# BOARD OF TRUSTEES SPECIAL MEETING

**Friday, November 7, 2025**
**9:00am – 3:00pm**

**Alameda Health System**
55 Harrison Street, Oakland, CA 94607
Ronna Jojola Gonsalves, Clerk of the Board
(510) 535-7515

LOCATION:
Open Session, In Person:
55 Harrison Street, Oakland
This meeting is in person only. There will be no Zoom option.

**See Parking Information Below**

## MEMBERS

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

## BOARD OF TRUSTEES MEETING AGENDA

**Public Comment Instructions**
Members of the public who wish to address the Board regarding an item on the agenda or in their purview may see the Clerk of the Board to sign up. Each speaker will be allotted between one and three minutes to speak, depending on the number of speakers present.

This is a reminder that this meeting is an in person only meeting. There will be no option to attend remotely. Please see below for directions to the meeting venue.

**OPEN SESSION / ROLL CALL**

**PUBLIC COMMENT**

**A. Welcome** **9:00 am**
*David Sayen, Board President*
*James E.T. Jackson, Chief Executive Officer*

**B. Service Area Market Analysis and Relationship to the Strategic Plan/COT Update 9:15 am**
*Mark Fratzke, Chief Operating Officer*
*Christy Roberg, Vice President Business Planning*

**C. Alameda Alliance and the Future of Medi-Cal in Alameda County** **10:15 am**
*Matt Woodruff, Chief Executive Officer, Alameda Alliance for Health*

*Break* *11:00 am*

**D. Chief Medical Officer Goals and Status of Quality Goals** **11:15 am**
*Lisa Laurent, MD, Chief Medical Officer*

*Lunch* **12:00 pm**

**E. Strategy and Board Roles** **1:00 pm**
*Kara Witalis, Witalis, LLC*

**(General Counsel Announcement as to Purpose of Closed Session)**

**CLOSED SESSION** **2:30pm**

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

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

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

**General Counsel Report on Action Taken in Closed Session**

**TRUSTEE COMMENTS**

**ADJOURNMENT**

**Directions for Parking:** There is a parking garage at 255 2nd Street, with a sky bridge on the third floor to the 55 Harrison Street building. Metered street level parking is also available.

**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. 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.***

ALAMEDA HEALTH SYSTEM

# Center for Operational Transformation

## Overview / Update

11.7.2025
Board Retreat

# What is COT

## Our Purpose:

The Center for Operational Transformation (COT) was created as part of AHS' long-term strategy to strengthen our organization's sustainability and better support our staff and patients by improving how we work and deliver on key initiatives in our strategic operating plan.

## What We Do:

- Ensure initiatives are feasible, data-informed, and measurable
- Provide business case development and fiscal guidance
- Deliver data analytics and hands-on project management support
- Support execution from concept through completion

# Right-sizing: COT Collaboration in Action

The right-sizing initiative demonstrates how COT's multidisciplinary team collaborates on complex organizational challenges

**Finance:** Financial modeling and budget impact analysis

**Strategy:** Productivity benchmarking and maintaining strategic alignment with market needs

**Clinical:** Clinical service modeling and care delivery optimization

**Operational:** Operational modeling and alignment

**Innovation:** Leveraging technology for efficient process optimization

**Project Management:** Implementation coordination and stakeholder engagement

# Who makes up COT

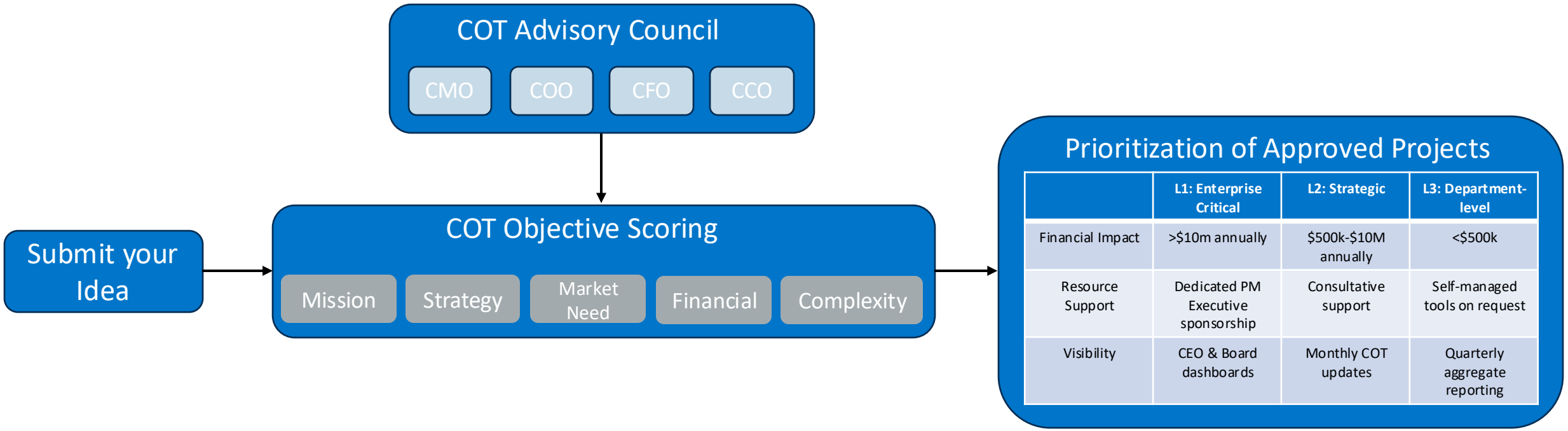
## Who We Are:

- The COT is made up of a multidisciplinary team (clinical, operational, innovation, financial, strategic) who partners with leadership to support informed decision-making.
- They help optimize programs and resources through deep analysis and collaborate across departments to guide improvements that benefit patients, staff, and the organization.

# Project Intake Process

## Intake Process:

- The new project intake process is now live and can be found on the COT website
- We have a temporary pause on approving new projects that would add expense to the organization unless the project is related to regulatory compliance or patient safety.




### Prioritization of Approved Projects

| | L1: Enterprise Critical | L2: Strategic | L3: Department-level |
|---|---|---|---|
| Financial Impact | >$10m annually | $500k-$10M annually | <$500k |
| Resource Support | Dedicated PM Executive sponsorship | Consultative support | Self-managed tools on request |
| Visibility | CEO & Board dashboards | Monthly COT updates | Quarterly aggregate reporting |

# COT Accomplishments: First Two Months

COT was established just two months ago and has rapidly built capacity

- Nearly fully staffed with multidisciplinary team
- Developed and launched comprehensive project intake process
- Reviewed 50+ operational initiatives for strategic alignment
- Actively engaged in several L1 priority projects, including right-sizing initiative
- Established COT Advisory Council for governance and physician engagement

# COT's Current Focus and What's Ahead

## Our current focus:

COT is addressing the financial challenges from federal legislation (H.R. 1) and potential state impacts. We're partnering with leadership on efficiency initiatives that improve operations while supporting data-informed decision-making across the organization.

## What's Ahead: Balanced transformation

Transformation is broader than a financial response—it's about improving efficiency, modernizing tools, and empowering every team member. Our work balances:

**Efficiency initiatives:** Improve operations and reduce costs while maintaining quality care

**Growth initiatives:** Expand services, reach more patients, and generate new revenue streams

**Change management model/approach:** Determining the approach to managing the people side of change

**Organizational healthcare knowledge:** Educating the organization on healthcare dynamics

*Thank you*

# *Appendix*

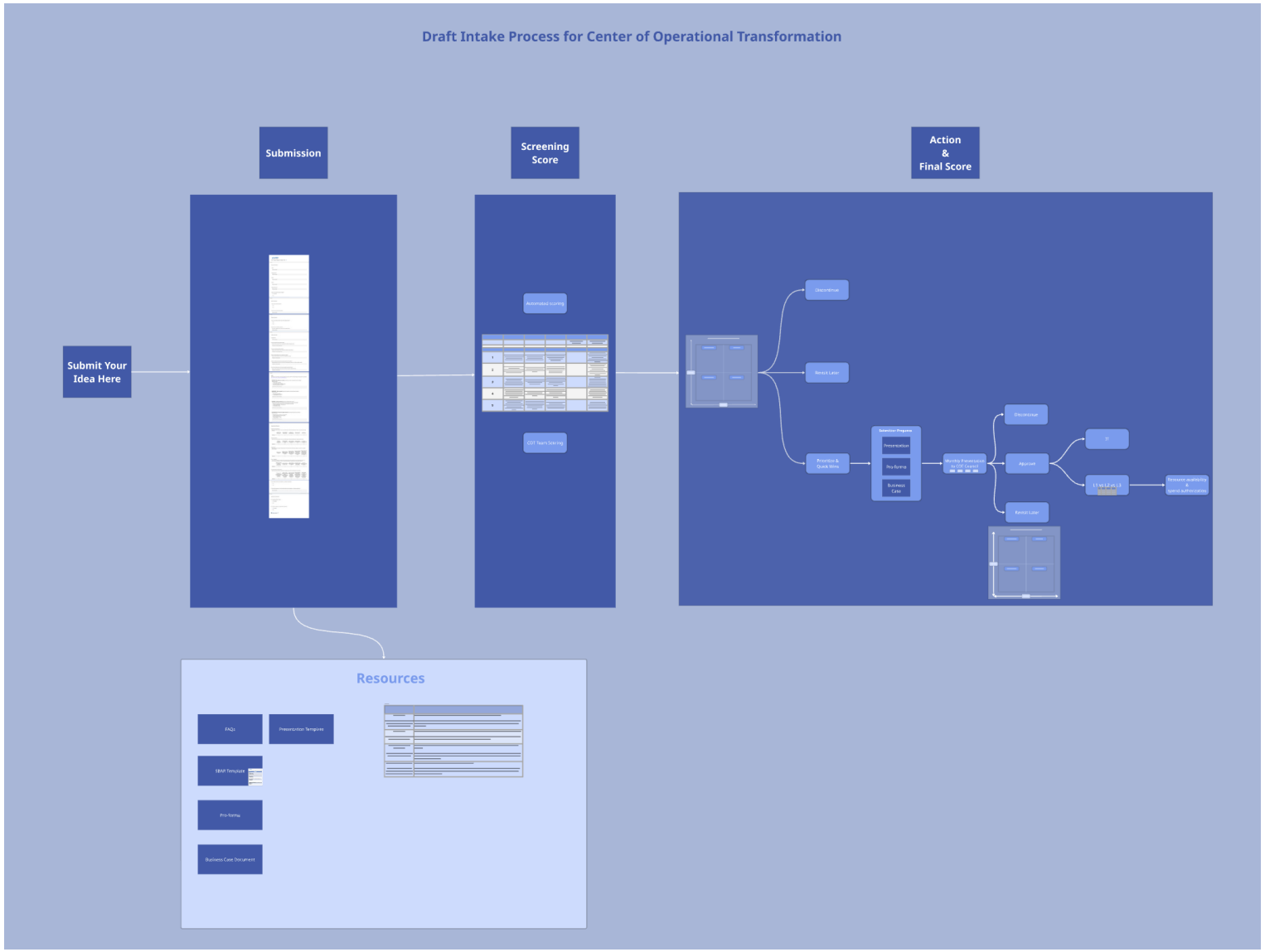
# Learn more:

**COT Intranet page:** https://ahs-connects.acmedctr.ad/cot

**H.R. 1 Impacts intranet page:** https://ahs-connects.acmedctr.ad/hr1-impacts/

**COT email:** COT@alamedahealthsystem.org

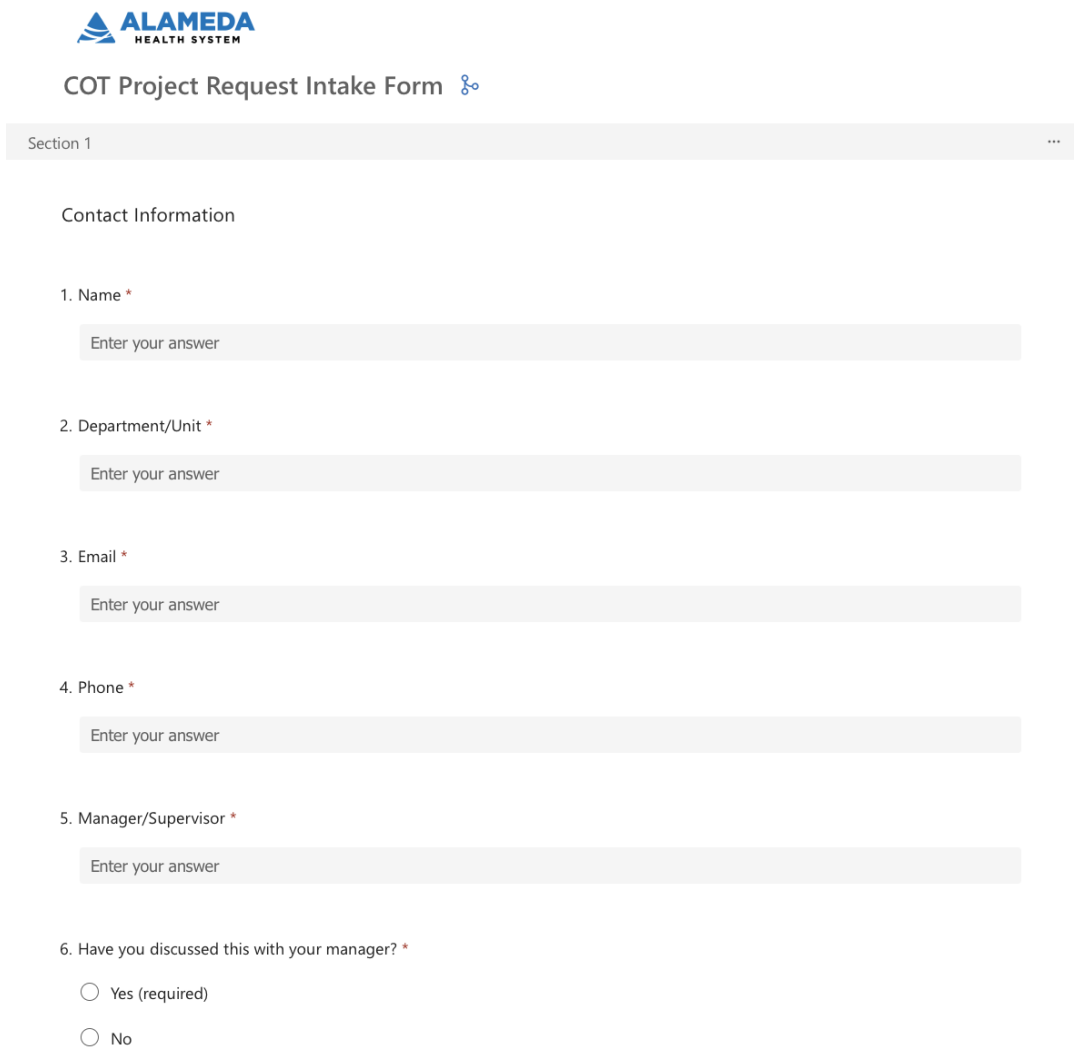
# Project Intake Process Detailed Overview




Note: This slide is not intended to be read. It is a high-level visual overview of the process

# Project Submission

**Project submission through Project Intake Request form on COT Intranet page:**
https://ahs-connects.acmedctr.ad/cot



# Screening Score

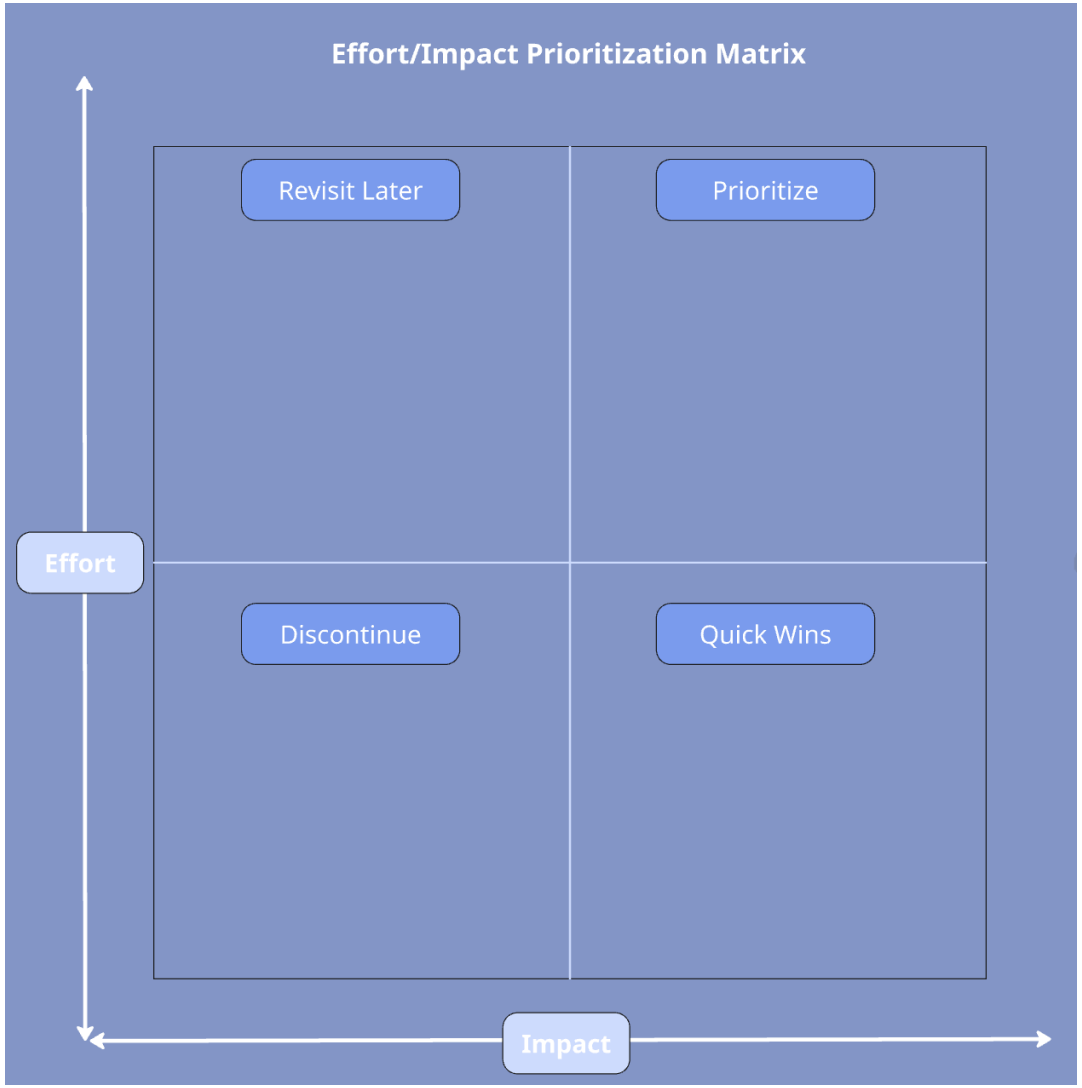
The goal is to create objectivity, transparency and internal consistency that is aligned with AHS' mission and strategy.

Please note: This is a working draft. Scoring and weighting for each column will be an iterative process requiring fine tuning over months/years.

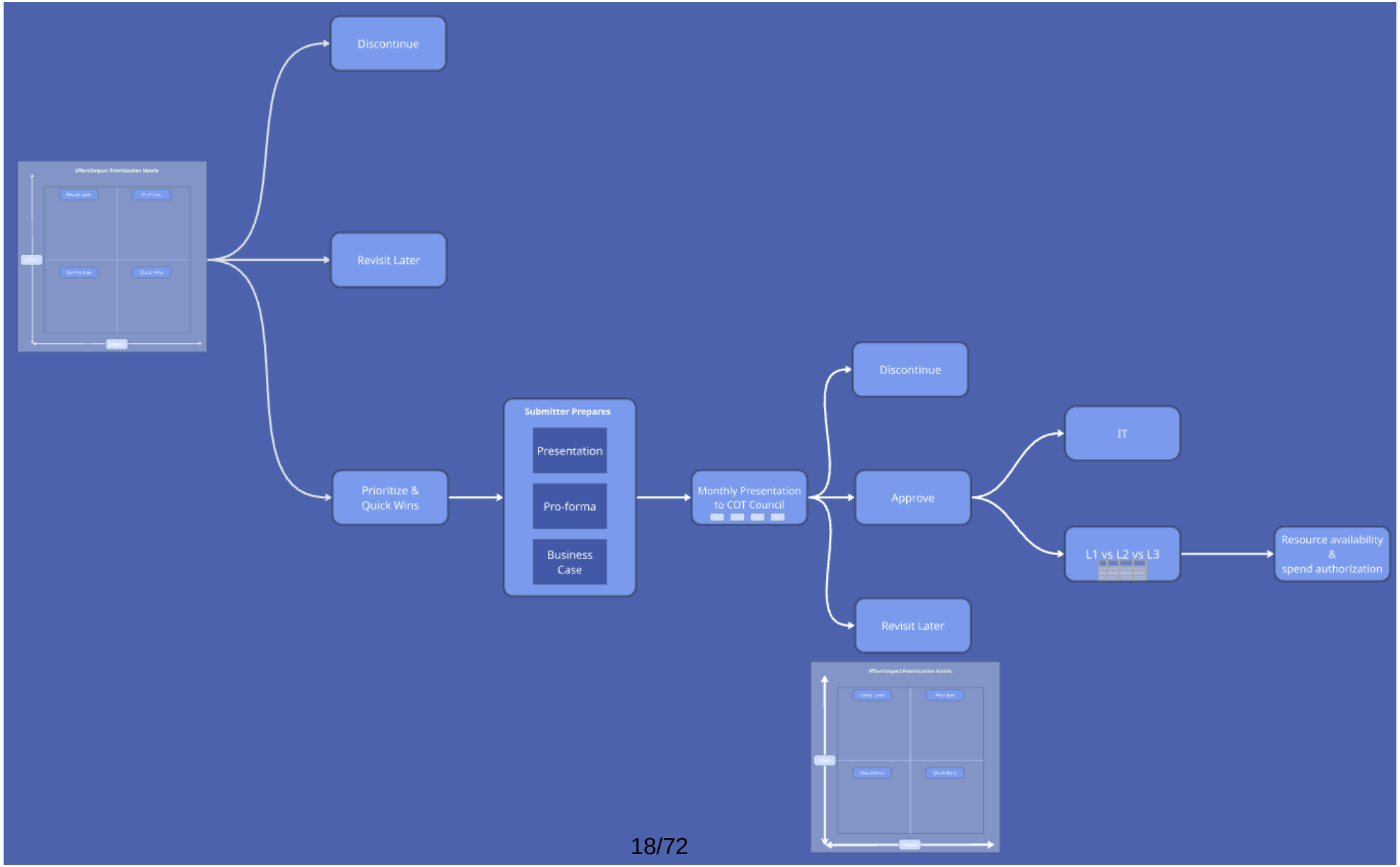
| **Axis** | Impact | Impact | Impact | Effort | Effort |
|---|---|---|---|---|---|
| | **Mission Alignment** | **Strategic Alignment** | **Market Need** | **Cost / Profitability (5-year ROI)** | **Complexity (Resource Requirements)** |
| **Weighting** | 25% | 20% | 25% | 15% | 15% |
| **Score** | | | | | |
| **1** | **Poor Alignment:** Neglects caring, may cause harm, spreads misinformation, or intentionally excludes groups. Outcomes are counterproductive. | **No Alignment:** Does not align with any of the four AHS strategic pillars. Initiative is disconnected from organizational strategic priorities. | **No Market Need:** Service is extensively offered throughout Alameda County with no barriers to access for our patient population. Multiple providers available. | **Significant Loss:** 5-year net loss of $1M or greater (≤ -$1,000,000) | **Extensive Resources:** Requires >2 years timeline with >10 FTEs. Involves significant organizational change, specialized expertise with high-risk dependencies, and extensive/intensive resources. |
| **2** | **Weak Alignment:** Token caring efforts, short-term fixes only, sporadic/inaccurate teaching, selective service favoring certain groups. Neutral impact with gaps in inclusivity. | **Weak Alignment:** Aligns with only 1 of the 4 AHS strategic pillars. Limited connection to organizational strategic direction. | **Limited Need:** Service is offered by several providers in Alameda County with minimal barriers to access (e.g., minor insurance limitations but generally accessible). | **Moderate Loss:** 5-year net loss of $1K to $999K (-$1,000 to -$999,000) | **Significant Resources:** Requires 1-2 years timeline with 5-10 FTEs. Requires new systems, specialized expertise, or cross-functional coordination. Higher risk of resource strain requiring robust planning. |
| **3** | **Moderate Alignment:** Standard support and caring, targeted healing, accurate teaching, broad service with some inclusivity. Positive outcomes but not comprehensive. | **Moderate Alignment:** Aligns with 2 of the 4 AHS strategic pillars. Reasonable connection to organizational strategic objectives. | **Moderate Need:** Service is offered by some providers in Alameda County, but barriers to access exist for our patient population (e.g., insurance requirements, commercial-only access). | **Break-even:** 5-year net revenue approximately $0 (±$1,000) | **Noticeable Resources:** Requires 6-12 month timeline with 3-5 FTEs. Noticeable commitment of time, and personnel. May require some new capabilities or resource reallocation. |
| **4** | **Strong Alignment:** Deep empathetic caring, lasting preventive healing, engaging evidence-based teaching, inclusive service bridging gaps for underrepresented groups. Measurable positive change. | **Strong Alignment:** Aligns with 3 of the 4 AHS strategic pillars. Strong connection to organizational strategic direction. | **High Need:** Service is offered by few providers in Alameda County (e.g., only major health systems like Kaiser/Sutter), with significant barriers to access for uninsured/underinsured patients. | **Moderate Profit:** 5-year net profit of $1K to $999K ($1,000 to $999,000) | **Modest Resources:** Requires 3-6 month timeline with 2-3 FTEs. Small increase in personnel. Managed with current resources and minimal disruption. |
| **5** | **Exemplary Alignment:** Profound empathy in all interactions, comprehensive resilience-building healing, innovative accessible teaching, universal service dismantling barriers.Transformative sustainable impact. | **Full Alignment:** Aligns with all 4 AHS strategic pillars (Stewardship, Quality Care, Staff/Physician Experience, and Community Connection). Fully integrated with organizational strategy. | **Critical Need:** Service is not currently offered in Alameda County OR offered by very few providers with high barriers preventing our patient population from accessing care. | **Strong Profit:** 5-year net profit of $1M or greater (≥ $1,000,000) | **Minimal Resources:** Requires <3 month timeline with <2 FTEs. Limited time investment. Managed with current resources and minimal disruption. |

# Effort/Impact Prioritization Matrix

Project scores determine effort and impact, which guide next steps for each submission.



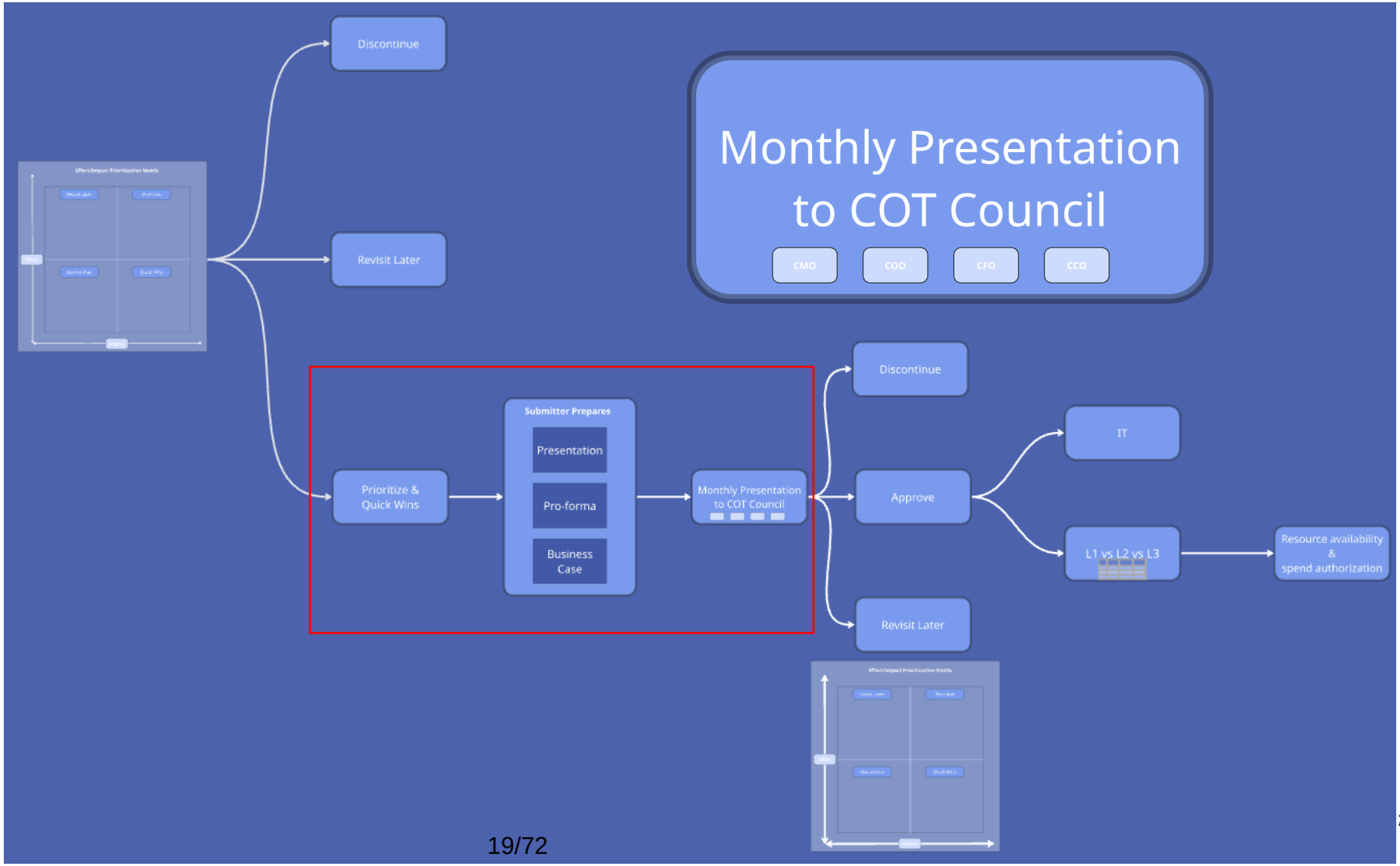
# Actions After Screening Score



# Monthly Presentation to COT Council

Projects scoring as "Prioritize" or "Quick Wins" will be invited to present their proposal to the COT Council.

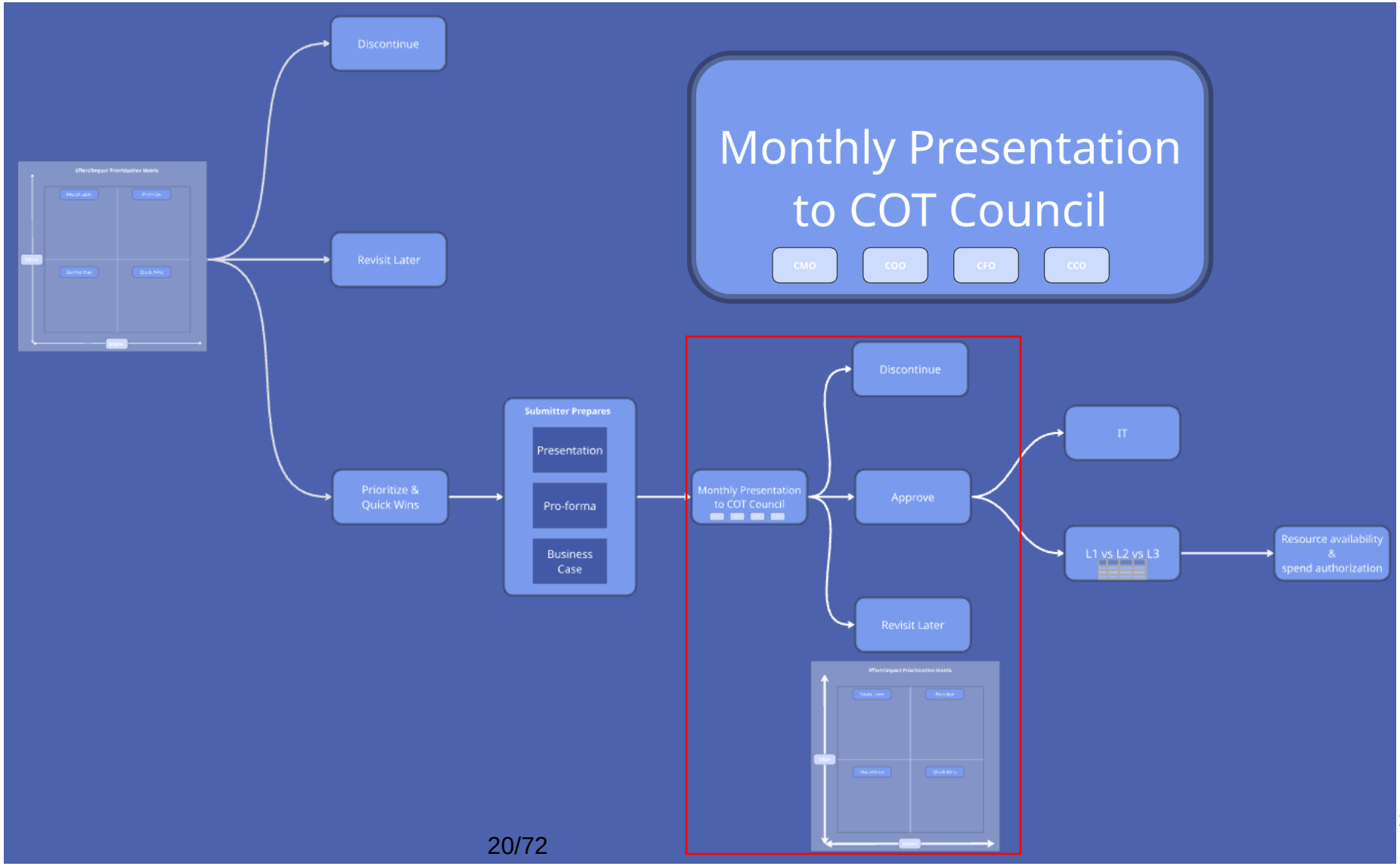
The submitter will prepare a brief presentation, pro-forma and business case with the support of the COT team



# Final Scoring by COT Council

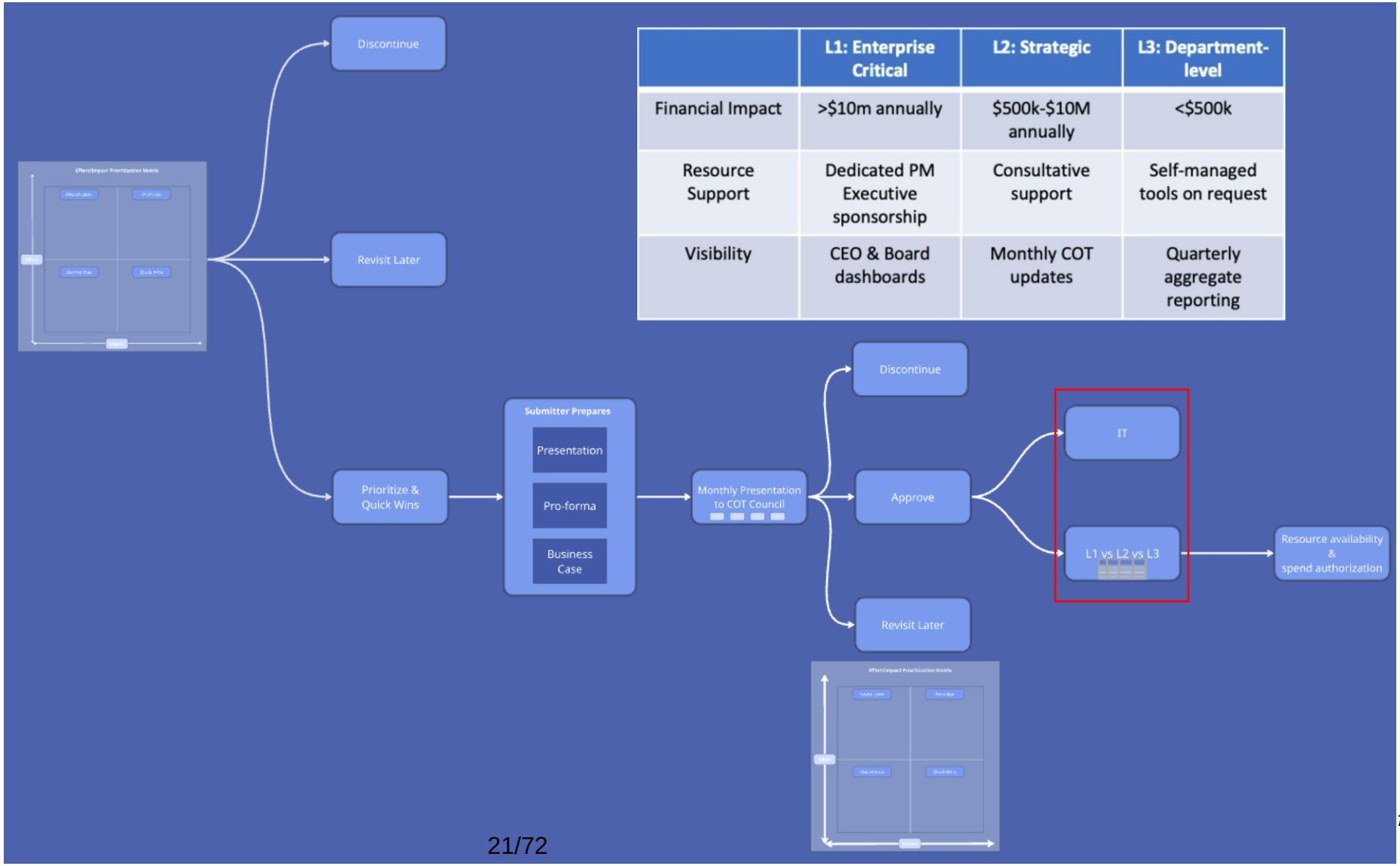
The COT Council will provide the final scores on all projects using the same objective scoring rubric

Projects scoring as "Prioritize" or "Quick Wins" will be approved



# Prioritization of Approved Projects

Approved projects will either be routed to ePMO (IT-specific projects) or slated as L1 vs L2 vs L3 based on the impact and resource requirement of the project

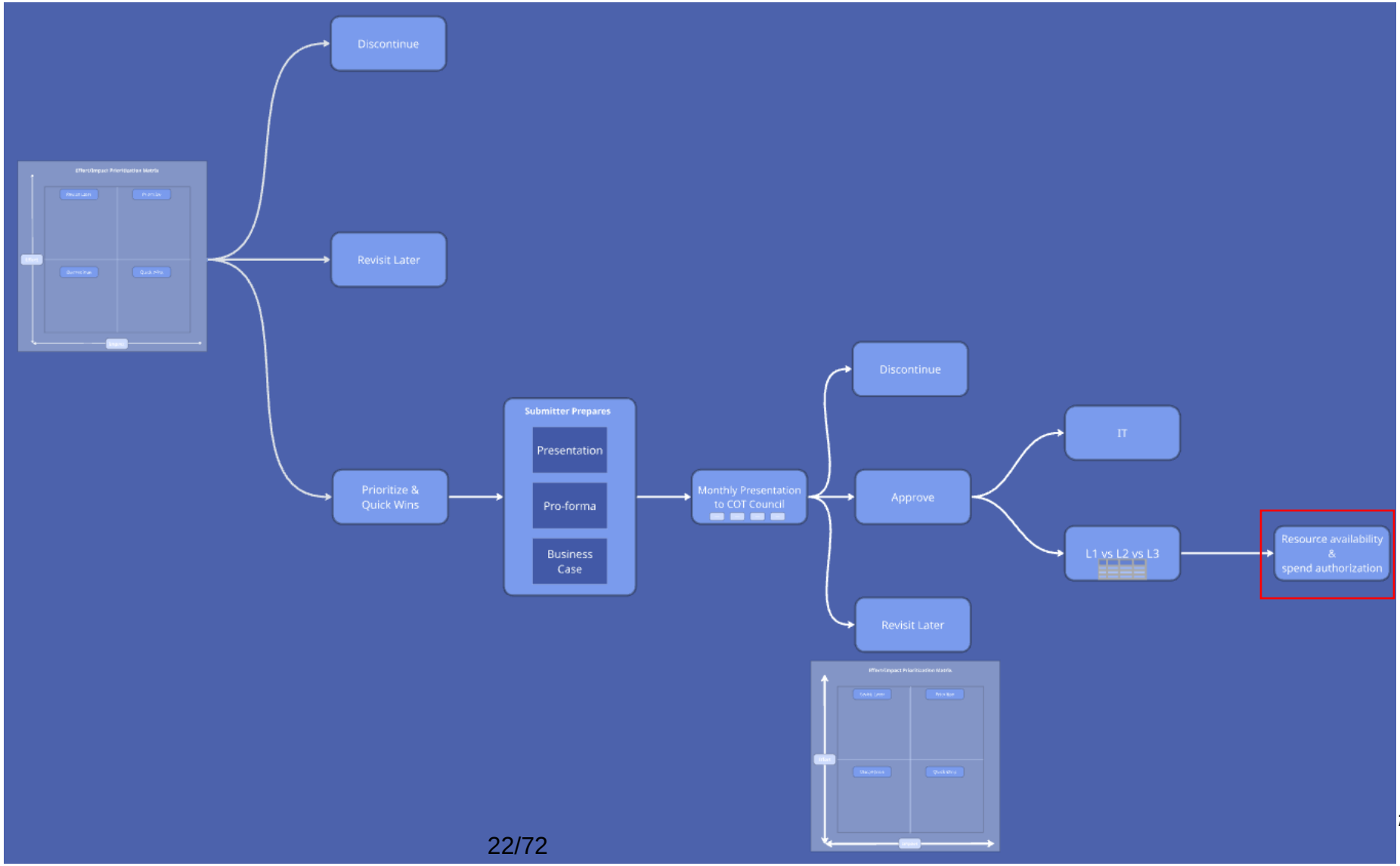



| | L1: Enterprise Critical | L2: Strategic | L3: Department-level |
|---|---|---|---|
| Financial Impact | >$10m annually | $500k-$10M annually | <$500k |
| Resource Support | Dedicated PM Executive sponsorship | Consultative support | Self-managed tools on request |
| Visibility | CEO & Board dashboards | Monthly COT updates | Quarterly aggregate reporting |

# Post-Approval Steps

The timing for starting approved projects depends on their effort/impact, as well as available resources and budget.

Please Note:
We're working to simplify the approval process for resources and spending, which supports our long-term financial planning.



# Alameda Alliance and the Future of Medi-Cal in Alameda County

# State and Federal Actions: Impacts on Medi-Cal Program

AHS Board Retreat
November 7, 2025



ALAMEDA Alliance FOR HEALTH

# Key Medicaid Impacts from H.R.1

## Eligibility and Access Requirements

- Work requirements
- 6-month eligibility checks
- Retroactive coverage restrictions
- Implementation of cost-sharing

## Abortion Providers Ban

- 1 year ban on federal Medicaid funding for certain entities that provide abortion services

## Immigrant Coverage limitations

- Decrease in federal medical assistance percentage (FMAP) for emergency UIS
- Constraints on lawful immigrant eligibility

## State Financing Restrictions

- MCO and provider tax limits
- State directed payment (SDP) restrictions
- Federal repayment penalties for improper payments related to eligibility

# Notable State Budget Provisions

| | 2026 | 2027 |
|---|---|---|
| 2025-26 CA State Budget | • Enrollment freeze for full-scope Medi-Cal expansion to UIS adult Californians (1/1/2026)<br>• Reinstatement of the Medi-Cal asset limit at $130,000 for an individual and $65,000 for each additional household member (1/1/2026)<br>• Elimination of PPS rates to clinics for state-only funded services provided to UIS individuals (7/1/2026)<br>• Elimination of Dental Benefits for UIS Adults (7/1/2026)<br>• Implementation of prior authorization for hospice services (7/1/2026)<br>• Elimination of supplemental payments to dental providers (7/1/26) | • Implementation of state-only $30 monthly premiums for UIS adult individuals (7/1/2027) |

# Medi-Cal Changes (H.R. 1/State Budget)

## Effective Now

- Provider Taxes (H.R. 1)
  - → Prohibits new Provider Taxes
  - → Imposes uniformity restrictions on the use of provider taxes – possible 3-year transition period approved by HHS?
  - → Reduces safe harbor limit by 0.5% annually starting in FY 2028 until they reach 3.5% in FY 2032.
- State Directed Payments (H.R. 1)
  - → Freezes state-directed payments (SDPs) to current rate and limits new SDPs for services provided to 100% of Medicare rates.
  - → DHCS estimates that hospital payments would be reduced by $2.6 billion in 2028, growing to $9.1 billion in 2031.
- Payments to Prohibited Entities [Family Planning & Abortion Providers] (H.R.1)
  - → 1-year ban on payments.
  - → July 29th Preliminary Injunction by District Court provides relief to all Planned Parenthood affiliates,; DHCS provides guidance that plans continue payments.
  - → On September 11th, an appellate court granted a stay of the preliminary injunction – allowing for Medicaid payments to be blocked. Alliance is awaiting guidance from the DHCS.
  - → Impact to Alameda Alliance: $2M in non-abortion services in FY 2025.

# Medi-Cal Changes (H.R. 1/State Budget)

## 2025

- Rural Health Transformation Program (H.R. 1)
  - → Appropriates $50 billion ($10 billion per year for five years, beginning in 2026) to be awarded to states for the support of qualifying rural health facilities.
  - → Distributes 50% funds equally among all approved states, 50% based on HHS methodology.
  - → Applications released by CMS mid-September. Approvals must be completed by December 31, 2025.
  - → HCAI is holding stakeholder webinars and released survey to inform the statewide application.

# Medi-Cal Changes (H.R. 1/State Budget)

## 2026

- Enrollment Freeze (2025 State Budget Act)
  - → Freezes new enrollment for undocumented adults (19 and older), includes three-month re-enrollment period and prevents enrollees from "aging out" of the program. Effective: January 1, 2026.
  - → The Alliance serves nearly 68K UIS members 19 years and older.
  - → Alameda County estimates that 2% of UIS members 19 and older will lose coverage.
- Asset Test (2025 State Budget Act)
  - → Sets $130k asset cap and $65k per additional household member. Effective: January 1, 2026.
- Prop 56 (2025 State Budget Act) – eliminates supplemental payments to dental providers. Effective: July 1, 2026.
- FQHCs and Rural Health Clinics (2025 State Budget Act) – eliminates supplemental rates for state funded services to undocumented members. Effective: July 1, 2026.
- Dental (2025 State Budget Act) – eliminates state-only dental coverage for undocumented population 19 years and older. Exception for emergency dental services. Effective: July 1, 2026.

# Medi-Cal Changes (H.R. 1/State Budget)

## 2026 continued…

- Coverage for Immigrants (H.R. 1)
  - → Limits the definition of "qualified immigrants eligible for Medicaid or CHIP. Excludes the following categories that currently receive FFP: asylum, refugees, and others.
  - → FMAP payments shall not be made to a state unless the person meets the definition of a qualified immigrant. Effective: October 1, 2026.
  - → Approximately 200k Californians will move to UIS category and subject to state enrollment freeze, premiums, etc.
  - → State data by county will be available soon.
- Redeterminations (H.R. 1)
  - → Requires 6-month eligibility redeterminations for adults in expansion population. Effective: December 31, 2026.
  - → The Alliance serves 150k expansion population members.
  - → The DHCS estimates that 3% of total Medicaid population will lose coverage due to this provision.

# Medi-Cal Changes (H.R. 1/State Budget)

## 2027

- Work Requirements (H.R. 1)
  - → 80 hours/month for 19-64 age group, with exemption for medically frail, parents/caregivers with children ages 13 or younger or a disabled individual. Effective: First quarter in 2027.
  - → The Alliance serves 150K Alliance members ages 19-64.
  - → The DHCS estimates that 20% of Medicaid enrollees will lose coverage.
- Section 1115 Budget Waiver Neutrality (H.R. 1)
  - → Requires that all new or renewed 1115 demonstration projects be certified as budget neutral by CMS. Effective: January 1, 2027.
  - → CMS likely to release guidance six months prior to effective date.
- Duplicative Enrollment (H.R. 1)
  - → Requires states to establish a verification system that ensures that applicants or enrollees do not have Medicaid in another state. Effective: January 1, 2027.
  - → Additional reporting will be required by health plans.

# Medi-Cal Changes (H.R. 1/State Budget)

## 2027 continued…

- Retroactive Coverage (H.R. 1)
  - → Shortens retroactive coverage to one month for expansion enrollees and two months for non-expansion enrollees. Currently three months. Effective: January 1, 2027.
  - → DHCS estimates that 86k or nearly 1% of enrollees lose coverage.
- Premiums (2025 State Budget Act)
  - → $30 monthly premiums for undocumented populations (between 19-59 years old). Pregnant people are excluded. Effective: July 1, 2027
  - → Approximately 61K undocumented Alliance members are 19-64 years old.

# Medi-Cal Changes (H.R. 1/State Budget)

## 2028

- State Directed Payments (H.R. 1) –
  - → SDPs would be reduced by 10% annually until they reach the allowable Medicare-related payment limit. Effective: January 1, 2028.
  - → DHCS estimates that hospital payments would be reduced by $2.6 billion in 2028, growing to $9.1 billion in 2031.
- Cost Sharing for Expansion Adults (H.R. 1)
  - → Cost sharing for Medicaid expansion adults with incomes over 100% FPL.
  - → Max $35 copay/services and no cost share for primary, mental health, prenatal, pediatric, SUD or ED services. Effective: October 1, 2028.
  - → 100% FLP = $15,650; enrollees may forgo coverage due to cost.
  - → The Alliance serves 150k expansion adults.
- New HCBS Waiver Option (H.R. 1)
  - → Allows states to expand HCBS program eligibility criteria and waive requirement that individuals require nursing home level of care. Effective: July 1, 2028.

# Alliance State Directed Payments to AHS and St. Rose

- St. Rose received payments through the Private Hospital Directed Payment (PHDP) program.
- AHS received payments through the Enhance Payment Program (EPP) and Quality Incentive Pool (QIP) Program.
- 2021 Directed Payment Totals: $138,232,165
- 2022 Directed Payment Totals: $147,803,321
- 2023 Directed Payment Totals: $170,794,642
- Average directed payments per year: $152,276,709

# AHS-assigned UIS Members and Cost

- The Alliance serves 80K members with Unsatisfactory Immigration Status (UIS).
- Cost of top 3 service categories utilized by all Alliance UIS members: Inpatient, ER and PCP specialty services.
  - 52% of total costs for UIS population (Jan-June 25)
  - Note: Pharmacy is the 2nd highest cost, however services are paid by for FFS delivery system (Medi-Cal Rx)
- Nearly 23k Alliance UIS members are assigned to AHS.
- One quarter of total services received by UIS members were provided by AHS (Jan-June 25)
  - $50.2 million was paid to AHS in the first six months of the year.
- 13% of Alliance UIS members received a service at AHS between Jan-June 25.

# MCP Payments and UIS Emergency Medicaid

- CMS updated interpretation of section 1903(v) of the Social Security Act applying to Medicaid managed care payments for emergency Medicaid for individuals with UIS ineligible for full Medicaid benefit.
- Reinterpretation to only apply for specific UIS ER payments for treatment of an emergency medical condition that have been rendered. Therefore, does not apply to Medicaid managed care payments, including risk-based capitation.
- CMS strongly recommends states to provide these UIS ER services through FFS delivery system to have the clearest documentation of verifiable data.
- CMS will not take enforcement actions on these new federal requirements until January 1, 2027.
- The DHCS is currently mapping out implications and proceeding under the assumption that CMS will honor its commitment to delay enforcement until 2027.

# Fiscal Year Impact

- Fiscal year end enrollment for FY2026 (July 2025-June 2026) expected to be 40K lower than June 2025 enrollment.
- First four months of the fiscal year have averaged 2,500-member decline month over month. (50% of decline is optional expansion)
- Both the Child and Adult categories of aid have seen small consistent declines since February 2025.
- Optional Expansion enrollment is at risk of significant decline with the passage of H.R.1.
- Undocumented member enrollment is at risk to be eliminated in FY27 with the passage of H.R.1.

# Fiscal Year Impact

- Material impact to enrollment has negative effect on financial results for fiscal years 2027 and 2028.
- Enrollment declines represent a 21% reduction in FY27 reducing enrollment to 309K and 23% reduction in FY28 reducing enrollment to 240K. This brings Alliance enrollment to pre single plan model and public health emergency levels.
- Medical Loss Ratio (MLR) levels expected to increase as healthier members are disenrolled leaving higher acuity members remaining enrolled in the Plan. MLR for FY27 estimated to be 96%. FY28 MLR estimated to be 97%
- Estimated Loss for FY27 and FY28 expected to be approximately $11.2M and $27M respectively.

# Moving Forward: Priorities

- Prioritize financial and operational stability
- Work closely with local safety net partners to gain deeper level of understanding of impact to Alliance members and Alameda County residents.
- At the direction of the Board of Supervisors, assist with coordination of ongoing meetings with affected safety net partners to plan for and proactively respond to upcoming changes with focus on mitigating impact to residents.
- Timely and culturally/linguistically appropriate communication with Alliance members to ensure they understand upcoming changes in eligibility and enrollment.

ALAMEDA HEALTH SYSTEM

# Board of Trustees Retreat

# Chief Medical Officer Goals and Status of Quality Goals

November 7, 2025

Lisa Laurent, MD MBA MSc CPE FAAPL FIOM

Special thank you to:

Annette Johnson, MBA, Director of Quality Analytics and Performance Improvement
Ana Torres, MPH CPHQ, Vice President of Quality
Susan Brajkovic, MJ BA RN, Regulatory Affairs Manager

ALAMEDA HEALTH SYSTEM

*“What does world class look like?”*

- At least *4 stars CMS* rating
- *Leapfrog A* safety grade
- *Magnet* designation or *Baldrige* Award
- *HCAHPS* (Hospital Consumer Assessment of Healthcare Providers and Systems) *> 80th percentile*
- *HIMSS EMRAM Stage 7* (Healthcare Information and Management Systems Society/Electronic Medical Record Adoption Model)
- *Top-decile* clinical outcomes and financial stability

*Culture* – Values-driven, psychologically safe, inclusive, learning-focused

*Mission* – Clear, lived daily, community-oriented, future-ready

*Clinical Outcomes* – Consistent excellence, evidence-based, digitally enabled, transparent, reliable

*Financial Sustainability* – Value-based, diversified, reinvesting in people and community

*Strategic perspective* – Long-term, adaptive, innovative, globally informed

*"AHS has some of the most impressive, best trained, and highest performing clinicians and teams in the country who consistently and reliably drive desired outcomes, provide expert care delivery, and adhere to rigorous scientific evidence-based best practices…*

*So, why aren't we CMS 5 star?"*

1. Differences in what's measured – CMS 5-star and Leapfrog emphasize *system*-level data, not individual clinician performance

2. Data lag and methodology issues

3. Patient experience (HCAHPS) is not = clinical quality

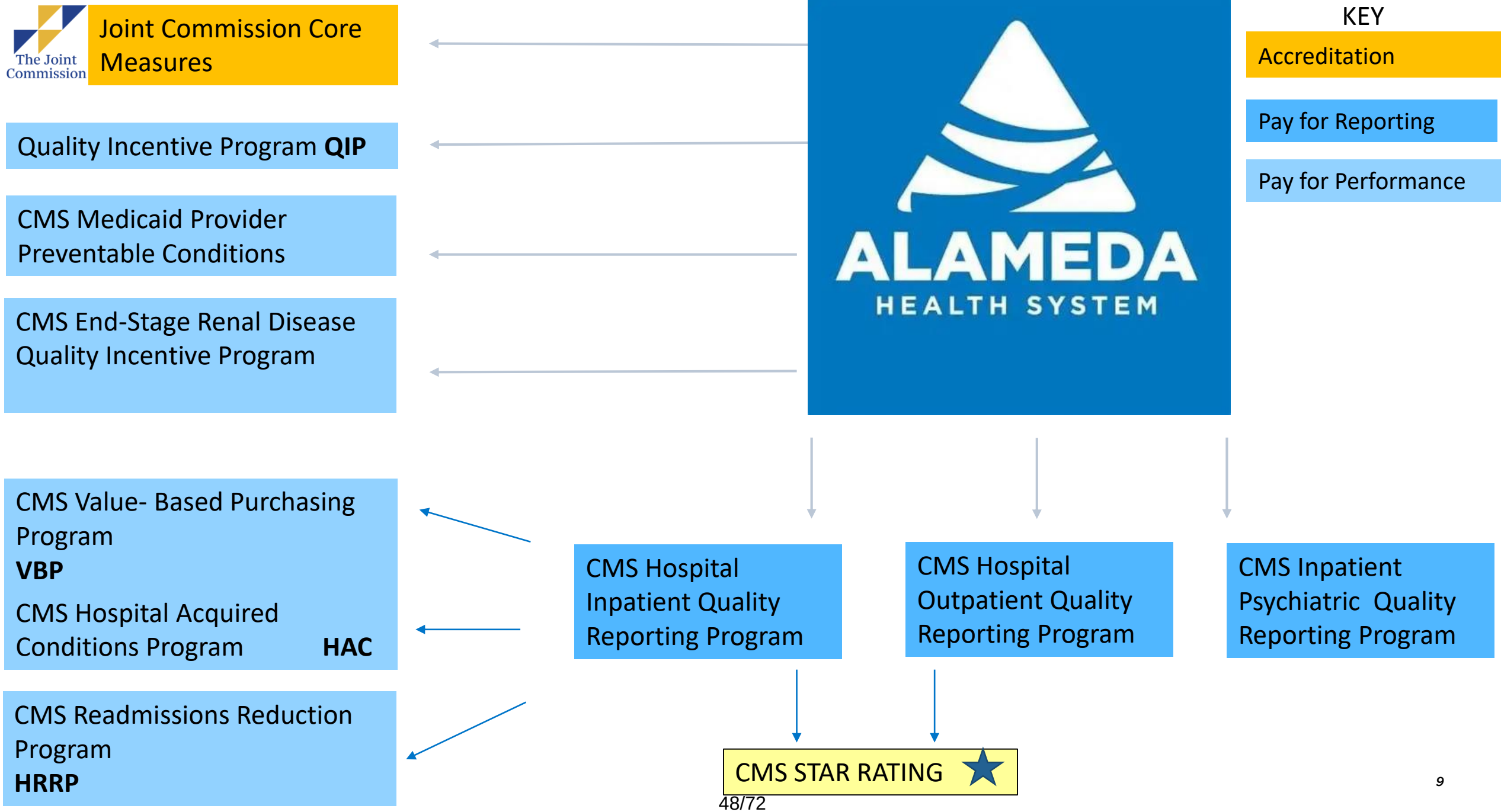
4. *Organizational, process and accountability factors (fragmented documentation and incorrect documentation nomenclature; inconsistent coding; inaccurate hospital-acquired condition reporting; lack of alignment across departments; need for and investment in physician education and real-time/proactive identification of opportunities)*

5. Social and case-mix factors (safety net organizations often face a "structural disadvantage" in these public reporting systems)

6. Perception and weighting differences

ALAMEDA HEALTH SYSTEM

# The CMS Star Journey at AHS: Foundational to Quality and Performance Excellence


Joint Commission Core Measures
Quality Incentive Program QIP
CMS Medicaid Provider Preventable Conditions
CMS End-Stage Renal Disease Quality Incentive Program
ALAMEDA HEALTH SYSTEM
KEY
Accreditation
Pay for Reporting
Pay for Performance
CMS Value- Based Purchasing Program
VBP
CMS Hospital Acquired Conditions Program HAC
CMS Readmissions Reduction Program
HRRP
CMS Hospital Inpatient Quality Reporting Program
CMS Hospital Outpatient Quality Reporting Program
CMS Inpatient Psychiatric Quality Reporting Program
CMS STAR RATING

| Overall Rating | Number of Hospitals (n= 2891) |
|---|---|
| 1 Star: HGH | 291 (10.1%) |
| 2 Star | 767 (26.6%) |
| 3 Star: ALH | 939 (32.5%) |
| 4 Star | 661 (22.9%) |
| 5 Star | 233 (8.1%) |

# Rating Comparative

## Level I Trauma Center

(Non- University /Academic Hospitals/Medical Centers)

| Level I Trauma Center Non-University/Academic | City, State | Beds | CMS Star Rating |
|---|---|---|---|
| **Star Rating 1** | | | |
| **Highland Hospital** | Oakland, CA | 236 | 1 |
| **Star Rating 2** | | | |
| **Los Angelas General Medical Center** | Los Angeles | 600 | 2 |
| **Star Rating 3** | | | |
| **Santa Clara Valley** | Santa Clara, CA | 731 | 3 |
| **Scripps Mercy** | San Diego, CA | 684 | 3 |
| **Riverside Community Hospital** | Riverside, CA | 478 | 3 |
| **Denver Health** | Denver, CO | 453 | 3 |
| **Cook County** | Chicago, Il | 464 | 3 |
| **Med Star – Washington** | Washington, DC | 926 | 3 |
| **Star Rating 4** | | | |
| **Penrose Health** | Colorado Springs | 522 | 4 |
| **Advocate Good Samaritan** | Downers Grove, IL | 333 | 4 |
| **Advocate Lutheran General** | Park Ridge, IL | 651 | 4 |
| **Star Rating 5** | | | |
| **Scripps Memorial** | La Jolla, CA | 357 | 5 |

# Rating Comparative

## Level I Trauma Center

(University /Academic Hospitals/Medical Center)

| Level I Trauma Center University/Academic | City, State | Beds | CMS Star Rating |
|---|---|---|---|
| **Star Rating 3** | | | |
| **Loma Linda University** | Loma Linda, CA | 507 | 3 |
| **Riverside University Health System** | Moreno Valley | 439 | 3 |
| **University Of California- Davis** | Davis, CA | 625 | 3 |
| **Loyola University** | Maywood, IL | 547 | 3 |
| **Star Rating 4** | | | |
| **University of Chicago** | Chicago, Il | 811 | 4 |
| **University of California Irvine** | Irvine, Ca | 411 | 4 |
| **UCLA- Ronald Reagan** | Torrance, CA | 570 | 4 |
| **Star Rating 5** | | | |
| **Northwestern Memorial** | Chicago, Il | 773 | 5 |
| **Stanford Health Care** | Palo Alto | 361 | 5 |
| **Cedars- Sinai Medical Center** | Los Angeles | 886 | 5 |

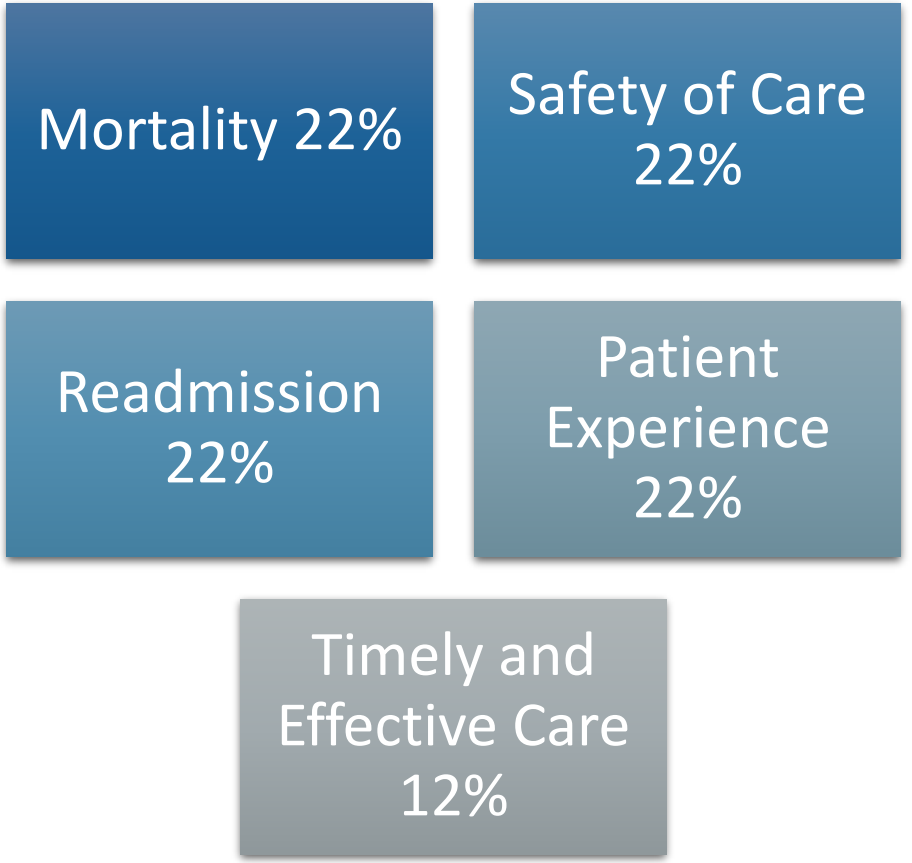
## Overall Star Rating

How individual hospitals perform compared to all hospitals across the country

5 categories of quality measures that make up the overall star rating

**Measures**

**Weight Used in Star Rating Calculation**



# Five Categories Quality Measures for CMS Star Rating

| | |
|---|---|
| Mortality | *Death rates in the 30 days following a hospitalization* |
| Safety of care | *Potentially preventable injury and complications due to care provided during a hospitalization* |
| Readmission | *Returns to the hospital following a hospitalization* |
| Patient Experience | *Results from the* Hospital Consumer Assessment of Healthcare Providers and Systems (*HCAHPS) Survey*<br><br>*A national, standardized, publicly reported survey of patients' perspectives of hospital care* |
| Timely and Effective | *How often or how quickly hospitals provide care that research shows get the best results for patients* |

# What's Included in July 2025 Star Rating

## Any metric reported under Inpatient Quality Reporting (IQR) and/or Outpatient Quality Reporting (OQR) can be included in star rating and categorized as:

- **Mortality: Weight 22%**
  - **Source: Claims**
  - Disease specific
  - Surgical in-patient
- **Readmissions : Weight 22%**
  - **Source: Claims**
  - Disease excessive days & readmissions,
  - All cause readmissions
  - Hospital visit rate after outpatient colonoscopy, chemotherapy, surgery (unplanned)
- **Safety of Care: Weight 22%**
  - **Source: Abstraction/Claims**
  - Hospital Acquired Infections (National Healthcare Safety Network)
  - Patient Safety Indicator 90 (Composite Harm) Claims
  - Complication Hip and Knee (Claims)
- **Patient Experience: Weight 22%**
  - **Source: 3rd Party Vendor Pt Surveying (Press Ganey)**
  - Hospital – Consumer Assessment of Healthcare Providers and Systems (H-CAHPS)
- **Timely & Effective Care: Weight 12%**
  - **Source: Varies**
  - Imaging efficiency (Claims)
  - Electronic Clinical Quality Measures (ECQMs) - Safe Opioid
  - Chart abstraction: Sepsis Bundle
  - ED patient left without being seen (Structural - portal through which we submit data)

- Performance periods range from July 2020 to June 2023
- Based on data submitted as October 2024
- This means performance today (2025) will not be reflected in our star rating until July 2027

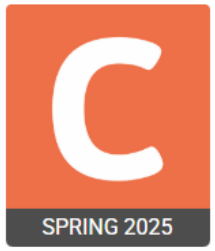
# Five Categories Quality Measures for CMS Star Rating

| Metrics | Value Based Purchasing | CMS Star Rating | Leapfrog | Other |
|---|---|---|---|---|
| **Mortality**/Complications<br>Acute Myocardial Infarction, CABG, Chronic Obstructive Pulmonary Disease, Heart Failure, Pneumonia<br>Complications: Hip/Knee ***(6 DRG cohorts)***<br>Claims Based | 25% of score | 22% of score<br>Same as VBP Plus Stroke | | |
| **Patient Experience**<br>HCAHPS<br>Com w/RN, Com w/MD<br>Staff Response, Com Meds, D/C Info, Clean/Quiet<br>Overall | 25% of score | 22% of score | 15.7% of score<br>Only Com w/RN, Com w/ MD, Staff Response, Com Meds, D/C Info | |
| **Safety**<br>Chart Abstracted: HAI/Sepsis Bundle<br>Claims: PSI90 | 25% of score | 22% of score | 50% of score<br>Plus:<br>Foreign Object Retained, Air Embolism,<br>Falls and Trauma,<br>Surgical Death | Hospital-Acquired Conditions Reduction |
| **Timely and Effective Care**<br>Claims<br>Chart Abstraction<br>Sepsis Bundle, ED Throughput, Outpt Core Measures, Imaging Efficiency | 25% of score<br>Only: Medicare Spending Per Beneficiary | 12% of score | | |
| **Readmissions**<br>Condition Specific<br>Procedure Specific<br>Hospital Wide<br>Claims | | 22% of score | | Hospital Readmissions Reduction Program |

# Quality and Performance Metrics
# Excellence vs. Opportunities

# Leapfrog Health Care Grades

This Hospital's Grade

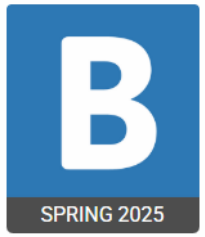



### Wilma Chan Highland Hospital Campus

1411 E. 31st Street
Oakland, CA 94602
Map and Directions

View this hospital's Leapfrog Hospital Survey Results

This Hospital's Grade

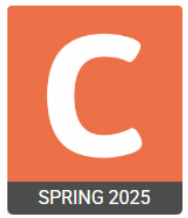



### Alameda Hospital

2070 Clinton Avenue
Alameda, CA 94501-4397
Map and Directions

View this hospital's Leapfrog Hospital Survey Results

This Hospital's Grade

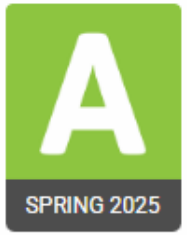



### San Leandro Hospital

13855 E. 14th Street
San Leandro, CA 94578
Map and Directions

View this hospital's Leapfrog Hospital Survey Results

This Hospital's Grade

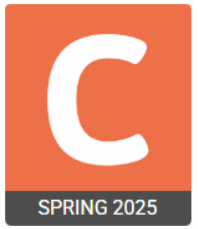



### Contra Costa Regional Medical Center

2500 Alhambra Avenue
Martinez, CA 94553-3156

View the full Score

This Hospital's Grade




### Zuckerberg San Francisco General Hospital and Trauma Center

1001 Potrero Avenue
San Francisco, CA 94110-3594
Map and Directions

View this hospital's Leapfrog Hospital Survey Results

This Hospital's Grade


### San Mateo Medical Center

222 W 39th Ave
San Mateo, CA 94403-4398
Map and Directions

View this hospital's Leapfrog Hospital Survey Results

# Hospital Acquired Infections Calendar Year 2025 to Date Included in Star Rating, VBP, Leapfrog, and HAC

| | Alameda Hospital | | Highland/San Leandro Hospital | | Fall Measure Performance Category | |
|---|---|---|---|---|---|---|
| **Performance information** | **Fall 2027 (CYTD 2025)** | **Fall 2025 (CY 2023)** | **Fall 2027 (CYTD 2025)** | **Fall 2025 (CY 2023)** | **Alameda** | **Highland/San Leandro** |
| HAI-1 Central Line Associated Bloodstream Infection (CLABSI) (ICU + select wards) | 0 | 0 | 0 | 0.802 | Same/ Better | Same/Better |
| HAI-2 Catheter Associated Urinary Tract Infections (CAUTI) (ICU only) | 0.9765 | 0 | 0.455 | 2.29 | Same | Same |
| HAI-3 Surgical Site Infection from colon surgery (SSI-colon) | N/A | N/A | 0.7852 | 3.104 | N/A | Same/Worse |
| HAI-4 Surgical Site Infection from abdominal hysterectomy (SSI-abdominal hysterectomy) | N/A | N/A | 3.861 | N/A | N/A | Worse/NA |
| HAI-5 MRSA Bacteremia | N/A | 0 | 0.966 | 0.39 | N/A | Same |
| HAI-6 Clostridium Difficile (C.diff) | 0 | 0.735 | 0.595 | 0.817 | Same | Same |

# Hospital Acquired Infections (HAI)

| HAI | FY25 SIR | FY25 Percentile | FYTD 26 SIR | FYTD 26 Percentile |
|---|---|---|---|---|
| **CAUTI** | 0.578 | Between 50th (0.547) and 55th (0.603) %tile | **0** | **Best Decile (10th %tile)** |
| **CLABSI** | 0 | **Best Decile (10th %tile)** | **0** | **Best Decile (10th %tile)** |
| **MRSA** | 1.09 | Between 75th (1.046) and 80th (1.173) %tile | **0** | **Best Decile (10th %tile)** |
| **C Diff** | 0.601 | Between 75th (0.579) and 80th (0.646) %tile | 0.312 | Between 45th (0.309) and 50th (0.346) %tiles |
| **SSI COLO** | 2.323 | Worse than 95th %tile | 2.548 | Worse than 95%tile |
| **SSI HYST** | NA (Predicted less than 1) | NA | NA: Predicted > 1 1 case this year | NA |

# Hospital Acquired Infections

| Days Since Last Hospital Acquired Infection | | | | | |
|---|---|---|---|---|---|
| Facility | CAUTI | CLABSI | C-DIFF | MRSA | SSI (CMS) |
| System | 141 | 546 | 43 | 225 | 45 |
| ALH | 266 | 1063 | 427 | 1398 | >365 |
| HGH | 141 | 546 | 43 | 254 | 45 |
| SLH | 571 | 637 | 63 | 225 | >365 |

# Driving HAI Performance

| Opportunity | Improvement Actions |
|---|---|
| CLABSI/CAUTI | ○ Daily monitoring of device maintenance and necessity<br>○ Nurse driven Foley removal protocol<br>○ Developing bladder management protocol |
| CLABSI/CAUTI/ C-Diff | ○ Reinforce testing criteria<br>• Appropriate signs and symptoms<br>• Source for obtaining samples<br>○ Guidance in EPIC for urine cultures and C-difficile<br>○ Implemented urine analysis with reflex to culture |
| SSI | ○ Focus on SSI prevention bundle<br>○ Colon procedure checklist<br>○ Improve documentation to improve SSI risk adjustment and case exclusion |

# HCAHPS (VBP, Star Rating, Leapfrog)

| HCAHPS (source Press Ganey) | National Percentile Ranks | | | |
|---|---|---|---|---|
| **Patient Experience (All)** | **HGH + SLH** | | **AH** | |
| | Change By CY 23 and CY25 | Current Percentile Rank | Change By Cy 23 and CY25 | Current Percentile Rank |
| **Rate hospital 0-10** | +5.5% | 66th | +3.4% | 37th |
| Recommend the hospital | | 75th | | 35th |
| Comm w/ Nurses Domain Performance | +5.6% | 23rd | -2.3% | 9th |
| Response of Hosp Staff Domain Performance | +3.5% | 58th | +8.1% | 47th |
| Comm w/ Doctors Domain Performance | +2.2% | 74th | -5.3% | 23rd |
| Cleanliness of hospital environment | +1.6% | 34th | +0.2% | 54th |
| Comm About Medicines Domain Performance | +0.5% | 62nd | -4.5% | 26th |
| Discharge Information Domain Performance | -0.1% | 40th | -0.2% | 20th |
| New*Restful Hosp Environment Domain Performance | New | 61st | New | 16th |
| New *Care Coordination Domain Performance | New | 35th | New | 13th |
| New *Info About Symptoms Domain Performance | New | 23rd | New | 16th |

Patient Experience is improving at HGH/SLH with 6 domains better than the national average

Patient experience is declining at Alameda with 6 domains below national 25th percentile

Patient experience is strongest contributor to Alameda's declining performance in CMS Star Rating, VBP, and Leapfrog

# Readmissions : Star Rating, HHRP

| HWR Overall, CMS - % Readmit within 30 Days | | |
|---|---|---|
| | FY 25 | FYTD 26 |
| **AHS Wide** | **12.60%** | **13.10%** |
| Alameda Hospital | 15.00% | 15.60% |
| Highland | 11.70% | 12.20% |
| San Leandro | 12.90% | 13.10% |

- Nationwide Benchmark - 15%
- Internal Performance FY25 was 12.6%, which does not include readmissions to hospitals external to AHS

FYTD 2026
Data from Jul'25-Sep'25

| CMS - % Readmit within 30 Days | AMI | | COPD | | Heart Failure | | Pneumonia | |
|---|---|---|---|---|---|---|---|---|
| | FY 25 | FYTD 26 | FY 25 | FYTD 26 | FY 25 | FYTD 26 | FY 25 | FYTD 26 |
| AHS Wide | 8.73% | 7.41% | 18.78% | 11.91% | 21.75% | 21.90% | 15.21% | 12.20% |
| Alameda Hospital | 12.50% | 0.00% | 10.26% | 22.22% | 28.97% | 32.35% | 16.59% | 14.58% |
| Highland | 8.77% | 8.00% | 14.29% | 11.77% | 16.96% | 19.23% | 14.71% | 11.43% |
| San Leandro | 0.00% | 0.00% | 25.26% | 6.25% | 23.19% | 17.65% | 13.95% | 10.00% |

| National Benchmark | 13.60% | 18.20% | 19.70% | 16% |
|---|---|---|---|---|

# Driving Readmission Performance

| Improvement Actions |
| --- |
| • Gather Voice of Patient via the Readmission Assessment tool in Epic |
| • Creation of the SNF Collaborative, strengthening the relationship between community SNF partners and AHS facilities to improve care transitions |
| • Development of a team to help identify and manage complex patients/discharges |
| • OnClick a new resource for Medicare FFS patients discharged home to ensure their needs are being met post discharge |
| • Conducted REACH pilot: Post Discharge Telehealth visit to resolve any questions and ensure patient's able to obtain medications and equipment |
| • Improving Discharge Teaching Targeting common readmissions per facility:<br>  • Alameda: Congestive Heart Failure<br>  • San Leandro: Kidney Failure and Dialysis<br>  • Highland: Sickle Cell Crisis/Pain Management |

# Length of Stay
*(Outstanding!)*

| Facility | Mean Length of Stay (Fiscal Year 2025) | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Vizient | | | American Essential Hospitals (AEH) | | | National Comparison | | |
| | Obs | Exp | Ratio | Obs | Exp | Ratio | Obs | Exp | Ratio |
| System | 5.14 | 5.13 | 1.00 | 6.30 | 5.92 | 1.06 | 5.49 | 5.62 | .98 |
| Alameda | 4.78 | 4.67 | 1.02 | | | | | | |
| Highland | 5.46 | 4.64 | 1.18 | | | | | | |
| San Leandro | 4.34 | 4.65 | .93 | | | | | | |

| Facility | Mean Length of Stay (Fiscal Year to Date 2026 – thru Aug 2025) | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Vizient | | | American Essential Hospitals (AEH) | | | National Comparison | | |
| | Obs | Exp | Ratio | Obs | Exp | Ratio | Obs | Exp | Ratio |
| System | 4.81 | 5.01 | .96 | 6.15 | 5.97 | 1.03 | 5.35 | 5.65 | .95 |
| Alameda | 4.61 | 5.34 | .86 | | | | | | |
| Highland | 5.07 | 4.87 | 1.04 | | | | | | |
| San Leandro | 3.93[65/72] | 5.26 | .75 | | | | | | |

ALAMEDA HEALTH SYSTEM

ALAMEDA HEALTH SYSTEM

# Next Steps:
# Impact and Action Plan, Opportunities and Strategies for Success

*The CMS Star Journey Multi-Disciplinary Task Force*

| Area/Key Performance | Impact/Action Plan |
| --- | --- |
| **Leverage Quality Department Talents** | Laser focus, prioritize and streamline initiatives that have greatest sustainable impact; address widespread data access and reliability issues; implement Leapfrog action plan |
| **Regulatory Readiness** | Improve regulatory compliance and decrease risk of deficiencies: Post mock survey preparedness action plan in place for The Joint Commission (TJC) survey; California Department of Public Health (CDPH) and Centers of Medicare & Medicaid Service (CMS) site visits |
| **Centers for Medicare & Medicaid Services (CMS) Star Ratings** | Create multi-disciplinary task force: Physicians, nurses, providers, IT/Epic, quality and operations leaders, patient experience team, case management, ACMOs, CPE, etc: Kick-off meeting Q4 2025. |
| **Length of Stay (LOS) & Early AM Discharges** | Continue LOS efforts; establish multi-disciplinary early AM discharges task force (as above) to optimize operational efficiency, improve patient throughput/experience, decrease Highland ER boarders, increase bed capacity/preserve network integrity: Kick-off meeting Q4 2025. |

# Driving Performance : Patient Experience

| Opportunity | Current Performance (CYTD 2025) % Top Box & Percentile | | | |
|---|---|---|---|---|
| **Patient Experience (All)** | **HGH + SLH** | | **AH** | |
| **Recommend the hospital** | 78.72 | 75th | 67.52 | 35th |
| **Comm w/ Nurses Domain Performance** | 75.97 | 23rd | 72.61 | 9th |
| **Response of Hosp Staff Domain Performance** | 64.83 | 58th | 62.58 | 47th |
| **Comm w/ Doctors Domain Performance** | 82.8 | 74th | 75.44 | 23rd |
| **Comm About Medicines Domain Performance** | 63.37 | 62nd | 57.92 | 26th |
| **Discharge Information Domain Performance** | 85.8 | 40th | 83.33 | 20th |
| **New *Care Coordination Domain Performance** | 70.87 | 35th | 66.11 | 13th |

# Driving Performance : Patient Experience

| Opportunity | Improvement Actions |
|---|---|
| **Patient Experience (All)**<br>**Recommend the hospital**<br>**Comm w/ Nurses Domain Performance** | • Daily Patient Leader Rounding w/ real time service recovery<br>• In Development: Standard comm tool for bedside shift reports<br>• Charge nurse leader retreat with Sim training & in-services for skill development<br>• Patient Admission Guide - for improving patient awareness, engagement in patient's care<br>• All patient facing departments huddle around visibility board<br>• In-service training on GIFT (Greet, Identify, Follow-up, Thank), customer service & comm service standards annually<br>• Purposeful hourly rounding (PHR) with validations/monitoring<br>• Care Board Completion & Accuracy with daily audits via leader rounding |
| **Response of Hosp Staff Domain Performance** | • No pass zone training in NEO (New Employee Orientation), NNO & in-service trainings<br>• In progress - Rover phone – RN is called directly with patient call light alert – reassign if time elapses |
| **Comm w/ Doctors Domain Performance** | • Provider Comm & Care Experience Required Training Module – Annually<br>• In Progress: GME boot camp comm training curriculum in development for interns & residents<br>• In Progress: Discharge Comm Standard work/scripting summary |
| **Comm About Medicines Domain Performance** | • Pharmacy Leader Patient Rounding – patients with poly pharm or complex therapies<br>• Med comm standard tool with patients– side effects & purpose of medication. |
| **Discharge Information Domain Performance** | • In progress: Discharge communication tool: staff to review AVS "symptoms & issues to look out for" with patient & family engagement scripting<br>• In progress: Estimated Discharge Date – Early patient & family engagement process & scripting |
| **New *Care Coordination Domain Performance** | • Care Coordination Leader Patient Rounds – for discharge needs after leaving hospital<br>• Family/Caregiver outreach on discharge planning |

# Strategic Partnership with Post Acute Services

Understand Success: Quality Best Practices Exchange

Objective: Leverage success in achieving high quality ratings to inform improvements for the acute care side

Presentations to Executive Leadership and Quality on Long Term Care (LTC) & Skilled Nursing Facilities (SNF) maintain high quality ratings

EX: staff training, workflows, documentation standards, leadership strategies

Identify specific interventions used in LTCs/SNFs that could be adapted upstream in the hospital setting

Ex: fall reduction, infection control, staffing models

Set up a bi-directional quality benchmarking initiative where both organizations share data, practices, and lessons learned

# Awards, Recognition and Accolades

BETA HEART (**H**ealing, **E**mpathy, **A**ccountability, **R**esolution, **T**rust)

- Just Culture
- Culture Measurement & Improvement
- Rapid Event Analysis
- Communication & Transparency
- Early Resolution

BETA OB QUEST for Zero

BETA ED QUEST for Zero

2024 CAPH (California Association of Public Hospitals)/SNI (Safety Net Institution) Quality Leader award for Pediatrics improvement in Care Redesign domain

2025 CAPH/SNI Quality Leader award for Breast Cancer screening efforts in the Equity domain

# Awards, Recognition and Accolades

QIP (Quality Improvement Project) - 100% quality score & maximum reimbursement

DHCS (Department of Healthcare Services) Top Performer Award at QIP Annual Conference in April 2025

2024 Merit Incentive Payment System (MIPS) Results: Achieved Incentive Threshold: 95.7 out 100

Stroke *Get With The Guidelines* Awards

- Alameda Hospital: Gold Plus with Target: Stroke Honor Roll and Target: Type 2 Diabetes Honor Roll
- Highland Hospital: Silver Plus with Target: Type 2 Diabetes Honor Roll
- Highland Hospital: Coronary Artery Disease STEMI Receiving Gold Plus with Target: Type 2 Diabetes
- Highland Hospital: Coronary Artery Disease NSTEMI Gold with Target: Type 2 Diabetes