	
Epinephrine PF Soln amp 1% - 2 mL		2	
Lidocaine PF Injection amp 1% - 2mL		10	
Cefazolin Injection Vial 1 gm		3	
Sterile Water for Injection SDV 10 mL		3	
Atropine Oint 1% - 3.5 gm		2	
Homatropine Soln 5% - 5 mL		2	
Lidocaine PF Injection 4% - 5 mL		6	
Gentamicin Injection SDV 80 mg/2mL		6	
Dexamethasone Injection SDV 4 mg/mL		8	

SLH OR Eye Medication Tray 2 Drug List

Drugs	Exp Date	QTY	QTY Used
Timolol Soln 0.5% - 5 mL		2	
Lidocaine/Epi Injection SDV 2%/1:200K – 20 mL		1	
Tetracaine Sterile Soln 0.5% - 2 mL		2	
Liquifresh PM Oint 3.5 gm		2	
Brinzolamide (Azopt) 1% - 10 mL		6	
Prednisolone (Pred-Forte) Soln 1% - 5 mL		3	
Fluorescein Sodium Ophth Strip 0.6 mg		3	
Lidocaine/Epi Injection SDV 1%/1:100K – 20 mL MDV		1	
Acetylcholine (Miochol-E) Soln – 2mL		3	
Trypan Blue (Vision Blue) Soln Syr 0.06% - 0.5 mL		5	
Pilocarpine Sterile Soln 2% - 15 mL		2	
Tetracaine Soln 0.5% - 15 mL		2	
Bupivacaine 0.75% - 10 mL		6	
Lidocaine Inj MDV 2% - 5 mL		6	
Lidocaine 2% - 50 mL		1	
Tetracaine (TetraVisc) Soln 0.5% - 5 mL		6	
Gatifloxacin (Zymaxid) Soln 0.5% - 2.5 mL		8	

OR Bleeding Kit

OR Bleeding Kit	GELFOAM (SIZE 100)	2
OR Bleeding Kit	Recothrom (5000 units)	4
OR Bleeding Kit	HEPARIN (1,000 UNITS/ ML) 10 ML	3
OR Bleeding Kit	HEPARIN (1,000 UNITS/ ML) 30 ML	1
OR Bleeding Kit	Gentamicin (80 MG/ 2 ML) 2 ML	4
OR Bleeding Kit	PROTAMINE (10 MG/ ML) 5 ML	1
OR Bleeding Kit	Visipaque (320mg/ml) 50ml	3
OR Bleeding Kit	30 ML SYRINGE	1
OR Bleeding Kit	18 GA HYPO NEEDLE	1
OR Bleeding Kit	MED LABELS	2

Radiology Emergency Drug (CT-box)

Radiology Emergency Drug (CT-Box)	Syringe w/ needle 3ml	3
Radiology Emergency Drug (CT-Box)	Atropine 1mg/ml vial	1
Radiology Emergency Drug (CT-Box)	Benadryl 50mg/ml vial	1
Radiology Emergency Drug (CT-Box)	Epinephrine Inj. 1 mg/ml (1:1000) 1 ml Vial (For anaphylaxis: Adults: 0.3 to 0.5 mg (0.3 to 0.5 ml) of 1 mg/ml solution given IM, preferred anterior thigh)	1
Radiology Emergency Drug (CT-Box)	Ammonia Inhalants	4
Radiology Emergency Drug (CT-Box)	Benadryl 25mg cap	4

Procedure Room Drug Box

Procedure Room Drug Box	Fentanyl 100mcg/2ml	8
Procedure Room Drug Box	Midazolam 5mg/5ml	8

ALAMEDA HEALTH SYSTEM

SEDATION, PROCEDURAL

Site	Alameda Health System	***Previous Revision Dates***	10/2011, 11/2013, 10/2014, 08/2018, 01/2022
Effective Date	05/03, 12/2018;	***Date Revised***	05/16/2022, 10/2025
Document Owner	VP, PATIENT CARE SERVICES	***Next Scheduled Review***	10/2028
Executive Responsible	Chair of Anesthesia, Chief Medical Officer		

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

Purpose

To provide guidelines for the administration of sedation, both moderate and deep, that is given for the purpose of enabling an invasive procedure.

Definitions

The four (4) levels of sedation/anesthesia are:

Depth of Sedation	Characteristics
Minimal (e.g., anxiolysis)	• Normal response to verbal commands/stimulation. • Unaffected airway, ventilation, and cardiovascular function. • Cognitive function and coordination may be impaired.
Moderate Sedation/Analgesia	• Purposeful response to verbal or tactile stimulation. • No intervention required to maintain a patent airway. • Ventilation adequate. • Cardiovascular function is usually maintained.
Deep Sedation/Analgesia	• Repeated or painful stimulation required for purposeful response. • Intervention may be required to maintain the airway. • Spontaneous ventilation may be inadequate. • Cardiovascular function is usually maintained.
General Anesthesia	• A drug induced loss of consciousness. • Unarousable even with painful stimulation. • Intervention is often required to maintain the airway. • Ventilation is frequently inadequate. • Cardiovascular function may be impaired.

Policy

1. Sedation may occur where appropriate monitoring, equipment, personnel, and supplies are readily available.
2. A minimum of two (2) clinicians shall be present during any moderate sedation procedure. At least one clinician must be a qualified physician or Advanced Practice Provider (APP) while the second clinician can be a Registered Nurse or qualified physician/APP.

a. The first clinician will be responsible for administering medications or directing the second clinician to administer medications on their behalf.
b. The second clinician will be responsible for monitoring the effectiveness of the sedation/analgesic agents and documenting the patient's response and status throughout the procedure. This second clinician can assist with minor, interruptible tasks as long as the patient is stable and continues to be monitored.

3. Patients receiving moderate or deep sedation will have IV access unless they receive IM Ketamine (Ketalar) only.

4. Only licensed practitioners, who have been granted privileges from Medical Staff to perform the planned level of sedation, may perform sedation procedures.
   a. There are distinct privileges for moderate sedation, and distinct privileges for deep sedation.
   b. Qualified Advanced Practice Providers (APPs) may perform moderate/deep sedation only under the supervision of a qualified physician as defined in the Advanced Practice Provider (APPs) Policy and Procedure Manual.

5. Registered Nurses who participate in moderate or deep sedation under the guidance of a physician/APP, shall maintain:
   a. Current Advanced Cardiac Life Support (ACLS), if caring for adult patients
   b. Pediatric Advanced Life Support (PALS), if caring for pediatric patients
   c. Completion of competency-based education on an annual basis with a minimum score of 90%.

6. RNs managing the care of patients receiving moderate sedation shall not leave the patient unattended or engage in tasks that would compromise continuous monitoring of the patient by the registered nurse. Registered nurse functions as described in this policy may not be assigned to unlicensed assistive personnel.

7. "Rescue" from a deeper level of sedation than intended requires an intervention by a practitioner with expertise in airway management and advanced life support. The rescue is conducted by a practitioner with expertise in airway management and advanced life support. The qualified practitioner corrects adverse physiologic consequences of the deeper-than- intended level of sedation and returns the patient to the originally intended level of sedation.

8. Sedation providers must be able to manage a patient in the planned level of sedation, and rescue patients from whatever level of sedation (or anesthesia) is achieved, either intentionally or unintentionally.

9. Patients requiring sedation will be evaluated, prior to a procedure, as detailed below, at a minimum: See Table below (8).

Element	**Responsible Person/Action**	
	Physician/APP	**Second Clinician**
a. Informed Consent	Obtain	Verify
b. Medical & Social history	Obtain	Review
c. Physical examination of cardiac and respiratory systems and vital signs	Obtain	Review
d. Airway assessment (see Appendix A - Mallampati Score)	Perform and document	

e. Aldrete Score (see Appendix A - Aldrete Score)		Obtain
f. Patient height & weight		Obtain
g. Pregnancy test results, when applicable	Verify	Verify
h. Current medication regimen (e.g., prescribed, over the counter, herbals, supplements) and medication taken within the last 48 hours including any as needed medications, especially opioids or other narcotics.	Obtain	Review
i. Allergies and sensitivities to medications	Verify	Obtain
j. Nothing by mouth (NPO) status	Verify	Verify
k. Availability of responsible individual to escort patient home if discharge planned.	Verify	Verify
l. ASA Class assessment (See Appendix A)	Perform and document	
m. Vital signs obtained 15 minutes prior to the start procedure	Review	Obtain
n. Pre-procedure education, according to the plan of care	Provide	Provide

10. Patients with any of the following may need special consideration.
    - known history of respiratory or hemodynamic instability
    - history of coagulation abnormality,
    - history of neurologic or cardiac disease that may be affected by medications administered for moderate sedation/analgesia,
    - history of renal or liver disease that may affect metabolism of medications administered for moderate sedation/analgesia,
    - previous difficulties with anesthesia or sedation,
    - severe sleep apnea or other airway related issues,
    - one or more significant co-morbidities,
    - pregnancy,
    - inability to communicate (e.g., aphasic),
    - inability to cooperate,
    - multiple drug allergies,
    - multiple medications with potential for drug interaction with sedative analgesics,
    - current substance abuse (e.g., street drugs, alcohol, non-prescribed prescription drugs),
    - ASA physical status classification of ASA III or above.

11. Pre-procedural fasting:
    a. For patients in need of an emergent procedure and for whom delay of procedure could lead to harm:
        i. Do not delay procedural sedation based on NPO status.
        ii. Perform, and document, aspiration precautions.

    b. NPO Guidelines for elective procedures include, <u>but are not limited to:</u>
        i. Clear liquids – 2-3 hours (e.g., water, fruit juices without pulp, clear tea, black coffee, Gatorade)
        ii. Light meal – 6 hours (e.g., dry toast and clear liquids)
        iii. Regular meal – 8 hours (any meat, fatty or fried foods that will delay gastric emptying)

iv. NPO after midnight
v. High-risk patients should have standard 8-hour fasting prior to sedation when possible.

12. Patients will be monitored continuously during the procedure.
    i. Monitoring shall be documented a minimum of every 5 minutes during the procedure based on the patient's condition, type and amount of medication administered, and length of the procedure. Monitoring includes but is not limited to the following: heart rate and function,
    ii. oxygenation, including end tidal CO2,
    iii. respiratory rate and adequacy of ventilation,
    iv. blood pressure,
    v. skin condition (at regular intervals).
    vi. Depth of sedation using an objective Sedation scoring scale

    b. The licensed practitioner should be notified of changes in condition.

13. The following equipment, minimally, are required during sedation:
    a. Emergency Airway equipment, Ambu-bag, and age-appropriate Crash Cart (or equivalent components).
    b. Suction and suction supplies.
    c. Oxygen supply, flow meter, and related Oxygen delivery devices
    d. All anticipated medications, including the appropriate reversal agents.
    e. Monitors – (pulse oximetry, non-invasive blood pressure, ECG, and end-tidal CO2).
14. Medications should be administered separately, in incremental doses, and titrated to desired effect per physician order.

15. Patients that have received sedation will be recovered by a registered nurse.

    a. Recovery time is patient dependent and will be influenced by the type and amount of sedation / analgesia administered, the procedure performed, and the patient's individual reaction to the medications.

    b. The RN should be aware of the characteristics of the medications administered and monitor patient accordingly.

    c. While recovering from sedation / procedure, RN will document assessment at least every 15 minutes, to include:
        - Blood Pressure
        - Pulse Oximetry values
        - Respiratory Rate
        - Heart Rate
        - Objective post-anesthesia scoring system (PASS)

    d. Patients who have received reversal agents must be monitored for a minimum of 2 hours after the last dose of the reversal agent, to assure that rebound sedation does not occur.

16. Follow AHS policy for "**Post Anesthesia and sedation discharge criteria**" for patient disposition after procedure.

17. Process Improvement:
    Reporting of Adverse Events: All cases in which the following events occur must be reported using the occurrence report system.

    i. All cases in which a reversal agent (I.E.: Naloxone or Flumazenil) is administered.

ii. All cases in which assisted ventilation is required.
iii. All unanticipated hospital admissions or increased level of care.
iv. All cases in which there is significant hypoxemia (defined as a reliable SaO2 of <90% for greater than 5 minutes or is <80% at any time).
v. Any significant new atrial or ventricular dysrhythmias or hemodynamic instability.
vi. Any untoward patient event or outcome.

a. The Sedation Committee will review each occurrence and make recommendations for improvement as deemed appropriate.

References (Reviewed 10/9/2025)

California Board of Registered Nursing, (1997), Conscious Sedation, CA BRN Sedation Statement

Joint Commission, (Current) Comprehensive Accreditation Manual for Hospitals

ASA (2002), Practice Guidelines for sedation and analgesia by non-anesthesiologists

Approvals

Departmental or Committee: Procedural Sedation Committee	Date: 10/2011, 11/2013, 10/2014, 09/12/2018, 01/2022
Patient Care Leadership Team	Date: 10/05/2018
Pharmacy and Therapeutics	Date: 10/2011, 10/2014, 10/2015
Clinical Practice Council	Date: 9/20/18, 01/2022, 03/2022
Medical Executive Committee	Date: 10/2011, 11/2013, 11/2014, 10/2018, 04/2022
Board of Trustees	Date: 1/2014, 3/2015, 11/2018, 05/2022

Appendix A – Mallampati Scoring/Classification, ASA Classification

Sedation Score

0	Alert
1	Occasionally drowsy, easy to arouse with verbal stimuli
2	Frequently drowsy, arouses to tactile stimuli
3	Somnolent, difficult to arouus, arouses to vigorous/ painful stimuli
4	Unresponsive

Mallampati Scoring/Classification

Class 1	Entire tonsil clearly visible.
Class 2	Upper half of tonsil fossa visible.
Class 3	Soft and hard palate clearly visible.
Class 4	Only hard palate visible.

ASA Physical Status Classification

Status	Definition	Example
P1	A normal healthy patient.	No physiologic, psychological, biochemical, or organic disturbance.
P2	A patient with mild systemic disease.	Cardiovascular disease, asthma, chronic bronchitis, obesity or diabetes mellitus.
P3	A patient with severe systemic disease.	Cardiovascular or pulmonary disease that limits activity; severe diabetes with systemic complications; history of myocardial infarction, angina pectoris, or poorly controlled hypertension.
P4	A patient with severe systemic disease that is a constant threat to life.	Severe cardiac, pulmonary, renal, hepatic, or endocrine dysfunction.
P5	A moribund patient who is not expected to survive without the operation (procedure).	Surgery is done as a last recourse or resuscitative effort; major multi-system or cerebral trauma, ruptured aneurysm, or large pulmonary embolus.
P6	A declared brain-dead patient whose organs are being removed for donor purposes.	

American Society of Anesthesiologists, Park Ridge, IL.

ALAMEDA HEALTH SYSTEM

PATIENT COMPLAINTS/GRIEVANCES

Effective Date	11/2025	***Date Revised***	09/2025
Document Owner	DARSHAN GREWAL (DIR, PATIENT SAFETY)	***Next Scheduled Review***	09/2028
Executive Responsible	Director, Patient Safety		

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

Purpose

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

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

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

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

To comply with CMS Conditions of Participation.

To comply with AHS's contractual agreements with Health Plans ~~payors.~~

Definition

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

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

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

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

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

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

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

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

Policy

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

2. Patients are informed of their right to file a complaint.
    a. AHS Patient Handbook AHS-Patient-Family-Handbook-2022.pdf
    b. AHS Website: Contact Us - Alameda Health System

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

Procedure

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

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

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

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

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

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

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

    a. On the AHS Intranet >Web Apps>Forms on Demand
    b. As an attachment to this policy
    c. In English, Spanish, Chinese and Arabic
9. The PCF is for patient or patient representative/family use only.

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

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

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

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

c. The results of the process
d. The date of completion of the complaint process

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

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

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

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

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

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

20. Other resources for complaint resolution include:
    a. The California Department of Public Health Services – (800) 554-0352
    b. Alameda County Long-term Care Ombudsman Program (SNF) – (510) 638-6878
    c. The Joint Commission – (800) 994-6610 or complaint@jointcommission.org
    d. For Alameda Alliance Patients only: Alameda Alliance for Health Member Services (510) 747-4567 or 1(877) 371-2222
    e. Medi-Cal Managed Care and Mental Health Office of the Ombudsman
    Phone: (888) 452-8609

Attachments:

Appendix A: AHS Patient Complaint Form

a) English

b) Spanish

c) Chinese

d) Arabic

~~Appendix B: Alameda Alliance for Health Grievance Forms:~~

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

~~Approvals:~~

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

Patient Complaint Form

Section 1: Patient Information					
LAST NAME	FIRST NAME	DOB (MM/DD/YYYY)	MEDICAL RECORD # (if known)		
MAILING ADDRESS	CITY	STATE	ZIP	TODAY'S DATE	
E-MAIL ADDRESS	PHONE	May we leave a voicemail?			

Section 2: Description of Complaint		
DATE/TIME OF INCIDENT	LOCATION OF INCIDENT (Room # /Department)	NAME OF STAFF INVOLVED (If known)

COMPLAINT IS REGARDING (check as many as apply)

- ☐ Access/Wait Time
- ☐ Care Related Issues
- ☐ Courtesy/Professionalism
- ☐ Communication
- ☐ Housekeeping/Environmental
- ☐ Billing
- ☐ Nursing
- ☐ Physician
- ☐ Lost Belongings
- ☐ Privacy/HIPAA
- ☐ Other _____

FACILITY/UNIT LOCATION

- ☐ San Leandro Hospital
- ☐ Highland Hospital
- ☐ Fairmont Hospital
- ☐ John-George Psychiatric Pavilion
- ☐ Alameda Hospital
- ☐ Hayward Wellness
- ☐ Eastmont Wellness
- ☐ Highland Wellness
- ☐ Newark Wellness
- ☐ Other _____

NATURE OF COMPLAINT (In your own words, please tells us why you are not happy with the care or service you received, attach additional paper if necessary):

_____

_____

_____

_____

_____

_____

RESOLUTION (As a result of your complaint, what would you like to see happen?):

_____

_____

_____

Section 3: Complainant Information		
NAME OF PERSON COMPLETING FORM (if not patient)		PERSON COMPLETING FORM: ☐ Patient ☐ Family Member ☐ Patient Representative
PHONE (if not patient)	MAILING ADDRESS OF PERSON COMPLETING FORM (if not patient)	

Patients please mail to:

Alameda Health System
Patient Safety Department
Mail Code 21009
7677 Oakport Street
Oakland, CA 94621
Phone 510-437-8484

If AHS Unit Manager/Director receives this form directly from patient or patient representative, please fax or email to the Patient Safety Department immediately.
FAX: 510-338-4161
Email:
PatientSafety@alamedahealthsystem.org

نموذج شكوى المريض

ALAMEDA HEALTH SYSTEM

القسم 1: معلومات المريض

اسم العائلة	الاسم الأول	تاريخ الميلاد (شهر/يوم/سنة)	رقم السجل الطبي (إن كان معروفًا)

العنوان البريدي	المدينة	الولاية	الرمز البريدي	تاريخ اليوم

عنوان البريد الإلكتروني	الهاتف	هل يمكننا ترك رسالة صوتية؟

القسم 2: وصف الشكوى

تاريخ/وقت الحادث	موقع الحادث (رقم الغرفة/القسم)	اسم الموظف المعني (إن كان معروفًا)

الشكوى بخصوص (حدد كل ما ينطبق)

- ☐ الوصول/وقت الانتظار
- ☐ المشكلات المتعلقة بالرعاية
- ☐ حسن المعاملة/المهنية
- ☐ الانتقال
- ☐ خدمة تنظيف الغرف/البيئة
- ☐ الفواتير
- ☐ التمريض
- ☐ الطبيب
- ☐ المتعلقات المفقودة
- ☐ الخصوصية/قانون نقل التأمين الصحي والمسؤولية (HIPAA)
- ☐ غير ذلك _____

موقع المنشأة/الوحدة

- ☐ مستشفى San Leandro Hospital
- ☐ مستشفى Highland Hospital
- ☐ مستشفى Fairmont Hospital
- ☐ John-George Psychiatric Pavilion
- ☐ مستشفى Alameda Hospital
- ☐ Hayward Wellness
- ☐ Eastmont Wellness
- ☐ Highland Wellness
- ☐ Newark Wellness
- ☐ غير ذلك _____

طبيعة الشكوى (يُرجى أن توضح لنا بأسلوبك الخاص سبب عدم رضاك عن الرعاية أو الخدمة التي تلقيتها، وإرفاق ورقة إضافية إذا لزم الأمر):

_____

_____

_____

_____

_____

_____

القرار (نتيجة لشكواك، ماذا تود أن يحدث؟):

_____

_____

_____

القسم 3: معلومات مقدم الشكوى

اسم الشخص الذي يملأ النموذج (إذا لم يكن المريض)	الشخص الذي يملأ النموذج: ☐ المريض ☐ أحد أفراد الأسرة ☐ ممثل المريض

الهاتف (إذا لم يكن المريض)	العنوان البريدي للشخص الذي يملأ النموذج (إذا لم يكن المريض)

يُرجى من المرضى إرساله بالبريد إلى: Alameda Health System
Patient Safety Department (قسم سلامة المرضى)
الرمز البريدي 21009
7677 Oakport Street
Oakland, CA 94621
الهاتف 510-437-8484

ALAMEDA HEALTH SYSTEM

إذا تلقى مدير/رئيس وحدة AHS هذا النموذج مباشرة من المريض أو ممثل المريض، فيُرجى إرساله بالفاكس أو البريد الإلكتروني إلى قسم سلامة المرضى على الفور.
الفاكس: 510-338-4161
البريد الإلكتروني:
PatientSafety@alamedahealthsystem.org

ALAMEDA HEALTH SYSTEM

病人投訴表格

第 1 部份：病人資料					
姓氏	名字	出生日期（月份/日期/年份）	醫療記錄號#（如知悉）		
郵寄地址	城市	州份	郵遞區號	今天日期	
電子郵件地址		電話	我們可以留言嗎？		

第 2 部份： 投訴描述		
事件發生日期/時間	事件發生地點（房間號碼# /部門）	涉及工作人員姓名（如知悉）

投訴涉及事項(盡量選擇適用的項目)

- ☐ 會面/等待時間
- ☐ 有關護理的問題
- ☐ 禮貌/專業程度
- ☐ 溝通
- ☐ 打掃衛生/環境
- ☐ 帳單
- ☐ 護士護理
- ☐ 醫生
- ☐ 遺失物品
- ☐ 私隱/HIPAA
- ☐ 其他 _____

設施/單位位置

- ☐ San Leandro 醫院
- ☐ Highland 醫院
- ☐ Fairmont 醫院
- ☐ John-George 精神科病院
- ☐ Alameda 醫院
- ☐ Hayward 健康中心
- ☐ Eastmont 健康中心
- ☐ Highland 健康中心
- ☐ Newark 健康中心
- ☐ 其他 _____

投訴性質（用你自己的話語，請告訴我們你對所接受的護理或服務不滿意的原因，如有必要請附上補充的紙張）：

_____

_____

_____

解決方案（ 根據你所作的投訴，你希望會看到什麼事情發生？）:

_____

_____

第 3 部分：投訴人資料		
填表人姓名（如不是病人）		填此表格的人： ☐ 病人 ☐ 家屬 ☐ 病人代表
電話（如不是病人）	填表人郵寄地址（如不是病人）	

病人請郵寄至:

ALAMEDA HEALTH SYSTEM

Alameda Health System
Patient Safety Department
Mail Code 21009
7677 Oakport Street
Oakland, CA 94621
Phone 510-437-8484

如果 AHS 部門經理/主任直接從病人或病人代表收到此表格，請立即傳真或發送電子郵件至病人安全部門。
傳真: 510-338-4161
電子郵件:
PatientSafety@alamedahealthsystem.org

ALAMEDA HEALTH SYSTEM

Formulario de quejas del paciente

Sección 1: Información del paciente

APELLIDO	NOMBRE	Fecha de nacimiento (MM/DD/AAAA)	N° DEL EXPENDIENTE MÉDICO (si se conoce)

DIRECCIÓN POSTAL	CIUDAD	Estado	Código Postal	FECHA DE HOY

DIRECCIÓN DE CORREO ELECTRÓNICO	TELÉFONO	¿Podemos dejar un mensaje de voz?

Sección 2: Descripción de la queja

FECHA/HORA DEL INCIDENTE	LUGAR DEL INCIDENTE (Número de consultorio/habitación /Departamento)	NOMBRE DEL PERSONAL INVOLUCRADO (Si se conoce)

LA QUEJA SE REFIERE A (marque todas las opciones que correspondan)

- ☐ Acceso/Tiempo de espera
- ☐ Asuntos relacionados al cuidado
- ☐ Cortesía/Profesionalismo
- ☐ Comunicación
- ☐ Limpieza/Medio ambiente
- ☐ Facturación
- ☐ Enfermería
- ☐ Médico
- ☐ Objetos perdidos
- ☐ Privacidad/HIPAA
- ☐ Otro _____

INSTALACIÓN/UBICACIÓN DE LA UNIDAD

- ☐ San Leandro Hospital
- ☐ Highland Hospital
- ☐ Fairmont Hospital
- ☐ John-George Psychiatric Pavilion
- ☐ Alameda Hospital
- ☐ Hayward Wellness
- ☐ Eastmont Wellness
- ☐ Highland Wellness
- ☐ Newark Wellness
- ☐ Otro _____

NATURALEZA DE LA QUEJA (En sus propias palabras, por favor, díganos por qué no está satisfecho con la atención o el servicio que recibió. Adjunte hojas adicionales si es necesario):

_____

_____

_____

_____

_____

_____

RESOLUCIÓN (A raíz de su queja, ¿qué le gustaría que sucediera?):

_____

_____

_____

Sección 3: Información del reclamante

NOMBRE DE LA PERSONA QUE LLENÓ EL FORMULARIO (si no es el paciente)		PERSONA QUE LLENÓ EL FORMULARIO:
TELÉFONO (si no es el paciente)	DIRECCIÓN POSTAL DE LA PERSONA QUE LLENÓ EL FORMULARIO (si no es paciente)	☐ Paciente ☐ Miembro de la familia ☐ Representante del paciente

Pacientes, envíen por correo a:

ALAMEDA HEALTH SYSTEM

Alameda Health System
Patient Safety Department
Mail Code 21009
7677 Oakport Street
Oakland, CA 94621
Phone 510-437-8484

If AHS Unit Manager/Director receives this form directly from patient or patient representative, please fax or email to the Patient Safety Department immediately.
FAX: 510-338-4161
Email:
PatientSafety@alamedahealthsystem.org

Pacientes, envíen por correo a: **Alameda Health System**
Patient Safety Department
Mail Code 21009
7677 Oakport Street
Oakland, CA 94621
Phone 510-437-8484

If AHS Unit Manager/Director receives this form directly from patient or patient representative, please fax or email to the Patient Safety Department immediately.
FAX: 510-338-4161
Email:
PatientSafety@alamedahealthsystem.org

Quality Assurance and Performance Improvement (QAPI) Plan

FY 2026

PURPOSE:
The Quality Assurance and Performance Improvement (QAPI) Plan describes Alameda Health System's (AHS) approach to developing, implementing, and maintaining an effective, data-driven quality, patient safety, and performance improvement program. The process of identifying, evaluating, prioritizing, and implementing quality, patient safety and performance improvement activities occurs throughout the continuum of care at AHS.

The six aims for improvement identified by the Institute of Medicine are at the core of the AHS quality, safety, and performance improvement program. AHS strives to provide care that is:

- Safe: avoid injuries to patients from care that is intended to help them
- Timely: reduce potentially harmful delays for both those who receive and those who give care
- Effective: provide services based on best evidence and accepted practice
- Efficient: avoid wasting equipment, supplies, ideas, and energy
- Equitable: provide care that does not vary in quality because of personal characteristics such as gender, age, sexual orientation, race, religion, disability, ethnicity, geographic location, and socioeconomic status
- Patient Centered: provide care that is respectful of and aligned with individual patient preferences, needs, and values

SCOPE:
The QAPI plan is a systemwide plan. It applies to the following AHS entities:

- Alameda Hospital
- San Leandro Hospital
- Wilma Chan Highland Hospital
- John George Psychiatric Hospital
- Post-Acute Care
- Ambulatory Care (Wellness Clinics and Highland Outpatient clinics)

OBJECTIVES:
The objectives of the QAPI program are to:

- Establish and maintain a culture of safety throughout the system.
- Promote and support a drive towards zero preventable harm.
- Support a just and fair culture that promotes a non-punitive culture of reporting.
- Increase desired patient outcomes, including patient satisfaction.
- Coordinate and lead improvement efforts using a multidisciplinary approach.
- Foster collaboration and teamwork to drive performance improvement, reduce risk, and enhance patient safety.
- Facilitate the rapid redesign of unsafe care processes and systems in response to actual and potential adverse events.
- Incorporate effective safety principles, such as human factors, during the design and redesign of clinical care systems.

- Collect data to monitor performance of new or revised processes, including patient, family and staff input, needs, perceptions of risk to patients, and suggestions for improvement.
- Align improvement activities with AHS strategic priorities.

GOVERNANCE: (See **Appendix A** for QAPI Governance Structure)
The Board of Trustees (BOT) is responsible for the oversight of the QAPI program. That oversight includes ensuring:

- That an ongoing program for quality, patient safety, and performance improvement is defined, developed, implemented, and maintained.
- That the program focuses on indicators related to improved health outcomes and addresses the prevention and reduction of medical errors.
- The program reflects the complexity of AHS and involves all departments and services, including those furnished by contract.
- The program addresses priorities for improvement.
- Improvement activities are evaluated.
- Adequate resources are provided to conduct the functions (measuring, assessing, improving, and sustaining) of the program.
- Clear expectations for safety are established and communicated systemwide.

The Quality and Professional Services Committee (QPSC) is advisory to the BOT. QPSC helps to ensure that the culture, policies, and procedures in place promote optimal care and provides oversight to the quality program, outcomes, and care.

The BOT delegates these responsibilities to the Chief Executive Officer and to the Medical Staff.

The Chief Executive Officer (CEO) is responsible for assuring that the QAPI program is implemented and evaluated. The CEO has established the structures and processes necessary to accomplish this objective. The CEO delegates the implementation and day-to-day management of the QAPI program to the medical staff and to the leadership team.

The Medical Staff, through the Medical Executive Committee (MEC), are responsible for providing leadership and oversight into the quality and safety of care provided by the organization and the medical staff. The MEC has formed the Quality Steering Committee (QSC), Quality Review Committees (QRC), and the Patient Safety Committee (PSC) to fulfill these responsibilities. (See Policy on "AHS Medical Staff Committees" for complete descriptions of the below committees)

QSC oversees implementation, review, and evaluation of the QAPI program and associated performance improvement activities and outcomes including:

- Directs ongoing systemwide performance improvement activities.
- Reports significant findings and recommending actions to the BOT, medical staff, administration, and, when deemed necessary, departments.
- Sets priorities for performance improvement.

- Evaluates and sponsors system-wide improvement initiatives and ensures alignment and feedback through governance.

PSC coordinates patient safety and risk management activities including:

- The review of patient safety events (Refer to "Reporting Adverse Events/Sentinel Events" Policy), associated corrective action plans and recommendations.
- Oversight of error reduction and recovery programs.
- Promotes compliance with statutory and regulatory requirements.
- Communicate with executive leadership on identified gaps in infrastructure, systems, or resources which may impact patient safety.
- Reviews and evaluates ongoing patient safety programs to ensure compliance, ongoing sustainability, and continuous improvement opportunities (i.e., BETA Heart Programs).

QRCs actively review and evaluate the care provided by the medical staff via the Peer Review Process. The QRC review process together with the Ongoing Professional Practice Evaluation (OPPE) and Focused Professional Practice Evaluation – For Cause (FPPE) ensure providers meet performance expectations and standard of care.

AHS Leadership is responsible for assuring that the QAPI program is implemented within their area of responsibility, and for sponsoring and ensuring alignment with the system-wide improvement initiatives.

All departments are responsible for ongoing quality and performance improvement activities. These efforts are monitored through the leadership structure, and key indicators are reported to the QSC on a scheduled basis.

In the Post-Acute setting, Facility leadership has oversight of quality assurance and performance improvement activities with interdisciplinary input from but not limited to Physician, Lab, Pharmacy, Infection Control, Patient Relations, Finance, Environmental Services, Engineering, Food and Nutrition Services, Rehabilitation Services, Nursing and Administration.

PERFORMANCE IMPROVEMENT ACTIVITIES

Performance improvement activities are continuous ongoing functions of a QAPI program. AHS continuously monitors and evaluates processes and outcomes of care. Dashboards and reports, containing goals and external benchmarks where available, are used to monitor and manage performance throughout the organization. The data collected is used to determine if the action plans and services provided are effective and sustainable, meet regulatory compliance, and support patient, resident, and family input. At minimum, AHS will collect data to monitor performance on the indicators listed in Appendix B.

The data is collected at least monthly and analyzed using statistical tools and techniques. The data is compared over time and displayed to leadership and staff in a manner that facilitates identification of performance, patterns, trends, and variations in performance that adversely affect safety or quality of care.

Selection of Performance Improvement Priorities

On an annual basis, the Board of Trustees, through QPSC and with input from quality, operational leaders and the medical staff identify the Objectives and Key Results which set system-wide priorities for the year. The selection is based on high risk, high volume, or problem prone areas and their effects on health outcomes, patient safety, and quality of care.

A coordinated evaluation and assessment of metrics is completed which includes the following activities:

1. Review and analysis of the following Programs/Information:
    a. National Quality Reporting Programs - Centers for Medicare and Medicaid Services (CMS), The Joint Commission (TJC), Promoting Interoperability (PI), Merit-based Incentive Payment System (MIPS) for Providers, and Leapfrog Safety Grade
    b. Hospital Acquired Conditions (HAC), Hospital Acquired Infections (HAI) as defined by National Healthcare Safety Network (NHSN), and Patient Safety Indicators (PSI).
    c. Payor quality performance programs such as Medi-Cal's Quality Incentive Program (QIP).
    d. Patient Safety trends including MIDAS (Incident Reports), Safety Alert tracking and trending, Root Cause Analyses, Total Harm rates, Failure Mode and Effects Analysis (FMEA), and performance improvement initiatives.
    e. Regulatory and survey findings, reportable adverse events, sentinel events, and efficacy of corrective action plans
    f. AHS System, Facility, and Unit Level dashboards of MIDAS safety alerts
    g. Patient Experience data

2. Consultation with system leaders to prioritize quality and safety issues in their respective areas.
3. Assessment of Objectives & Key Results (OKRs) data on a monthly and annual frequency for ongoing improvement opportunities.
4. Goal setting based on national benchmarks and internal stakeholder analysis.

The magnitude of activities involved in measuring and assessing performance at both the departmental level and the aggregate organizational level means that the potential number of opportunities for improvement is very large. Considering limits on time and resources, pursuing all possible improvements

is not possible. Improvement priorities must be clarified and set. Once a key initiative in an area or function is identified, the following selection criteria is used:

- Determine if the project meets at least one of the following criteria:
  - Aligns with the mission and strategic objectives
  - Meets regulatory, licensure, and accreditation requirements
  - Establishes the effectiveness, timeliness, and stability of processes
- Prioritize project based on:
  - Reason for inclusion: low volume, high risk; problem prone areas; improved outcomes; patient or provider safety; quality of care
  - Significance of the issue: low, moderate, high
  - Severity of the issue: low, moderate, high
  - Prevalence of the issue: isolated and localized, multiple areas, systemwide

Measurement and Performance Improvement

The Objectives & Key Results (OKR) dashboards define strategic goals to meet our Mission and Vision. They are used to assess the ongoing performance of the organization. (See Appendix C for OKR Dashboard Metric Definitions)

- OKRs combine aspirational objectives and practical, measurable indicators, enabling key results.
- System goals and targets are set through analysis of past performance; identification of best practices; and review of national, regional, or local benchmarks.

Areas for improvement are identified routinely and systematically by assessing quality of care from actual and/or potential events.

Performance Improvement Projects

Performance Improvement Projects are different from ongoing Performance Improvement Activities. Performance improvement Projects require a significant amount of up-front planning, including definition of objectives, and have a definitive beginning and end date (time-limited).

<u>Identification</u>

Improvement projects are identified by assessing the current performance against the desired outcomes. Data on current performance is obtained in various ways including clinical / departmental self-assessments, patient reported data, formal organizational review that identifies gaps, gap analysis, and audits of organizational objectives. Areas showing gaps between targets and performance are candidates for major improvement initiatives.

<u>Improvement Teams</u>

An A-3 document will be developed by and for each performance improvement project team; this document will provide background, define the current state, define goals for future state, outline the key gaps to be closed and track progress toward those goals. Equity is integrated into the performance improvement planning process by incorporating relevant considerations into the initial data review, goal setting, and intervention design. All performance improvement efforts define the targeted patient population and include their unique voice and needs in the plan. QSC will approve based on selection

criteria and monitor performance improvement via the A-3. Progress and results of the projects will be reported to the QSC.

Operational leaders can pursue other quality and performance improvement projects based on department identified priorities, safety alerts, and other factors.

PI Methodology

AHS utilizes the Plan-Do-Study-Act (PDSA) cycle to improve processes or conduct system improvements. The PDSA cycle is an iterative, four-stage problem solving model which is also referred to as Rapid Cycle Improvement.

Plan: Plan the test/ improvement including a plan for collecting data.
Do: Run the test/ improvement on a small scale.
Study/Check: Analyze the results and compare them to your predictions.
Act: Based on what you learned, plan for your next step or PDSA cycle.

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Patient Safety Program

In the quest for zero preventable harm, AHS strives to identify potential patient safety risks early and to reduce, mitigate and eliminate actual or potential risks to patients. Potential patient safety risks are identified via:

- Review MIDAS event reports to identify events, trends, patterns, and variation in patient care.
- Investigation of adverse occurrences, sentinel events, near miss events, potentially compensable events, and claims to determine how similar events may be averted.
- Performance of Root Cause Analysis and Actions to mitigate organizational risks.
- Collaboration with other departments in change projects, assessments, and training that promote all aspects of patient safety and risk management.
- Review complaints and grievances by patients, families, and visitors.
- Review of regulatory or accreditation agency findings.
- Processes identified through AHS' performance improvement program.
- Proactive risk assessment activities which may include:
    - Failure Mode and Effects Analysis (FMEA)
    - Annual SCORE Culture of Safety surveys with actionable improvements in teamwork and safety climate domain
    - Mock surveys / assessments, regulatory rounds / activities
    - Focused risk assessments as requested by the PSC, QSC, or other committees.

Data collected on potential patient safety risks are aggregated and analyzed to determine if there are opportunities to improve safety and reduce risks. If opportunities are identified, AHS will:

- Prioritize those processes that demonstrate significant variation from desired practice
- Allocate the necessary resources to mitigate the risks identified
- Establish performance measures to address those processes that have been identified as "high risk" to patient safety.
    - Opportunities to reduce errors that reflect system issues are addressed through the performance improvement program.
    - Opportunities to reduce errors that reflect the performance of individual care providers are addressed through the medical staff QRC process and/or the AHS human resources process using the Just Culture framework.

The Patient Safety Program is closely aligned with BETA risk reduction and safety programs.
AHS actively participates in, deploys, or supports:

- ED and OB Quest for Zero to improve reliability and reduce risk exposure.
- Administration of the Culture of Safety survey with structured debriefing to understand physician and staff perceptions of organizational culture and engagement.
- A process for early identification and rapid response to harm events. Harm events may include adverse occurrences, sentinel events, near miss events, compensable events and claims with the goal of determining how similar events may be averted.
- A "human factors" approach to event investigation using a fair, just culture framework.

- Honest and empathic communication with patients and family members to support a culture shift toward greater transparency.
- A proactive process for providing emotional support for members of the health care team involved in or affected by an adverse event.
- A formal method for early resolution when harm has occurred.

System and Process Failures

System and process failures are reported regularly to the PSC. In addition, at least annually, a report is submitted to BOT, through QPSC, of:

- All System or Process Failures
- Number/Type of Sentinel Events
- If Patient/Family was notified of the events
- Actions to improve safety (proactive/response)
- Analyses of adequacy of staffing (including the number, skill mix, and competency)

Training and Education

AHS provides ongoing patient safety training for staff and health care practitioners. Examples of safety training include:

- Quality, Patient Safety and Regulatory Skills Lab
- Performance Improvement Skills Lab
- Data Literacy Skills Lab
- SBAR (Situation, Background, Assessment, Recommendation) communication Training
- Patient Safety Event Management
- Just Culture Training

When assessment reveals continuing needs for knowledge and skills, specific training is frequently provided on a “just-in-time” basis.

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Regulatory Affairs Program

Regulatory compliance in healthcare is about providing high-quality patient care. The Regulatory Affairs team assures compliance with laws, standards and regulations designed to keep patients safe and provide a safe environment for the provision of care.

Regulatory Affairs manages licensing, certification, regulatory and accreditation programs that support ongoing compliance with the Centers for Medicare and Medicaid (CMS), Food and Drug Administration (FDA), California Department of Public Health (CDPH), Alameda County Public Health Department, The Joint Commission (TJC) Hospital Accreditation and Certification Programs and other oversite activities. This includes:

- Managing facility licenses for adherence to the state requirements under the California Code of Regulations (including Title 8, 16, 22 and 24), Health and Safety Code, Business and Professions Code.
- Assure adherence to the local Alameda County Public Health Department (ACPHD) ordinances, requirements, or Emergency Orders
- Ensures timely reporting to CDPH and/ ACPHD of adverse events as stipulated by state statutes and regulations.
- Serves as the liaison between CDPH, other regulatory bodies, and the facility during any investigation or site visit.

**For Post-Acute, the site Administrators, Directors of Nursing, CAO of Post-Acute Services and the Director of Clinical Executive Operations Team have oversight of compliance in post-acute settings.*

The following locations are currently accredited through TJC:

- Alameda Hospital - Hospital Accreditation, Primary Stroke Certification & Laboratory Accreditation
- Fairmont Hospital – (outpatient services)
- Hospital Accreditation, Behavioral Health Certification & Laboratory Accreditation
- Highland Hospital - Hospital Accreditation, Primary Stroke Certification
- John George Psychiatric Hospital – Hospital Accreditation & Laboratory Accreditation
- San Leandro Hospital – Hospital Accreditation, Primary Stroke Certification & Laboratory Accreditation

GOALS:

AHS has established the following QAPI goals for FY 2026:

1. Achieve systemwide and location specific OKR goals.
2. Develop systemwide performance improvement education infrastructure
3. Improvement with SCORE Survey Teamwork and Safety Climate score

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FY 2026 PI Projects

Project	Reason	Measurable progress
Surgical Site Infection (SSI) Reduction	AHS is working to eliminate hospital acquired infections. In pursuit of this goal AHS is targeting an infection ratio less than predicted. SSI contributes to extended hospitalizations, antibiotic resistance, and increased mortality risk.	To be reported to QSC monthly
Fall Reduction	AHS is focused on achieving zero preventable harm. Falls are the second most frequent cause of harm in hospitals, extending hospital stays, and can have lifelong harm due to loss of wellbeing and independence. AHS is targeting performance better than the national average per the National Database of Nursing Quality Indicators (NDNQI).	To be reported to QSC monthly
HAPI Prevention	In pursuit of zero preventable harm, AHS is focused on reducing hospital acquired pressure injuries prevalence to less than or equal to NDNQI 50th percentile. HAPI prevention is crucial to reduce patient suffering, prevent complications, improve length of stay, and lower healthcare costs.	To be reported to QSC monthly
Readmission Reduction	The stress, uncertainty, and disruption caused by repeated hospital visits can be emotionally draining and delay restoration of health and independence. AHS is committed to improved communication, care coordination, and a successful transition post hospitalization and strives to achieve performance equal to or better than the National average.	To be reported to QSC monthly

The QAPI priorities and goals may be reprioritized based on significant organizational performance findings, or changes in regulatory requirements, patient population, environment of care, and needs of patient or staff. Priorities may be reset by the QSC in consultation with leadership and medical staff leadership.

Quality Assurance and Performance Improvement (QAPI) Plan

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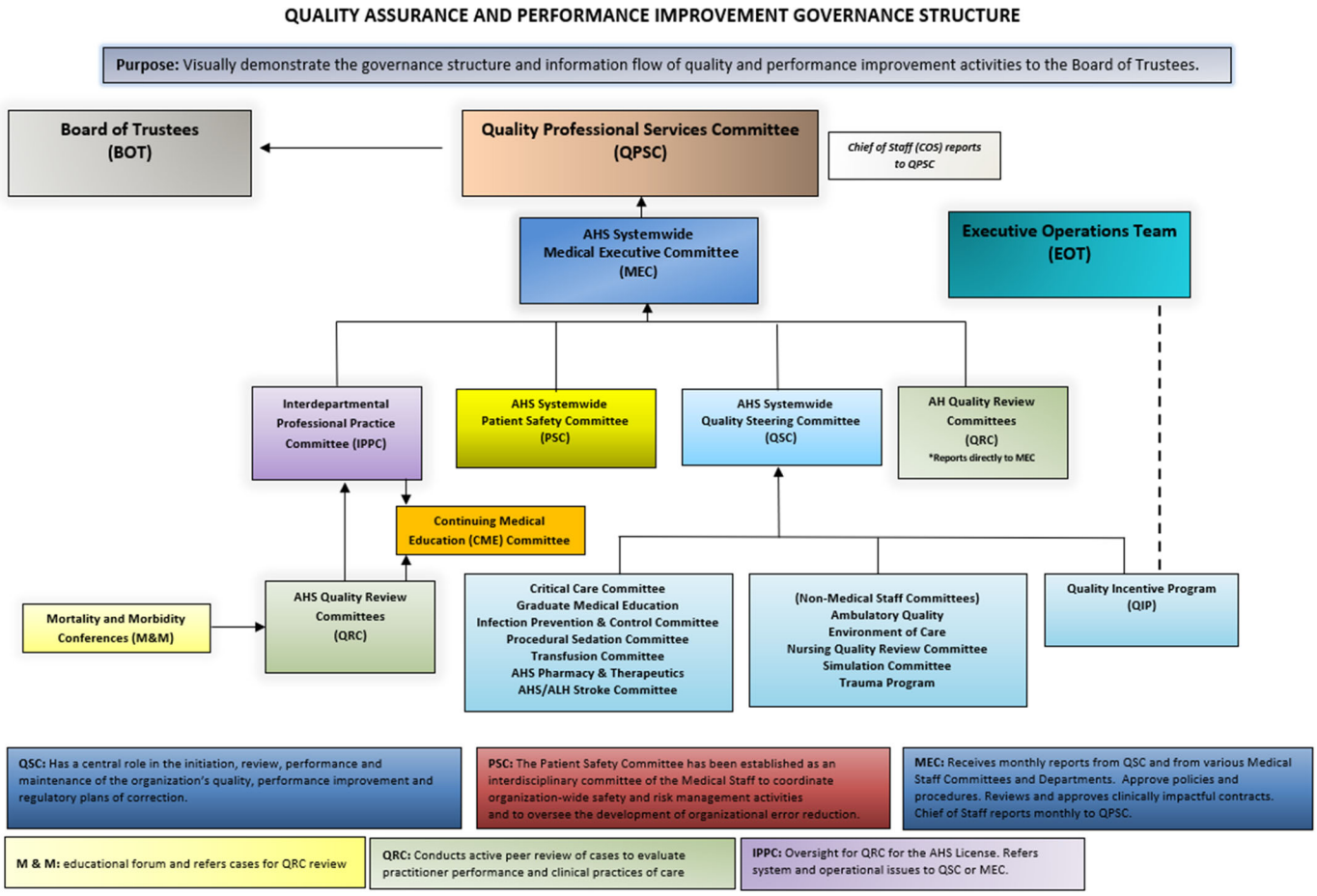
APPENDIX A: Quality Assurance and Performance Improvement Governance Structure



APPENDIX B: Required data collection

At minimum, AHS will collect data to monitor performance on the following:

- Improvement priorities identified by leaders
- Operative or other procedures that place patients at risk of disability or death
- Surgeries in which postoperative diagnosis (clinical or pathological) were unexpected and could indicate that a clinically significant diagnostic error occurred. The medical staff determine which unexpected postoperative diagnosis is significant.
- Adverse events related to moderate or deep sedation or anesthesia
- The use of blood and blood components
- Reported and confirmed transfusion reactions
- Use of restraints
- Resuscitative services including:
    - number and location of cardiac arrests (for example, ambulatory area, telemetry unit, critical care unit, etc.)
    - outcomes of resuscitation (for example, return of spontaneous circulation, survival to discharge
    - transfer to higher level of care
- Resuscitation data analysis to identify system improvement opportunities.
- Significant medication errors
- Significant adverse drug reactions
- Organ procurement
- Patient perception of safety and quality of care, treatment, and services
- Patient thermal injuries that occur during magnetic resonance imaging (MRI) exams
- Incidents and injuries related to the presence of ferromagnetic objects in the MRI scanner room
- Incidents where the radiation dose index, dose length product, or size-specific dose estimate from diagnostic CT examinations exceed expected dose index ranges identified in imaging protocols. Incidents should be compared to external benchmarks.
- Incidents related to overexposure to radiation during diagnostic computed tomography examinations and provision of fluoroscopic services

REFERENCE:
TJC Performance Improvement Chapter
CMS Conditions of Participation, QAPI Program
HSC 1279.6

Quality Assurance and Performance Improvement (QAPI) Plan

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APPENDIX C: FY 2026 Quality OKR Proposal: Metric Definitions

Fiscal Year 2026 Quality OKR Proposal: Metric Definitions

OBJECTIVES	KEY RESULTS	Definition	Strategic Key Results Link	Recommendation
Safe Care - Caring, Healing, Teaching All				
Provide safe care	Total Patient Harms	The number of potential health-care acquired patient harms Includes: CLABSI, CAUTI, MRSA BSI, C-Diff, SSI, Patient Falls with injuries, Hospital Acquired Pressure Injuries and Behavior Events that result in Injury	Leapfrog, CMS Star Rating. HAC Penalty, QIP	Revise - Reportable HAPIs, Focus 6 Surgical Categories for SSI (Colon, C-Section, Gallbladder, Hysterectomy, Spinal Fusion, Small Bowel)
	Sepsis Bundle	Compliance to Sepsis early recognition and intervention guidelines. This is an "all-or-nothing" measure, meaning all elements must be met to receive credit. Follows CMS/TJC SEP 1 Definition	CMS Star Rating	Add
	Sepsis Mortality O/E Ratio	The observed to expected ratio is a comparison of the actual number of sepsis-related deaths in a hospital (observed) to the predicted number of deaths (expected).	CMS Star Rating	Keep
Timely, Effective, and Efficient Care				
Promote wellbeing	All Cause 30-day readmission rate	Percentage of inpatient acute med-surg encounters, regardless of payer type, with an unplanned readmission to any AHS facility within 30 days for any cause for acute care inpatients	CMS Star Rating, Readmission Penalty	Keep
Provide accessible care	Waitlist time - New Specialty Referral	The amount of days between when a new patient to AHS requests/referred for an initial specialty care appointment to the day of appointment.	Ambulatory Access	Revise % of Specialty Clinics at Goal
	ED Boarding Time for Admitted Patients Community/HGH	Median time from Decision to Admit to departure from the emergency department for admitted patients.	CMS Star Rating	Keep

Fiscal Year 2026 Quality OKR Proposal : Metric Definitions

OBJECTIVES	KEY RESULTS	Definition	Strategic Key Results Link	Recommendation
Equitable Care				
Serving all: Deliver Whole Person Care	Health-related Social Needs Assessment Completed on Hospital Inpatient and Outpatient Encounters	The percentage of hospital inpatient and hospital outpatient encounters where the patient is screened for social determinants of health: food insecurity, housing, transportation, safety and utilities	Process Readmissions Link Stewardship: Grow and optimize resources for the patient care continuum to meet the community need	Revise Expand to Hospital Based Outpatient Encounters (ED, Same Day Surgery, Imaging, Testing) Add 2nd Metric Screening Positivity Rate
Patient-Centered Care				
Be the most welcoming system to receive care	Likelihood to recommend care composite	Percentage of patients who would recommend AHS (includes rehab, acute, ambulatory, ED, outpatient surgery, dental, radiology)	Leapfrog, Star Rating	Keep

Policy	
Document Title: Against Medical Advice	**Reference # tbd**
Level x System ☐ Site	**Effective Date: 5/2003** **Last Review Date: 11/2009, 6/2013, 6/2016,** **Last Revision date: 9/26/2025**

1.0 POLICY STATEMENT

1.1 Adult patients with decision-making capacity have the right to consent to their own medical care and treatment and to refuse such treatment as listed in Title 22, California Code of Regulations, Section 70707(b)(10). Patients (or their legal representatives) shall be given adequate information to make informed decisions prior to refusing medical care and treatment whenever possible, including the risk in leaving, benefits of further examination and or treatment, and any alternative.

1.2 The medical record will contain description of the exam, treatment, or both if applicable, that was refused if the patient left against medical advice (AMA). The department must take reasonable steps to secure the individual's written informed refusals.

2.0 PURPOSE

2.1 To provide guidance regarding appropriate steps to take when an individual seeking services in the Emergency Department (ED), Labor & Delivery (L&D) or other inpatient setting leaves or makes a demand to leave prior to the completion of treatment or against the advice of the treating physician.

3.0 SCOPE

3.1 The purpose of this policy is to delineate organizational procedures in response to patient's decision to refuse medical treatment and leave the hospital or Emergency Department against medical advice. Patients who leave against medical advice will be advised of their rights and receive adequate information to make an informed decision prior to refusing treatment.

3.2 This policy applies to all employees who are employed by AHS.

4.0 DEFINITION OF AGAINST MEDICAL ADVICE

4.1 An inpatient or outpatient who insists on leaving after a Physician determines the patient has a medical condition that requires stabilizing treatment. The details of the discussion with the individual, including the risks and benefits of treatment and leaving without receiving treatment should be documented in electronic medical records.

4.2 An individual who leaves the hospital after being triaged, but before receiving treatment. Any details about the reason the individual provided for leaving without being seen should be documented in the electronic medical record.

4.2 An individual for whom medical examination has been initiated or completed who then leaves the hospital without notifying anyone of the medical team. Details about what

screening and treatments of any kind up to the point of elopement should be documented in the electronic medical record.

5.0 RESPONSIBILITIES

5.1 The Chief Nursing Officer (CNO) has the authority, responsibility, and accountability for all non-MD clinical services within the hospital.

5.2 The Director of Nursing Practice (DONP) has the authority, responsibility, and accountability for all non-MD clinical services within Ambulatory Care.

6.0 POLICY TEXT

6.1 Patients who Elope, or Leave Against Medical Advice (AMA) – Inpatient, ED and L&D.

6.1.1 All reasonable efforts should be made to conduct a Mental Status Examination, potential consequences of action and risk involved in leaving and benefits of continued hospitalization before the individual leaves, with documentation of the discussions and efforts made to prevent the individual from leaving.

6.1.2 Department or unit staff will complete the AMA sections in clinical documentation system.

6.1.3 An individual for who leaves the hospital after being triaged but before receiving medical treatment should be noted in the electronic medical record.

6.1.4 An individual whose medical treatment has been initiated or completed who then leaves the hospital without notifying anyone should be noted in the clinical documentation system as having eloped. Details about what screening (and treatment, if any) had been completed up to the point of the elopement should be documented in the clinical documentation system under AMA and electronic medical record.

6.1.5 An individual who receives a medical examination but, then declines treatment and insists on leaving after Physician determines an medical condition requiring a stabilizing treatment should be documented as having left AMA and leaving without treatment, should be documented in electronic medical records.

6.1.6 In all cases, the form "Leaving Hospital Against Medical Advice," will offered to the patient or legal guardian for signature in the presence of at least one witness. The original is kept with the patient's records. If the individual refused to sign the form, a notation by the staff will be placed for example: "individual refused

to sign." The staff will document in the clinical documentation system under disposition that the patient leaves AMA.

6.2 If discharged medications are required, the provider will place an order to have the prescription filled. The patient, family or patient's representative may pick-up the medications at the pharmacy of choice.

6.2.1 Patient should be taken to the hospital discharge area via wheelchair.

6.2.2 Once the patient leaves the hospital AMA, they are considered discharged. If the patient returns to the hospital, they will need to go to the ED or be readmitted by a Physician.

REFERENCES

CALIFORNIA HOSPITAL ASSOCIATION APPENDIX 1-A PATIENT RIGHTS

RELATED POLICIES

MEDICAL INCAPACITY HOLD POLICY

	Policy	
	School of Nursing and Paraprofessional Affiliation Requirements	**Reference # tbd**
	Level X System ☐ Site	**Effective Date:** 10/2025 **Next Review Date:** 10/2028
	Document Owner: Director of Clinical Professional Practice	

POLICY STATEMENT

The purpose of this policy is to establish clear and consistent requirements for nursing students or paraprofessionals clinical placements ensuring a safe, structured, and supportive learning environment that promotes high-quality patient care while aligning with organizational standards. This policy specifies the requirements that nursing students, paraprofessionals, and clinical faculty must fulfill prior to participating in any clinical experiences, including cohorts or preceptorships, at any AHS facilities. It ensures the maintenance of patient care standards in all student learning situations and defines the responsibilities, accountability, and limitations associated with nursing student/paraprofessional assignments and the patient care they provide. By outlining these expectations, the policy supports compliance with regulatory requirements, fosters professional development, and safeguards the delivery of safe, high-quality care to all patients.

PURPOSE

AHS is committed to supporting the education and professional development of nursing students and paraprofessionals as part of our dedication to advancing the nursing profession and ensuring high-quality patient care.

To achieve this, the organization collaborates with academic institutions to provide nursing students/paraprofessionals with meaningful clinical education experiences. This partnership fosters the integration of theoretical knowledge with practical application in a supportive and structured.

SCOPE

This policy applies to all AHS employees, contractors and faculty. In addition to all nursing/paraprofessional students and faculty completing or facilitating a clinical or preceptorships at any AHS facility.

DEFINITIONS

1. Clinical Cohort – A group of students supervised by an educator identified by the academic institution as a clinical instructor.

2. Preceptorship – One student who is assigned to work directly with an RN/Paraprofessional preceptor for a specific length of time.

3. Paraprofessional - A person who is trained to assist a professional in their work but is not licensed to practice as a fully qualified professional. Paraprofessionals work under the supervision or guidance of a licensed professional and help carry out tasks that support the primary work of nursing or providing patient care.

RESPONSIBILITIES

All AHS staff from all campuses must comply with this policy. The Chief Clinical Officer serves as the executive responsible for the oversight of this policy. The Director of Clinical Nursing Practice collaborates with Nurse Leaders to review policy content and recommend revisions as needed to ensure alignment with clinical standards and regulatory requirements.

GUIDELINES

1. A current affiliation agreement must be in place prior to and maintained during student placement.

2. New affiliation agreements will be initiated by the Academic Clinical Liaison or System Director of Clinical Professional Practice within the Nursing Professional Development. An affiliation agreement request should be emailed to AHSClinicalPlacement@alamedahealthsystem.org

3. AHS facilities are responsible for the care provided to all patients. Therefore, the AHS Registered Nurse (RN)/Paraprofessional assigned to care for the patient is responsible for all the care delivered to their patients, even those assigned to students.

4. Clinical instructors and students are subject to AHS policies and procedures and must adhere to the same standards set for AHS employees regarding patient welfare and general hospital operations.

5. Academic clinical instructors are responsible for supervising students, including overseeing direct patient care provided by students and ensuring compliance with established policies and procedures.

6. During clinical rotations, the student practices under the supervision and direction of the faculty identified by the academic institution. When a student performs in a preceptorship, the student is functioning under the supervision of the RN/paraprofessional preceptor.

7. The school is responsible for ensuring the students are adequately prepared to perform assigned clinical duties in alignment with their course objectives and learning outcomes. Prior to engaging in clinical practice, students must demonstrate competence through formal evaluation in the classroom, college skills lab, or simulation center.

8. The AHS Registered Nurse/Paraprofessional responsible for the patient's care shall evaluate and validate all medical record entries made by students. The Registered Nurses'/Paraprofessionals' electronic signature confirms that all student entries in the medical record have been reviewed and approved.

9. Student are allowed to be on-site and involved in patient care activities under the following

conditions:

a. A current affiliation agreement is in place with the student's academic institution.
b. A clinical or preceptorship has been approved by the Academic Clinical Liaison or System Director of Clinical Professional Practice in the Nursing Professional Development.
c. All faculty and students must have been cleared of all onboarding requirement including all health and safety, drug test, criminal background check, American Heart Association (AHA) BLS only.
d. Students and faculty who are AHS employees, participating in an approved clinical or preceptorship, must be current with AHS annual health and safety requirements.

10. Prior to beginning clinical or a preceptorship, students and faculty must adhere with AHS requirement for onboarding and submitting all required documentation in the centralized clinical placement system according to the following:
    a. Confidentiality, HIPPA, Protected Health Information (PHI), Standard Universal Precautions, abuse reporting -child, dependent, elderly, annual compliance training, EPIC, and any additional modules required. Nursing students and faculty employed at AHS are not required to submit this information.
    b. All Onboarding requirements shall be verified for completion by the Academic Clinical Liaison, Systems Director of Clinical Professional Practice or designee.

11. Department orientation should be completed by the student and the faculty (unless they are existing AHS employees).

12. When on site, students and faculty must display school ID badge and AHS badge.

13. At the conclusion of clinical or preceptorship, the AHS badges should be returned to the badging office.

Policy Text

1. All requests must be submitted through my Clinical Exchange (myCE) or current centralized placement system for all clinical placements or preceptorships by the following:

Fall	*May 1*
Spring	*October 1*
Summer	*March 1*

2. The list of clinical coordinators is maintained in myCE or current centralized placement system and it

is the responsibility of the academic institution to update as needed.

3. If approved, the AHS Academic Clinical Liasion or designee will approve the request in my myCE or current centralized placement system A notification will be sent to input the students names and complete the Clinical Information Form to AHSClinicalPlacement@alamedahealthsystem.org within one week of approval.

4. All students and clinical instructor's health, safety, documents, and AHS Nursing Student orientation modules must be completed and approved at least 4 weeks before the clinical start date.

5. The students and clinical instructor must complete EPIC training prior to first day of clinical. The date will be coordinated by the Academic Clinical Liaison or designee.

6. Department orientation checklist should be completed an uploaded in myCE or current centralized placement system within the first week of clinical. The Clinical instructor is responsible to ensure this is completed and the Academic Clinical Liaison or designee will verify this is completed.

7. Student Assignments are completed by the Clinical Instructor the day before clinical and posted on the units. The students are allowed to prelab between 4:00 pm to 6:00 pm only making their presence known to the Assistant Nurse Manager or Charge Nurse. The student is expected to be dressed in business casual with a lab coat or clinical white top with School ID and AHS badge visible.

8. The Clinical Instructors is responsible to ensure the badges are returned to the badging office. If a students is functioning in a preceptorship, that student is responsible to return the badge to the badging office. Both the clinical instructor and the preceptee should send an email to AHSClinicalPlacement@alamedahealthsystem.org when returned.

9. The Academic Clinical Liaison or designee will verify with the badging office the return of the students and clinical faculty badges.

10. Nursing/Paraprofessional Students or Academic Faculty who have an injury and or exposure should do the following:

    a. Follow school's policy for non-emergency injury/exposure sustained by a student during a clinical rotation or preceptorship.
    b. Notify the instructor, AHS Management immediately after the incident. The instructor should notify the Academic Clinical Liaison or System Director of Clinical Professional Practice should be notified within 24 hours of incident.
    c. Clinical Faculty or Instructors may choose to seek medical attention from AHS as a patient or from their own personal physician.

d. Report exposures of communicable diseases to AHS Infection control and refrain from working

11. If a medical error occurs, the student or staff RN/Paraprofessional working with the student, notifies the instructor and nursing management within 1 hour of occurrence. The AHS RN/Paraprofessional assigned to the patient will follow the policy for medical error reporting and complete the necessary documentation. The instructor should notify the Academic Clinical Liaison or System Director of Clinical Professional Practice should be notified within 24 hours of incident via telephone and a follow-up email to AHSClinicalPlacement@alamedahealthsystem.org.

12. All nursing students or paraprofessionals planning to engage in an evidence-based project, quality improvement project (QI), performance improvement (PI) project must gain the approval from the Academic Clinical Liaison and the Systems Director of Clinical Professional Practice.

REFERENCES

TJC:

- LD.04.01.01
- HR.01.01.01
- HR.01.02.07
- HR.01.04.01

ATTACHMENTS

Appendix A Request for Affiliation Agreement
Appendix B Clinical Information Request Form (CIR)
Appendix C Student Practice Limitations
Appendix D AHS Clinical Placement FAQs

Appendix A
Request for Affiliation Agreement

Thank you for your interest in completing your clinical rotation or preceptorship at Alameda Health System (AHS). Please note the following requirements:

A current contract between your school and AHS must be in place before we can process your placement request. Please check with your school's clinical placement coordinator to verify if a contract exists. If no contract is in place, the process to establish one typically takes up to 60 days after your school submits the required information to AHS.

Important: We cannot proceed with your placement request until:

A. A fully executed contract is in place between your school and AHS
B. Your school has entered your request into myClinical Exchange (myCE)

Please see steps listed below:

1. Verify with your school current contract with AHS
2. Verify with your school if your request was placed in myCE
3. Verify your school has provided necessary documents to AHSClinicalPlacement@alamedahealthsystem.org (Clinical Information Form (CIR)
4. Once this is received, the onboarding process will begin and need to be completed in a timely manner. A delay in completion could result in you not being able to complete your clinical at AHS.

Onboarding process: Health and Safety requirements according to AHS requirements; Background Check according to AHS requirements; online modules; EPIC training (IT will email you the dates and times of this training).

5. After all the onboarding requirements have been completed, send an email to AHSClinicalPlacement@alamedahealthsystem.org for verification. If there is a discrepancy noted, you will be contacted
6. EPIC training will be scheduled, and an email notification will be sent indicating the date and time of class.
7. Before your first day on AHS campus, your badge will need to be picked up (clinical rotation-your instructor; preceptorship -by your). Badges should be picked up by the Clinical Instructor in the clinic tower in A2 on the second floor. To ensure someone is in the office and your badge is ready, call the badging office at 510-437-4441.
8. Badges should be returned to the badging office on the last day of your clinical rotation. An email should be sent to AHSClinicalPlacement@Alamedahealthsystem.org (cohort-instructor;preceptorship-student)

Appendix B

Clinical Information Request Form (CIR)

School Name:
Program:
Clinical Location:
Clinical Timeframe (begin and end): Day of Week Time

Please **type** in the information listed below and **highlight** any students or instructor who is a current/previous AHS employee or previous nursing student. There is a maximum of 8 students per instructor. This form should be emailed back within 72 hours of request or within 1 week of clinical cohort or preceptor acceptance. Failure to do so may result in delay in access to required onboarding documents and EPIC.

Classification	Last Name	First Name Mdl Intl	Date of Birth	Phone Number	Employee Email
Ex.Student or Instructor	*Donnavan*	*William L*	*01/01/2001*	*510-777-9311*	*willpower@gmail.com*

Appendix C
Nursing Student Practice Limitations

Students perform tasks under the supervision of School Clinical Instructors. Student nurses ***may not independently:***

1. Hang, administer, or verify blood or blood products without hospital personnel
2. Initiate, maintain, and/or monitor continuous IV titratable medications on IV pumps
3. Perform bedside point of care (POC) testing
4. Give IV push meds other than saline and heparin flush solutions
5. Program PCA pumps or change the syringe and/or tubing
6. Administer parenteral chemotherapy drugs: IM, SQ, IVPB, IV
7. Administer intermittent epidural analgesia
8. Initiate, maintain, and/or monitor continuous epidural analgesia
9. Administer intrapleural medications
10. Access subcutaneous ports: port-a-caths, infuse-a-ports
11. Administer medications via arterio-venous access devices: grafts, Permacaths
12. Manipulate or drain external ventricular devices
13. Take verbal or phone orders
14. Select isolation patients that require the use of N95 Mask
15. Initiate restraints
16. EPIC documentation must be co-signed

Appendix D

AHS Clinical Placement Frequently Asked Questions (FAQs)

1. Where do I inquire about a potential clinical/preceptorship or any clinical communication at AHS?

   Email AHSClinicalPlacement@alamedahealthsystem.org

   If you are a school, please indicate school name and nature of email in the subject line.

2. What should I do if I would like to complete my clinical/preceptorship at AHS?

   Verify with your school current contract with AHS
   Verify with your school if your request was placed in myCE
   Verify your school has provided necessary documents and requests to AHSClinicalPlacement@alamedahealthsystem.org (Clinical Information Form (CIR)

3. How do I initiate a contract?

   The school Point of Contact (POC) should submit an email to AHSClinicalPlacement@alamedahealthsystem.org indicating your interest (cohort, preceptorships), program type, potential start date, and any other relevant information. In this email, include an attachment of your school's W9. Once this is received, the contracts department from AHS will email the school's identified POC a template of AHS contract to review. Any issues with contract language will be communicated directly with the contract department and the school's POC until an agreement is reached. After which, the contract department will send a copy of the ratified contract to both the school and the Clinical Education department. The contract approval process could take up to 60 days.

4. How do I request clinical/preceptorships at AHS?

   The School's POC must enter the request on myCE to be considered. The timelines to be considered are as follows:

Fall	May 1
Spring	October 1
Summer	March 1

   Requests outside of these timeframes will not be considered.

5. Who do I contact initially if I (school POC) cannot enter clinical/preceptor request on myCE?

You should contact myCE via email: mCEsupport@healthstream.com Phone: 1-800521-0574 (Press 1, Press#, Press4) Hours of operation: 9am-6pm CST Mon-Fri. If it is not resolved at that level, please email AHSClinicalPlacement@alamedahealthsystem.org to assist.

6. Do the schools POC and Clinical Instructor need to provide the clinical objectives for the course when approved for clinical?

   Yes. The schools POC should provide it to AHSClinicalPlacement@alamedahealthsystem.org when names submitted after approval and provide to the Department Manager on the first day of clinical to be posted on the unit during your clinical days (see AHS Timeline for Clinical Placement).

7. Can the students begin clinical without all their Health and Safety requirements, Background Checks, and onboarding modules completed?

   No. All onboarding requirements and documents must be completed prior to beginning clinical.

8. Can the Clinical Instructor/Department Management change the assignment location of clinical placement?

   No. Assignments are given by the Hospital and cannot be changed without the approval of the Academic Clinical Liaison and or Director of Education. Any challenges with placement should be escalated to the Academic Clinical Liaison and emailed to AHSClinicalPlacement@alamedahealthsystem.org .

9. Is the Clinical Instructor expected to be accessible to students and staff at all times and provide a level of supervision appropriate to the students' proficiency in the nursing curriculum during clinical timeframes?

   Yes

10. Are the students in clinical cohorts required to prepare the night before their clinical assignment?

    Yes. The Clinical Instructor is required to make student assignments the evening before 4:00pm. The students should come to the units prelab their assigned the patient the next morning between 4:00pm to 6:00pm only. The student must check in with the Assistant Nurse Managers (ANM) and or Charge Nurses upon arrival to the unit. Must wear business casual attire with either a lab coat or clinical white top. School ID and AHS ID must be visible**. Students are expected to comply with HIPPA and Confidentiality according to AHS policies. Printing or taking pictures of the patient's chart is prohibited and will lead to immediate dismissal of the cohort/preceptorship.**

11. Does the assignment need to be posted on the unit and or given to the shift Assistant Nurse Manager?

Yes. It should be posted in the designated location provided by the unit and or provided to the shifts ANM or Charge Nurse before shift start.

12. How do I obtain my AHS badge for my clinical/preceptorship?

After the school POC received the notification, the badges are ready, the clinical instructor/preceptor should contact the badging office at 510-437-4771 to arrange a time to pick up the badges for their cohort/self if preceptee. The badging office is located at Highland 1411 E 31st in the old building A 1. Must have badges before the first day of clinical on the unit.

13. How does the Clinical Instructor/student access eLearning to complete their onboarding modules after they receive their learning IDs?

Go to: https://login.elsevierperformancemanager.com

Enter the Learning ID you received as your username. The default password is hello.
After which, click on the 2024 AHS Nursing Student Orientation to complete the module.

14. Who do I contact if I am having difficulty accessing eLearning?

Elsevier at 866-344-2088.

15. If the student or instructor cannot access EPIC during clinical, what should be the next steps?

Please initially contact IT at 510-437-4503 to resolve. If it still cannot be access, the clinical instructor should send an email to AHSClinicalPlacement@alamedahealthsystem.org. to resolve.

16. What are the in-person requirements for John George Psychiatric Hospital (JGPH)?

Because JGPH is a specialty area, there are additional in-person requirements for onboarding that are not negotiable. The students and instructor need to attend two additional 8-hour days of training (consecutive) prior to being able to be on the units. Flexibility is required as this is coordinated by the JGPH educator and team. The students will not be allowed to attend until this is completed.

17. If I am a continuing student or have previously completed clinical at an AHS facility and completed the required online Nursing Student Orientation module, do I need to complete it again?

Yes. The Nursing student orientation module must be completed by the faculty and staff annually (every Fall semester)

18. If I am an AHS employee, do I need to complete the Health, Safety, Background, and the online Student Orientation module requirements for onboarding?

No. As a current AHS employee, they are already compliant with the regulatory requirements for onboarding and annual requirements. They will only need to obtain the student sticker for the badge to identify them working in a student capacity during their clinical rotation or preceptorship. The student will receive a notification to pick up the sticker from the badging office when ready.

19. Are there Health, Safety, and Background check requirements that must be renewed in myCE.

Yes. Besides the required time specific health and safety requirement (i.e. influenza, tb, BLS/ACLS, respiratory fit test, annual physical and etc.-see myCE for full list), a Background check and drug test must be completed Annually (every August) according to AHS policy.

20. Are the students allowed to complete their clinical and preceptorships when the state regulatory agencies are on the premises.

No. The clinical instructor will be contacted when the clinical/preceptorship activities can resume.

ALAMEDA HEALTH SYSTEM

PCP ASSIGNMENT AND PANEL SIZE POLICY: PRIMARY CARE – ADULT MEDICINE, FAMILY MEDICINE, AND PEDIATRICS

Site	Alameda Health System (Wellness Centers)	***Previous Revision Dates***	02/2018, 2022, 01/11/2025
Effective Date	02/2018	***Date Revised***	10/2025
Document Owner	ACMO, Ambulatory Services	***Next Scheduled Review***	10/2028

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

Purpose

The purpose of this policy is to define and set guidelines for managing target panel size for primary care providers (PCP) in Adult Medicine, Family Medicine and Pediatric service areas.

Background

A fundamental building block to a high functioning primary care clinic is an established relationship between a patient and primary care provider (PCP). Empanelment, the deliberate process of assigning patients to a primary care provider, is fundamental to ensuring continuous, team-based healing relationships, enhanced access, population- based care, patient satisfaction, and coordinating care. The positive impacts of seeing the same provider on patient experience, clinical care, and outcomes have been unequivocally demonstrated by research and practice. Furthermore, panel size shall be established and maintained to ensure access goals are met.

Not all PCP clinical time is spent in traditional primary care sessions. For example, providers may have group medical visits, convenient care clinics, or other special clinic sessions. These "Targeted Need" clinics can add value to patient care by offering more primary care services while reducing provider burnout and increasing job satisfaction. Primary care panel sizes should be adjusted depending on type of clinical work

Definitions

1. Assigned Patient – a patient assigned to an AHS medical home from a third party (Alameda Alliance, HPAC or other contracting entity); the patient maybe not have been assigned to a primary care provider or have yet received care from his/her medical home

2. Active Patient - a patient with at least one E/M billing coded visit in adult medicine, family practice, or pediatrics clinic in last 12 months at one of the AHS's defined primary care clinics

3. Empanelment - the deliberate attempt to identify the group of patients for whom a medical provider or team is responsible.

4. Empaneled Patient – a patient with at least one E/M visit in last 36 months at one of the AHS's defined primary care clinics who has been assigned to an AHS Primary Care Provider (PCP)

5. Inactive, Empaneled Patient – patient who has been seen previously at an AHS medical home but has not had an E/M visit at an AHS medical home in the last 36 months

6. New Patient to AHS Primary Care System – patient who has never been seen at an AHS primary care clinic

7. New Patient to Provider – a patient not seen previously by a particular primary care provider, but may have been seen by another provider in primary care at AHS

8. Panel size – the number of unique active patients (one E/M visit in 12 months) under the care of a specific provider care team

9. Primary Care Provider (PCP) – a physician, nurse practitioner or physician assistant who assumes responsibility for the comprehensive primary care of a patient. This includes preventive care, chronic care, and coordinated care with hospitalizations, specialty care and ancillary support services. A PCP must work a minimum of 24 hours per week. Exceptions can be made with approval of the medical director or for teaching practices.

10. Provider – a physician, nurse practitioner or physician assistant who may or may not assume responsibility for the comprehensive primary care of a patient

11. Provider panel - the group of patients for whom a provider and his or her care team is responsible

12. Targeted Need Clinic – any clinical session in primary care that does not follow the standard scheduling template

Policy

All active and assigned patients will be assigned to a primary care provider according to the guidelines in the table, with the exception of Targeted Need Clinics which are defined below. A list of PCPs will be reviewed and updated if needed at least every six months. Panel sizes may be weighted best on national best practice and weighting formulas.

Adult Medicine/Family Medicine/Pediatrics
(excludes Adult Immunology Clinic)

Type of Provider	Target Number of Active Patients Assigned (for Full Time Equivalent)*
Physician	1250 active patients or 2000 active + inactive patients .
Nurse Practitioner/Physician Assistant	1000
Resident □□PGY1 □□PGY2 □□PGY3	70

*Panel size is adjusted based on FTE

1. Targeted Need clinics can take a variety of forms including group medical visits, convenient care (same day/walk-in) clinics, or other special clinic sessions such as Women's health, addiction medicine, or joint injection clinics.

2. The availability and design of Targeted Need clinics should reflect existing or anticipated patient need. The creation of a Targeted Need clinic requires approval from the clinic medical director.

3. Targeted Need clinics must be open to and potentially benefit all patients of the department, regardless of what their PCP assignment is.

4. Only empaneled primary care providers are eligible to have a Targeted Need clinic. Special circumstances outside of this require the approval of the clinic medical director and the ACMO.

5. The maximum amount of FTE allowed for Targeted Need clinic time is 0.1 FTE per provider. Special circumstances outside of this require the approval of the clinic medical director and the ACMO.

6. If a provider works 0.1 FTE in a Targeted Need clinic, then the provider's primary care panel size is adjusted proportionally based on FTE spent on traditional primary care, and thus is reduced by Targeted Need clinical time. If a provider works less than 0.1 FTE in a Targeted Need clinic, then the primary care panel size is not adjusted.

7. Clinic medical directors and practice managers are responsible for measuring the usefulness and productivity of Targeted Need clinics. If these clinics do not consistently match the productivity of primary care sessions, then the existence of the clinic should be re-evaluated.

Procedure

New Providers

New providers will be expected to be at full target panel size within one year of hire.

Opening and Closing Panel

Provider panels will be closed to new patients once they are at 110% of capacity. Panels will be reopened when panel has reached 90% capacity.

Reporting

Panel size will be reported on the Ambulatory Dashboard at both the clinic and provider level. Elements include:

1. Provider name
2. Provider FTE
3. Provider status: active, inactive (on leave for more than 30 days)
4. Provider target panel size
5. # active patients assigned
6. # inactive assigned patients assigned
7. Total panel size (active + inactive, assigned)
8. Status of template - open/close

Procedure for PCP Assignment

The following protocol, which is based on visit history, shall be used when panels require scrubbing:

1. Patients who have seen only one PCP for all visits are assigned to that PCP.
2. Patients who have seen more than one provider are assigned to the PCP they have seen most often.
3. Patients who have seen multiple providers the same number of times are assigned to the PCP who performed their most recent physical or health check.
4. Patients who have seen a provider but not a PCP will be assigned to a PCP with an open panel.

The standard work established for primary care shall be followed to facilitate accurate PCP assignment

Changing Medical Home and/or PCP Assignment

Any request to change medical home or primary care provider (from patient or provider) shall follow the Medical Home/PCP Change Request standard work.

Approvals

Ambulatory Operations Council	**Date: January 2022**

Clinical Practice Council	**Date: July 2025**
Medical Executive Committee	**Date: October 2025**
Board of Trustees	**Date: November 2025**

	Policy	
	Title: Responsible Use of AI	**Reference # tbd**
	Level ☐ X System ☐ Site	**Effective Date: 7/2025** **Next Review Date: 7/2028**
	Document Owner: E'Jaaz Ali	

POLICY STATEMENT

It is the policy of Alameda Health System to ensure the responsible development, deployment, and legally compliant use of Artificial Intelligence technology ("AI") across the system.

PURPOSE

Responsible AI use includes respecting individual employees' and patients' privacy rights; promoting transparency and fairness; minimizing bias; ensuring accountability; and utilizing AI in a safe and secure manner that strives to protect individuals from physical, emotional, environmental, and/or digital harm.

SCOPE

This policy applies to all employees, contractors, and third-party vendors who have access to AHS systems, networks, and data. This policy applies to all AI systems, tools, and application implemented or utilized within the health system for clinical care, research, administration, and other operational purposes.

DEFINITIONS

Artificial Intelligence (AI): The use of algorithms and computational models to simulate human intelligence in performing tasks such as decision-making, pattern recognition, and prediction.

Bias: Systematic error in AI implementations that can lead to unfair or inaccurate outcomes for specific groups of patients.

Clinical Use: The use of AI in a clinical setting or for patient treatment/patient care purposes.
Company Data: Data created, maintained, or used with AHS applications and resources

Data Privacy: The protection of patient and operational data from unauthorized access, use, or disclosure.

Generative AI: artificial intelligence that responds to a user's prompt or request with generated original content, such as audio, images, software code, text or video.

Machine Learning (ML): A subset of AI where systems learn and improve from data without explicit programming for every task.

Malicious Software: any software designed to harm or exploit computers, devices, network, or data, including ransomware.

Non-Clinical Use: The use of AI in any setting that is not a Clinical Use.

Output: Any information or effect a program produces

Predictive AI: statistical analysis with machine learning algorithms to find data patterns and forecast future outcomes. It extracts insights from historical data to make accurate predictions about the most likely upcoming event, result or trend.

Public AI: Any artificial intelligence application or algorithm that is available through the internet

Transparency: Ensuring AI operations and decision-making processes are interpretable and understandable.

POLICY TEXT

A. Governance and Oversight

1. The Data Governance Committee will oversee the acquisition, implementation, and evaluation of all AI technologies.
2. Those who seek use of AI Solutions must submit their request to the Data Governance Committee.
3. The committee must include diverse representation from clinical, technical, legal, operational, and ethical expertise.
4. All AI systems must undergo formal review and approval by the Data Governance Committee (DGC) before being reviewed by the Information Security Office prior to implementation of the AI Solution. Both DGC and ISO approval are required before implementation of any AI Solution.
5. The Data Governance Committee shall evaluate each proposed AI Solution based on an individualized assessment of the product and its intended uses at AHS. The Committee may, at its discretion, apply different standards for AI Solutions with an intended Clinical Use and those with an intended Non-Clinical Use.

B. Permitted Use Cases and Necessary Validation

1. AI tools may only be used for purposes consistent with Alameda Health System's mission, or used to improve/enhance one of the following: patient care, safety, security, operational efficiency, and research.
2. To support health equity and mitigate bias AI systems should promote diversified data, diversified representation, transparency and routine monitoring for bias risk.
3. Before adoption for a Clinical Use, each AI application must undergo rigorous testing and validation to demonstrate clinical effectiveness, safety, and reliability.

4. As part of the Security Risk Assessment for AI Solutions with an intended Clinical Use, external AI vendors must provide validation studies and ensure tools comply with applicable regulations, such as HIPAA, state and federal laws, and FDA approvals for medical devices.
5. Potential errors in Outputs may occur for a variety of reasons. All Outputs must be verified by reasonable means as identified in the applicable training, documentation, or guidelines for the AI Solution, or, in the absence of identified reasonable means, users must seek guidance and assistance from the DGC.
6. Approved users of AI must ensure AI is used to enhance—not replace—human decision-making. Users of AI are responsible for decisions made and actions taken based on AI Outputs and must exercise care and caution when relying on AI, particularly in the context of Clinical Use. Users of AI are also responsible for ensuring the accuracy and appropriateness of any written work product they create with the assistance of an AI Solution.
7. Before relying on Outputs, Users must engage in an independent review by taking the following into account:
    a. Proofreading: Carefully proofread the Output for grammar, spelling, and punctuation errors.
    b. Edit as Needed: If necessary, make edits to improve clarity, coherence, and overall quality of the Output.
    c. Exercise Human Oversight: Human oversight is a critical part of the final review process. Human oversight of AI Solutions and Outputs serves to identify solution-specific and Output dependent nuances, vulnerabilities, potential shortcomings, and opportunities for continued improvement.

C. Patient Privacy and Data Security

1. AI tools must comply with HIPAA and other relevant federal/state privacy/security laws to protect patient data.
2. Employ secure methods for data collection, storage, and processing, including encryption and access controls.
3. Protected Health Information (PHI) can only be shared with AHS approved AI tools/vendors where a Business Associate Agreement is in place and cannot be shared, inputted, or otherwise disclosed with any other AI tools.
4. Do not include any patient data for training AI models, unless a Business Associate Agreement is in place with the AI implementation vendor.
5. All AI solutions must be vetted and approved by the Information Security Office. The Office will conduct a Security Risk Assessment on the solution and its components.

6. Information or materials subject to California Evidence Code Section 1157 and/or the attorney-client or attorney work product privileges may not be input into any AI Solution.

D. Cybersecurity and Malicious Use

1. The use and development of AI Solutions can pose cybersecurity risks to AHS's systems, devices and infrastructure. To protect Company resources and data and the privacy of other Users, Workforce Members, and/or individuals when using or developing AI Solutions, Users must not:
    a. Develop or deploy Malicious Software.
    b. Create, distribute, or support creation or distribution of offensive, discriminatory, or illegal content.
    c. Manipulate or deceive others.
    d. Violate, infringe, or attempt to violate or infringe the legal and civil rights and liberties of others.
    e. Infringe, or attempt to infringe, on the intellectual property rights of the Company or others.
    f. Engage in activity that may violate others' privacy.
    g. Use or attempt to use the AI Solution to circumvent or attempt to circumvent Company policies or procedures, including but not limited to, Information Security Policies and Information Security Standards.
    h. Tamper with Outputs or related processes in AI Solution development or deployment.
    i. Maliciously prompt or alter the AI Solution, including through prompt injection, prompt obstruction, data dumping, or otherwise engage in any unauthorized modifications that could compromise the integrity of the AI Solution or Outputs.
    j. Upload to, or use, any Company Data with an unauthorized public AI Solution.
        - Workforce members who want to use public generic AI must only use Public Available Information in conjunction with the AI tool
        - Public Available Information is information that is not otherwise protected by law and has been made available for public distribution or is a matter of public record.
    k. Use unauthorized public AI Solutions to generate, revise, or manipulate Outputs for any Company purposes (e.g., software development, communications, decision-making, etc.).
    l. Use or further disseminate for use, any raw Output that has not undergone thorough testing, including but not limited to common security standards,

such as, but not limited to vulnerability scanning through enterprise scanning tools, static code analysis, and addressing security issues.

E. Transparency and Explainability

1. In order to be approved for use in clinical settings or with patient data, AI systems must be interpretable and provide clear explanations for their recommendations or outputs.
2. Patients and staff must be informed when AI is used in care delivery or decision-making processes when required by Federal and/or State Law.

F. Continuous Monitoring and Improvement

1. The Data Governance Committee shall establish mechanisms for ongoing performance monitoring of AI tools, including audits and post-implementation evaluations.
2. AI systems must have protocols for error reporting and correction.
3. Sunset or update outdated AI systems to ensure they remain aligned with best practices and current data.

RESPONSIBILITIES:

A. **Compliance:**

1. Compliance with this policy is mandatory for all personnel and entities associated with Alameda Health System.
2. Regular training and awareness programs shall be conducted to ensure all users understand their responsibilities regarding the use of AI.
3. Compliance with AI and data policies shall be included as part of the regular internal and external audits.

B. **Violations:**

1. Violations of this policy may result in disciplinary action, including termination of employment, legal sanctions, and other consequences as deemed appropriate.
2. Repeated violations shall be addressed through additional training or other corrective measures.
3. Significant violations must be reported to senior management and may be escalated to regulatory authorities if necessary.
4. Violations by Business Associates and vendors may result in termination of their agreement, denial of access to the AHS network, and liability for any damage to property and equipment.

	Policy	
	Title: Responsible Use of AI	**Reference # tbd**
	Level ☐ X System ☐ Site	**Effective Date: 7/2025** **Next Review Date: 7/2028**
	Document Owner: E'Jaaz Ali	

ALAMEDA HEALTH SYSTEM	Patient Non-Discrimination to Access Health Care Services	Reference # Version
	LEVEL X☐ System ☐ Site	EFFECTIVE DATE: 7/1/2025 NEXT REVIEW DATE: **7/2028**

PURPOSE

To comply with the Federal non-discrimination regulation of the Affordable Care Act (ACA), section 1557 that prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs or activities.

SCOPE

As a covered entity, we must provide a notice of non-discrimination to participants, beneficiaries, enrollees, and applicants of our health programs and activities, and members of the public. This policy supports the federal and state regulations on non-discrimination of patient's access to health care services at AHS.

DEFINITIONS

"Discrimination or to discriminate" shall mean to treat someone differently or less favorably based on one or more of the following protected classifications: race, color, religion, sex (including pregnancy and sexual harassment), sexual orientation, gender identity, genetic information, national origin, age, disability, marital status, familial status or other protected classification.

"Disability" shall mean a physical or mental impairment that substantially limits one or more of the major life activities of an individual. Included in the definition are individuals who have a record of such an impairment, or are regarded as having such an impairment.

"Harassment" shall mean unwelcomed conduct (whether verbal or physical) that is based on race, color, religion, sex (including pregnancy and sexual harassment), sexual orientation, gender identity, genetic information, national origin, age, disability, marital status, familial status or other protected classification and creates an environment that would be intimidating, hostile or offensive to a reasonable person. Such harassing behavior may include, but is not limited to, offensive jokes, slurs, epithets or name calling, physical assaults or threats, intimidation, ridicule or mockery, insults, offensive objects or pictures, and any other conduct or behavior that interferes with services provided in the health care environment.

"Retaliation" shall mean any adverse action taken against an individual for making a good faith complaint of employment discrimination or participating in any investigation or proceeding concerning a complaint of employment discrimination. Retaliation includes threatening, intimidating, harassing or any other conduct that would discourage a reasonable person from engaging in activity protected under this policy.

RESPONSIBILITIES

This policy applies to all classifications of faculty, staff, student workers, and other paid or non-paid classifications of workers that perform work for AHS and interact with patients.

POLICY

Alameda Health System is committed to ensuring that all its facilities, programs and activities are accessible to all individuals, including individuals with disabilities. In turn, AHS provides this policy to foster a health care environment that is free from unlawful harassment and discrimination in accordance with federal, state and local law and one where patients are treated with equality, in a welcoming and respectful manner.

AHS will provide equal access to health care services to all patients. As a recipient of federal financial assistance, AHS prohibits discrimination against its patients on the basis of race, color, religion, sex (including pregnancy), sexual orientation, gender identity, genetic information, national origin, age, disability, marital status, familial status or other protected classification. AHS also prohibits retaliation against any individual who files a complaint, or participates in the investigation of a complaint, filed under one or more of the aforementioned prohibitions.

COMMUNICATION AND TRAINING

1. **Training:** Individuals who perform work for AHS and who interact with patients shall be provided training regarding the Patient Non-Discrimination to Access Health Care Services policy during new worker orientation and through annual competency training thereafter.
2. **Communication to Patients:** The policy shall be made available on AHS website to all patients and information about the policy posted in all prominent physical locations, such as patient care areas, waiting areas, and entrances where health care services are provided.
3. **Communication Considerations:** AHS provides effective alternate means of communicating patient rights and responsibilities to patients/guardians/families in a manner appropriate to their age, understanding, ability, and language preference, having rights/responsibilities read to them, or provided through a language or American Sign Language interpreter service at no cost to the patient. Additional auxiliary aids for the hearing impaired (i.e., Text Telephone ("TTY")/Telecommunication Device for the Hearing Impaired ("TDD"), written materials, telephone handset amplifiers, assistive listening devices, television closed captioning, and writing tablets, are also made available.
4. **Making Facilities and Programs Accessible for Persons with Disabilities**: AHS shall inform patients of the availability of, and make reasonable accommodations for patients in accordance with, federal, state and local laws.

VIOLATIONS

Individuals with AHS who are determined to have violated this policy shall be subject to disciplinary action up to and including separation from AHS. Violations include, but are not limited to: engaging in discriminatory or retaliatory conduct towards any individual covered under this policy; intentionally engaging in factual misrepresentations during the pendency of an investigation; failing to cooperate in an investigate when called as a witness or respondent; promoting or enabling discriminatory or retaliatory conduct by others towards a patient or other individual covered under this policy.

REFERENCES

Age Discrimination Act of 1975 ("Age Act")
Americans with Disabilities Act of 1990, as amended ("ADA")
Section 504 of the Rehabilitation Act of 1973
Section 1557 of the Affordable Care Act (ACA)
Title VI of the Civil Rights Act of 1964

ALAMEDA HEALTH SYSTEM

October 22, 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: October 22, 2025

Item Description: Medical Staff Policies and Procedures

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

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

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

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

Board Action Requested: Approval

AHS & AH Medical Staff:

- Standardized Procedures for Advanced Practice Providers in The Department of Orthopaedic Surgery

Alameda Health System

STANDARDIZED PROCEDURES FOR ADVANCED PRACTICE PROVIDERS IN THE DEPARTMENT OF ORTHOPAEDIC SURGERY

Department	Orthopaedic Surgery Department	***Effective Date***	10/28/25
Campus	All	***Date Revised***	
Unit	Inpatient/Outpatient	***Next Scheduled Review***	10/2028
Manual	Interdisciplinary Practice	***Author***	Department Chair, Orthopaedic Surgery
Replaces the following Policies:		***Responsible Person***	Chief of Staff

Procedure Statement

This standardized procedure fulfills Alameda Health System requirements and expectations for defining the scope of practice for Advanced Practice Providers. Standardized procedures are developed collaboratively by nursing, medicine, and administration to comply with the California Business and Profession Code, Nursing Practice Act (NPA) Section 2725 and further clarified in California Code of Regulation (CCR 1480).

Purpose

It is the intent of this document to authorize the Advanced Practice Providers (APP) within the Department of Orthopaedic Surgery 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 Orthopaedic Surgery.

Application

In addition to general requirements set forth in this policy, APPs must demonstrate evidence of current licensure, relevant training and/or experience, professional competence, and continuously meet the qualifications, standards, and requirements specific to APPs, and for Medical staff members to the extent they may logically apply to APPs, as set forth in Medical Staff Bylaws, the Rules, privilege forms and policies.

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 Orthopaedic Surgery.
   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 receives any notification or investigation of his/her 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 Orthopaedic Surgeon 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 entering the hospital as trauma activations
d. Patients seen as consultations to the trauma/surgery service
e. Traumatic conditions, for example:
    i. Neck trauma
    ii. Extremity trauma
    iii. Blunt trauma
    iv. Penetrating trauma

2. **Authorized Duties and Practice**

The APP is authorized to do the following patient-related activities within the scope of practice defined by Title 16:

a. Take the patient's medical history and perform a physical examination for any presenting problem;
b. Order specific laboratory studies and x-rays, and other studies as appropriate for that patient;
c. Collect specimens as indicated for additional tests;
d. Perform pertinent laboratory tests;
e. Perform any other procedure for which they have been granted privileges;
f. Counsel patients and their families on health promotion, diagnosis and management options;
g. Diagnose and treat conditions listed above;
h. Complete medical records for every patient encounter in the department of Orthopaedic Surgery computer based format followed by all providers in the Department of Orthopaedic Surgery.

3. **Procedures and Minor Surgeries**

a. APP at time of hire will need to demonstrate competency in each of the basic orthopedic surgery skills. The APP will follow existing orthopedic surgery department protocols for each procedure done in the orthopedic patient, including sterile procedure, sedation, observation and confirmatory testing.
b. For procedures that require consent, the APP will be responsible for obtaining informed consent from the patient
c. At the completion of the procedure the APP will write a procedure note that includes any complications and the name of the attending Orthopaedic Surgeon.
d. The following list of procedures APP can do for orthopedic patients once granted privileges and demonstrated competency by direct observation or documented prior work experience.
    i. Orthopedic procedures:
        - First Assist (RNFA certificate required for NPs)
        - Wound closure with sutures and/or staples
        - Wound care
        - Pressure sore/burn care
        - Insert IV lines

- Insert Foley catheters; irrigate if indicated
- Joint, tendon sheath, and bursa injection
- Soft tissue injection
- Application of splints and casts
- Closed reduction of simple fractures
- Application and adjustment of orthopedic traction
- Aspiration of abscesses, cysts, and seromas
- Removal of superficial foreign bodies
- Removal of percutaneous hardware
- Staple/suture removal

ii. Anesthesia
- Digital block
- Local anesthesia administration

iii. Medical/Surgical
- Arterial puncture
- Biopsy – skin
- Biopsy – muscle
- Excision of skin and subcutaneous lesions
- Incision and drainage of skin infections/subcutaneous lesions

4. **Protocols**
   a. The nurse practitioner/physician assistant has been granted privileges within the Alameda Health System to perform the requested procedures.
   b. The nurse practitioner/physician assistant has been trained to perform the procedure(s), has been observed satisfactorily performing the procedure(s) by another provider competent in that skill, and continued competency is assessed per AHS policy.
   c. The nurse practitioner/physician assistant is following standard medical technique for the procedures as described in the Resources listed in this document.
   d. Appropriate patient consent is obtained, if necessary, before the procedure.
   e. All biopsied tissue is sent for a pathology report.
   f. All other applicable Standardized Procedures in this document are followed during health care management.
   g. All General Policies regarding Review, Approval, Setting, Education, Evaluation, Patient Records, Supervision and Consultation in these Standardized Procedures are in force.

Drug Orders and Furnishing

POLICY
The advanced practice provider is authorized to furnish or order drugs and devices under the following protocols:

PROTOCOLS
1. The nurse practitioner/physician assistant 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 done through protocol registration in a United States Institutional Review Board or Expanded Access authorized clinical trial.
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 nurse practitioners/physician assistants 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 nurse practitioner/physician assistant 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 nurse practitioner/physician assistant 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 advance practice provider 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.

5. **Standard of Care**

Standards for adequacy of diagnosis, management and treatment shall be in accordance with hospital Policy and Procedure, clinic protocols, current community standards of care, Orthopaedic Surgery Department protocols or current texts/articles on Orthopaedic Care found in the Department of Orthopaedic Surgery.

6. **Consultation and Referral**

The APP will be providing health care as outlined in this document. In general, communication with a physician who is a current member in good standing of the Medical Staff, and who holds privileges in the Department of Orthopaedic Surgery 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:

a. Open fracture
b. Swelling concerning for compartment syndrome
c. Rapid neurologic decline
d. Infection involving joint or tendon sheath
e. Postoperative wound issue
f. Necrotizing infection
g. Unexplained abnormal lab test
h. Acute change in mental status/behavior
i. Probable or proven malignancy

7. **Other duties**

The patient must be informed that the provider is an APP and be given the opportunity to request care by a physician should the patient desire it.

8. **APP - Nursing Staff Relationship**

The APP is authorized to give nursing personnel orders for all laboratory and x-ray studies, treatment and medication for those patients for whom the APP is providing medical care. Orders given by the APP are orders generated in agreement with the Consulting Physician. Any questions regarding these orders that are not satisfactorily resolved through discussion with the APP should be brought to the Consulting Physician before being carried out.

9. **Agreement Review**

The signature on the Attestation by the APP acknowledges agreement to practice within the limits of the foregoing standardized procedures/practice guidelines. Upon its review, if changes are made, new signatures will be necessary.

10. **References/Resources**

- AHS/AH Medical Staff Bylaws
- Medical Staff Advanced Practice Provider policy and procedure manual

- Medical Staff Privilege forms
- Nurse Practice Act in the California Business and Professions Code
- Physician Assistant Practice Act
- References that define Standard of care for Orthopaedic Surgery 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	9/23/25
Credentials Committee	10/9/25
CPC	
Medical Executive Committee	
QPSC/Board of Trustees	

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: _____

Contract Approvals - November 2025

Contract Approvals
November 2025

1. Renewal agreement with Symplr Care Management LLC for provision of patient safety and quality reporting software applications. The term of this agreement is effective January 1, 2026 through December 31, 2028. The estimated impact of this agreement is $1,112,847.
Christine Yang, Chief Information Officer

2. New agreement with LAZ Parking California, LLC for provision of parking services. The term of this agreement is effective January 1, 2026 through December 31, 2028. The estimated impact of this agreement is $6,937,194.
Mark Fratzke, Chief Operating Officer

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

Board Summary - Symplr - Revised v2

Contractor/Vendor Name:	Symplr Care Management LLC ("Symplr")
Description:	Alameda Health System (AHS) is seeking Board approval to enter into a 3-year agreement with Symplr Care Management LLC, a subsidiary of Symplr, a leading U.S. healthcare operations software company headquartered in Houston, Texas. Established in 2006, Symplr provides a suite of enterprise healthcare software solutions used by more than 9,000 healthcare organizations nationwide, including the majority of U.S. hospitals. Its products support compliance, credentialing, workforce management, contract management, quality improvement, and care management operations. AHS' Quality & Patient Safety team currently relies on Symplr's Midas suite of tools to track, review, and improve patient care across the system. Since 2013, AHS has maintained an agreement ("Agreement") with Symplr for two modules—Midas Care Management and Midas DataVision—which have been critical for managing patient safety events, monitoring utilization, aggregating data for quality reporting, and ensuring compliance with state and federal requirements. In 2022, AHS added a third module, Midas Statit, which enhances AHS's capabilities in automating provider peer review and performance monitoring, analytics, and quality benchmarking. Together, these three tools provide an integrated approach to improving patient outcomes, supporting regulatory reporting, and advancing the organization's continuous improvement efforts. The Agreement includes hosting, system maintenance, software updates, and technical support for all three modules. Per terms of the proposed 3-year renewal agreement ("Renewal"), AHS has negotiated lower annual rate increases than in the current Agreement. Renewal rate increases will be limited to 3% annually compared to the 6% or higher annual rate increases under the current Agreement. This represents a meaningful reduction from historical escalation rates, helping AHS stabilize software costs while expanding system functionality. Approval of this Renewal ensures AHS's continued access to essential software that underpins its quality and patient safety programs, enhances analytic capacity through the addition of the Statit module, and provides long-term cost control. The proposed Renewal value is $1,112,847 over the 3-year term. AHS recommends Board approval of the Symplr agreement to maintain and strengthen these critical tools that support regulatory compliance, data-driven quality improvement, and the delivery of safe, high-quality patient care throughout the AHS system.
Contract Type and Term:	Renewal January 1, 2026 through December 31, 2028
Termination Clause:	In the event of a party's breach of any material term of this agreement or any respective attachment, the non-breaching party has the right to terminate, by providing 30 days' written notice, the respective Attachment and the license granted thereunder.

<table>
<tr><td>Total Spend with Vendor:</td><td>
<table>
<tr><th>Description</th><th>Board Approval</th><th>Total</th></tr>
<tr><td>3-Year Renewal Agreement (Midas Care Management, Midas Statit, and Midas DataVision Services)</td><td></td><td>$1,112,847</td></tr>
<tr><td>Total Requested Amount:</td><td>Approval Requested</td><td>$1,112,847</td></tr>
</table>
</td></tr>
<tr><td>Cost Savings</td><td>This new 3-year agreement locks in all 3 Symplr modules – Care Management, DataVision, and Statis—at a 3% annual increase from 2026 through 2028, helping control rising software costs while ensuring continued access to essential quality and compliance tools. AHS staff negotiated improved terms after Symplr's initial proposal of a 3-year, 5% annual increase with auto-renewal, and a subsequent 5-year, 2% offer that still included auto-renewal. The final agreement—3 years at 3% with no auto-renewal—meets AHS's financial and operational goals and is significantly better than prior increases of 6–12% for the Care Management and DataVision modules of the Symplr platform in 2023–2024.</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 staff recommends approval of this agreement because it secures ongoing access to essential software that supports AHS's quality, safety, and regulatory compliance functions while adding enhanced performance analytics. The new agreement also provides cost savings by replacing a high-escalation evergreen contract with a fixed-term arrangement that limits annual increases to 3 percent.</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>Vice President Applications</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>

BOT Summary - LAZ Parking Contract - 2025 - Revised (Clean)

Contractor/Vendor Name:	LAZ Parking California, LLC ("LAZ Parking" or "LAZ")
Description:	In recognition of Alameda Health System's ("AHS") continued efforts to maintain high quality services while minimizing fiscal impact, AHS partnered with Vizient, our Group Purchasing Organization ("GPO") to solicit quotes for the existing parking, shuttle and valet services offered at Highland, San Leandro and Alameda Hospitals ("HGH", "SLH" and "AH", respectively, "Hospitals", collectively). Quotes were obtained from 3 vendors: Douglas Parking, Metropolis California, LLC ("Incumbent"), and LAZ Parking California, LLC. Upon careful review, AHS leadership determined that LAZ Parking was best positioned to meet our parking services needs going forward. LAZ Parking has 43 years of experience in the industry and an extensive healthcare portfolio under which LAZ manages the parking needs for over 180 Healthcare systems, which is part of their 5,300 site portfolio. In addition to providing valet parking services at Hospitals, LAZ Parking will provide kiosk parking management, HGH shuttle services to/from local BART stations, and employee parking permit management services (collectively, "Parking Services"). Under the new Agreement, LAZ will manage 1,114 parking spaces and provide valet services for approximately 800 cars per month at the Hospitals. Parking staff providing services at AHS facilities will be represented by Teamsters Local 853 with 90% living in Alameda County. LAZ has stated that they have a strong relationship with the Teamsters, as they collaborate at another healthcare parking location in Oakland. Total costs are partially offset by annual parking revenue in the amount of ~ $1.5M. As a member of the Vizient Group Purchasing Organization ("GPO"), AHS receives discounts on goods and services purchased from vendors who are also members of the GPO. LAZ Parking is a GPO vendor, which results in additional savings in the form of a small share-back rebate to AHS amounting to approximately $135K annually. AHS leadership remains firmly committed to delivering high-quality service to both patients and staff. Following a thorough assessment of parking and shuttle service needs at AHS facilities, AHS leadership evaluated the feasibility of managing these services internally through AHS operations. This assessment included hiring AHS staff and bringing the service fully in-house. The analysis concluded that internal operation would result in an estimated $1.5 million increase in annual expenditures compared to the cost of contracting. Based on the above, AHS leadership recommends entering into a parking services agreement with LAZ Parking. Board approval is respectfully requested to proceed with this agreement, which includes the scope of services outlined below. • HGH ○ Parking and valet service at Koret Building Garage and Upper Vallecito Lot

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<tr><td></td><td>

Parking and valet service at Highland Care Pavilion (“HCP”) garage and the offsite lot
Shuttle service including stops at Lake Merritt Bart station, the offsite lot, and HGH campus
Parking permit management services
Transportation Assistance for patients by Golf Cart

AH

Parking and valet services
Shuttle services for Seismic Project

SLH

Services as-needed

</td></tr>
<tr><td>Contract Type and Term:</td><td>Services Agreement
January 1, 2026 – December 31, 2028</td></tr>
<tr><td>Termination Clause:</td><td>Without Cause Termination: AHS may terminate without cause upon 30 days’ notice. Vendor may terminate without cause upon 60 days’ notice.</td></tr>
<tr><td>Total Spend with Vendor:</td><td>
<table>
<tr><th>Description</th><th>Board Approval</th><th>Total</th></tr>
<tr><td>Parking Services Agreement (1/1/26 – 12/31/28)</td><td>Approval Requested</td><td>$6,606,851</td></tr>
<tr><td>5% Contingency</td><td>Approval Requested</td><td>$330,343</td></tr>
<tr><td>Total Estimated Spend:</td><td>Approval Requested</td><td>$6,937,194</td></tr>
</table>
</td></tr>
<tr><td>Estimated Cost Savings:</td><td>AHS leadership negotiated $146,000 in savings through negotiated reductions in vendor rates. AHS will also realize ~ $135,000 annually in additional savings from Vizient rebates.</td></tr>
<tr><td>Fiscal Implications:</td><td>The proposed agreement will be accounted for in future budget requests.

While this agreement is included in the budget, these services generate revenue in the amount of ~ $1.5M annually from the collection of garage parking fees and staff parking-permit fees, the value of which is remitted to AHS. As a result, this agreement is partially self-funding resulting in a total net cost over the 3-year term of $2,437,194.</td></tr>
<tr><td>Reasons for Recommendation:</td><td>LAZ Parking has proven itself to be a high-performing service provider in the Bay Area for multiple Healthcare systems. Through the assessment process, LAZ has demonstrated the ability to quickly and reliably adjust service delivery to support our changing needs.</td></tr>
<tr><td>Impacted Facilities:</td><td>
<table>
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<tr><td></td><td>x</td><td></td><td>x</td><td>x</td><td></td></tr>
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</td></tr>
<tr><td>Coordination with Medical Staff:</td><td>N/A</td></tr>
</table>

Administrative Review:	VP of Support Services
Prior BOT Review/Action:	N/A
Executive Sponsor	Chief Operating Officer

2025-11-05 - FIN D98 - Lifetime Spend REPORT

MONTHLY REPORT
LIFETIME VENDOR SPEND - NOVEMBER 2025

Vendor Name	Revised Contract Term	Proposed Contract Spend	Total Lifetime Vendor Spend (including proposed contract)	Proposed Contract Description	Status
Anderson Flooring	9/25/2025 – 12/01/2025	$205,895.00	$3,516,220.00	Common Areas/Hallways. Remove and dispose of existing carpet tile and rubber base. Furnish and install Bentley Ground Rules 20mil LVT color Wait Your Turn. Furnish and install 4" rubber cove base. Furnish and install rubber transitions as needed. Work to be done on regular night time shift hours Monday-Friday. ADD ALT to moisture	Executed
26CAP002 Lescure Company	10/10/2025 -5/01/2026	$445,400.00	$4,549,206.00	This proposal is for the Alameda Hospital Medical Vacuum System Replacement.	Executed
Health Advocate LLC	5/1/2018 – 10/31/2026	$ -	$2,948,091.27	The vendor has 73 accounts remaining, in various stages of completion. We want to extend this contract to cover their access to patient account information and payment of any contingency fees related to these remaining accounts. The current agreement expires 6/30/2025 and we'll need this amendment to have no specific end date, but to end upon the completion of the all 73 accounts.	Executed
Symplr Care Management LLC	10/1/2025 - 9/30/2026	$ -	$1,885,182.32	This contract provides AHS with a Gold support package at no cost, which includes dedicated vendor project management and system engineering support for the upcoming Midas Care Management platform upgrade. The package is being provided at $0 cost as a goodwill offering to address past quality issues, and will ensure AHS's Midas platform is properly upgraded and	Executed

2025-11-05 FIN - D99 - Contract Cumulative Spend to date Report

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
13	Nelson T. Lewis Construction Co., Inc.	$3,197,080	10/15/2025	6/15/2026	FC - 10-1-25 BOT Approved 10-8-25	St. Rose Hospital cath lab upgrade.		St. Rose Chief Administrative Officer

14	ePlus Technology, Inc.	$1,800,000	11/1/2025	10/31/2028	FC - 10-1-25 BOT Approved 10-8-25	Data loss protection services.		Chief Information Officer
15	Switch, Ltd.	$1,509,294	2/16/2026	2/15/1931	FC - 10-1-25 BOT Approved 10-8-25	Data center services.		Chief Information Officer
16	Lescure Company, Inc.	$1,668,200	11/1/2025	3/31/2027	FC - 10-1-25 BOT Approved 10-8-25	Architectural and structural work for Alameda Hospital HVAC replacement project.		Chief Operating Officer
17	Matrix HG, Inc.	$1,214,436	11/1/2025	10/31/2026	FC - 10-1-25 BOT Approved 10-8-25	Installation of COVID prevention HVAC upgrades at JGPH.		Chief Operating Officer
	Total Amount for FY 25 year to date	$513,053,420						

St. Rose Hospital
An ALAMEDA HEALTH SYSTEM Affiliate

Fiscal Year 2026 Budget

Board of Directors

Fiscal Year 2026 Budget – Key Assumptions

- **Revenue**
  - Overall increase in charge master at 4.54% starting 10/1/2025.
    - ED increase - 6%
    - All other services – 4%

- **Volume**
  - Retain GI cases (100) and Neuro cases (35) transferred last year.
  - Sub Acute license expected around second quarter; ramp up starts January, 2026.
  - All other volumes consistent with FY2025.

- **Supplemental Funding**
  - SCA provided assumptions
    - QAF – Phase IX (Jan25-Dec25) CMS approval is expected by end of 2025 or 1st quarter of 2026.
    - QAF – Phase X (Jan26-Dec26) DHCS started pulling relevant data and HCAI started preparing a model.
    - DSH – 55.31% expected reductions beginning SFY 2026-2027

- **Labor Expenses**
  - Salaries and wages are projected to increase by an average of 4.5% in upcoming year due primarily to union contracts that include negotiated wage adjustments.
  - In addition, a modest salary adjustments for non-represented are also planned to address/prevent pay disparities as a result of the negotiated union increases.
  - Estimated total amount of increases - $2.0M

Fiscal Year 2026 Budget – Key Assumptions

- **Labor Expenses (continuation)**
  - Budgeted FTEs based on current staffing
    - Registry – adjusted for hired management positions: HR, Surgery, Radiology, ER/ICU
  - Benefits based on Alliant's estimates - $1.3M
  - Overtime was budgeted for a 50% reduction with total elimination in non-patient facing departments. This adjustment reflects the organization's continuous efforts to improve operational efficiency and align expenditures with current financial realities.

- **Supplies and Purchased Services**
  - CPI assumed to be 3%
    - Subacute increased based on volume

- **Professional Fees/Contracted Physicians**
  - AHS management fee calculated based on existing agreement and estimated collections ($2.9M).
  - Physician contracts based on contracts in place, with rate adjustments including the following proposed additions/changes: ($942K)
    - **Associate CMO**, Effective 1/1/2026, offset by cancellation of current medical directorship contract (supporting Case Management/UM), (.5 FTE/20hrs week) ending December 2025.
    - **GI**, Effective 1/1/2026, currently no coverage. This is for 24/7/365 call coverage. Since January 2025, over 100 GI patients were transferred to outside facilities.

Fiscal Year 2026 Budget – Key Assumptions

- **Professional Fees/Contracted Physicians (continuation)**
  - **Neurology**, Effective 1/1/2026, this is for 24/7/365 call coverage. Since January 2025, over 35 neuro patients were transferred to outside facilities
  - **Orthopedics**, Effective 11/1/2025, anticipated increase.
  - **Nephrology**, Effective 11/1/2025, this is for 24/7/365 call coverage. Existing group, West Coast Kidney Institute has existing coverage at Alameda and San Leandro hospitals. Existing dialysis director agreement will be eliminated, partly offsetting the cost.
  - **Morrison Healthcare**, Café management, started July 15, 2025 ($74K)

- **Depreciation**
  - Budgeted at 6% ($250K) increase, due to capitalization of Sub Acute project.

- **General Administrative**
  - Budgeted at 5% increase, due to increasing insurance premiums and taxes.

Fiscal Year 2026 Budget – Key Assumptions (MOB & Foundation)

- **Medical Office Building, Inc. (MOB)**
  - Rental revenue is the only source of cash flow for MOB, projected at $1.7M, derived directly from signed lease agreements. Annual rent escalations of 3% are applied as outlined in the agreements. Assuming expiring tenant contract will be renewed or will move to month-to-month agreement.
  - The assumptions of 3% increase in operating expenses will clearly be covered by the projected rent revenue.

- **St. Rose Hospital Foundation (SRF)**
  - Contribution reflects a decrease in projected donation. Last year's one-time donations of $350K are not budgeted.
  - Projected to incur losses of $895K due to a $1.0M donation to St. Rose, similar to what occurred in FY2025.

Consolidated Financial Statement
Fiscal Year 2026 Proposed Budget (In Thousands)

	Projected 2025*	Proposed BUDGET 2026	Var ($)	Var (%)
Total Net Patient Service Revenue	$100,944	$104,044	$3,100	3.1%
Total Other Revenue	$40,956	$39,095	($1,861)	-4.5%
TOTAL OPERATING REVENUE	**$141,900**	**$143,139**	**$1,239**	**0.9%**
Less: Operating Expenses	$130,390	$138,719	$8,330	6.4%
EBITDA	**$11,510**	**$4,420**	**($7,091)**	**-61.6%**
Total Non-Operating Exp/(Income)	$5,070	$5,393	$323	6.4%
Non-Recurring Items	($4,728)	$0	$4,728	-100.0%
NET INCOME/(LOSS)	**$1,713**	**($973)**	**($2,686)**	**-156.8%**

**Projected 2025 excludes:*

- *Closed departments: Labor & Delivery and Nursery*
- *Severance pay paid to Alecto and Director of Nursing , $3.2M*
- *Sub Acute: Projected to improve Census, up to maximum of 15 patients*
- *Other Operating Revenue: Includes IGT/Measure A; MOB Rent Revenue & SRF Donations*

Fiscal Year 2026 Proposed Budget – Patient Services Revenue (In Thousands)

	Projected 2025	Proposed BUDGET 2026	Var ($)	Var (%)
Gross Patient Revenue				
Inpatient	$287,507	$299,484	$11,977	4%
Outpatient	$149,878	$157,526	$7,648	5%
Sub Acute**	2,424	11,352	$8,928	368%
Gross Patient Service Revenue	**$439,809**	**$468,361**	**$28,552**	**6%**
Less: Total Deductions	362,334	388,683	26,348	7%
Net Patient Service Revenue	**$77,475**	**$79,679**	**$2,204**	**3%**
Collection Ratio	**17.6%**	**17.0%**		

- Gross Revenues increase overall 7%
  - CDM increase by 4.54% starting 10/1/2025
  - Sub Acute charges were developed using a staggered census model. Patient volumes are expected to increase throughout the year.

Fiscal Year 2026 Proposed Budget – Supplemental Funding & Other Revenue (In Thousands)

	Projected 2025*	Proposed BUDGET 2026	Var ($)	Var (%)
HQAF Provider Fee	$19,239	$20,640	$1,401	7.3%
SB DSH	$4,230	$3,725	($505)	-11.9%
Supplemental Patient Revenue	**$23,469**	**$24,365**	**$896**	**3.8%**
Other Operating Revenue	$40,956	$39,095	($1,861)	-4.5%
Total Operating Revenue	**$141,900**	**$143,139**	**$1,239**	**0.9%**

- The Big Bill (HR1) has changed the applicable standards under which CMS is reviewing the CY2025 HQAF program, but the precise impact is highly uncertain. Currently, the amount will stay equivalent to most recent CY2025 estimate by SCA and not to increase for FY2026 budget year.
- SCA provided $0.5M estimated reduction due to Medicaid DSH cut effective October 1, 2025.
- Alameda County Measure A funding consistent with prior year
  - IGT maximum funding available - $36.984M
  - Other revenue: Cafeteria, OP Pharmacy, Opioid-related grant program revenue, etc. - $412K

- MOB rent revenue - $1.7M
- Foundation donation - $1.0M

Fiscal Year 2026 Proposed Budget – Operating Expenses (Excluding Labor) (In Thousands)

	Projected 2025*	Proposed BUDGET 2026	Var ($)	Var (%)
Operating Expenses				
Labor	83,693	88,840	$5,147	6%
Professional Fees****	11,731	14,064	2,333	20%
Purchased Services	6,473	6,644	171	2%
Materials and supplies	10,837	11,264	427	4%
Facilities	4,438	4,514	75	2%
HQAF Provider Fee	10,370	10,440	70	1%
General Administritive	2,847	2,954	106	4%
Total Operating Expenses	**$130,390**	**138,719**	**$8,330**	**6%**

- **Professional Fees**
  - Associate CMO (offset) – effective January 2026
  - GI (new) - effective January 2026
  - Neurology (new) - effective January 2026
  - Ortho (increased rate) - effective November 2025
  - Severance pay paid to Alecto and Director of Nursing , $3.2M
  - Morrison Healthcare, Cafeteria management
- **Purchased Services** – 3% increase ($171K), accounted for rising contractual rates, inflationary cost pressures and continuation of essential service agreements necessary to support daily operation.
- **Materials and Supplies** – 3% increase ($337K), reflected the impact of inflation and vendor price increases
- **Facilities** – 3% increase ($75K), accounted for higher costs associated with building maintenance, utilities and other facility-related services to sustain efficient and safe operation.
- **General Administrative** – 5% increase ($106K), accounted for inflationary adjustments and growth in costs necessary to support core administrative functions.

Fiscal Year 2026 Proposed Budget – Labor Expenses (In Thousands)

	Projected 2025	Proposed BUDGET 2026	Var ($)	Var (%)
Salaries & Wages	$63,641	68,162	$4,522	7.1%
Benefits	$17,321	$18,648	$1,326	7.7%
Registry & Contract Labor	$2,730	$2,030	($701)	-25.7%
Total Labor Costs	**$83,693**	**$88,840**	**$5,147**	**6.2%**
FTE's	**542.2**	**550.5**		

- **Salaries and Wages – average rate increase 4.5%**
  - Non-Union - effective 10/1/2025, excluding recently hired management positions (in market)
  - Teamsters – effective 10/1/2025
  - Stationary Engineers Local 39 - effective 1/1/2026
  - ESC Local 20 - effective 2/1/2026
  - CNA - effective 6/1/2026

- **Benefits** – 7.7% increase, projected increases in health claims, retirement plan contributions and other employee-related benefit costs.
- **Registry and contract labor** – 25.7% decrease ($701K). The significant reduction is primarily attributed to the successful recruitment and onboarding of key management positions that were previously filled through temporary or contract arrangement – HR, Surgery, Radiology, ER and ICU.

Fiscal Year 2026 Proposed Budget – Non-Operating Expenses/(Income) (In Thousands)

	Projected 2025	Proposed BUDGET 2026	Var ($)	Var (%)
Depreciation Expense	$4,079	4,327	$248	6.1%
Interest Expense	$1,366	$1,436	$69	5.1%
Donation Expense	$1,000	$1,006	$6	0.6%
Non Operating Cost/(Income)	($1,376)	($1,376)	($0)	0.0%
Total Non-Operating Exp/(Income)	**$5,070**	**$5,393**	**$323**	**6.4%**

- Depreciation to increase due to capitalized projects
- Interest expense expected to increase due to growing unpaid AHS management fee
- Donation expense by Foundation; non-operating income for the Hospital - $1.0M
- Investment income is expected to remain consistent with prior year.

Fiscal Year 2026 Proposed Budget - Volume

	Actual 2023	Actual 2024	Actual 2025	Proposed BUDGET 2026	Variance	Var (%)
PATIENT DAYS						
Acute	14,392	12,834	11,316	11,386	70	1%
Sub Acute	0	0	1,112	1,112	0	0%
Total	**14,392**	**12,834**	**12,428**	**12,498**	**70**	**1%**
AVERAGE DAILY CENSUS						
Acute	39.4	35.1	31.0	31.0	0.0	0%
Sub Acute*	0.0	0.0	5.2	5.2	0.0	0%
Total	**39.4**	**35.1**	**36.2**	**36.2**	**0.0**	**0%**
DISCHARGES						
Acute	3,484	3,335	3,206	3,241	35	1%
Sub Acute	0	0	30	30	0	0%
Total	**3,484**	**3,335**	**3,236**	**3,271**	**35**	**1%**
Average Length of Stay (ALOS)	4.3	4.0	3.6	3.6	0.0	0%
Geometric Mean Length of Stay (GMLOS)	3.7	3.9	3.9	3.9	0.0	0%
Case Mix Index (CMI)	1.5518	1.4960	1.5430	1.5430	0.0000	0%
OUTPATIENT SERVICES						
Emergency Visits	25,771	26,421	26,216	26,251	35	0.1%
Surgeries	1,126	1,055	975	975	0	0%
Inpatient	694	592	558	558	0	0%
Outpatient	432	463	417	417	0	0%
GI Lab Procedures	290	126	0	65	65	100%
Cath Lab Procedures	568	532	573	573	0	0%

**Sub Acute Budgeted Census:*

- *1st Quarter – 7 patients*
- *2nd Quarter – 9 patients*
- *3rd Quarter – 11 patients*
- *4th Quarter – 15 patients*

Fiscal Year 2026 Proposed Budget – Capital Expenditures

- **Capital Freeze**
  - Limit to maintenance capital for the first three years
  - Capital expenditure not budgeted; release capital as growth targets achieved
- **Cath Lab**
  - Approved Cath Lab project ($5.2M), anticipated to begin in November, no other capital expenditures are in process
- **BCHIP funding approved - $62.4M**
  - Building a 20-bed inpatient medical psychiatry unit
  - Building a 20-bed geriatric psychiatry unit

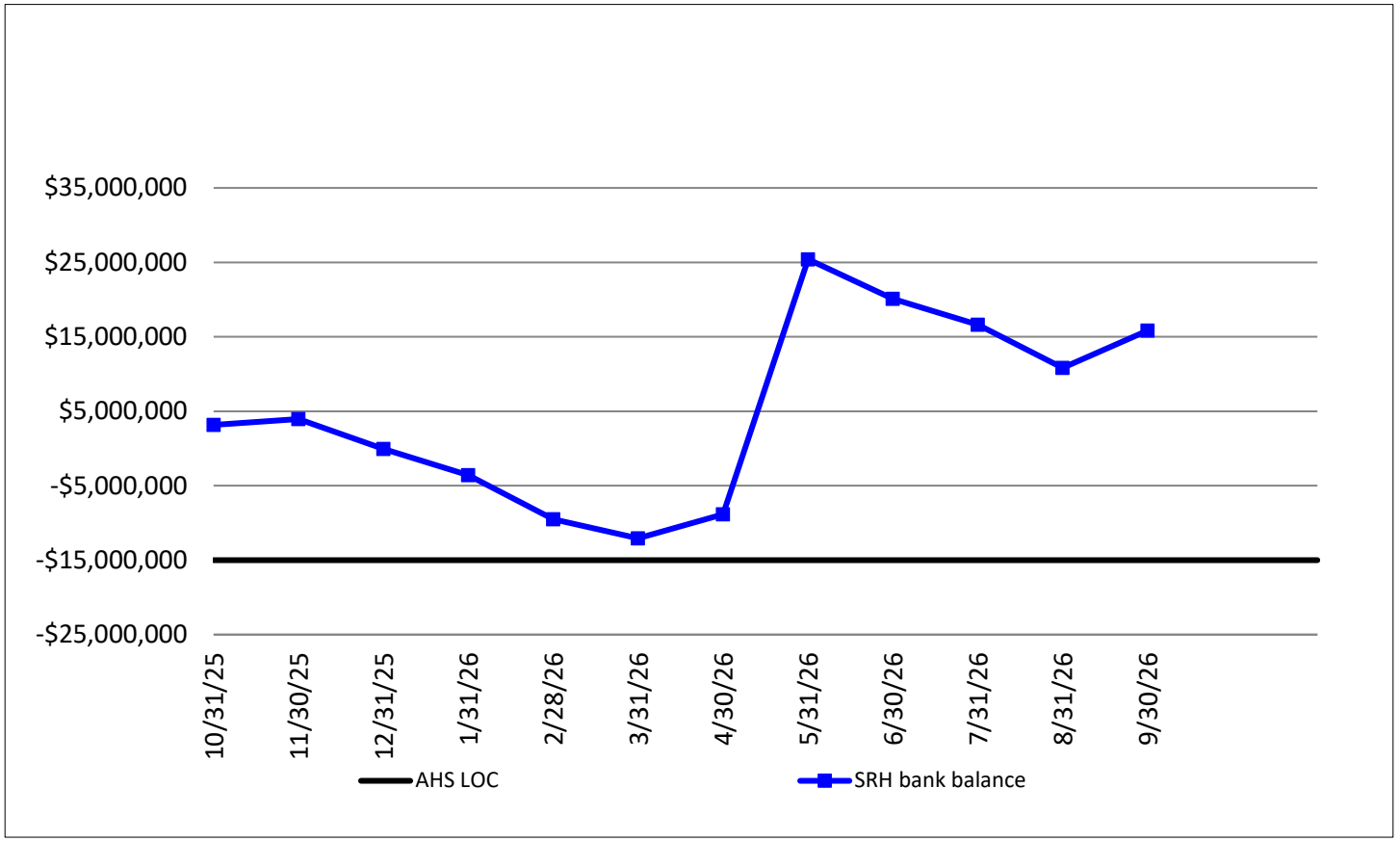
	FY2022	FY2023	FY2024	FY2025
Land Improvements	9,169	80,790	-	-
Building & Building Improvements*	3,563,372	2,080,715	159,528	5,473,357
Capital Leases	182,909	-	718,673	-
Automobiles	33,834	-	-	-
Furniture	-	19,183	-	-
Equipment	625,132	1,218,833	612,100	61,712
Computer Hardware	7,974	98,299	123,946	15,391
Computer Software	51,218	313,869	42,800	61,632
Work-in-Progress	794,571	794,571	307,998	193,936
	5,268,179	**4,606,260**	**1,965,044**	**5,806,028**

**FY2022 - Includes Donation of Radiation Oncology Building to SRH (based on VMG appraisal) - $3.1M*

**FY2023 - Includes Donation of Bay Valley Building to SRH (based on appraised value) - $1.8M*

**FY2025 - Includes capitalized Sub Acute project - $5.4M*

Fiscal Year 2026 Proposed Budget – Projected Cash Flow



- St. Rose has $15.0M line of credit with AHS and is projecting to draw funds starting January 2026.
- St. Rose is expected to pay off the balance with the IGT funding which is expected to be received in May 2026, same timing as last year.

Fiscal Year 2026 Proposed Budget – Community Contribution

- **Planning for St. Rose**

Projected IGT Funding - SFY 2026-2027 (In Thousands)	
Maximum amount for St. Rose Hospital	**36,984,000**
Contribution from County through Measure A	7,000,000
Contribution from _____	-
Contribution from _____	-
Contribution from _____	-
Source TBD	11,492,000
Non Feredal financial participation	**18,492,000**
Federal Financial participation - 50%	18,492,000
	36,984,000

Department of Internal Medicine BOT Annual Report

NOVEMBER 12, 2025

Outline

Department of Medicine Scope

Advocacy, Community & Connection

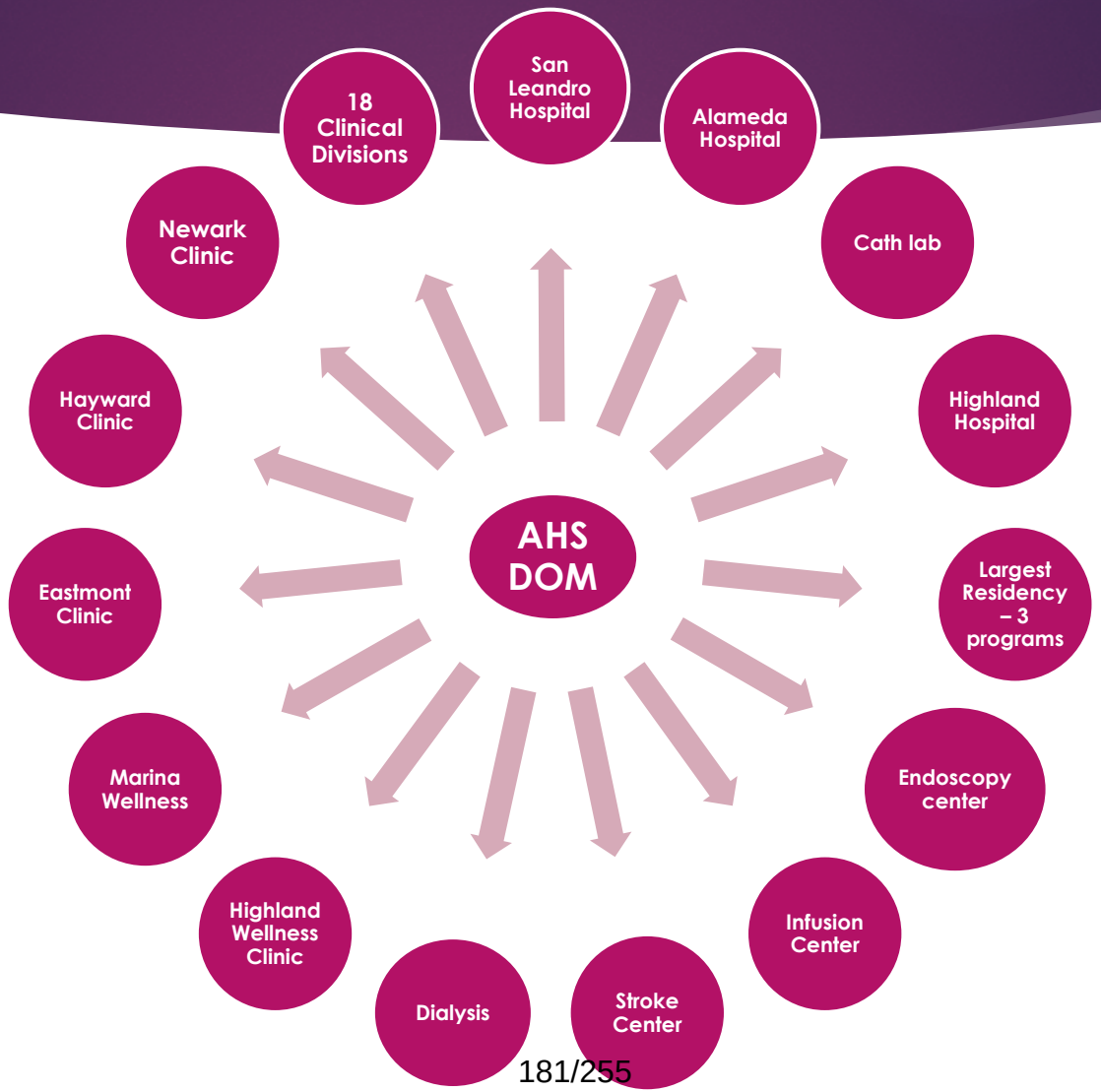
Growth & Access

Quality Metrics

Looking Ahead

DOM SWOT

Who we are…our scope



Who we are…our numbers

- **AHS Department Medicine:**
  - **32% of all AHS physicians (300/936 total)**

- **AHS Resident numbers:**
  - **56% of all residents at AHS (74/132 total)**

Who we are…Vision, Mission & Values

- **Vision – who we want to be**

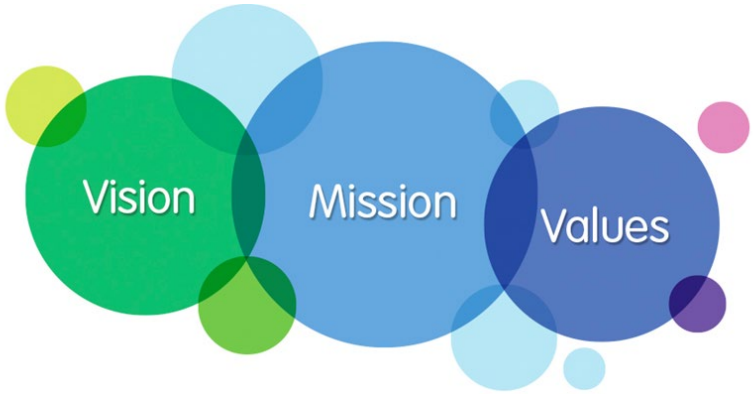
  Leading with Excellence for Patients, Equity, Safety, and Education

- **Mission – who we are**

  We strive to provide high quality, reliable, and compassionate care every day for every patient and to train future doctors to do the same.

- **Core Values – the rules we play by**

  BETTER
  - **B**uild & Improve
  - **E**xcellence
  - **T**eaching
  - **T**rust & Teams
  - **E**quity
  - **R**espect



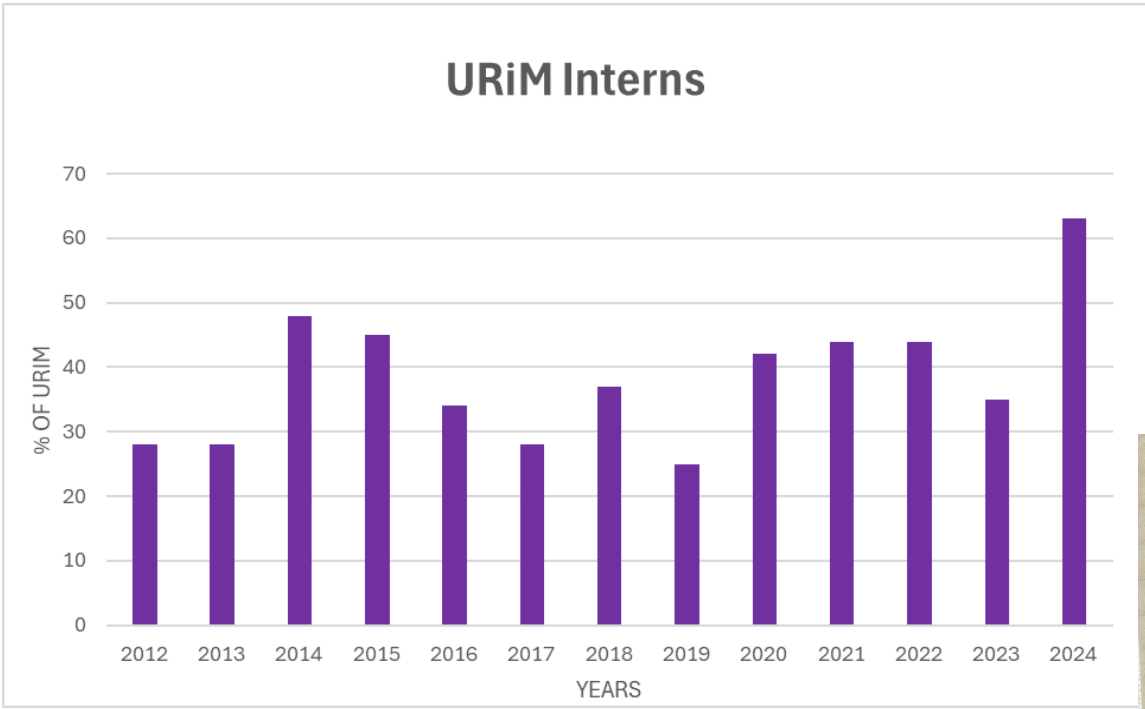
"Thank you for calling me. How can I help?"

Advocacy, Community & Equity

- IM ACE Committee
- URiM Med Student Scholarship
- Community advocacy
- Celebration of cultures
- Holistic review for recruitment

Advocacy & Community

Community Representation



UCSF URM includes African American/Black, Filipino, Hmong or Vietnamese, Hispanic/Latinx, Native American/Alaskan Native, Native Hawaiian/Other Pacific Islander

Workforce sustainability…investing in our future

- Middle school to faculty
  - HealthPath
  - Health Justice Interns
  - Health Coaches
  - Medical Students
  - Residents
  - Fellowships
  - Faculty Development
  - Training APPs

Undergraduate Medical Education

- 175+ medical students trained in the last year
- New Department of Internal Medicine Undergraduate Education Committee

St. George's University
Grenada, West Indies

TOURO COLLEGE
OF OSTEOPATHIC MEDICINE
Where Knowledge and Values Meet

CALIFORNIA NORTHSTATE UNIVERSITY
COLLEGE of MEDICINE

Berkeley UCSF
Joint Medical Program

UCSF
University of California
San Francisco

CHSU
CALIFORNIA
HEALTH SCIENCES
UNIVERSITY

IM Residency

Mission: To graduate physician leaders who will provide high-quality, bio psychosocially oriented, culturally relevant care to vulnerable populations

We Train & Match Fellows!

- Pulmonary and Critical Care – HGH/CPMC, UCSF
- Gastroenterology – HGH/CPMC
- Addiction Medicine Fellowship - HGH

2024-2025 Fellowship Matches

Dr. Elias Ghafoor
Georgetown University
Nephrology

Dr. Connie Ha
Stanford University
Palliative Care

Dr. Harpreet Kaur
UC Davis
Nephrology

Dr. Sumire Noguchi
UC Davis
Endocrinology

Dr. Tochi Nwaneri Nwosu
UC Davis
Palliative Care

Dr. Swecha Potharaj
University of Colorado
Endocrinology

Dr. Omair Syed
University of Indiana
Hematology/Oncology &
Palliative Care Combined

We recruit our own!

New DOM Faculty Members!

35% Highland Trained

Neurocrit Care (2025) 43:671–681
https://doi.org/10.1007/s12028-025-02252-x

NEUROCRITICAL CARE SOCIETY

RESEARCH ARTICLE

Prognostic Language in Critical Neurologic Illness

A Multicenter Mixed-Methods Study

Adeline Goss, MD, Connie Ge, MD, Sybil Crawford, PhD, Kelsey Goostrey, MPH, Praewpannanrai Buddadhumaruk, MS, RN, Catherine L. Hough, MD, MSc, Bernard Lo, MD, Shannon Carson, MD, Jay Steingrub, MD, Douglas B. White, MD, MAS, and Susanne Muehlschlegel, MD, MPH

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Neurology® 2023;101:e558-e569. doi:10.1212/WNL.0000000000207462

Abstract

Background and Objectives

There are no evidence-based guidelines for discussing prognosis in critical neurologic illness, but in general, experts recommend that clinicians communicate prognosis using estimates, such as numerical or qualitative expressions of risk. Little is known about how real-world clinicians communicate prognosis in critical neurologic illness. Our primary objective was to characterize prognostic language clinicians used in critical neurologic illness. We additionally explored whether prognostic language differed between prognostic domains (e.g., survival, cognition).

MORE ONLINE

CME Course
NPub.org/cmelist

Keywords: Palliative care, Prognosis, Uncertainty, Stroke, Decision-making (shared)

PubMed Disc

An illustration of an Alzheimer's-affected brain depicts abnormal levels of proteins (brown and blue) that form plaques that collect between neurons, disrupting cell function. NATIONAL INSTITUTE ON AGING/NATIONAL INSTITUTES OF HEALTH/AP

Contemporary Clinical Trials
Volume 158, November 2025, 108101

Implementation strategies for self-measured blood pressure monitoring in racially and ethnically diverse populations (InSPIRED): A study protocol

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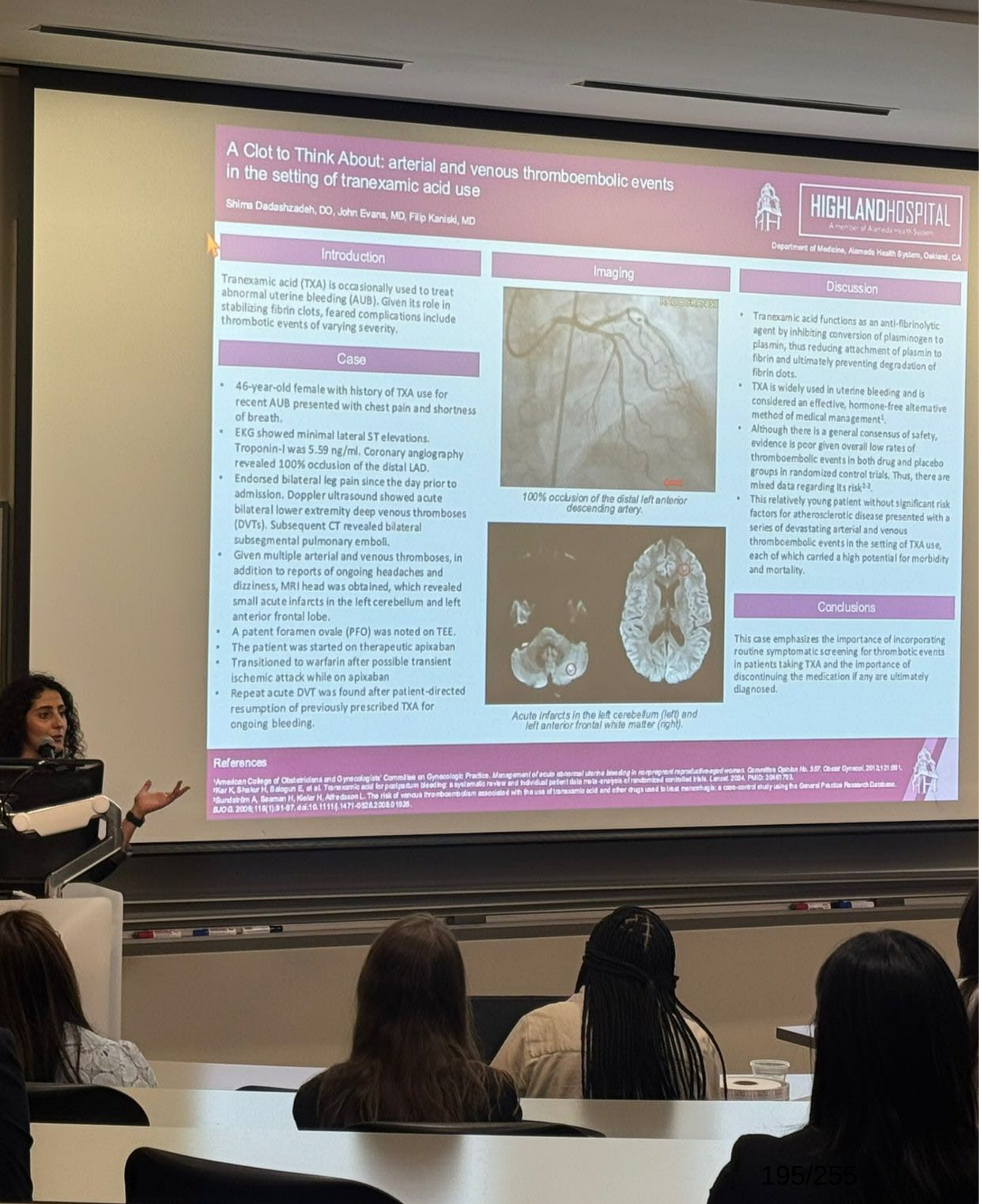
Abstract

Introduction

Self-measured blood pressure (SMBP) monitoring with clinical support is an evidence-based practice to improve hypertension control. However, it can be challenging to implement in safety-net systems that disproportionately serve low-income and/or racial/ethnic minority populations at risk of worse hypertension outcomes. We therefore



A Clot to Think About: arterial and venous thromboembolic events in the setting of tranexamic acid use
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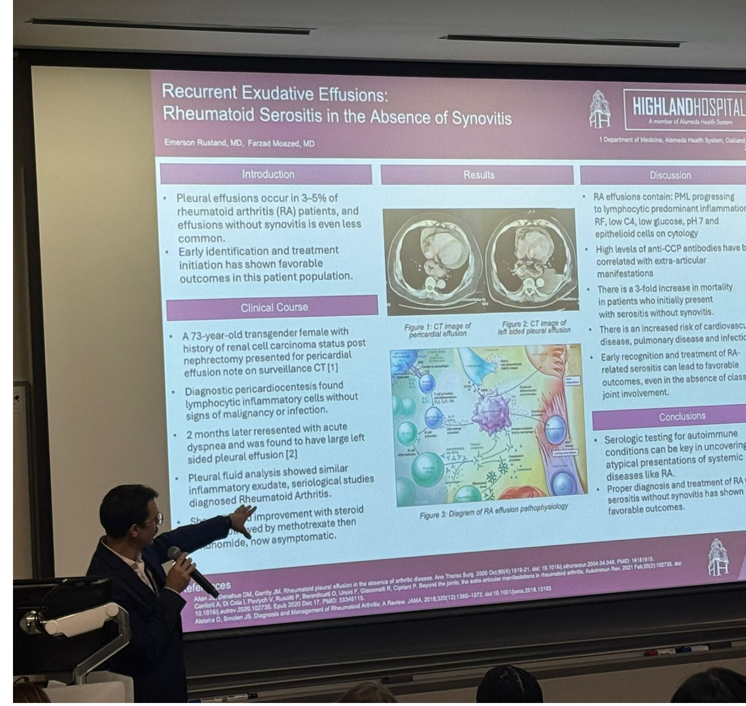
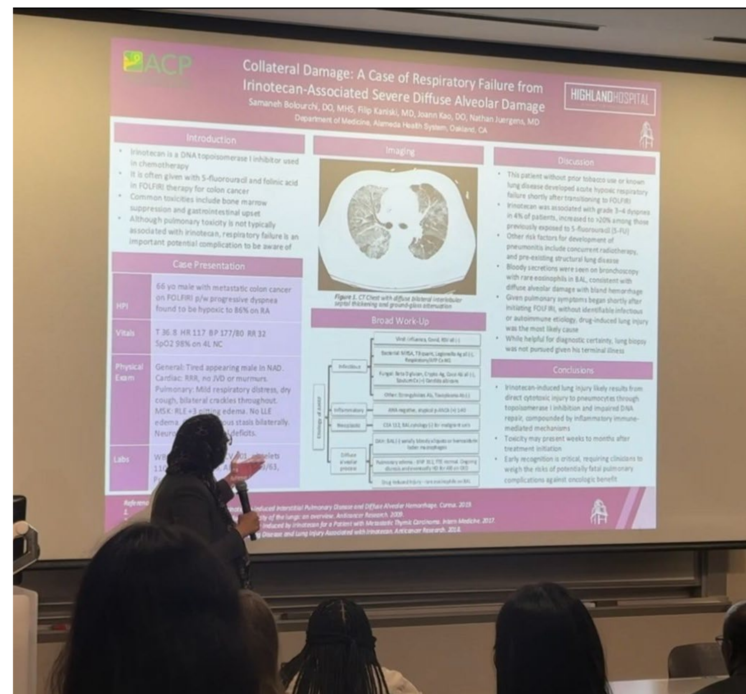
HIGHLANDHOSPITAL
A member of Alameda Health System
Department of Medicine, Alameda Health System, Oakland, CA
Introduction
Tranexamic acid (TXA) is occasionally used to treat abnormal uterine bleeding (AUB). Given its role in stabilizing fibrin clots, feared complications include thrombotic events of varying severity.
Case
46-year-old female with history of TXA use for recent AUB presented with chest pain and shortness of breath.
EKG showed minimal lateral ST elevations. Troponin-I was 5.59 ng/ml. Coronary angiography revealed 100% occlusion of the distal LAD.
Endorsed bilateral leg pain since the day prior to admission. Doppler ultrasound showed acute bilateral lower extremity deep venous thromboses (DVTs). Subsequent CT revealed bilateral subsegmental pulmonary emboli.
Given multiple arterial and venous thromboses, in addition to reports of ongoing headaches and dizziness, MRI head was obtained, which revealed small acute infarcts in the left cerebellum and left anterior frontal lobe.
A patent foramen ovale (PFO) was noted on TEE.
The patient was started on therapeutic apixaban
Transitioned to warfarin after possible transient ischemic attack while on apixaban
Repeat acute DVT was found after patient-directed resumption of previously prescribed TXA for ongoing bleeding.
Imaging
100% occlusion of the distal left anterior descending artery.
Acute infarcts in the left cerebellum (left) and left anterior frontal white matter (right).
Discussion
Tranexamic acid functions as an anti-fibrinolytic agent by inhibiting conversion of plasminogen to plasmin, thus reducing attachment of plasmin to fibrin and ultimately preventing degradation of fibrin clots.
TXA is widely used in uterine bleeding and is considered an effective, hormone-free alternative method of medical management1.
Although there is a general consensus of safety, evidence is poor given overall low rates of thromboembolic events in both drug and placebo groups in randomized control trials. Thus, there are mixed data regarding its risk2,3.
This relatively young patient without significant risk factors for atherosclerotic disease presented with a series of devastating arterial and venous thromboembolic events in the setting of TXA use, each of which carried a high potential for morbidity and mortality.
Conclusions
This case emphasizes the importance of incorporating routine symptomatic screening for thrombotic events in patients taking TXA and the importance of discontinuing the medication if any are ultimately diagnosed.
References



Recurrent Exudative Effusions:
Rheumatoid Serositis in the Absence of Synovitis
Emerson Rustand, MD, Farzad Moazed, MD
HIGHLANDHOSPITAL
Introduction
Pleural effusions occur in 3-5% of rheumatoid arthritis (RA) patients, and effusions without synovitis is even less common.
Early identification and treatment initiation has shown favorable outcomes in this patient population.
Clinical Course
A 73-year-old transgender female with history of renal cell carcinoma status post nephrectomy presented for pericardial effusion note on surveillance CT [1]
Diagnostic pericardiocentesis found lymphocytic inflammatory cells without signs of malignancy or infection.
2 months later reresented with acute dyspnea and was found to have large left sided pleural effusion [2]
Pleural fluid analysis showed similar inflammatory exudate, seriological studies diagnosed Rheumatoid Arthritis.
Results
Figure 1: CT image of pericardial effusion
Figure 2: CT image of left sided pleural effusion
Figure 3: Diagram of RA effusion pathophysiology
Discussion
RA effusions contain: PML progressing to lymphocytic predominant inflammation, RF, low C4, low glucose, pH 7 and epithelioid cells on cytology
High levels of anti-CCP antibodies have been correlated with extra-articular manifestations
There is a 3-fold increase in mortality in patients who initially present with serositis without synovitis.
There is an increased risk of cardiovascular disease, pulmonary disease and infection
Early recognition and treatment of RA-related serositis can lead to favorable outcomes, even in the absence of classic joint involvement.
Conclusions
Serologic testing for autoimmune conditions can be key in uncovering atypical presentations of systemic diseases like RA.
Proper diagnosis and treatment of RA serositis without synovitis has shown favorable outcomes.



ACP
Collateral Damage: A Case of Respiratory Failure from Irinotecan-Associated Severe Diffuse Alveolar Damage
Samaneh Bolourchi, DO, MHS, Filip Kaniski, MD, Joann Kao, DO, Nathan Juergens, MD
Department of Medicine, Alameda Health System, Oakland, CA
HIGHLANDHOSPITAL
Introduction
Irinotecan is a DNA topoisomerase I inhibitor used in chemotherapy
It is often given with 5-fluorouracil and folinic acid in FOLFIRI therapy for colon cancer
Common toxicities include bone marrow suppression and gastrointestinal upset
Although pulmonary toxicity is not typically associated with irinotecan, respiratory failure is an important potential complication to be aware of
Case Presentation
HPI
66 yo male with metastatic colon cancer on FOLFIRI p/w progressive dyspnea found to be hypoxic to 86% on RA
Vitals
T 36.8 HR 117 BP 177/80 RR 32 SpO2 98% on 4L NC
Physical Exam
General: Tired appearing male in NAD. Cardiac: RRR, no JVD or murmurs. Pulmonary: Mild respiratory distress, dry cough, bilateral crackles throughout.
Labs
Imaging
Figure 1. CT Chest with diffuse bilateral interlobular septal thickening and ground-glass attenuation
Broad Work-Up
Discussion
This patient without prior tobacco use or known lung disease developed acute hypoxic respiratory failure shortly after transitioning to FOLFIRI
Irinotecan was associated with grade 3-4 dyspnea in 4% of patients, increased to >20% among those previously exposed to 5-fluorouracil (5-FU)
Other risk factors for development of pneumonitis include concurrent radiotherapy, and pre-existing structural lung disease
Bloody secretions were seen on bronchoscopy with rare eosinophils in BAL, consistent with diffuse alveolar damage with bland hemorrhage
Given pulmonary symptoms began shortly after initiating FOLFIRI, without identifiable infectious or autoimmune etiology, drug-induced lung injury was the most likely cause
While helpful for diagnostic certainty, lung biopsy was not pursued given his terminal illness
Conclusions
Irinotecan-induced lung injury likely results from direct cytotoxic injury to pneumocytes through topoisomerase I inhibition and impaired DNA repair, compounded by inflammatory immune-mediated mechanisms
Toxicity may present weeks to months after treatment initiation
Early recognition is critical, requiring clinicians to weigh the risks of potentially fatal pulmonary complications against oncologic benefit

DOM In the News!

Grantee Examples

ALAMEDA HEALTH SYSTEM

Alex Diaz from Alameda: Creating an updated home visit curriculum to deepen residents' knowledge of specific social determinants of health that impact the community they serve.

UCSF Hospital Medicine
Department of Medicine

Katie Brooks UCSF: Through this project, internal medicine residents will learn, practice and reflect on bias mitigation skills while admitting patients to a safety net hospital.

Alameda Health System
@AlamedaHealth

Research shows that skin diseases are undercounted in Black patients, and are more deadly for people of color. Dr. Leon Clark, chief dermatologist at Alameda Health System, is committed to changing that. alamedahealthsystem.org/why-is-skin-di...

More from Globe IdeasSubmit to Globe IdeasSubmit a Letter to the Editor

IDEAS

What should we think of the new Alzheimer's drugs?

I'm a neurologist whose mother is taking one of these medications, and even I am struggling with this question.

By **Adeline Goss** Updated July 30, 2024, 3:00 a.m.

Division Highlights

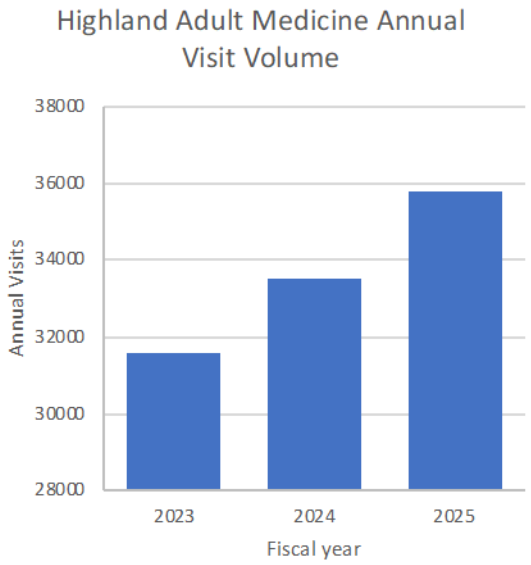
Division Highlights

- General Internal Medicine
  - Primary Care – K6
  - Hospital Medicine – HGH
  - Hospital Medicine – SLH
  - Hospital Medicine – AIM Group (Fairmont, Rehab, JG)
  - IM Residency – Largest (3 programs)

- Medicine Subspecialties
  - Cardiology
  - Pulmonary & CCM
  - Gastroenterology
  - Oncology
  - Nephrology
  - Neurology
  - Dermatology
  - Endocrinology
  - Infectious Disease
  - Rheumatology
  - Palliative Care
  - HIV Medicine
  - Geriatrics

DOM Growth & Access

- **Primary Care**
  - Expansion to evening primary care clinics
- **Hospital Medicine**
  - 63 Hospitalists providing 24/7 inpatient coverage across AHS (33K/yr)
  - New Doc of the Day service, New Physician Avisor Program
- **Cardiology**
  - EP Volume increased by 257%
  - Interventional volumes increased by 22%, Clinics 12%
- **PCCM** - Marked increase in RVU/encounters in PCCM



	2023	2024	2025 Jan-Sept	2025 adjusted
Encounters	8366.00	12840.00	10126.00	13501.33
RVUs	18427.01	25850.57	21456.64	28608.85

DOM Growth & Access

- **Gastroenterology**
  - 4000 endoscopy procedures/year (200 increase each year)
  - 144 ERCP procedures performed (cost savings 1.5 million)
  - 2025 American College of Gastroenterology Service Award for Colorectal Cancer Outreach, Prevention & Year-Round Excellence (SCOPY).
- **Palliative**
  - Fairmont 97 consults
  - Increased clinics 390 -> 594
  - Increased patients seen w/in 3 days (decreased LOS and readmission)
  - Increased inpatient consults 946->1254
- **Hematology/Oncology**
  - Increased outpatient visits in Oncology - **7,411 visits to 9,103 visits**
  - Increased Infusion Center Visits per year
  - 7 New chemo regimens introduced

DOM Growth & Access

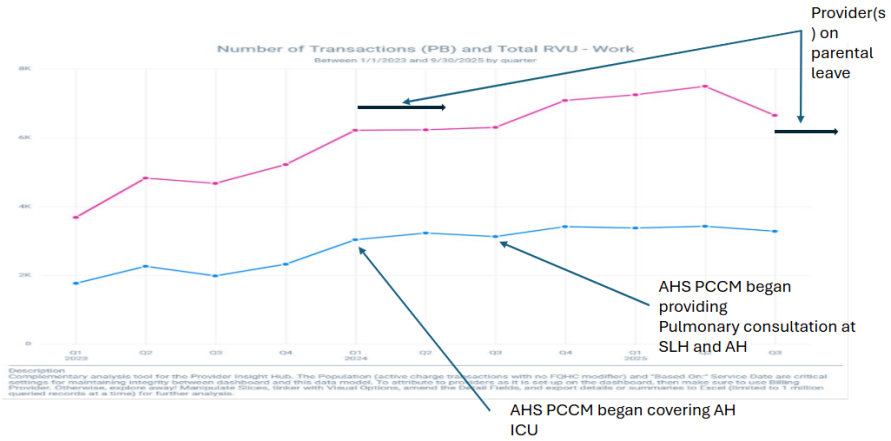
- **Dermatology**
  - Launched Hidradenitis Suppurativa Specialty Clinic
  - Year-over-year increase in consult volume without FTE increase.
  - Hosted first employee skin cancer screening at Highland (125+ screened)
- **Nephrology**
  - CRRT at SLH
  - Increased clinic access now at HGH, Eastmont and Newark
- **Rheumatology**
  - maintained excellent access (TNAA < 14d) and no backlog
- **ID** – New ID Clinic 2026
- **Neurology -** New patient wait time down from 3 mo. To <2 weeks

Quality and Patient Safety

- All members participate in QI/PS
- DOM reps at all levels of AHS Quality from Resident to Committee Chair level to the Board of Trustees
  - Resident QI Projects
  - Code Blue, Critical Care, P&T, Patient Safety, Co-chair IPPC
  - QPSC
- IM QI/PS Focus Areas
  - Peer Review
  - Education and Scholarship
  - Data Analytics & Health Equity
  - Process Improvement

Division of Pulmonary/Critical Care
Chief: Benson Chen, MD

Steady Increasing RVU Productivity for PCCM 2023-2025:



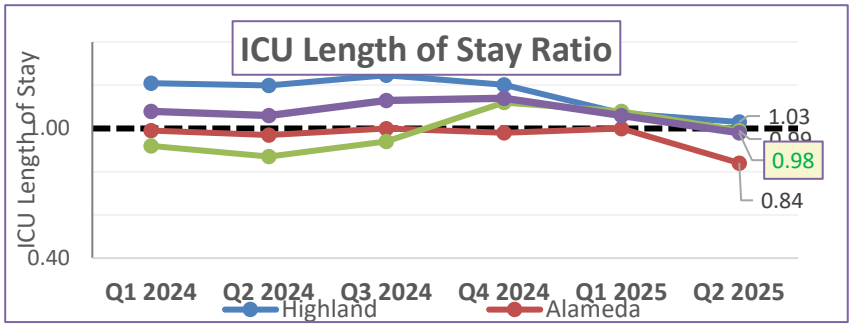
QI Components of CMS Star Ratings

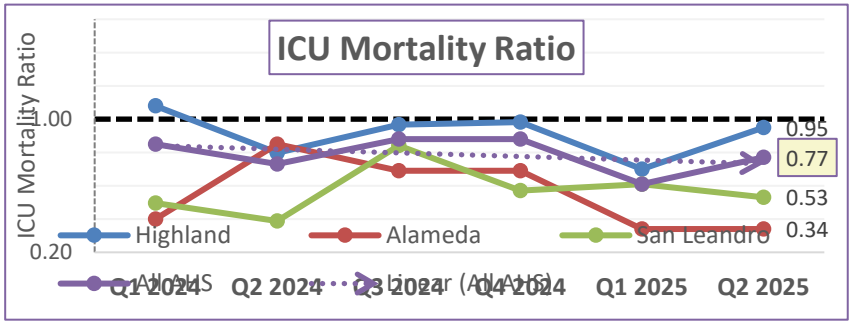
AHS System

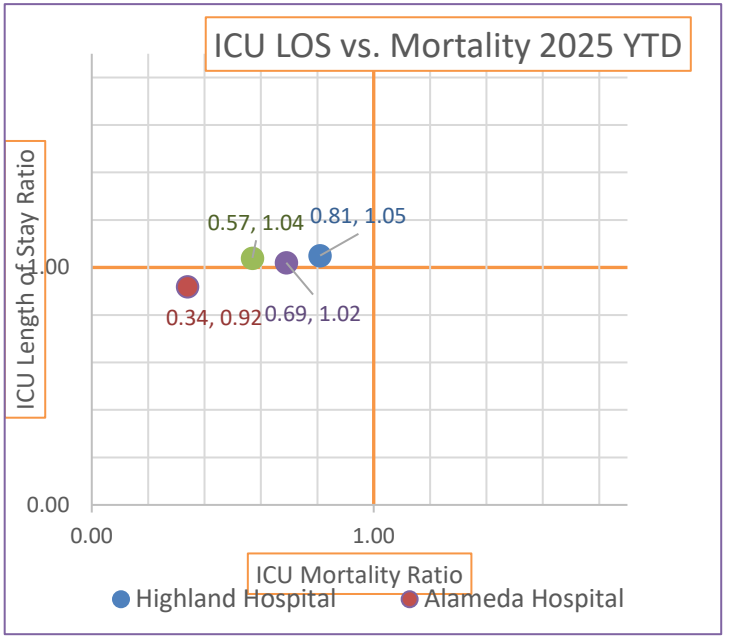
Hospital Acquired Infections

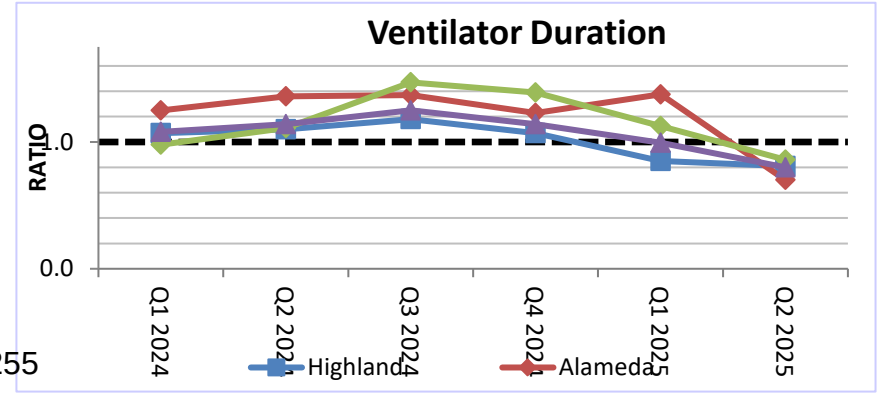
Infection Type	Last Infection	Events Fy25	Events Fy26	Days Since Last Infection
CAUTI	6/11/2025	9	0	117
CLABSI	5/2/2024	0	0	522

Excellent Observed to Expected ICU Metrics



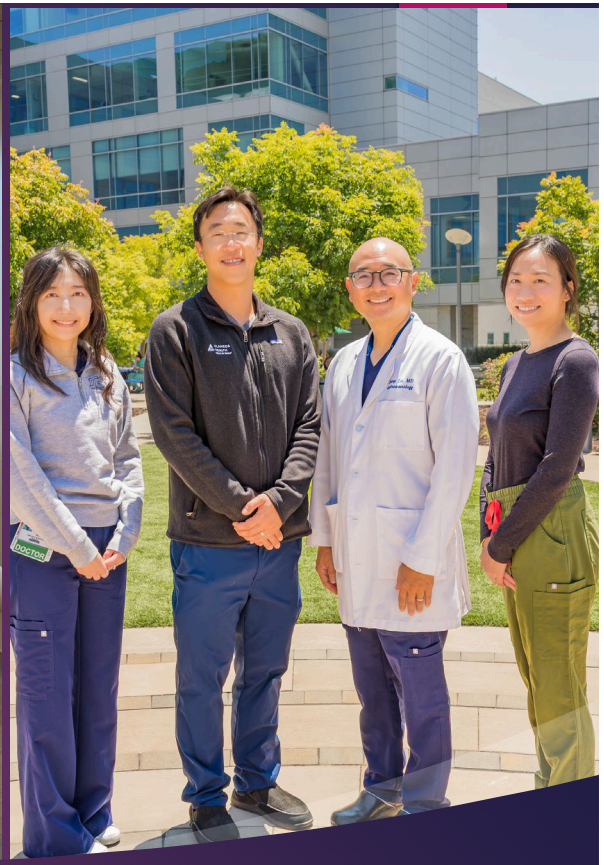






Quality & Safety Metrics

- **Primary Care**
  - 28 Quality Incentive Pool (QIP) metrics, worth $34 million
  - Outcomes meet or exceed QIP targets > 90% of metrics
- **Cardiology**
  - GOLD Award for STEMI and NSTEMI care 2021 – 2025!
  - DBT > 90th% with complication rate low and >90th %
- **Hospital Medicine**
  - Community – LOS 3.53; Readmission 12.1%; OLOS:ELOS = 0.81
  - HGH – Dec tele use 80%; DC before noon in 30%
  - All: MD communication 93%
- **Gastroenterology**
  - >98% cecal intubation rate (benchmark >90%)
  - 52% polyp detection rate (benchmark 40%)
  - 95% ampulla cannulation rate (benchmark >90%)
- **Oncology** - Chemo Pump decreased inpatient admissions by 50% for chemo



Looking Forward

Division of Geriatrics
Chief - Vacant

- Inpatient, Outpatient, and E-Consults started and now on pause
- Level 1 Trauma certification requirement
- Improved outcomes in ortho sugeries(hips/knee)
- Collaboration with general surgery & internal medicine service
- System-wide commitment to be **Age Friendly Healthcare System**
- Strong foundation needed to meet needs of the fastest growing population of vulnerable patients in our county
  - Programs (Falls, Dementia w/ behavior d/o, delirium)
  - Multidisciplinary Teams
  - Inpatient/Outpatient Physician Arms

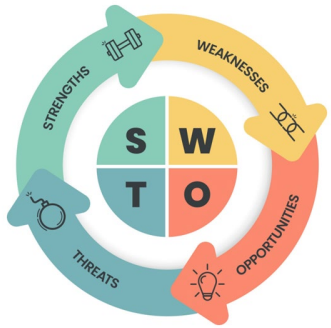
Department of Medicine – SWOT

Strengths

- Clinical Expansion (all 18 Divisions)
  - Cardiology/EP
  - Stroke Center at HGH
  - GI ERCP
  - Pulmonary EBUS
  - Nephrology CRRT
  - Hospital Medicine DOD
  - Palliative Care
  - Dermatology HS Clinic
  - Primary Care Evening Clinic
- Scholarship/Education
- Teamwork & Culture
- Retention
- Scope of Services
- Physician Engagement/Citizenship

Weaknesses

- Throughput
- Access
- Operational efficiency
- Geriatrics and aging population
- Data analytics for QI, revenue, etc
- Financial knowledge support – FTE replacements, proformas, etc.



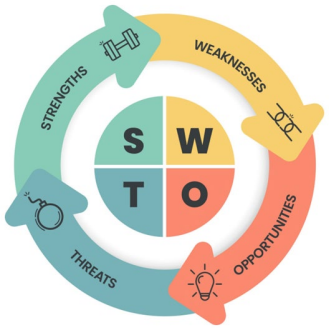
Department of Medicine - SWOT

Opportunities

- Quality & Patient Safety
- Chief Turnover (opportunity for change/resilience)
- Inter-Departmental Collaboration
- Revenue/Billing/Productivity
- Growth Mindset
- Service-line models

Threats

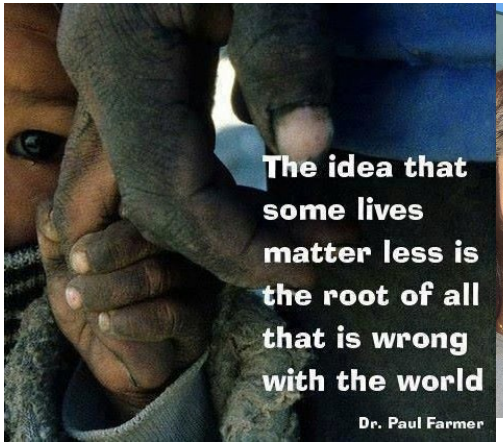
- Access
- Research and Clinical Trials
- Federal funding changes
- Federal immigration actions
- Certification/Regulatory requirements
- Space limitations
- Aging population



DOM Leads Together

Gratitude

- Tremendous year
- Inspired group
- Hard work, but so worth it
- Thank YOU ALL!



STAFF REPORTS (Written)

ALAMEDA HEALTH SYSTEM

September 2025 Financial Report
Finance Committee - November 5, 2025

September 2025 Financial Report
Finance Dashboard

September-2025

	Metric	FY2026 Goal YTD	Actual YTD	YTD	Trend Lines
Volume					
	Total Adjusted Discharges	7,906	8,277		
	Total Adjusted Patient Days	91,628	92,208		
Revenue Cycle					
	Collection Ratio	19.5%	19.3%		
	Cash as % of Net Revenue	100.0%	106.2%		
	Gross Days in Patient Receivables	62.0	62.8		
Labor					
	Productivity %	100.0%	101.0%		
	Registry as % of Total FTEs	3.9%	4.2%		
	Overtime % excl Company 30	4.5%	5.7%		
	Total FTEs	5,115	5,181		
	FTE per Adjusted Discharge	0.96	0.93		
	*Labor Cost/FTE w/o GASB	$238,296	$241,987		
Profitability					
	Total Cost per Adjusted Discharge	$50,616	$48,775		
	Total Cost per Adjusted Patient Days	$4,367	$4,378		
	Net Income	$6,359	$8,875		
	EBIDA Margin	3.5%	4.1%		
	NNB (Net Negative Balance)	<$95M	-$36,214		
	Net Position	>$0	-$51,223		
Capital					
	Capital Spent	$7,318	$4,512		
	% of Capital Spent		61.7%		

*Labor costs excludes contracted physicians; Includes Registry travel & housing costs

September 2025 Financial Report
Volume Highlights – Part 1

	Sep-25	MTD Budget	Var	% Var	YTD Actual	YTD Budget	Var	% Var	YTD PY Actual	Var	% Var
GENERAL ACUTE											
Patient Days	5,708	6,290	-582	-9.2%	17,747	18,764	-1,017	-5.4%	18,531	-784	-4.2%
Discharges	1,202	1,203	-1	-0.1%	3,777	3,610	167	4.6%	3,581	196	5.5%
Average Length of Stay	4.7	5.2	0.5	9.2%	4.7	5.2	0.5	9.6%	5.2	0.5	9.2%
CMI	1.649	1.658	-0.009	-0.5%	1.596	1.655	-0.059	-3.5%	1.654	-0.058	-3.5%
Emergency Visits	9,497	8,926	571	6.4%	28,584	26,527	2,057	7.8%	27,229	1,355	5.0%
Trauma Cases	317	368	-51	-13.8%	976	994	-18	-1.8%	1,038	-62	-6.0%
Observation Equivalent Days	674	671	3	0.5%	1,979	2,070	-91	-4.4%	1,976	3	0.2%
Total Surgeries	732	676	56	8.3%	2,131	2,143	-12	-0.6%	2,324	-193	-8.3%
PSYCH											
Psych Patient Days	2,027	2,039	-12	-0.6%	6,156	6,035	121	2.0%	5,986	170	2.8%
Psych Discharges	230	226	4	1.6%	647	670	-23	-3.5%	645	2	0.3%
Average Length of Stay	8.8	9.0	0.2	2.1%	9.5	9.0	-0.5	-5.7%	9.3	-0.2	-2.5%
PES Equivalent Days	767	711	55	7.8%	2,333	2,179	154	7.1%	2,179	154	7.1%
REHAB											
Rehab Patient Days	769	778	-9	-1.1%	2,122	2,198	-76	-3.5%	2,108	14	0.7%
Rehab Discharges	54	59	-5	-8.2%	160	166	-6	-3.8%	154	6	3.9%
Average Length of Stay	14.2	13.2	-1	-7.7%	13.3	13.2	0	-0.3%	13.7	0.4	3.1%

September 2025 Financial Report
Volume Highlights – Part 2

	Sep-25	MTD Budget	Var	% Var	YTD Actual	YTD Budget	Var	% Var	YTD PY Actual	Var	% Var
SNF with Sub-Acute											
Average Daily Census	278.3	275.7	2.6	1.0%	278.1	275.7	2.5	0.9%	271.6	6.5	2.4%
Occupancy %	96%	95%	0%		96%	95%	0%		94%	0%	
Bed Holds	82	73	9	11.8%	128	280	-152	-54.3%	278	-150	-54.0%
Total Clinic Visits	36,495	34,884	1,611	4.6%	105,935	109,881	-3,946	-3.6%	102,372	3,563	3.5%
FQHC Visits	30,778	29,562	1,216	4.1%	89,084	92,020	-2,936	-3.5%	85,081	4,003	4.7%
Non-FQHC Visits	5,717	5,322	395	7.4%	16,851	17,861	-1,010	-5.7%	17,291	-440	-2.5%
PAYOR MIX											
Insurance %	6.6%	7.9%	-1.3%		6.6%	7.4%	-0.8%		7.3%	-0.7%	
Medi-Cal %	61.6%	60.5%	1.1%		60.0%	61.9%	-2.0%		62.1%	-2.0%	
Medicare %	27.5%	26.0%	1.5%		29.2%	25.7%	3.4%		26.5%	2.7%	
Other Govt %	1.4%	2.2%	-0.8%		1.4%	1.7%	-0.4%		1.6%	-0.3%	
Self-Pay %	2.9%	3.4%	-0.6%		2.9%	3.2%	-0.3%		2.5%	0.4%	
Total Payor Mix %	100.0%	100.0%	0.0%		100.0%	100.0%	0.0%		100.0%	0.0%	

September 2025 Financial Report
YTD Highlights

- Favorable YTD revenue variance of $6.6M.
  - Net patient revenue exceeding budget ($1.8M); although the collection percentage was 0.3% below budget, it was offset by higher volumes.
  - SAC law settlement on older claims ($3.1M).
  - Alliance P4P ($1.2M)

- Unfavorable YTD expense variance of $3.5M.
  - Labor costs unfavorable by $7.2M from unfavorable staff wages and registry ($5.7M), health insurance ($3.0M) offset by favorable provider wages and contracts ($1.5M).
  - Non-labor cost favorable by $3.6M with the largest positive variances in materials and supplies ($2.0M) and purchased services ($1.9).
    - Lower costs associated with fewer patient days/LOS and trauma cases.

	September 2025				Year-To-Date				FY 2025	
	Actual	Budget	Variance	% Var	Actual	Budget	Variance	% Var	YTD	% Var
Operating revenue	$ 138,113	$ 134,250	$ 3,863	2.9%	$ 413,524	$ 406,883	$ 6,641	1.6%	$ 380,071	8.8%
Operating expense	133,654	133,307	(347)	(0.3)%	403,709	400,167	(3,542)	(0.9)%	380,464	(6.1)%
Operating income (loss)	**4,459**	**943**	**3,516**	**372.9%**	**9,815**	**6,716**	**3,099**	**46.1%**	**(393)**	**2597.5%**
Other non-operating activity	(273)	(89)	(184)	(206.7)%	(940)	(357)	(583)	(163.3)%	(348)	(169.9)%
Net Income (loss)	**$ 4,186**	**$ 854**	**$ 3,332**	**390.2%**	**$ 8,875**	**$ 6,359**	**$ 2,516**	**39.6%**	**$ (741)**	**1297.2%**
EBIDA adjustments	2,713	2,585	128		7,984	8,062	(78)		11,116	
EBIDA	**$ 6,899**	**$ 3,439**	**$ 3,460**		**$ 16,859**	**$ 14,421**	**$ 2,438**		**$ 10,375**	
Operating Margin	3.2%	0.7%	2.5%		2.4%	1.7%	0.7%		(0.1)%	
EBIDA Margin	5.0%	2.6%	2.4%		4.1%	3.5%	0.6%		2.7%	

September 2025 Financial Report
Net Patient Services Revenue Highlights

- Gross patient service revenue is favorable driven by outpatient services.
  - General Acute inpatient days are below budget and Length of Stay (LOS) improved to 4.7.
    - CMI 0.5% lower than budget and 3.5% YTD; consistent with lower LOS.
    - Trauma 13.8% below budget and 1.8% YTD.
    - Inpatient surgery 6.5% above budget and below 2.0% YTD.
  - ED visits 6.4% above budget and 7.8% YTD.
  - Outpatient surgery favorable 9.8% MTD and 0.7% YTD.
  - SNF average daily census 1.0% favorable MTD and YTD; bed holds exceeding plan.
  - JGP days 0.6% below budget and above 2.0% YTD; PES favorable both MTD and YTD.
- NPSR Collection ratio YTD was 19.3% which is lower than expected.
  - Commercial Payer mix below budget offset by higher volumes
  - Rate increases for government and Managed Medi-Cal were included in budget evenly and have not been realized.

	September 2025				Year-To-Date				FY 2025	
	Actual	Budget	Variance	% Var	Actual	Budget	Variance	% Var	YTD	% Var
Inpatient service revenue	$ 218,188	$ 219,706	$ (1,518)	(0.7)%	$ 659,571	$ 658,388	$ 1,183	0.2%	$ 633,304	4.1%
Outpatient service revenue	160,977	145,744	15,233	10.5%	475,011	445,219	29,793	6.7%	432,328	9.9%
Professional service revenue	41,659	41,513	146	0.4%	123,570	127,745	(4,175)	(3.3)%	119,937	3.0%
Gross patient service revenue	420,824	406,963	13,861	3.4%	1,258,152	1,231,351	26,801	2.2%	1,185,568	6.1%
Deductions from revenue	(339,659)	(327,410)	(12,249)	(3.7)%	(1,015,657)	(990,647)	(25,010)	(2.5)%	(956,770)	6.2%
Net patient service revenue	**81,165**	**79,553**	**1,612**	**2.0%**	**242,495**	**240,704**	**1,791**	**0.7%**	**228,798**	**(6.0)%**
Collection % - NPSR	19.3%	19.5%	(0.2)%		19.3%	19.5%	(0.2)%		19.3%	
Capitation and HPAC	4,470	4,548	(77)	(1.7)%	13,443	13,643	(201)	(1.5)%	13,752	(2.2)%
Other government programs	46,776	45,415	1,361	3.0%	137,201	136,245	956	0.7%	121,876	12.6%
Other operating revenue	5,702	4,734	967	20.4%	20,385	16,291	4,094	25.1%	15,645	30.3%
Total operating revenue	**$ 138,113**	**$ 134,250**	**$ 3,863**	**2.9%**	**$ 413,523**	**$ 406,884**	**$ 6,640**	**1.6%**	**$ 380,071**	**8.8%**

September 2025 Financial Report
Governmental and Other Revenue Highlights

- Other government programs favorable by $1.4M from Alliance P4P ($1.2M) and FEMA ($0.2M). YTD, favorable by $1.0 million from Alliance P4P ($1.2M) and offset by other programs ($0.2M).
- Other operating revenue favorable by $1.0M from higher retail pharmacy ($0.8M), SRH management fee not included in the budget ($0.3M), other favorable miscellaneous operating revenue ($0.2M) offset by unfavorable grant revenue ($0.3M). YTD, favorable driven by the settlement on low pay patient accounts ($3.1M) and SRH management ($0.9M).

	September 2025				Year-To-Date				FY 2025	
	Actual	Budget	Variance	% Var	Actual	Budget	Variance	% Var	YTD	% Var
Net patient service revenue	81,165	79,553	1,612	2.0%	242,495	240,704	1,791	0.7%	228,798	(6.0)%
Capitation and HPAC	4,470	4,548	(77)	(1.7)%	13,443	13,643	(201)	(1.5)%	13,752	(2.2)%
Medi-Cal Waiver	8,502	8,474	29	0.3%	25,496	25,421	76	0.3%	28,372	(10.1)%
Measure A and parcel tax	12,760	12,760	0	0.0%	38,279	38,279	0	0.0%	38,356	(0.2)%
Supplemental Programs	25,515	24,182	1,333	5.5%	73,425	72,546	879	1.2%	55,148	33.1%
Other government programs	**46,776**	**45,415**	**1,361**	**3.0%**	**137,200**	**136,245**	**955**	**0.7%**	**121,876**	**12.6%**
Grant Revenue	1,056	1,376	(320)	(23.2)%	3,037	3,785	(748)	(19.8)%	3,123	(2.8)%
Other Operating Revenue	4,646	3,359	1,287	38.3%	17,348	12,506	4,842	38.7%	12,522	38.5%
Other operating revenue	**5,702**	**4,734**	**967**	**20.4%**	**20,385**	**16,291**	**4,094**	**25.1%**	**15,645**	**30.3%**
Total operating revenue	**$ 138,113**	**$ 134,250**	**$ 3,863**	**2.9%**	**$ 413,522**	**$ 406,884**	**$ 6,639**	**1.6%**	**$ 380,071**	**8.8%**

September 2025 Financial Report
Expense Highlights excluding Labor

- Purchased services favorable from outside medical services ($1.2M), software licenses ($0.9M) offset by unfavorable variance ($0.4M) spread across various departments. The ambulance vendor refunded overpayments after sending duplicate invoices from their sister company ($1.2M). YTD, favorable from outside medical services ($1.8M), software licenses ($1.1M) offset by unfavorable variance in HIM coding ($0.7M) and the remaining variance ($0.3M) spread across various departments. The HIM coding variance is partially offset by the positive variance in registry.
- Material and supplies favorable from pharmaceuticals ($0.4M), non-medical supplies ($0.4M) offset by unfavorable variance in surgical supplies ($0.3M). YTD, favorable from pharmaceuticals ($1.0M), medical supplies ($0.6M), non-medical supplies ($0.6M) offset by surgical supplies ($0.2M).

	September 2025				Year-To-Date				FY 2025	
	Actual	Budget	Variance	% Var	Actual	Budget	Variance	% Var	YTD	% Var
Labor costs	$ 103,516	$ 100,791	$ (2,725)	(2.7)%	$ 315,321	$ 308,142	$ (7,179)	(2.3)%	$ 293,754	(7.3)%
Purchased services	8,646	10,393	1,747	16.8%	25,593	27,494	1,901	6.9%	23,267	(10.0)%
Materials and supplies	12,898	13,371	473	3.5%	37,696	39,707	2,011	5.1%	36,570	(3.1)%
Facilities	3,220	3,367	147	4.4%	10,482	9,338	(1,144)	(12.3)%	8,838	(18.6)%
Depreciation and amortization	2,431	2,483	52	2.1%	7,013	7,666	653	8.5%	10,729	34.6%
General and administrative	2,943	2,902	(41)	(1.4)%	7,604	7,820	216	2.8%	7,306	(4.1)%
Total operating expense	**$ 133,654**	**$ 133,307**	**$ (347)**	**(0.3)%**	**$ 403,709**	**$ 400,167**	**$ (3,542)**	**(0.9)%**	**$ 380,464**	**(6.1)%**

September 2025 Financial Report
Expense Highlights excluding Labor (part 2)

- Facilities favorable from utilities ($0.3M) offset by higher equipment/facility repairs ($0.2M). YTD, unfavorable from higher equipment/facility repairs ($1.7M) and offset by lower utilities ($0.6M). Approximately $0.7M of the unfavorable repairs variance is the result of FY25 invoices that were not accrued in June 2025. An audit adjustment for FY25 was booked and will reduce FY26 expense in October by $0.7M.
- Depreciation and amortization approximates budget with offsetting variance between equipment depreciation and amortization. YTD, favorable from lower equipment depreciation ($1.3M) offset by higher lease and software amortization ($0.6M).
- General and administrative approximates budget for month. YTD, favorable from timing of recruitment expense ($0.2M).

	September 2025				Year-To-Date				FY 2025	
	Actual	Budget	Variance	% Var	Actual	Budget	Variance	% Var	YTD	% Var
Labor costs	$ 103,516	$ 100,791	$ (2,725)	(2.7)%	$ 315,321	$ 308,142	$ (7,179)	(2.3)%	$ 293,754	(7.3)%
Purchased services	8,646	10,393	1,747	16.8%	25,593	27,494	1,901	6.9%	23,267	(10.0)%
Materials and supplies	12,898	13,371	473	3.5%	37,696	39,707	2,011	5.1%	36,570	(3.1)%
Facilities	3,220	3,367	147	4.4%	10,482	9,338	(1,144)	(12.3)%	8,838	(18.6)%
Depreciation and amortization	2,431	2,483	52	2.1%	7,013	7,666	653	8.5%	10,729	34.6%
General and administrative	2,943	2,902	(41)	(1.4)%	7,604	7,820	216	2.8%	7,306	(4.1)%
Total operating expense	**$ 133,654**	**$ 133,307**	**$ (347)**	**(0.3)%**	**$ 403,709**	**$ 400,167**	**$ (3,542)**	**(0.9)%**	**$ 380,464**	**(6.1)%**

September 2025 Financial Report
Expense Highlights – Labor

- Salaries and wages (staff) and registry unfavorable from higher FTEs (48 FTEs/$0.6M) and higher rate ($2.3M). YTD, higher FTE (86 FTEs/$3.5M) and higher rate ($2.2M).
- Providers are favorable for the month and YTD. Employed Providers now include physicians and other providers, such as midwives and CRRTs. Variances by specialty detailed on subsequent slide.
  - Salaries and wages (providers) favorable from lower FTEs (17 FTEs/$0.6M) offset by unfavorable rate ($0.3M). YTD, lower FTEs (20 FTEs/$2.2 M) offset by higher rate ($0.3M).
  - Physician contract services approximate budget for month and unfavorable YTD.

	September 2025				Year-To-Date				FY 2025	
	Actual	Budget	Variance	% Var	Actual	Budget	Variance	% Var	YTD	% Var
Salaries and wages (staff)	$ 63,033	$ 59,310	$ (3,723)	(6.3)%	$ 188,171	$ 180,615	$ (7,556)	(4.2)%	$ 171,394	(9.8)%
Salaries and wages (providers)	10,381	10,715	334	3.1%	31,254	33,170	1,916	5.8%	30,584	(2.2)%
Registry	3,376	4,175	799	19.1%	10,863	12,720	1,857	14.6%	12,627	14.0%
Physician contract services	3,675	3,768	93	2.5%	11,241	10,829	(412)	(3.8)%	11,163	0.0%
Employee benefits (taxes, insurance)	15,570	15,308	(262)	(1.7)%	49,247	46,566	(2,681)	(5.8)%	44,910	(9.7)%
Retirement	7,481	7,515	34	0.5%	24,545	24,242	(303)	(1.2)%	23,077	(6.4)%
Total labor costs	**$ 103,516**	**$ 100,791**	**$ (2,725)**	**(2.7)%**	**$ 315,321**	**$ 308,142**	**$ (7,179)**	**(2.3)%**	**$ 293,754**	**(7.3)%**
Compensation ratio	75.0%	75.1%	0.1%		76.3%	75.7%	-0.6%		77.3%	
Paid FTEs - staff	4,749	4,670	(79)	(1.7)%	4,693	4,593	(100)	(2.2)%	4,604	(1.9)%
Paid FTEs - providers	289	306	17	5.6%	286	306	20	6.6%	282	(1.3)%
Paid FTEs - registry	186	217	31	14.3%	202	216	14	6.5%	206	2.1%
Total FTEs	5,224	5,193	(31)		5,181	5,115	(66)		5,092	

September 2025 Financial Report
Physician Expenses Variance

- Hospital coverage exceeding budget
  - ED costs over budget consistent with higher volumes
- Other specialties below budget consistent with lower than budget FTE

Budget Variances by Physician Specialty
(in thousands)

	Current Month - Sep 2025			Year to Date		
Specialty	**Salaries**	**Contract**	**Total**	**Salaries**	**Contract**	**Total**
General Surgery	0	(312)	(312)	0	(632)	(632)
ED	(10)	(212)	(222)	258	(860)	(602)
General Dentistry	65	0	65	231	0	231
Medical Oncology	0	152	152	0	247	247
Psychiatry	12	112	124	121	250	371
Wellness Centers	90	(23)	67	462	(72)	390
OB/GYN	89	32	121	352	76	429
Neurosurgery	0	198	198	0	594	594
Other	87	147	234	492	(15)	477
	$ 334	**$ 93**	**$ 428**	**$ 1,916**	**$ (412)**	**$ 1,504**

**Specialities with variance over $200k YTD are listed separately. All other are grouped under "Other".*

September 2025 Financial Report
Expense Highlights – Labor

- Employee Benefits unfavorable from higher self-funded health ($1.1M) offset by lower Kaiser premium ($0.3M), FICA ($0.3M), and other benefits ($0.2M). YTD, unfavorable from higher self-funded health ($4.3M) offset by lower Kaiser premium ($0.8M), FICA ($0.6M), and other benefits ($0.2M).
- Retirement approximates budget. YTD, unfavorable from ACERA ($0.7M) offset by favorable variance from AHMG retirement plan ($0.4M).

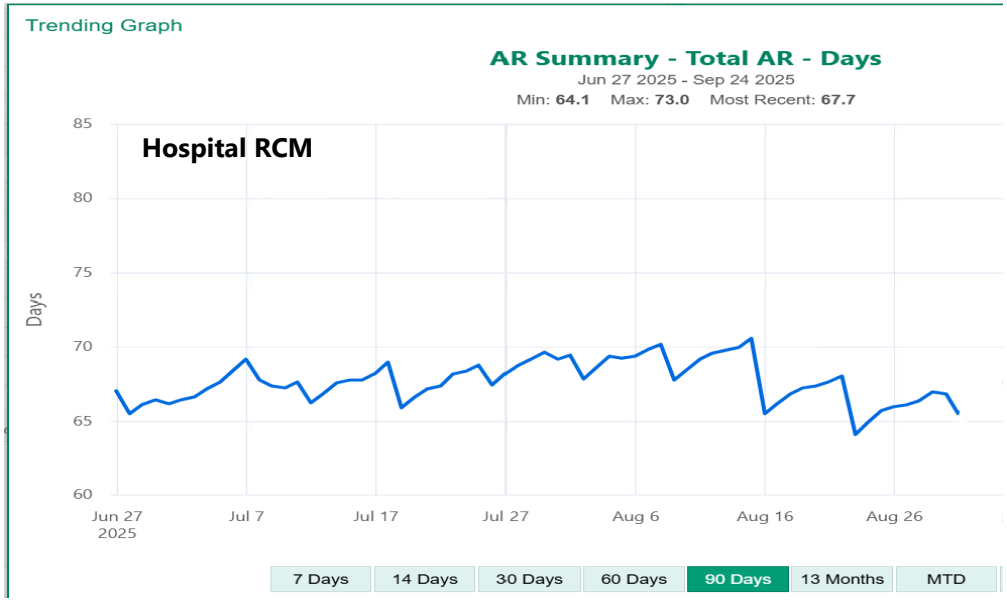
	September 2025				Year-To-Date				FY 2025	
	Actual	Budget	Variance	% Var	Actual	Budget	Variance	% Var	YTD	% Var
Salaries and wages (staff)	$ 63,033	$ 59,310	$ (3,723)	(6.3)%	$ 188,171	$ 180,615	$ (7,556)	(4.2)%	$ 171,394	(9.8)%
Salaries and wages (providers)	10,381	10,715	334	3.1%	31,254	33,170	1,916	5.8%	30,584	(2.2)%
Registry	3,376	4,175	799	19.1%	10,863	12,720	1,857	14.6%	12,627	14.0%
Physician contract services	3,675	3,768	93	2.5%	11,241	10,829	(412)	(3.8)%	11,163	0.0%
Employee benefits (taxes, insurance)	15,570	15,308	(262)	(1.7)%	49,247	46,566	(2,681)	(5.8)%	44,910	(9.7)%
Retirement	7,481	7,515	34	0.5%	24,545	24,242	(303)	(1.2)%	23,077	(6.4)%
Total labor costs	**$ 103,516**	**$ 100,791**	**$ (2,725)**	**(2.7)%**	**$ 315,321**	**$ 308,142**	**$ (7,179)**	**(2.3)%**	**$ 293,754**	**(7.3)%**
Compensation ratio	75.0%	75.1%	0.1%		76.3%	75.7%	-0.6%		77.3%	
Paid FTEs - staff	4,749	4,670	(79)	(1.7)%	4,693	4,593	(100)	(2.2)%	4,604	(1.9)%
Paid FTEs - providers	289	306	17	5.6%	286	306	20	6.6%	282	(1.3)%
Paid FTEs - registry	186	217	31	14.3%	202	216	14	6.5%	206	2.1%
Total FTEs	5,224	5,193	(31)		5,181	5,115	(66)		5,092	

September 2025 Financial Report
Balance Sheet Key Metrics

- Days in Cash are 2.9 and higher than year-end; typically, below 5.0 days.
- Gross AR Days increased 0.8 days, and Net AR Days increased 2.7 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 $51.2M and decreased $9.0M from June 30, 2025 reflecting YTD Net Income.
- Net Negative Balance is a payable of $36.2M. NNB consists of the liquidity facility (loan) of $63.3M 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.

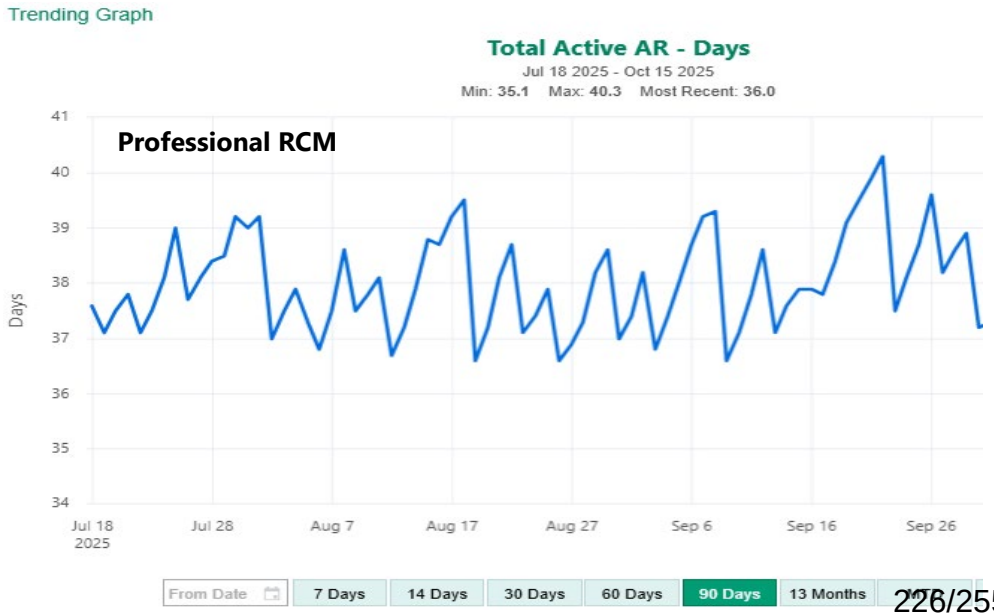
	Sep-25	Aug-25	FY 2025
Days in cash	2.9	1.8	1.2
Gross days in patient receivable	62.8	62.0	62.4
Net days in patient receivable	47.4	44.7	45.5
Due from/(to) third-party payors	$ 282,422	$ 220,760	$ 154,653
Due from/(to) County	$ (49,259)	$ (25,188)	$ 39,481
Days in accounts payable	32.5	35.0	38.1
% of AP over 60 days	3.5%	3.0%	10.6%
Net position - fund balance/(deficit)	$ (51,223)	$ (55,411)	$ (60,267)
Net negative balance - receivable/(payable)	$ (36,214)	$ 4,834	$ 26,631

September 2025 Financial Report
AR Trending



Hospital Revenue Cycle Key Indicators

- HB AR Days increased by 1.3 days compared to prior month.
  - HB AR Days target is 57.0
  - August AR Days 66.0, September AR Days 67.3
- September collections were $55.0M. Lower than the average of the prior twelve months at $62.1M.
- The federal government shut-down has not had a significant impact on Medicare payments through September.



Professional Revenue Cycle Key Indicators

- PB AR Days decreased by 1.8 days compared to prior month.
  - PB AR Days target is 33.0
  - August AR Days 37.4, September AR Days 37.3
- September collections were $11.8M. Higher than average of the prior twelve months at $11.2M.

September 2025 Financial Report
Patient Collections

- FY26 patient collections approximately 15.8 % higher than the same period in FY25.
- No payments received from the County for JGP in September.
  - JGP FY25 contract with the County was amended from $49.2M to $74.2M; final FY25 payment was paid in October 2025 for $0.9M.
  - FY26 interim contract executed for $81.4M.

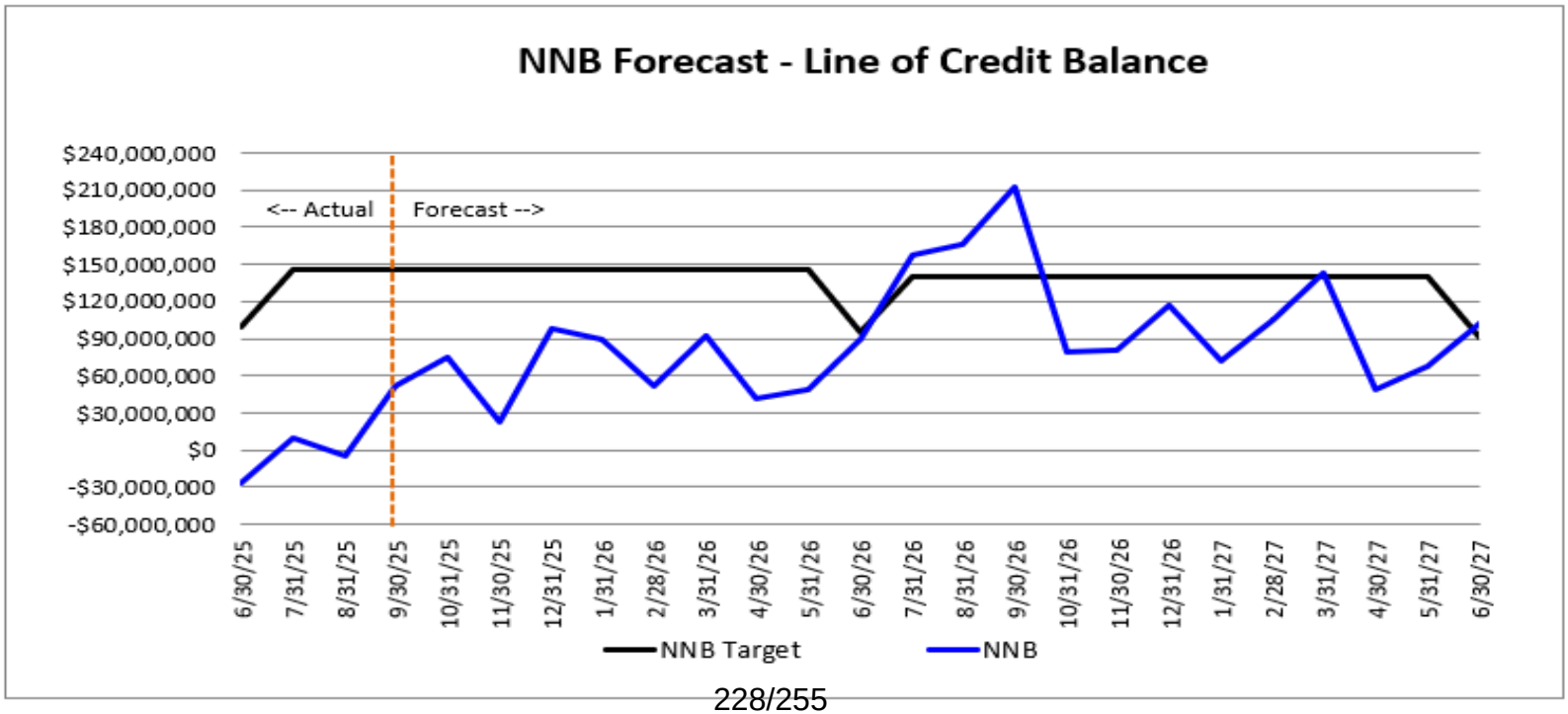
PATIENT COLLECTIONS
(in thousands)

	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	-	66,819	66,819	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**	**216,838**	**257,417**	**943,182**	**831,444**	**776,453**	**705,637**
% change between fiscal years			15.8%	13.4%	7.1%	10.0%	

September 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 and slightly over 6/30/27.
  - The NNB improved by $9.3M over last month.
  - Patient receipts continue to be strong.
  - AB85 Realignment funding received for $4.1M; not previously in forecast.

- Items that were added to forecast.
  - St. Rose funding for IGT contribution of $10.0M for FY2025 and FY2026 pending Trustees' approval.
  - St. Rose expected to access the line of credit starting in January 2026 and repaid in full by June 2026.



September 2025 Financial Report
Material Items Impacting NNB Forecast

- GPP CY2025 Q3 (in October) was updated from $25.7M to $26.5M based on DHCS notification.
- All other activity has remained constant with the prior 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 finalize in November 2025.

Material Items Included in NNB Forecast
(in thousands)

	Oct-25	Nov-25	Jan-26	Feb-26	Mar-26	FY26 Q4	FY27 Q1	FY27 Q2	FY27 Q3	FY27 Q4
GPP (quarterly)	$ 8,063	$ -	$ 20,100	$ 18,474	$ 5,600	$ 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	-	-	-	45,800	-	-	-	-	51,300	-
Medi-Cal Waiver (fy11)	-	29,169	-	-	-	-	-	-	-	-
BHCS (JGP/Alameda County) - fy26	-	18,252	6,084	6,084	6,084	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	-	-	3,000	3,000	3,000	(9,000)	-	-	-	-
Donation to St. Rose Hospital	-	-	-	-	10,000		-	-	10,000	
	$ 21,757	$ 58,221	$ 54,981	$ 73,358	$ 35,484	$ 111,915	$ 36,222	$ 195,202	$ 145,651	$ 146,210

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 Consolidated Results
Financial Summary & YTD Highlights

- SRH's YTD net income is $5.2M, $23.4M favorable to budget
  - The budget did not include the full donation of the local share for the IGT; receipt of IGT funding in May 2025 ($30.3M), exceeding budget by $23.2M.
  - Net patient service revenue variance, favorable 2.4%, driven by timing of supplemental revenue (DSH payments).
  - Expenses favorable overall ($861M), savings driven by Sub Acute delays opening/lower census, partially offset by high health benefits.

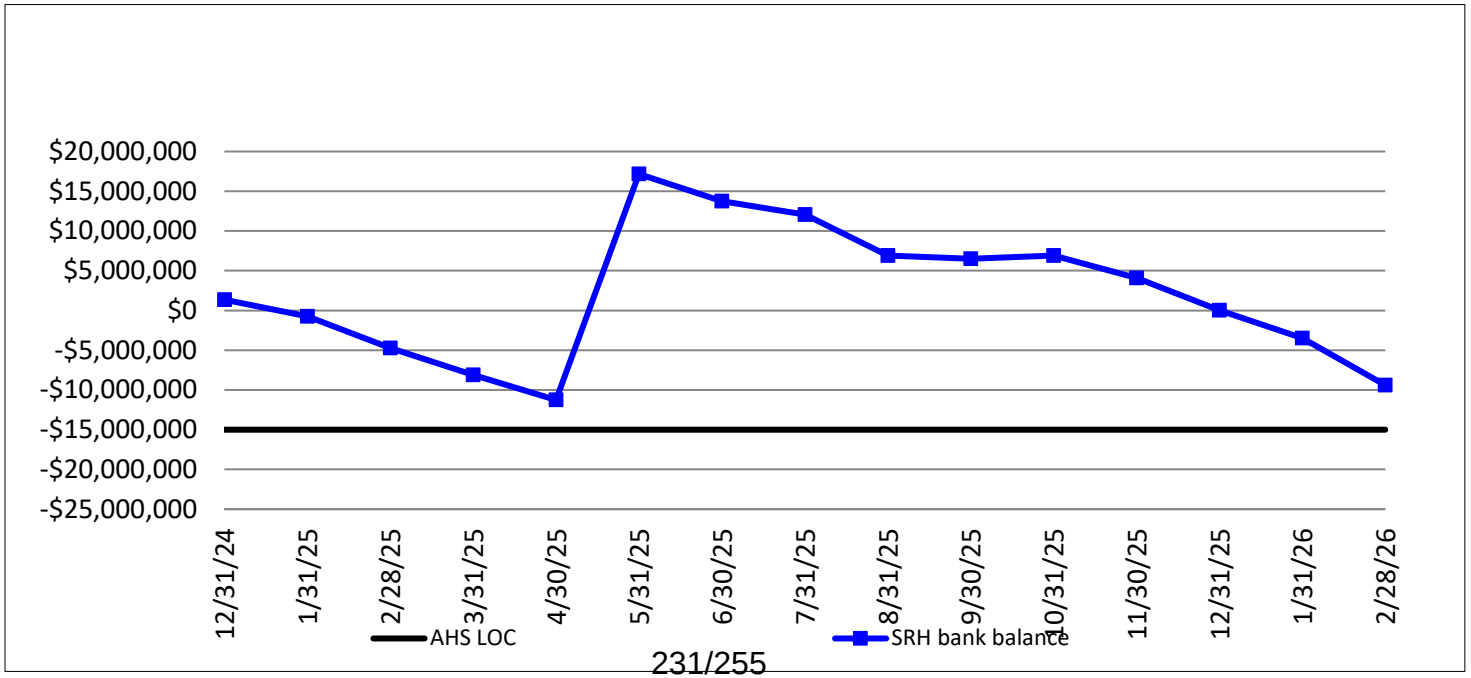
- MOB's YTD net income is $462.8K, exceeding budget by $133K (40.4%)
  - Rent revenue higher than budget from additional tenant (LaFamilia)
  - Still deferring repairs.

- Foundation's YTD net loss is $578.7K, unfavorable by $680.6K 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.

	August 31, 2025				Year-To-Date			
	Actual	**Budget**	**Var ($)**	**Var (%)**	**Actual**	**Budget**	**Var ($)**	**Var (%)**
Total Net Patient Service Revenue	$9,614	$8,742	$871	10.0%	$94,934	$92,708	$2,226	2.4%
Total Other Revenue	$175	$936	($761)	-81.3%	$40,621	$17,333	23,288	134.4%
TOTAL OPERATING REVENUE	**$9,788**	**$9,678**	**$110**	**1.1%**	**$135,555**	**$110,041**	**$25,514**	**23.2%**
Less: Operating Expenses	$11,776	$11,509	($267)	-2.3%	$125,904	$126,764	861	0.7%
EBITDA	**($1,988)**	**($1,831)**	**($157)**	**8.6%**	**$9,651**	**($16,723)**	**$26,375**	**-157.7%**
Total Non-Operating Exp/(Income)	$385	$382	$3	0.8%	$4,585	$4,321	$264	6.1%
Restr Donation - (AA Geropscych)	$0	$292	($292)	-100.0%	$0	$3,208	(3,208)	-100.0%
NET INCOME/(LOSS)	**($2,372)**	**($1,921)**	**($452)**	**23.5%**	**$5,067**	**($17,836)**	**$22,903**	**-128.4%**

August 2025
Cash Flow Projection

- SRH started drawing down from AHS LOC in January 2025 and has borrowed $11M through May 6, 2025. Interest was accrued on the County's cost of fund rate. Total amount drawn, along with the interest incurred to date ($109K), was paid off on June 12, 2025.
- SRF donated $1M to SRH on April 16, 2025.
- IGT funding received on May 28, 2025 - $30.3M
  - Paid in full AHS LOC ($11M)
  - Continue catching up on paying vendors especially health benefit-related invoices
- The current projection indicates that the IGT will 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.



Growing Responsibly Through Innovation & Teamwork GRIT

- Charge capture and CDI teams yielding significant improvement $6M in Q1
- LOS work showing positive progress $400k in Q1
- EWC dental expansion ramp up slower than plan
- Labor improvements behind target

GRIT Tracking - FY2026 Q1 YTD

(In Thousands)

#	Project Name	FY2026 Target YTD Q1	FY2026 Budget YTD Q1	FY2026 Actual YTD Q1	Variance	Metric	Status
1	OP Non-FQ Charge Capture(Enterprise CDI)	$1,485	$1,485	$4,366	$2,881	Charge per case increased by $474 (9%)	
2	OR Charge Level	$1,565	$1,565	$1,604	$39	HGH OR Charge/Case increased by $4,157 (18%); SLH OR Charge/Case increased by $4,346 (22%)	
3	Provider Productivity	$183	$0	$0	$0	Based on RVUs for GI, Ortho & Urology specialties, did not achieve 20% percentile productivity and remains at 10%	
4	Reduce Overtime %	$287	$287	($690)	($978)	Actual OT % at 5.6% to a target of 4.5%	
5	Staffing Efficiency	$2,194	$2,194	$0	($2,194)	Reduction of 12 FTEs for the quarter was not achieved. Total reduction for the year is 45 FTEs.	
6	EWC Dental Expansion	$2,277	$2,277	$1,363	($914)	Actual volumes at 3,884 to a budget of 6,490 (60%)	
7	Decrease in Opportunity Days	$899	$899	$395	($505)	Opportunity has improved by 263 days, however target was at 600 days.	
Grand Total		$8,890	**$8,707**	**$7,036**	**($1,671)**		

September 2025 Financial Report
Medicare GMLOS Benchmark – Trend of Excess Days

Acute Care Hospitals: HGH, SLH, AH (excludes any rehab)

- LOS Variance Days | September: There were 2,214 excess days which is a 1.56% monthly Increase. This reflects the total # of actual days in a bed in excess of the allowed # of days compared to the Medicare acuity model benchmark.
- Medicare GMLOS Benchmark: Compares the total AHS patient population against the Federal regulatory guidelines (Medicare), regardless if the patient is a non-Medicare State (APR) payer or a Medicare Federal (MSDRG) payer.

ALAMEDA HEALTH SYSTEM

MEMORANDUM

1411 East 31st Street
Oakland, CA 94602

TO: AHS Finance Committee
FROM: Kim Miranda, CFO
DATE: October 31, 2025
SUBJECT: September 2025 Financial Report

Financial Summary

Net Income for the month was $4.2 million compared to a budget of $0.9 million and favorable to budget by $3.3 million and 390.2%. Operating Revenue was $138.1 million and favorable to budget by $3.9 million and 2.9%. Operating Expense was $133.7 million and unfavorable to budget by $0.3 million and 0.3%. Earnings before interest, depreciation, and amortization (EBIDA) were $6.9 million and the EBIDA Margin was 5.0% compared to a budget EBIDA of $3.4 million and a budget EBIDA Margin of 2.6%. For the month, EBIDA was favorable to budget by $3.5 million.

	September 2025				Year-To-Date				FY 2025	
	Actual	Budget	Variance	% Var	Actual	Budget	Variance	% Var	YTD	% Var
Operating revenue	$ 138,113	$ 134,250	$ 3,863	2.9%	$ 413,524	$ 406,883	$ 6,641	1.6%	$ 380,071	8.8%
Operating expense	133,654	133,307	(347)	(0.3)%	403,709	400,167	(3,542)	(0.9)%	380,464	(6.1)%
Operating income (loss)	**4,459**	**943**	**3,516**	**372.9%**	**9,815**	**6,716**	**3,099**	**46.1%**	**(393)**	**2597.5%**
Other non-operating activity	(273)	(89)	(184)	(206.7)%	(940)	(357)	(583)	(163.3)%	(348)	(169.9)%
Net Income (loss)	**$ 4,186**	**$ 854**	**$ 3,332**	**390.2%**	**$ 8,875**	**$ 6,359**	**$ 2,516**	**39.6%**	**$ (741)**	**1297.2%**
EBIDA adjustments	2,713	2,585	128		7,984	8,062	(78)		11,116	
EBIDA	**$ 6,899**	**$ 3,439**	**$ 3,460**		**$ 16,859**	**$ 14,421**	**$ 2,438**		**$ 10,375**	
Operating Margin	3.2%	0.7%	2.5%		2.4%	1.7%	0.7%		(0.1)%	
EBIDA Margin	5.0%	2.6%	2.4%		4.1%	3.5%	0.6%		2.7%	

Net Income year-to-date (YTD) was $8.9 million compared to a budget of $6.4 million and favorable to budget by $2.5 million and 39.6%. Operating Revenue was $413.5 million and favorable to budget by $6.6 million and 1.6%. Operating Expense was $403.7 million and unfavorable to budget by $3.5 million and 0.9%. EBIDA was $16.9 million and the EBIDA Margin was 4.1% compared to the budget EBIDA of $14.4 million and a budget EBIDA Margin of 3.5%. For the year, EBIDA is favorable to budget $2.4 million.

Operating Revenue

Gross Patient Service Revenue (patient charges) was $420.8 million for the month and favorable to budget by $13.9 million and 3.4%. Inpatient fell below budget by 0.7%. Outpatient charges and Professional fees were above budget by 10.5% and 0.4%, respectively. For the year, Gross Patient Service Revenue was $1,258.2 million and favorable to budget by $26.8 million and 2.2%. Inpatient and Outpatient charges were above budget by 0.2% and 6.7%, respectively, and Professional Fee charges fell below budget by 3.3%.

	September 2025				Year-To-Date				FY 2025	
	Actual	Budget	Variance	% Var	Actual	Budget	Variance	% Var	YTD	% Var
Inpatient service revenue	$ 218,188	$ 219,706	$ (1,518)	(0.7)%	$ 659,571	$ 658,388	$ 1,183	0.2%	$ 633,304	4.1%
Outpatient service revenue	160,977	145,744	15,233	10.5%	475,011	445,219	29,793	6.7%	432,328	9.9%
Professional service revenue	41,659	41,513	146	0.4%	123,570	127,745	(4,175)	(3.3)%	119,937	3.0%
Gross patient service revenue	420,824	406,963	13,861	3.4%	1,258,152	1,231,351	26,801	2.2%	1,185,568	6.1%
Deductions from revenue	(339,659)	(327,410)	(12,249)	(3.7)%	(1,015,657)	(990,647)	(25,010)	(2.5)%	(956,770)	6.2%
Net patient service revenue	**81,165**	**79,553**	**1,612**	**2.0%**	**242,495**	**240,704**	**1,791**	**0.7%**	**228,798**	**(6.0)%**
Collection % - NPSR	19.3%	19.5%	(0.2)%		19.3%	19.5%	(0.2)%		19.3%	
Capitation and HPAC	4,470	4,548	(77)	(1.7)%	13,443	13,643	(201)	(1.5)%	13,752	(2.2)%
Other government programs	46,776	45,415	1,361	3.0%	137,201	136,245	956	0.7%	121,876	12.6%
Other operating revenue	5,702	4,734	967	20.4%	20,385	16,291	4,094	25.1%	15,645	30.3%
Total operating revenue	**$ 138,113**	**$ 134,250**	**$ 3,863**	**2.9%**	**$ 413,523**	**$ 406,884**	**$ 6,640**	**1.6%**	**$ 380,071**	**8.8%**

Inpatient charges were slightly lower than budget for the month driven by lower patient days. General Acute Length of Stay (LOS) is 4.7 for the month and the year which is better than budget, 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 YTD were driven by Emergency Room visits which exceeded budget by 6.4% and 7.8%, respectively. Outpatient surgeries also exceeded budget for the month and for the year by 9.8% and 0.7%, respectively. Professional Fees were favorable for the month due to higher clinic visits which exceeded budget by 1,611 and 4.6%. For the year, Professional fees were below budget due to lower clinic visits by 3,946 and 3.6%. Physician wRVU were above budget by 13.7% for the month and 14.0% for the year driven by hospital services. Overall, adjusted patient days were higher than budget for the month and year. Adjusted discharges exceed budget by 3.5% for the month and 4.7% for the year.

Net Patient Revenue

Net Patient Service Revenue (NPSR) was $81.2 million and favorable to budget by $1.6 million and 2.0%. YTD, NPSR was $242.5 million favorable compared to budget $1.8 million and 0.7%. The collection ratio was 19.3% for the month and unfavorable to budget by 0.2% which is consistent with YTD. The commercial payer mix is 6.6% for the month and YTD which is unfavorable to budget. Trauma cases were below budget by for the month and YTD by 13.8% and 1.8%, respectively. Trauma cases tend to drive a higher commercial mix. Rate increases for Government and Alliance contracts have not occurred and were spread evenly in the budget. 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 $46.8 million and favorable to budget by $1.4 million and 3.0% based on the transactions below.

- Pay-for-Performance (P4P) CY2024 incentive, from Alameda Alliance, increased revenue by $1.2 million.
- FEMA COVID expenses claimed awarded for $0.2 million.

For the year, the Other Government Program Revenue is $137.2 million and favorable to budget by $1.0 million and 0.7% based on the transactions below.

- Pay-for-Performance (P4P) revenue increased from successfully meeting CY2024 Alameda Alliance quality metrics for additional payment of $1.2 million.
- FEMA revenue received for successful filing of Covid-related expenditure was $0.2 million. Total FEMA receipts, starting in FY2024, are $7.1 million.
- Prop 56 was lower than budget by $0.5 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 positive $0.1 million, is spread across several programs.

Other Operating Revenue

Other Operating Revenue for the month was $5.7 million and favorable to budget by $1.0 million and 20.4% based on the transactions below.

- Retail pharmacy revenue was favorable by $0.8 million.
- St. Rose Hospital management fee favorable by $0.3 million, which was not included in the budget.

For the year, Other Operating Revenue was $20.4 million and favorable by $4.1 million and 25.1% based on the transactions below.

- Payor settlement received on older patient accounts of $3.1 million.
- Retail pharmacy revenue favorable by $0.5 million.
- St. Rose Hospital management fee $0.9 million, which was not included in the budget.
- Other operating revenue favorable by $0.3 million.
- Offset by unfavorable grant revenue from timing differences of $0.7 million.

Operating Expense

Operating Expense was $133.7 million for the month and unfavorable to budget by $0.3 million and 0.3% Physician contract services have been included with labor costs and are discussed in a subsequent section.

	September 2025				Year-To-Date				FY 2025	
	Actual	Budget	Variance	% Var	Actual	Budget	Variance	% Var	YTD	% Var
Labor costs	$ 103,516	$ 100,791	$ (2,725)	(2.7)%	$ 315,321	$ 308,142	$ (7,179)	(2.3)%	$ 293,754	(7.3)%
Purchased services	8,646	10,393	1,747	16.8%	25,593	27,494	1,901	6.9%	23,267	(10.0)%
Materials and supplies	12,898	13,371	473	3.5%	37,696	39,707	2,011	5.1%	36,570	(3.1)%
Facilities	3,220	3,367	147	4.4%	10,482	9,338	(1,144)	(12.3)%	8,838	(18.6)%
Depreciation and amortization	2,431	2,483	52	2.1%	7,013	7,666	653	8.5%	10,729	34.6%
General and administrative	2,943	2,902	(41)	(1.4)%	7,604	7,820	216	2.8%	7,306	(4.1)%
Total operating expense	**$ 133,654**	**$ 133,307**	**$ (347)**	**(0.3)%**	**$ 403,709**	**$ 400,167**	**$ (3,542)**	**(0.9)%**	**$ 380,464**	**(6.1)%**

Non-labor expense variances net to a favorable variance of $2.4 million for the month as follows:

- Purchased services for the month were favorable to budget by $1.7 million and 16.8% driven by favorable variances in outside medical services ($1.2 million), software licenses ($0.9 million) offset by unfavorable variances across various categories ($0.4 million). A refund was received from the ambulance vendor for duplicate invoices from their sister company after the company was reorganized ($1.2 million).
- Materials and supplies were favorable to budget of $0.5 million and 3.5% driven by favorable variances in pharmaceutical ($0.4 million), computer/minor equipment ($0.4 million) offset by unfavorable variance in surgery supplies ($0.3 million).
- Facilities for the month were favorable to budget by $0.1 million and 4.4% driven by favorable variances in equipment repairs ($0.5 million), utilities ($0.3 million) offset by facility repairs ($0.7 million). Most of the facility variance was for Highland Hospital and related to prior year invoices which will be adjusted.
- Depreciation and amortization approximate budget driven by a favorable variance for equipment depreciation ($0.4 million) offset by higher lease/software amortization ($0.4 million).
- General and administrative costs approximate budget driven by favorable timing variance for recruitment ($0.1 million) offset by higher insurance premiums ($0.1 million).

For the year, Operating Expense was $403.7 million and unfavorable to budget by $3.5 million and 0.9%. Labor costs are discussed in a subsequent section. Non-labor expense variances net to a favorable variance of $3.6 million as follows.

- Purchased services were favorable to budget by $1.9 million and 6.9% driven by favorable variances in outside medical services ($1.8 million) and software licensing ($1.1 million) partially offset by unfavorable variances spread across various departments ($0.3 million) and HIM coding ($0.7 million). The HIM coding variance is partially offset by the positive variance in registry.
- Materials and supplies were favorable to budget by $2.0 million and 5.1% driven by favorable variances in pharmaceuticals ($1.0 million), other medical supplies ($0.6 million), computer equipment ($0.3 million), and other non-medical supplies ($0.3 million), partially offset by unfavorable variance in surgical supplies ($0.2 million).
- Facilities were unfavorable to budget by $1.1 million and 12.3% driven by unfavorable variance in facility repairs ($1.7 million) partially offset by a favorable variance for utilities ($0.6 million). Approximately $0.7 million of the unfavorable facility repair variance is the result of FY2025 invoices that were not accrued in June 2025. An audit adjustment for FY2025 was booked and will reduce the FY2026 expense in October.
- Depreciation and amortization were favorable to budget by $0.7 million and 8.5% driven by favorable variance from timing of equipment depreciation ($1.3 million) and offset by higher than anticipated amortization of leases and software agreements ($0.6 million).
- General and administrative costs were favorable to budget by $0.2 million and 2.8% driven by favorable variance for timing of recruitment ($0.2 million).

Labor Costs

Labor costs for the month were $103.5 million and unfavorable to budget by $2.7 million and 2.7%. YTD, labor costs were $315.3 million and unfavorable to budget by $7.2 million and 2.3%. Starting in September 2025, physician contract services were moved to the labor cost section to show a complete picture of staffing utilized to provide direct patient care and support services.

	September 2025				Year-To-Date				FY 2025	
	Actual	Budget	Variance	% Var	Actual	Budget	Variance	% Var	YTD	% Var
Salaries and wages (staff)	$ 63,033	$ 59,310	$ (3,723)	(6.3)%	$ 188,171	$ 180,615	$ (7,556)	(4.2)%	$ 171,394	(9.8)%
Salaries and wages (providers)	10,381	10,715	334	3.1%	31,254	33,170	1,916	5.8%	30,584	(2.2)%
Registry	3,376	4,175	799	19.1%	10,863	12,720	1,857	14.6%	12,627	14.0%
Physician contract services	3,675	3,768	93	2.5%	11,241	10,829	(412)	(3.8)%	11,163	0.0%
Employee benefits (taxes, insurance)	15,570	15,308	(262)	(1.7)%	49,247	46,566	(2,681)	(5.8)%	44,910	(9.7)%
Retirement	7,481	7,515	34	0.5%	24,545	24,242	(303)	(1.2)%	23,077	(6.4)%
Total labor costs	**$ 103,516**	**$ 100,791**	**$ (2,725)**	**(2.7)%**	**$ 315,321**	**$ 308,142**	**$ (7,179)**	**(2.3)%**	**$ 293,754**	**(7.3)%**
Compensation ratio	75.0%	75.1%	0.1%		76.3%	75.7%	-0.6%		77.3%	
Paid FTEs - staff	4,749	4,670	(79)	(1.7)%	4,693	4,593	(100)	(2.2)%	4,604	(1.9)%
Paid FTEs - providers	289	306	17	5.6%	286	306	20	6.6%	282	(1.3)%
Paid FTEs - registry	186	217	31	14.3%	202	216	14	6.5%	206	2.1%
Total FTEs	5,224	5,193	(31)		5,181	5,115	(66)		5,092	

Total salary and wages (staff) and registry for the month were $66.4 million and unfavorable to budget by $2.9 million and 4.6% driven by higher volume (48 FTEs/$0.6 million) and higher rates ($2.3 million). YTD, this category was $199.0 million and unfavorable by $5.7 million and 2.9% driven by higher volume (86 FTEs/$3.5 million) and higher rates ($2.2 million). AHS is using UKG timekeeping to track registry utilization. At this point, timing differences occur between when invoices are paid, and the hours included to calculate FTE that are causing variances for the month.

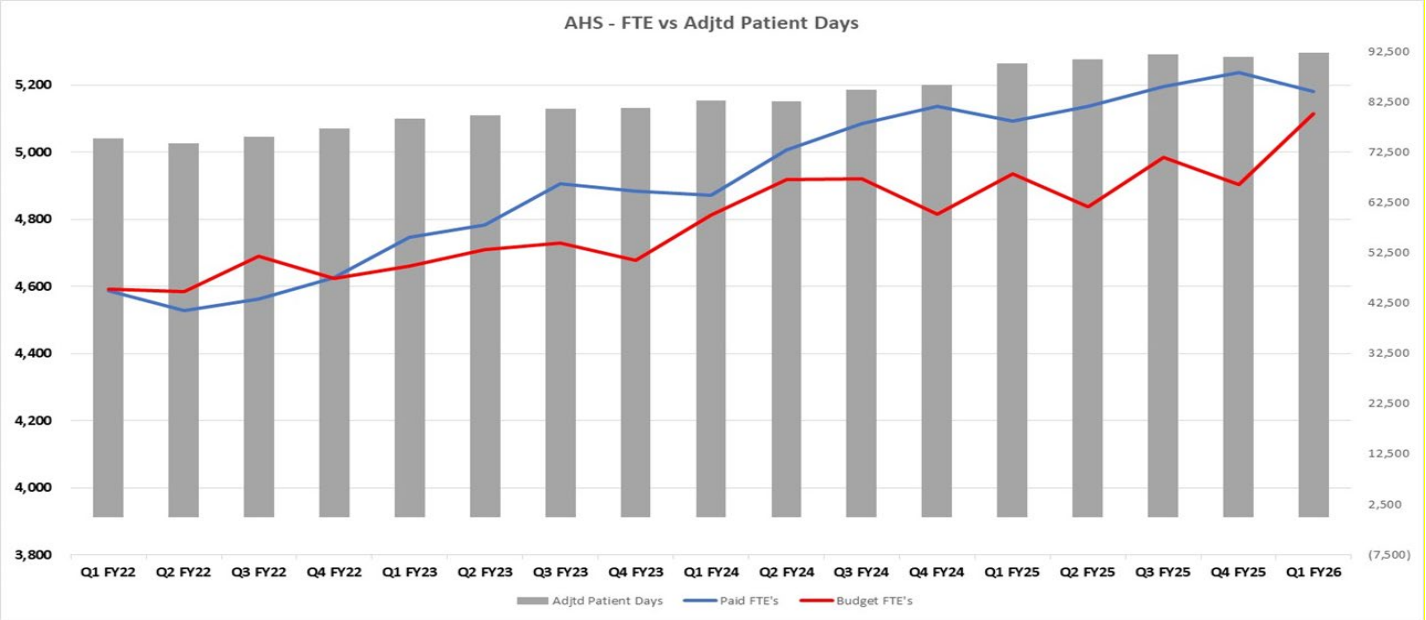
Total salary and wages (providers) and physician contract services for the month were $14.1 million and favorable to budget by $0.4 million and 2.9%. YTD, this category was $42.5 million and favorable to budget by $1.5 million and 3.4%. Specialties with the largest negative variances for both the month and year were General Surgery and Emergency. As a reminder, contract providers do not provide hours to calculate an FTE.

Employee benefits were unfavorable for the month by $0.3 million and 1.7% driven by self-funded health insurance ($1.1 million) offset by positive variance in FICA ($0.3 million), Kaiser insurance plan ($0.3 million), and other benefits ($0.2 million). YTD, employee benefits were unfavorable to budget by $2.7 million and 5.8% driven by self-funded health ($4.3 million) offset by positive variances for Kaiser insurance plan ($0.8 million), FICA ($0.6 million), and other benefits ($0.2 million).

Retirement approximate budget for the month. YTD, retirement expense was unfavorable $0.3 million and 1.2% from ACERA ($0.6 million) offset by positive variances for other AHS plans ($0.3 million).

FTE Trending

For the month, Paid FTE was 5,224 compared to a budget of 5,193 which was unfavorable to budget by 31 and 0.6%. YTD, Paid FTE was 5,181 compared to a budget of 5,115 which was unfavorable to budget by 66 and 1.3%. The FTE trend graph reflects paid FTE and adjusted patient days (Total Gross Revenues / Inpatient Revenues = Outpatient Factor x Patient Days) by quarter beginning in FY2022. Overall, adjusted patient days (gray bars) have recovered to pre-COVID19 levels; however, growth of FTEs is outpacing the growth in adjustment patient days. As a reminder, pre-COVID19 adjusted patient days for FY2018 Q4 was approximately 83,000 with 4,400 FTEs.



Balance Sheet and Financial Condition

The Balance Sheet key financial metrics are reflected in the table below.

	Sep-25	Aug-25	FY 2025
Days in cash	2.9	1.8	1.2
Gross days in patient receivable	62.8	62.0	62.4
Net days in patient receivable	47.4	44.7	45.5
Due from/(to) third-party payors	$ 282,422	$ 220,760	$ 154,653
Due from/(to) County	$ (49,259)	$ (25,188)	$ 39,481
Days in accounts payable	32.5	35.0	38.1
% of AP over 60 days	3.5%	3.0%	10.6%
Net position - fund balance/(deficit)	$ (51,223)	$ (55,411)	$ (60,267)
Net negative balance - receivable/(payable)	$ (36,214)	$ 4,834	$ 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 62.8 days and 0.8 days higher than last month due to lower cash receipts. Net Days in AR were 47.4 and 2.7 days higher than the previous month due to more net revenue per calendar day of 0.4%. 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 million to $74.2 million, total $73.4 million through September 2025. The final payment of $0.8 million was received in October 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 interim contract was signed for $81.4 million on October 13, 2025.

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	-	66,819	66,819	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**	**216,838**	**257,417**	**943,182**	**831,444**	**776,453**	**705,637**
	% change between fiscal years		15.8%	13.4%	7.1%	10.0%	

Accounts Payable
Days in Accounts Payable are 32.5 at the end of the month and were 2.5 days lower than 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 3.5% 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 $282.4 million, which increased $61.7 million over last month. Key items are noted below.

- Payment received for AB85 Realignment FY2024 ($3.9 million).
- Payment received for Physician SPA FY2024 ($2.7 million).
- Payment received for Alameda Alliance CY2024 Pay-for-Performance and HEI ($1.2 million).
- Payment received for Medi-Cal SNF Cost Settlement CY2024 Q1 and Q2 ($1.0 million).
- IGT funded for GPP CY2025 Q3 ($38.6 million).
- Minor cost report adjustments and monthly accruals ($31.9 million).

Net Reimbursement Supplemental Programs as of 9/30/2025					
Programs	**FY97-20**	**FY21-25**	**FY26**	**Net Balance**	**Comments**
Medicare Cost Report	(1,617)	(4,676)	(166)	(6,458)	Older years pending disputed SSI ratio and outlier holds for both OPPS/IPPS services from CMS.
Medi-Cal P14 Waiver	4,225	(1,779)	(2,215)	231	P14 audits are in various stages of completion. Currently DHCS has finalized up to FY19.
Current Waiver (GPP & CalAIM)	-	33,012	25,210	58,222	Global Payment Program (GPP) subsidizing remaining uninsured. GPP extended to 2026 as CalAIM.
AB85 Realignment	0	(90,719)	-	(90,719)	Realignment reserves for HPAC amendment passing through the County for physical health for Medi-Cal and Indigent populations.
Physician SPA	(6,000)	1,160	2,835	(2,005)	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)	(1,250)	(24,578)	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	130,480	16,932	147,412	EPP (Enhanced Payment Program). New supplemental program for services provided to Medi-Cal Managed Care.
Medi-Cal Managed Care QIP	0	134,819	13,283	148,102	QIP (Quality Incentive Program). New supplemental program for services provided to Medi-Cal Managed Care.
Medi-Cal Managed Care Rate Range	(0)	69,800	12,950	82,750	Subsidize rates for Medi-Cal Managed Care members in Alameda County.
Medi-Cal Managed Care GME	0	5,935	426	6,362	CMS approved in March 2020. GME is paying concurrently with fiscal year.
Medi-Cal Managed Care DP-NF Pass-Through	-	6,449	-	6,449	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	926	105	1,031	The State began their reconciliation.
AB915	-	2,353	2,202	4,555	AB915/Medi-Cal Hospital OP cost settlement. DHCS began reconciling older years during FY23.
All Other Supplemental Programs	0	3,643	1,861	5,504	Hospital Fee, NDPH & P4P programs
Subtotal	**$ (11,313)**	**$ 275,998**	**$ 72,173**	**$ 336,858**	
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)**	**$ 275,998**	**$ 72,173**	**$ 282,422**	

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 County Receivable and Payable

Due To/From County of Alameda

	Sep-25	Aug-25	FY 2025
Due from County of Alameda	$ 32,376	$ 24,799	$ 45,740
Capital designation receivable	7,000	7,000	7,000
Due from County of Alameda	**39,376**	**31,799**	**52,740**
Due to County of Alameda	(3,590)	(2,878)	(2,379)
County IGT funding	(78,448)	(43,229)	-
Capital cost payable	(6,597)	(10,880)	(10,880)
Due to County of Alameda	**(88,635)**	**(56,987)**	**(13,259)**
Net due from/(to) County	**$ (49,259)**	**$ (25,188)**	**$ 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 ($6.6 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. AHS paid 90% for the FY2023 filing ($4.3 million) in September 2025. 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 September 30, 2025, is negative $51.2 million, which improved $4.2 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 $36.2 million payable on September 30, 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 ($63.3 million payable) decreased by the County Restricted Cash Fund ($27.1 million) which is included in Cash.

Contingencies

John George Pavilion (JGP)

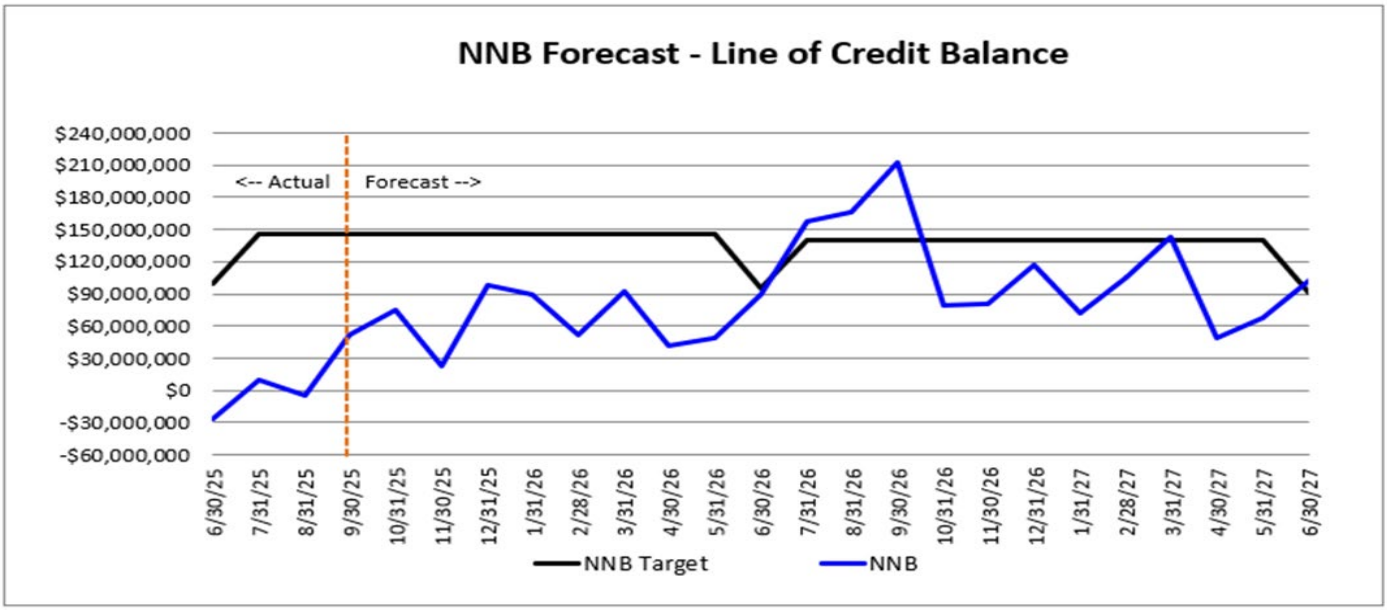
The County continues to struggle with the implementation of new software, SmartCare. JGP technical services have been input into SmartCare to be billed and paid for by the State although AHS has not received any information from the County on denials or payments they have received. AHS and the County 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 based on the maximum contract amount; however, they are withholding approximately 20% pending resolution with the State. AHS has no information on how the maximum contract amounts were determined or the status of claims or if more adequate funding will happen. AHS and the County signed the FY2026 interim contract on October 13, 2025, which increased funding to $81.4 million.

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, 2027 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 and slightly over the June 30, 2027 limit of $90.0 million. The forecast reflects AHS operations consistent with the approved budget; however, the forecast updates as actual activity is reflected in the cashflow model. The forecast NNB for June 30, 2026 improved by $9.3 million compared to the previous month's forecast. The key factors were 1) patient receipts continue to be strong and 2) additional $4.1 million in FY2024 AB85 Realignment was received (not previously in forecast).



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 Q3 increased from $25.7 million to $26.5 million based on DHCS notification.
- SRH will access the line of credit starting in January 2026 at a run rate of $3.0 million per month with repayment expected in June 2026.
- SRH will need support to maximize the FY26 IGT funding. Donations of $10.0 million were included for both years pending Trustees' approval.
- SRH FY2026 budget was approved on October 28, 2026 by the SRH Board of Directors.

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	Jan-26	Feb-26	Mar-26	FY26 Q4	FY27 Q1	FY27 Q2	FY27 Q3	FY27 Q4
GPP (quarterly)	$ 8,063	$ -	$ 20,100	$ 18,474	$ 5,600	$ 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	-	-	-	45,800	-	-	-	-	51,300	-
Medi-Cal Waiver (fy11)	-	29,169	-	-	-	-	-	-	-	-
BHCS (JGP/Alameda County) - fy26	-	18,252	6,084	6,084	6,084	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	-	-	3,000	3,000	3,000	(9,000)	-	-	-	-
Donation to St. Rose Hospital	-	-	-	-	10,000		-	-	10,000	
	$ 21,757	$ 58,221	$ 54,981	$ 73,358	$ 35,484	$ 111,915	$ 36,222	$ 195,202	$ 145,651	$ 146,210

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 September 30, 2025
(In Thousands)

	September 2025				Year-To-Date				FY 2025		
	Actual	Budget	Variance	% Variance	Actual	Budget	Variance	% Variance	YTD	Variance	% Variance
Operating revenue											
Net patient service revenue	$ 81,165	$ 79,553	$ 1,612	2.0%	$ 242,495	$ 240,704	$ 1,791	0.7%	$ 228,798	$ 13,697	6.0%
Capitation revenue	4,470	4,548	(78)	(1.7)%	13,443	13,643	(200)	(1.5)%	13,752	(309)	(2.2)%
Other government programs	46,776	45,415	1,361	3.0%	137,201	136,245	956	0.7%	121,876	15,325	12.6%
Other operating revenue	5,702	4,734	968	20.4%	20,385	16,291	4,094	25.1%	15,645	4,740	30.3%
Total operating revenue	**138,113**	**134,250**	**3,863**	**2.9%**	**413,524**	**406,883**	**6,641**	**1.6%**	**380,071**	**33,453**	**8.8%**
Operating expense											
Labor costs	103,516	100,791	(2,725)	(2.7)%	315,321	308,142	(7,179)	(2.3)%	293,754	(21,567)	(7.3)%
Purchased services	8,646	10,393	1,747	16.8%	25,593	27,494	1,901	6.9%	23,267	(2,326)	(10.0)%
Materials and supplies	12,898	13,371	473	3.5%	37,696	39,707	2,011	5.1%	36,570	(1,126)	(3.1)%
Facilities	3,220	3,367	147	4.4%	10,482	9,338	(1,144)	(12.3)%	8,838	(1,644)	(18.6)%
Depreciation and amortization	2,431	2,483	52	2.1%	7,013	7,666	653	8.5%	10,729	3,716	34.6%
General and administrative	2,943	2,902	(41)	(1.4)%	7,604	7,820	216	2.8%	7,306	(298)	(4.1)%
Total operating expense	**133,654**	**133,307**	**(347)**	**(0.3)%**	**403,709**	**400,167**	**(3,542)**	**(0.9)%**	**380,464**	**(23,245)**	**(6.1)%**
Operating income (loss)	**4,459**	**943**	**3,516**	**372.9%**	**9,815**	**6,716**	**3,099**	**46.1%**	**(393)**	**10,208**	**2597.5%**
Non-operating activity											
Interest income (expense)	(282)	(102)	(180)	(176.5)%	(971)	(396)	(575)	(145.2)%	(387)	(584)	(150.7)%
Other nonoperating revenue	9	13	(4)	(30.8)%	31	39	(8)	(20.5)%	39	(8)	(20.6)%
Total non-operating activity	**(273)**	**(89)**	**(184)**	**(206.7)%**	**(940)**	**(357)**	**(583)**	**(163.3)%**	**(348)**	**(592)**	**(169.9)%**
Net income (loss)	**$ 4,186**	**$ 854**	**$ 3,332**	**390.2%**	**$ 8,875**	**$ 6,359**	**$ 2,516**	**39.6%**	**$ (741)**	**$ 9,616**	**1297.2%**
EBIDA adjustments											
Interest income (expense)	282	102	180		971	396	575		387	584	
Depreciation and amortization	2,431	2,483	(52)		7,013	7,666	(653)		10,729	(3,716)	
Total EBIDA adjustments	2,713	2,585	128		7,984	8,062	(78)		11,116	(3,132)	
EBIDA	**$ 6,899**	**$ 3,439**	**$ 3,460**		**$ 16,859**	**$ 14,421**	**$ 2,438**		**$ 10,375**	**$ 6,484**	

ALAMEDA HEALTH SYSTEM (consolidated)
Balance Sheet
As of September 30, 2025
(In Thousands)

	Current Month	Prior Month	FYE 2025
ASSETS			
Cash & cash equivalents	$ 12,750	$ 7,430	$ 14,556
Patient account receivables, net	111,700	102,855	101,401
Due from third-party payors	470,875	409,009	346,479
Due from County of Alameda	39,376	31,799	52,740
Due from State of California	26,883	25,711	25,635
Inventories	12,558	12,545	12,267
Other current assets	23,295	24,414	17,592
TOTAL CURRENT ASSETS	**697,437**	**613,763**	**570,670**
Restricted cash equivalents	27,133	27,133	27,133
Right-to-use lease assets, net	29,734	30,358	31,604
Right-of-use subscription assets, net	4,763	4,655	5,050
Capital assets - nondepreciable	9,021	9,021	9,021
Capital assets - depreciable, net	129,421	128,745	129,675
TOTAL NONCURRENT ASSETS	**200,072**	**199,912**	**202,483**
DEFERRED OUTFLOWS OF RESOURCES	**105,415**	**105,415**	**105,415**
TOTAL ASSETS & DEFERRED OUTFLOWS	**$ 1,002,924**	**$ 919,090**	**$ 878,568**
LIABILITIES & NET ASSETS			
Accounts payable and accrued expenses	$ 74,333	$ 75,862	$ 79,162
Accrued compensation	49,527	42,223	63,953
Due to third-party payors	188,453	188,249	191,826
Due to County of Alameda	88,635	56,987	13,259
Other Payables	43,357	41,887	37,834
TOTAL CURRENT LIABILITIES	**444,305**	**405,208**	**386,034**
Liquidity facility - County of Alameda	63,347	22,299	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	28,099	28,647	29,739
Subscription obligations, net of current portion	1,892	1,843	1,993
Other long-term liabilities	0	0	0
TOTAL LONG TERM LIABILITIES	**568,679**	**528,130**	**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)	8,875	4,687	19,339
FUND BALANCE	**(51,223)**	**(55,411)**	**(60,267)**
TOTAL LIABILITIES, DEFERRED INFLOWS, & FUND BALANCE	**$ 1,002,924**	**$ 919,090**	**$ 878,568**

ALAMEDA HEALTH SYSTEM (consolidated)
Statement of Cash Flows
For the Period Ended September 30, 2025
(in thousands)

	Current Month	Year-to Date	FYE 2025
CASH FLOWS FROM OPERATING ACTIVITIES			
Operating income (loss)	$ 4,459	$ 9,815	$ 23,794
Depreciation and amortization	2,431	7,013	36,849
Net changes in operating assets and liabilities:			
Patient account receivables, net	(8,845)	(10,299)	4,695
Due from/to third-party payors	(61,662)	(127,769)	(9,320)
Due from/to County	24,071	88,740	(14,681)
Due from State	(1,172)	(1,248)	(1,371)
Inventory	(13)	(291)	(280)
Other current assets	1,119	(5,703)	30
Accounts payable and accrued expenses	(1,527)	(4,829)	(6,325)
Accrued compensation	7,304	(14,426)	7,686
Other current payables	1,470	5,523	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	**(32,365)**	**(57,537)**	**51,751**
CASH FLOWS FROM NONCAPITAL FINANCING ACTIVITIES			
Change in liquidity facility	41,048	62,845	(4,599)
Interest payments on working capital loan	370	1,111	4,402
Receipts of rental income	9	31	(253)
Net cash provided by (used in) noncapital financing activities	**41,427**	**63,987**	**(450)**
CASH FLOWS FROM CAPITAL AND FINANCING ACTIVITIES			
Purchase and construction of capital assets	(2,001)	(3,927)	(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	(572)	(1,748)	(6,730)
Interest payments on lease liabilities	91	277	1,232
Payments of subscription obligations	(517)	(668)	(4,532)
Interest payments on subscription obligations	28	49	128
Capital contributions and transfers	-	169	1,015
Net cash provided by (used in) capital and financing activities	**(2,971)**	**(5,848)**	**(31,606)**
CASH FLOWS FROM INVESTING ACTIVITIES			
Interest and investment income	(771)	(2,408)	(9,964)
Net cash provided by (used in) investing activities	**(771)**	**(2,408)**	**(9,964)**
CHANGES IN CASH AND CASH EQUIVALENTS	**5,320**	**(1,806)**	**9,731**
CASH AND CASH EQUIVALENTS, beginning of period	34,563	41,689	31,958
CASH AND CASH EQUIVALENTS, end of period	**$ 39,883**	**$ 39,883**	**$ 41,689**

ALAMEDA HEALTH SYSTEMS Volume Reports

Month: September

	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: AHS ALL CAMPUS											
Total Adjusted Patient Days	30,457	30,133	324	1.1%	92,208	91,628	580	0.6%	90,213	1,995	2.2%
Total Adjusted Discharges	2,713	2,621	91	3.5%	8,277	7,906	371	4.7%	7,758	520	6.7%
GENERAL ACUTE											
Patient Days	5,708	6,290	-582	-9.2%	17,747	18,764	-1,017	-5.4%	18,531	-784	-4.2%
Discharges	1,202	1,203	-1	-0.1%	3,777	3,610	167	4.6%	3,581	196	5.5%
Average Daily Census	190.3	209.7	-19.4	-9.2%	192.9	204	-11.1	-5.4%	201.4	-8.5	-4.2%
Average Length of Stay	4.7	5.2	0.5	9.2%	4.7	5.2	0.5	9.6%	5.2	0.5	9.2%
Adjusted Patient Days	11,080	11,545	-466	-4.0%	33,980	34,768	-787	-2.3%	34,428	-447	-1.3%
Adjusted Discharges	2,333	2,209	125	5.6%	7,232	6,689	543	8.1%	6,653	579	8.7%
Occupancy %	64%	70%	-7%		65%	68%	-4%		68%	-3%	
CMI	1.649	1.658	-0.009	-0.5%	1.596	1.655	-0.059	-3.5%	1.654	-0.058	-3.5%
Emergency Visits	9,497	8,926	571	6.4%	28,584	26,527	2,057	7.8%	27,229	1,355	5.0%
Left Without Being Seen (LWBS)	455	571	116	25.5%	1,439	1,730	291	20.2%	1,929	490	34.1%
Trauma Cases	317	368	-51	-13.8%	976	994	-18	-1.8%	1,038	-62	-6.0%
Observation Equivalent Days	674	671	3	0.5%	1,979	2,070	-91	-4.4%	1,976	3	0.2%
Total Surgeries	732	676	56	8.3%	2,131	2,143	-12	-0.6%	2,324	-193	-8.3%
IP Surgeries	329	309	20	6.5%	972	992	-20	-2.0%	916	56	6.1%
OP Surgeries	403	367	36	9.8%	1,159	1,151	8	0.7%	1,408	-249	-17.7%
Deliveries	148	146	2	1.5%	472	427	45	10.5%	398	74	18.6%
PSYCH											
Psych Patient Days	2,027	2,039	-12	-0.6%	6,156	6,035	121	2.0%	5,986	170	2.8%
Psych Discharges	230	226	4	1.6%	647	670	-23	-3.5%	645	2	0.3%
Average Daily Census	67.6	68	-0.4	-0.6%	66.9	65.6	1.3	2.0%	65.1	1.8	2.8%
Average Length of Stay	8.8	9	0.2	2.1%	9.5	9	-0.5	-5.7%	9.3	-0.2	-2.5%
Adjusted Patient Days	2,522	2,503	18	0.7%	7,666	7,408	258	3.5%	7,398	267	3.6%
Adjusted Discharges	286	278	8	2.9%	806	823	-17	-2.1%	797	8	1.1%
PES Equivalent Days	767	711	55	7.8%	2,333	2,179	154	7.1%	2,179	154	7.1%
REHAB											
Rehab Patient Days	769	778	-9	-1.1%	2,122	2,198	-76	-3.5%	2,108	14	0.7%
Rehab Discharges	54	59	-5	-8.2%	160	166	-6	-3.8%	154	6	3.9%
Average Daily Census	25.6	25.9	-0.3	-1.1%	23.1	23.9	-0.8	-3.5%	22.9	0.2	0.7%
Average Length of Stay	14.2	13.2	-1	-7.7%	13.3	13.2	0	-0.3%	13.7	0.4	3.1%
Adjusted Patient Days	769	778	-9	-1.1%	2,122	2,198	-76	-3.5%	2,108	14	0.7%
Adjusted Discharges	54	59	-5	-8.2%	160	166	-6	-3.8%	154	6	3.9%
Occupancy %	92%	93%	0%		82%	85%	0%		82%	0%	

ALAMEDA HEALTH SYSTEMS Volume Reports

Month: September

	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: AHS ALL CAMPUS											
SNF with Sub-Acute											
SNF Patient Days	8,349	8,270	79	1.0%	25,587	25,362	226	0.9%	24,985	602	2.4%
SNF Discharges	15	23	-8	-35.5%	49	71	-22	-31.4%	58	-9	-15.5%
Average Daily Census	278.3	275.7	2.6	1.0%	278.1	275.7	2.5	0.9%	271.6	6.5	2.4%
Average Length of Stay	556.6	355.9	-200.7	-56.4%	522.2	355.2	-167	-47.0%	430.8	-91.4	-21.2%
Adjusted Patient Days	8,620	8,282	338	4.1%	26,423	25,404	1,019	4.0%	25,751	672	2.6%
Adjusted Discharges	15	23	-8	-33.5%	51	72	-21	-29.2%	60	-9	-15.4%
Occupancy %	96%	95%	0%		96%	95%	0%		94%	0%	
Bed Holds	82	73	9	11.8%	128	280	-152	-54.3%	278	-150	-54.0%
TOTAL FTE, HOURS, WRVU											
Total Paid FTE	5,224	5,192	-31	-0.6%	5,181	5,115	-66	-1.3%	5,092	-89	-1.7%
Total Productive FTE	4,478	4,428	-50	-1.1%	4,498	4,406	-92	-2.1%	4,359	-139	-3.2%
Total Paid FTE per AOB	5.15	5.17	0.02	0.5%	5.17	5.14	-0.03	-0.7%	5.19	0.02	0.5%
Worked Hours Per APD	25.2	25.2	0	-0.1%	25.6	25.3	-0.4	-1.4%	25.4	-0.2	-0.9%
Worked Hours Per AD	283	290	7	2.3%	286	293	7	2.5%	295	10	3.3%
Physician wRVU	134,503	118,271	16,233	13.7%	402,271	352,815	49,456	14.0%	371,485	30,786	8.3%
Total Clinic Visits	36,495	34,884	1,611	4.6%	105,935	109,881	-3,946	-3.6%	102,372	3,563	3.5%
FQHC Visits	30,778	29,562	1,216	4.1%	89,084	92,020	-2,936	-3.5%	85,081	4,003	4.7%
Non-FQHC Visits	5,717	5,322	395	7.4%	16,851	17,861	-1,010	-5.7%	17,291	-440	-2.5%
PAYOR MIX											
Insurance %	6.6%	7.9%	-1.3%		6.6%	7.4%	-0.8%		7.3%	-0.7%	
Medi-Cal %	6.8%	8.6%	-1.9%		7.2%	9.6%	-2.5%		9.5%	-2.3%	
Medi-Cal MC %	54.8%	52.0%	2.9%		52.9%	52.3%	0.6%		52.6%	0.3%	
Medicare %	20.1%	18.5%	1.6%		22.0%	18.5%	3.4%		19.1%	2.9%	
Medicare MC %	7.4%	7.5%	-0.1%		7.2%	7.2%	-0.1%		7.4%	-0.2%	
Other Govt %	1.4%	2.2%	-0.8%		1.4%	1.7%	-0.4%		1.6%	-0.3%	
Self-Pay %	2.9%	3.4%	-0.6%		2.9%	3.2%	-0.3%		2.5%	0.4%	
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: September

	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	4,167	4,519	-352	-7.8%	12,680	13,145	-465	-3.5%	12,912	-232	-1.8%
Total Discharges	760	784	-24	-3.1%	2,407	2,281	126	5.5%	2,201	206	9.4%
Total Adjusted Patient Days	7,585	7,829	-244	-3.1%	22,824	23,111	-288	-1.2%	22,610	214	0.9%
Total Adjusted Discharges	1,383	1,359	25	1.8%	4,333	4,011	322	8.0%	3,854	478	12.4%
GENERAL ACUTE											
Patient Days	4,167	4,519	-352	-7.8%	12,680	13,145	-465	-3.5%	12,912	-232	-1.8%
Discharges	760	784	-24	-3.1%	2,407	2,281	126	5.5%	2,201	206	9.4%
OP Factor	1.8267	1.7377	-0.089	-5.1%	1.8065	1.7644	-0.0421	-2.4%	1.7568	-0.0497	-2.8%
Average Daily Census	138.9	150.6	-11.7	-7.8%	137.8	142.9	-5.1	-3.5%	140.3	-2.5	-1.8%
Average Length of Stay	5.5	5.8	0.3	4.9%	5.3	5.8	0.5	8.6%	5.9	0.6	10.2%
Adjusted Patient Days	7,612	7,853	-242	-3.1%	22,907	23,192	-286	-1.2%	22,684	223	1.0%
Adjusted Discharges	1,388	1,363	25	1.9%	4,348	4,025	324	8.0%	3,867	482	12.5%
Occupancy %	82%	89%	-7%		82%	85%	-3%		83%	-1%	
Emergency Visits	4,865	4,552	313	6.9%	14,657	13,280	1,377	10.4%	13,592	1,065	7.8%
Left Without Being Seen (LWBS)	308	526	218	70.8%	970	1,581	611	63.0%	1,554	584	60.2%
Trauma Cases	317	368	-51	-13.8%	976	994	-18	-1.8%	1,038	-62	-6.0%
Observation Equivalent Days	235	298	-62	-20.9%	722	959	-237	-24.7%	828	-106	-12.8%
Total Surgeries	487	439	48	10.8%	1,464	1,398	66	4.7%	1,364	100	7.3%
IP Surgeries	265	250	15	5.8%	798	791	7	0.9%	737	61	8.3%
OP Surgeries	222	189	33	17.5%	666	607	59	9.7%	627	39	6.2%
Deliveries	148	146	2	1.5%	472	427	45	10.5%	398	74	18.6%
TOTAL FTE, HOURS, WRVU											
Total Paid FTE	1,891	1,855	-36	-1.9%	1,858	1,806	-52	-2.9%	1,812	-46	-2.6%
Total Productive FTE	1,605	1,577	-28	-1.8%	1,610	1,552	-59	-3.8%	1,539	-72	-4.7%
Total Paid FTE per AOB	7.48	7.11	-0.37	-5.2%	7.49	7.19	-0.3	-4.2%	7.37	-0.12	-1.6%
Worked Hours Per APD	36.3	34.5	-1.8	-5.1%	37.1	35.3	-1.8	-5.1%	35.8	-1.3	-3.7%
Worked Hours Per AD	199	199	0	0.0%	195	203	8	3.9%	210	14	6.9%
Physician wRVU	4	7	-4	-49.4%	10	17	-7	-39.8%	16	-6	-37.0%
OTHER STATS											
GI Procedures	489	334	155	46.4%	1,177	1,051	126	11.9%	1,043	134	12.8%
Cardiac Procedures	172	54	118	220.1%	437	180	257	142.2%	169	268	158.6%
HGH Cath Lab and IR Procedures	998	545	453	83.0%	2,474	1,420	1,054	74.2%	1,730	744	43.0%
Total Clinic Visits	2,382	1,877	505	26.9%	6,989	6,944	45	0.6%	6,900	89	1.3%
Specialty	1543	1178	365	31.0%	4,658	3,652	1,006	27.5%	4,011	647	16.1%
Behavioral Health	839	699	140	20.0%	2,331	3,292	-961	-29.2%	2,889	-558	-19.3%
PAYOR MIX											
Insurance %	7.2%	8.6%	-1.4%		7.2%	8.6%	-1.4%		8.4%	-1.2%	
Medi-Cal %	8.2%	8.9%	-0.7%		7.5%	10.2%	-2.7%		9.9%	-2.5%	
Medi-Cal MC %	52.6%	51.4%	1.2%		51.3%	52.0%	-0.7%		52.6%	-1.3%	
Medicare %	19.3%	16.5%	2.8%		21.2%	16.3%	4.9%		16.8%	4.5%	
Medicare MC %	7.8%	7.9%	-0.1%		7.9%	7.3%	0.5%		7.5%	0.4%	
Other Govt %	1.6%	2.1%	-0.5%		1.5%	2.0%	-0.5%		1.9%	-0.4%	
Self-Pay %	3.4%	4.6%	-1.3%		3.5%	3.5%	-0.1%		3.0%	0.5%	
Total Payor Mix %	100.0%	100.0%	0.0%		100.0%	100.0%	0.0%		100.0%	0.0%	
CAMPUS CMI											
CMI Highland	1.76	1.746	0.014	0.8%	1.677	1.744	-0.067	-3.9%	1.744	-0.067	-3.9%

ALAMEDA HEALTH SYSTEMS Volume Reports

ALAMEDA HEALTH SYSTEM

Month: September

	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	5,931	5,980	-49	-0.8%	18,451	18,468	-17	-0.1%	18,194	257	1.4%
Total Discharges	236	203	33	16.3%	713	651	62	9.4%	661	52	7.9%
Total Adjusted Patient Days	9,162	8,921	241	2.7%	28,146	27,333	813	3.0%	27,706	440	1.6%
Total Adjusted Discharges	365	303	62	20.4%	1,088	964	123	12.8%	1,007	81	8.1%
GENERAL ACUTE											
Patient Days	793	860	-67	-7.8%	2,667	2,767	-100	-3.6%	2,861	-194	-6.8%
Discharges	225	191	34	17.7%	687	615	72	11.7%	637	50	7.8%
OP Factor	1.9471	1.8488	-0.098	-5.3%	1.8974	1.8213	-0.076	-4.2%	1.8772	-0.02	-1.1%
Average Daily Census	26.4	28.7	-2.2	-7.8%	29	30.1	-1.1	-3.6%	31.1	-2.1	-6.8%
Average Length of Stay	3.5	4.5	1	21.6%	3.9	4.5	0.6	13.7%	4.5	0.6	13.6%
Adjusted Patient Days	1,544	1,590	-46	-2.9%	5,060	5,040	21	0.4%	5,371	-310	-5.8%
Adjusted Discharges	438	353	85	23.9%	1,304	1,120	183	16.3%	1,196	108	9.0%
Occupancy %	40%	43%	-3%		44%	46%	-2%		47%	-3%	
Emergency Visits	1,743	1,609	134	8.3%	5,286	4,844	442	9.1%	5,009	277	5.5%
Left Without Being Seen (LWBS)	60	0	-60	-100.0%	180	0	-180	-100.0%	114	-66	-36.7%
Observation Equivalent Days	250	206	44	21.2%	635	555	80	14.4%	592	43	7.3%
Total Surgeries	24	12	12	93.3%	55	52	3	5.4%	297	-242	-81.5%
IP Surgeries	16	12	4	28.8%	41	52	-11	-21.4%	53	-12	-22.6%
OP Surgeries	8	0	8	0.0%	14	0	14	0.0%	244	-230	-94.3%
SNF with Sub-Acute											
SNF Patient Days	5,138	5,120	18	0.4%	15,784	15,701	83	0.5%	15,333	451	2.9%
SNF Discharges	11	12	-1	-6.9%	26	36	-10	-28.2%	24	2	8.3%
SNF OP Factor	1.0079	1.0017	-0.006	-0.6%	1.0076	1.0017	-0.006	-0.6%	1.0051	-0.003	-0.3%
Average Daily Census	171.3	170.7	0.6	0.4%	171.6	170.7	0.9	0.5%	166.7	4.9	2.9%
Average Length of Stay	467.1	433.5	-33.6	-7.7%	607.1	433.4	-173.7	-40.1%	638.9	31.8	5.0%
Adjusted Patient Days	5,179	5,128	50	1.0%	15,904	15,727	178	1.1%	15,411	493	3.2%
Adjusted Discharges	11	12	-1	-6.3%	26	36	-10	-27.8%	24	2	8.6%
Occupancy %	95%	94%	0%		95%	94%	0%		92%	0%	
Bed Holds	50	41	9	22.4%	38	179	-141	-78.7%	175	-137	-78.3%
TOTAL FTE, HOURS, WRVU											
Total Paid FTE	637	618	-19	-3.1%	631	613	-18	-2.9%	601	-30	-5.0%
Total Productive FTE	545	532	-13	-2.4%	549	531	-18	-3.4%	514	-34	-6.7%
Total Paid FTE per AOB	2.09	2.08	-0.01	-0.4%	2.06	2.06	0	0.1%	2	-0.07	-3.3%
Worked Hours Per APD	10.2	10.2	0	0.3%	10.2	10.2	0	-0.4%	9.8	-0.5	-5.0%
Worked Hours Per AD	256	301	45	14.9%	265	289	24	8.4%	269	3	1.3%
Total Clinic Visits	1,430	1,211	219	18.0%	4,350	3,761	589	15.6%	3,846	504	13.1%
Specialty	1,430	1,211	219	18.0%	4,350	3,761	589	15.6%	3,846	504	13.1%
PAYOR MIX											
Insurance %	6.5%	8.7%	-2.2%		7.2%	7.7%	-0.5%		8.1%	-0.9%	
Medi-Cal %	4.9%	5.2%	-0.3%		5.4%	6.4%	-0.9%		7.4%	-2.0%	
Medi-Cal MC %	52.1%	51.5%	0.5%		51.5%	50.3%	1.1%		50.2%	1.3%	
Medicare %	22.4%	21.7%	0.7%		24.1%	22.3%	1.9%		22.7%	1.4%	
Medicare MC %	10.1%	10.4%	-0.4%		8.2%	10.2%	-2.0%		10.3%	-2.1%	
Other Govt %	1.3%	2.1%	-0.7%		1.4%	1.5%	-0.1%		1.3%	0.1%	
Self-Pay %	2.8%	0.5%	2.3%		2.2%	1.7%	0.5%		0.1%	2.1%	
Total Payor Mix %	100.0%	100.0%	0.0%		100.0%	100.0%	0.0%		100.0%	0.0%	
CAMPUS CMI											
CMI Alameda	1.38	1.427	-0.047	-3.3%	1.401	1.471	-0.07	-4.8%	1.469	-0.068	-4.6%

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Month: September

	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	1,517	1,688	-171	-10.1%	4,522	5,050	-528	-10.5%	4,866	-344	-7.1%
Total Discharges	271	287	-16	-5.4%	843	880	-37	-4.2%	897	-54	-6.0%
Total Adjusted Patient Days	3,293	3,383	-90	-2.7%	9,775	10,180	-405	-4.0%	9,944	-170	-1.7%
Total Adjusted Discharges	588	574	14	2.4%	1,822	1,773	49	2.7%	1,833	-11	-0.6%
GENERAL ACUTE											
Patient Days	748	910	-162	-17.8%	2,400	2,852	-452	-15.9%	2,758	-358	-13.0%
Discharges	217	228	-11	-4.7%	683	714	-31	-4.3%	743	-60	-8.1%
OP Factor	2.625	2.3623	-0.263	-11.1%	2.5583	2.3494	-0.209	-8.9%	2.3799	-0.178	-7.5%
Average Daily Census	24.9	30.3	-5.4	-17.8%	26.1	31	-4.9	-15.9%	30	-3.9	-13.0%
Average Length of Stay	3.4	4	0.6	13.8%	3.5	4	0.5	12.1%	3.7	0.2	5.3%
Adjusted Patient Days	1,963	2,150	-187	-8.7%	6,140	6,701	-561	-8.4%	6,564	-424	-6.5%
Adjusted Discharges	570	538	32	5.9%	1,747	1,676	71	4.2%	1,768	-21	-1.2%
Occupancy %	40%	48%	-9%		41%	49%	-8%		48%	-6%	
Emergency Visits	2,889	2,766	123	4.5%	8,641	8,403	238	2.8%	8,628	13	0.2%
Left Without Being Seen (LWBS)	87	45	-42	-47.9%	289	149	-140	-48.3%	261	-28	-9.7%
Observation Equivalent Days	189	167	22	13.0%	622	556	66	11.8%	556	66	11.9%
Total Surgeries	221	224	-3	-1.4%	612	693	-81	-11.7%	663	-51	-7.7%
IP Surgeries	48	46	2	4.1%	133	149	-16	-10.8%	126	7	5.6%
OP Surgeries	173	178	-5	-2.8%	479	544	-65	-12.0%	537	-58	-10.8%
REHAB											
Rehab Patient Days	769	778	-9	-1.1%	2,122	2,198	-76	-3.5%	2,108	14	0.7%
Rehab Discharges	54	59	-5	-8.2%	160	166	-6	-3.8%	154	6	3.9%
Rehab OP Factor	1	1	0	0.0%	1	1	0	0.0%	1	0	0.0%
Average Daily Census	25.6	25.9	-0.3	-1.1%	23.1	23.9	-0.8	-3.5%	22.9	0.2	0.7%
Average Length of Stay	14.2	13.2	-1	-7.7%	13.3	13.2	0	-0.3%	13.7	0.4	3.1%
Adjusted Patient Days	769	778	-9	-1.1%	2,122	2,198	-76	-3.5%	2,108	14	0.7%
Adjusted Discharges	54	59	-5	-8.2%	160	166	-6	-3.8%	154	6	3.9%
Occupancy %	92%	93%	0%		82%	85%	0%		82%	0%	
Bed Holds	0	-2	2	-100.0%	2	0	2	0.0%	0	2	0.0%
TOTAL FTE, HOURS, WRVU											
Total Paid FTE	471	479	8	1.8%	478	468	-9	-2.0%	466	-11	-2.4%
Total Productive FTE	406	408	2	0.5%	407	398	-10	-2.5%	392	-15	-3.9%
Total Paid FTE per AOB	4.29	4.25	-0.04	-0.9%	4.49	4.23	-0.26	-6.2%	4.32	-0.18	-4.2%
Worked Hours Per APD	21.1	20.7	-0.5	-2.3%	21.9	20.5	-1.4	-6.7%	20.7	-1.2	-5.7%
Worked Hours Per AD	118	122	3	2.8%	118	118	0	0.3%	112	-5	-4.5%
PAYOR MIX											
Insurance %	6.2%	8.1%	-2.0%		5.9%	6.6%	-0.7%		6.3%	-0.4%	
Medi-Cal %	1.2%	7.7%	-6.5%		6.0%	9.0%	-3.0%		9.0%	-3.0%	
Medi-Cal MC %	57.8%	48.8%	9.1%		49.8%	48.8%	1.0%		48.5%	1.3%	
Medicare %	22.2%	22.6%	-0.3%		25.6%	22.8%	2.8%		23.3%	2.3%	
Medicare MC %	8.6%	7.4%	1.2%		8.4%	8.3%	0.1%		8.5%	-0.1%	
Other Govt %	1.6%	2.2%	-0.6%		1.8%	1.4%	0.4%		1.4%	0.4%	
Self-Pay %	2.4%	3.2%	-0.9%		2.5%	3.1%	-0.6%		2.9%	-0.4%	
Total Payor Mix %	100.0%	100.0%	0.0%		100.0%	100.0%	0.0%		100.0%	0.0%	
CAMPUS CMI											
CMI San Leandro	1.472	1.554	-0.082	-5.3%	1.46	1.483	-0.024	-1.6%	1.482	-0.022	-1.5%

ALAMEDA HEALTH SYSTEMS Volume Reports

Month: September

	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	2,027	2,039	-12	-0.6%	6,156	6,035	121	2.0%	5,986	170	2.8%
Total Discharges	230	226	4	1.6%	647	670	-23	-3.5%	645	2	0.3%
Total Adjusted Patient Days	2,436	2,434	2	0.1%	7,407	7,197	210	2.9%	7,165	241	3.4%
Total Adjusted Discharges	276	270	6	2.2%	778	799	-21	-2.6%	772	6	0.8%
PSYCH											
Psych Patient Days	2,027	2,039	-12	-0.6%	6,156	6,035	121	2.0%	5,986	170	2.8%
Psych Discharges	230	226	4	1.6%	647	670	-23	-3.5%	645	2	0.3%
Psych OP Factor	1.244	1.2278	-0.016	-1.3%	1.2452	1.2275	-0.018	-1.4%	1.2359	-0.009	-0.8%
Average Daily Census	67.6	68	-0.4	-0.6%	66.9	65.6	1.3	2.0%	65.1	1.8	2.8%
Average Length of Stay	8.8	9	0.2	2.1%	9.5	9	-0.5	-5.7%	9.3	-0.2	-2.5%
Adjusted Patient Days	2,522	2,503	18	0.7%	7,666	7,408	258	3.5%	7,398	267	3.6%
Adjusted Discharges	286	278	8	2.9%	806	823	-17	-2.1%	797	8	1.1%
PES Equivalent Days	767	711	55	7.8%	2,333	2,179	154	7.1%	2,179	154	7.1%
PES Visits	881	796	85	10.7%	2,527	2,528	-1	0.0%	2,525	2	0.1%
PES Hours	18,401	16,770	1,631	9.7%	55,993	49,477	6,516	13.2%	52,291	3,702	7.1%
PES Hours per Visit	21	21	0	0.9%	22	20	-3	-13.2%	21	-1	-7.0%
TOTAL FTE, HOURS, WRVU											
Total Paid FTE	405	387	-18	-4.7%	396	372	-24	-6.5%	382	-13	-3.5%
Total Productive FTE	349	328	-20	-6.2%	343	318	-26	-8.1%	329	-15	-4.5%
Total Paid FTE per AOB	4.99	4.77	-0.22	-4.6%	4.92	4.75	-0.17	-3.5%	4.91	-0.01	-0.1%
Worked Hours Per APD	24.5	23.1	-1.4	-6.1%	24.4	23.2	-1.2	-5.0%	24.1	-0.3	-1.1%
Worked Hours Per AD	216	208	-8	-3.9%	232	209	-23	-11.0%	224	-8	-3.6%
Physician wRVU	8,576	8,350	225	2.7%	24,931	26,830	-1,899	-7.1%	26,711	-1,780	-6.7%
PAYOR MIX											
Insurance %	6.9%	5.8%	1.2%		4.9%	4.6%	0.3%		4.1%	0.8%	
Medi-Cal %	8.8%	11.3%	-2.5%		9.9%	11.8%	-1.8%		11.7%	-1.8%	
Medi-Cal MC %	58.4%	50.4%	8.1%		57.8%	52.3%	5.5%		52.0%	5.8%	
Medicare %	21.8%	21.8%	0.0%		23.1%	21.7%	1.5%		23.7%	-0.5%	
Medicare MC %	3.4%	4.3%	-0.9%		3.5%	3.6%	-0.1%		3.7%	-0.2%	
Other Govt %	-0.6%	4.2%	-4.7%		-0.9%	1.5%	-2.4%		0.7%	-1.6%	
Self-Pay %	1.3%	2.3%	-1.1%		1.7%	4.6%	-2.9%		4.2%	-2.5%	
Total Payor Mix %	100.0%	100.0%	0.0%		100.0%	100.0%	0.0%		100.0%	0.0%	
CAMPUS CMI											
CMI Behavioral Health	1.402	1.317	0.085	6.4%	1.391	1.33	0.062	4.6%	1.33	0.061	4.6%

ALAMEDA HEALTH SYSTEMS Volume Reports

Month: September

	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	3,211	3,150	61	1.9%	9,803	9,661	142	1.5%	9,652	151	1.6%
Total Discharges	4	11	-7	-65.0%	23	35	-12	-34.6%	34	-11	-32.4%
Total Adjusted Patient Days	4,203	4,216	-13	-0.3%	12,733	13,118	-385	-2.9%	13,027	-294	-2.3%
Total Adjusted Discharges	5	15	-10	-65.8%	30	48	-18	-37.4%	46	-16	-34.9%
SNF with Sub-Acute											
SNF Patient Days	3,211	3,150	61	1.9%	9,803	9,661	142	1.5%	9,652	151	1.6%
SNF Discharges	4	11	-7	-65.0%	23	35	-12	-34.6%	34	-11	-32.4%
SNF OP Factor	1.074	1.0011	-0.073	-7.3%	1.075	1.0017	-0.073	-7.3%	1.0721	-0.003	-0.3%
Average Daily Census	107	105	2	1.9%	106.6	105	1.5	1.5%	104.9	1.6	1.6%
Average Length of Stay	802.8	275.6	-527.1	-191.3%	426.2	274.7	-151.5	-55.2%	283.9	-142.3	-50.1%
Adjusted Patient Days	3,449	3,154	295	9.4%	10,539	9,678	861	8.9%	10,348	191	1.8%
Adjusted Discharges	4	11	-7	-62.5%	25	35	-11	-29.8%	36	-12	-32.2%
Occupancy %	98%	96%	0%		98%	96%	0%		96%	0%	
Bed Holds	32	33	-1	-1.6%	90	102	-12	-11.3%	103	-13	-12.6%
TOTAL FTE, HOURS, WRVU											
Total Paid FTE	300	294	-6	-2.1%	295	294	-1	-0.5%	297	2	0.7%
Total Productive FTE	256	250	-7	-2.6%	255	253	-3	-1.0%	257	2	0.6%
Total Paid FTE per AOB	2.14	2.09	-0.05	-2.5%	2.13	2.06	-0.07	-3.5%	2.1	-0.03	-1.6%
Worked Hours Per APD	10.4	10.1	-0.3	-3.0%	10.5	10.1	-0.4	-4.1%	10.4	-0.2	-1.7%
Worked Hours Per AD	8387	2797	-5590	-199.9%	4495	2783	-1712	-61.5%	2945	-1550	-52.6%
Total Clinic Visits	1,905	2,233	-328	-14.7%	5,512	7,156	-1,644	-23.0%	6,545	-1,033	-15.8%
Behavioral Health	1,893	2,227	-334	-15.0%	5,476	7,135	-1,659	-23.3%	6,515	-1,039	-15.9%
Rehab	12	6	6	100.0%	36	21	15	71.4%	30	6	20.0%
PAYOR MIX											
Insurance %	0.6%	0.8%	-0.2%		1.6%	0.9%	0.7%		1.4%	0.2%	
Medi-Cal %	5.9%	7.0%	-1.2%		4.5%	6.8%	-2.3%		8.3%	-3.7%	
Medi-Cal MC %	75.6%	69.7%	5.9%		77.2%	69.1%	8.1%		68.2%	9.0%	
Medicare %	17.5%	19.8%	-2.3%		16.1%	20.0%	-3.9%		19.3%	-3.2%	
Medicare MC %	1.6%	2.6%	-1.0%		1.1%	2.7%	-1.7%		2.7%	-1.6%	
Other Govt %	0.1%	-0.1%	0.2%		0.1%	0.1%	0.0%		0.2%	-0.1%	
Self-Pay %	-1.2%	0.2%	-1.4%		-0.6%	0.4%	-1.0%		-0.1%	-0.5%	
Total Payor Mix %	100.0%	100.0%	0.0%		100.0%	100.0%	0.0%		100.0%	0.0%	