QUALITY PROFESSIONAL SERVICES COMMITTEE MEETING

Wednesday, November 19, 2025
5:00pm-6:00pm

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

LOCATION:
Open Session: HCP Conference Center, see above address

Members of the public may also participate at the following ZOOM Meeting Link:[1]
https://alamedahealthsystem.zoom.us/j/9361457125?pwd=4JnAmhDnBaLqY4GWf4PQBwp3w0Puy2.1&omn=84957721824
Meeting ID: 936 145 7125
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COMMITTEE MEMBERS
Greg Garrett
Lilavati Indulkar, MD, Chair
Donna Linton
Nicholas Moss, MD

NON-VOTING MEMBERS
Chief of Staff – AHS Medical Staff
Chief of Staff - AH Medical Staff

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

NOTE: In the event that a quorum of the Board of Trustees participates on this Committee, the meeting is noticed as a Special Meeting of the Board of Trustees; however, no final Board of Trustees action can be taken.

QUALITY PROFESSIONAL SERVICES COMMITTEE MEETING AGENDA

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

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

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

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

OPEN SESSION / ROLL CALL

PUBLIC COMMENT

A. ACTION: Consent Agenda

A1. Approval of the Minutes of the October 22, 2025 Quality Professional Services Committee Meeting

A2. Recommendation to the Board of Trustees for approval of the AHS Medical Staff Policies and Procedures listed below:

AHS and AH Medical Staff:

New Policy for AHS & AH Medical Staff:
- Medical Staff Credentialing Information Integrity and Data Security

Revised Polices for AHS & AH Medical Staff:
- Medical Staff Credentialing and Privileging of Providers
- Medical Staff Ongoing Monitoring and Evaluation of actions Related to Providers
- Medical Staff Routine Focused Professional Practice Evaluation (FPPE)/Proctoring
- Standardized Procedures for Advanced Practice Providers in the Department of Surgery

Retired Policy for AHS & AH Medical Staff:
- Medical Staff Credentialing Systems Control

A3. Approval of the AHS Medical Staff Revised Application Forms and Revised Privilege Forms listed below:

Revised Privilege Forms for AHS & AH:
- Anesthesiology
- Radiology
- Surgery Advanced Practice Provider

Revised Governing Documents/Forms for AHS & AH:
- Medical Staff and APP Pre-application
- Pre-Application Consent Acknowledgement
- Medical Staff and APP Voluntary Resignation form

Recommendation: Motion to Approve

END OF CONSENT AGENDA

B. REPORT/DISCUSSION: Medical Staff Reports
AHS Medical: Berenice Perez, MD, Chief of Medical Staff
AH Medical: Catherine Pyun, DO, Chief of Medical Staff

C. REPORT/DISCUSSION: Quality Reports

C1. Regulatory Affairs, Quality OKR Dashboard
Ana Torres, Vice President, Quality

C2. Post Acute
Richard Espinoza, Chief Administrative Officer, Post Acute

D. DISCUSSION: Harm - Falls and HAPI
Terrance Fitzgerald Shaw, ACNO/CAO Northern Region
Chris Adams, ACNO/CAO Southern Region

E. DISCUSSION: QIP Audit Results
Natalie Curtis, MD, Medical Director, Value Based Care

F. CLOSED SESSION

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

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

(Reconvene to Open Session)

G. OPEN SESSION

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

ADJOURNMENT

ADDENDUMS

- Agenda Item C1 OKRs
- Agenda Item C2 Post Acute
- Agenda Item E, QIP

Our Mission
Caring, Healing, Teaching, Serving All

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

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

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

The Board of Trustees is the Policy Body of the Alameda Health System. The Board has several standing Committees where Board matters are the subject of discussion at which members of the public are urged to testify. Board procedures do not permit: 1) persons in the audience at a Committee meeting to vocally express support or opposition to statements by Board Members or by other persons testifying; 2) ringing and use of cell phones, pagers, and similar sound-producing electronic devices; 3) signs to be brought into the meeting or displayed in the room; 4) standing in the meeting room. Citizens are encouraged to testify at Committee meetings and to write letters to the Clerk of the Board or to its members, 1411 East 31st Street Oakland, CA 94602.
Members of the public are advised that all Board and Committee proceedings are recorded (audio), including comments and statements by the public in the course of the meetings. Copies of the audio recordings will be made available to the public. Copies of the agendas and supporting documents can be found here: http://www.alamedahealthsystem.org/meeting-agendas-and-minutes/**. By attending and participating in Board/Committee meetings, members of the public consent to audio recording of any statements they may make during the proceedings.**

Disability Access
The Meeting Rooms are wheelchair accessible. Assistive listening devices are available upon request at the Clerk of the Board's Office. To request accommodation or assistance to participate in the meeting, please contact the Clerk of the Board. Requests made at least 48 hours in advance of the meeting will help to ensure availability.

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

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

ACTION: Consent Agenda

QUALITY PROFESSIONAL SERVICES COMMITTEE MEETING

Wednesday, October 22, 2025
5:00pm-7:00pm

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

LOCATION:
Open Session: HCP Conference Center, see above address

COMMITTEE MEMBERS
Greg Garrett
Lilavati Indulkar, MD, Chair
Donna Linton
Nicholas Moss, MD

NON-VOTING MEMBERS
Chief of Staff – AHS Medical Staff
Chief of Staff - AH Medical Staff

QUALITY PROFESSIONAL SERVICES COMMITTEE MEETING MINUTES

THE MEETING WAS CALLED TO ORDER AT 5:02 pm

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

ABSENT: Donna Linton, Excused

PUBLIC COMMENT: None

A. DISCUSSION: Clinical Highlights
Lilavati Indulkar, MD, Chair

Trustee Indulkar introduced Nicky Reynicke, RN, who would conduct a presentation regarding the AHS chronic care team.

Trustee Moss asked if enrolling in the chronic care certification program would allow the visits to get reimbursed. Mr. Reynicke said that was correct. There were other clinics that had a chronic care team, but they were not enrolled in the certification yet.

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Trustee Garrett asked about the certification process. Mr. Reynicke said there was paperwork and a small fee. There also had to be a quality coordinator for the certification.

Trustee Indulkar said that a lot of the data she had seen was from the insurance industry, but for every patient that decreased in A1C saved $700-$1000 per patient and over a space of a couple of years could equate to $13,000 per patient.

B. ACTION: Consent Agenda

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

B1. Approval of the Minutes of the September 24, 2025 Quality Professional Services Committee Meeting

B2. Recommendation to the Board of Trustees for approval of the System Wide Policies:

- 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

B3. Recommendation to the Board of Trustees for 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

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

Revised Privilege Forms for AHS & AH:

- Orthopaedic Surgery – Advanced Practice Provider

Trustee Moss moved and Trustee Garrett seconded to approve the consent agenda.

ACTION: A motion was made and seconded to approve the consent agenda. A roll call was taken, and the motion passed.
AYES: Trustee Garrett, Indulkar, Moss
NAYS: None
ABSTENTION: None

END OF CONSENT AGENDA

C. REPORT/DISCUSSION: Medical Staff Reports
AHS Medical: Berenice Perez, MD, Chief of Medical Staff
AH Medical: Catherine Pyun, DO, Chief of Medical Staff

Trustee Garrett asked if there would be additional information at future meetings regarding the capital expenses. Mr. Fratzke said he would look to the clinical leaders to let them know what was needed. Dr. Perez said she would check in and get back to them.

D. REPORT/DISCUSSION: Quality Reports

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

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

E. DISCUSSION: AHS Patient Experience
Angela Ng, MD, Director, Care Experience

Trustee Indulkar asked if the surveys indicated any areas of disparities or discrepancies. Dr. Ng said that one positive discrepancy was that the Spanish speaking patient's response rates were higher. There was also interesting matrix regarding gender, females tended to give partial ratings. The younger generations seemed to have a different set of things that were most important to them.

Trustee Indulkar asked if there were three resources that were needed. Dr. Ng said there were things they were working on improving, such as screens in the ED, obtaining updates in real time, and patient education resources.

Trustee Garrett said they knew the executive leadership was working to prioritize requests for expenses and the Board was trying to provide policy guidance on areas they thought should be prioritized. Making sure the leadership had a list of these areas that should be put on a high priority would be useful

Mr. Azizi said the Quality Committee of the Board would meet in Closed Session to discuss the items as set forth on the agenda.

F. CLOSED SESSION

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

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

(Reconvene to Open Session)

G. OPEN SESSION

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

Mr. Azizi reported that the Committee met in Closed Session and considered credentialing reports for each of the medical staffs and approved credentials/privileges for fully qualified practitioners recommended by the medical staffs.

ADJOURNMENT 6:23pm

ALAMEDA HEALTH SYSTEM

November 19, 2025

TO: Quality Professional Services Committee

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

SUBJECT: **Agenda Item:** A3

Meeting Date: November 19, 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.

New policies are developed and existing policies are revised in accordance with best practice, legal and regulatory requirements.

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 of Policies

New Policy for AHS & AH Medical Staff:

- Medical Staff Credentialing Information Integrity and Data Security

Revised Polices for AHS & AH Medical Staff:

- Medical Staff Credentialing and Privileging of Providers
- Medical Staff Ongoing Monitoring and Evaluation of actions Related to Providers
- Medical Staff Routine Focused Professional Practice Evaluation (FPPE)/Proctoring

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

Retired Policy for AHS & AH Medical Staff:

- Medical Staff Credentialing Systems Control

Alameda Health System

MEDICAL STAFF CREDENTIALING INFORMATION INTEGRITY AND DATA SECURITY

Department	Medical Staff Services	***Effective Date***	11/19/2025
Campus	AHS, AH	***Date Revised***	
Unit	All	***Next Scheduled Review***	11/2028
Manual	Medical Staff	***Author***	Manager, Medical Staff Services
Replaces the following Policies: Medical Staff Credentialing System Controls		***Responsible Person***	Vice President, Physician Services

Purpose

This purpose of this policy is to describe the ongoing monitoring process the Alameda Health System follows for storing, modifying, and safeguarding credentialing information.

Policy Statement

Alameda Health System maintains and safeguards the information used in the Alameda Health System and Alameda Hospital Medical Staff's credentialing and recredentialing process against inappropriate documentation and updates.

Procedure

A. Scope of Credentialing Information

Credentialing information protected under this integrity policy will include:

- Provider applications and attestations
- Primary source verifications
- Credentialing activity documents:
  - Verification dates
  - Report dates
  - Credentialing/privileging dates
  - Credentialing/privileging decisions
  - Signature/initials of the verifier or reviewer
- Credentialing Committee minutes
- Application level
- Checklists/audits

B. Staff Responsibilities/Access

Staff are assigned user roles based on areas of responsibility as defined in their job description. Each user role is assigned specific view/edit system access as needed to perform their duties which may include editing or updating the credentialing information; only administrators or end user-super users have access to delete images and records, when appropriate. Modifications can be made to credentialing information when there is supporting information for the change.

Other credentialing activities and documents may be updated if the policy identifies that credentialing information changes and/or updates are appropriate.

The Medical Staff Manager, or designee, is responsible for the oversight of credentialing information integrity functions, including the audit monitoring process and corrective actions.

The staff responsible for documenting credentialing activities are categorized below, there are no facility restrictions with the exception that the ARM reviewers are limited to their assigned department/medical staff:

Group	Position/Title	Group Function
Administrator	VP Medical Staff Services; Systems Analysts; Medical Staff Manager	Full access to Credentialing module.
Apogee Administrator (Network Management/Provider Enrollment)	Provider Enrollment Manager; Sr. System Analyst	Full access to Network Management module.
Apogee Super User	Provider Enrollment Coordinators	Restricted access to Network Management module (excludes backend table and system maintenance). Update function in Credentialing module.
User Groups - End User-Super User	Senior Credentialing Coordinator	Restricted access to Credentialing module (excludes system maintenance).
User Groups – End User Access and ARM	Medical Staff/Credentialing Coordinators; Administrative Project Assistants	Limited access to Credentialing module (excludes backend table and system maintenance). No ability to delete images or records (except to correct covering/supervising provider to pull from system).
User Group: APA Users	Administrative Project Assistants, Interns	Minimal access to Credentialing module to upload documents, access practitioner task list and record/field entries. No ARM access, with the exception of ARM audit.
Administrative Reviewers	Medical Staff Division/Department Chairs; Chiefs of Staff; Chief Executive Officer/Chief	Administrative review module only, write function limited to evaluation and requested privilege approval.

	Medical Officer, or designee	

C. Documenting Updates to Credentialing Information

Updates to existing credentialing information is appropriate if credentialing information changes.

When an update is made to credentialing information, the Credentialing system Audit Detail Train will automatically record what was updated, the date and time the update was made and who made the update; the Credentialing Staff will include relevant explanations and reasons regarding what information was updated. When a new verification is required, the verification will be initiated, or the system will automatically generate, (via webcrawl) all appropriate documentation requirements to include the credentialing staff (user) identifier date of the verification and stored in the applicant's credentialing file. When a verification is retrieved manually (not via webcrawl), commentary may be stamped on a primary source document to identify receipt or reference additional supporting information if not included. Automated webcrawl results may be relied upon as the acquired date and updated expiration date (if available functionality) for primary source verification performed between credentialing cycles.

Primary source verifications may not be modified (edited/updated) when verification information changes, rather a new primary source verification will be completed.

When data requires an update, such as when the element expires requiring reverification, the previously primary source verified record is not altered, rather a new verification will be completed and the relevant data fields updated. The original verification documentation is retained in the credential file.
When updates are made, supporting documentation will include what was updated, why it was updated and by whom. File notes, comments or corresponding documents may be used to document supplemental information not otherwise automatically documented. Supporting documentation is not required when updates are made to correct typos/punctuation, add organizational assigned elements (i.e., office address, malpractice insurance) and when deleting a duplicate entry.

The Credentialing Staff enters information regarding the update into the appropriate field (described above).

Type of updates to existing credentialing that are appropriate:

- Error/Omission identified such as typographical errors.
- New information is available and needs to be added.
- Documents appended to incorrect provider profile.
- Updates to expired credentials.
- Updating or changing provider data information.

D. Inappropriate Documentation and Updates

The following documentation and updates to credentialing information outlined above are inappropriate:

- Falsifying credentialing dates (i.e., staff verification date, attestation date, credentialing decision date, etc.)
- Creating documents without performing the activity (i.e., photocopying a prior credential and updating information as a new credential.)
- Fraudulently altering existing documents (i.e., committee minutes, clean-file reports, ongoing monitoring logs, etc.)
- Attributing verification or review to an individual who did not perform the activity.
- Updates to information by unauthorized individuals.

E. Auditing, Documenting and Reporting Information Integrity

Alameda Health System completes an annual credentialing information integrity audit of the credentialing staff's documentation and updates to the credentialing information.

The credentialing information integrity audit will be completed using the Credentialing Information Integrity Audit and Analysis tool. Inappropriate documentation or updates identified will be tracked on this tool and the findings will be reported to the Vice President of Physician Services for review and determination of actions as appropriate.

The audit universe includes the provider files for all initial and reappointments made during the look-back period (prior 12 months). A random sample of provider files will be selected using 5% or 50 files, whichever is less.

The random sample includes at least 10 initial applications and 10 reappointment applications. If fewer than 10 providers were appointed and/or reappointed within the look-back period, all files will be included.

The audit tool includes the following information:

1. Report date
2. Title of individuals who conducted the audit
3. The 5% or 50 files auditing methodology.
    a. auditing period
    b. file audit universe size
    c. audit sample size
4. The audit log:
    a. file identifier
    b. type of credentialing information audited
5. Findings for each file.
    a. rationale for inappropriate documentation and updates, if applicable
6. The number or percentage and total inappropriate documentation and updates by type of credentialing information.

The CII Audit and Analysis tool will be completed and maintained even if no inappropriate documentation and updates are found.

F. Analysis, Corrective Action and Follow-Up of Information Integrity Issues

An annual qualitative analysis will be conducted for each instance of inappropriate documentation or update identified during the audit to determine the underlying cause.

If an instance of inappropriate documentation or update is identified, the CII Audit and Analysis tool will include the following:

- Titles of credentialing staff involved in conducting the qualitative analysis
- The identified cause of each finding

Documentation of the corrective actions planned or taken will be documented on the audit tool, including dates of action and who is responsible for implementation, to address all inappropriate documentation and updates.

A reaudit of the inappropriate documentation or updates identified will be conducted and documented in the tool within 3-6 months following the annual audit to evaluate the effectiveness of the corrective actions taken.

The reaudit will include practitioner files for all credentialing decisions made, or due to be made, 3–6 months after the annual audit.

If noncompliance with integrity policies and procedures is identified during the reaudit, a qualitative analysis will also be included to assess the nature and cause of the noncompliance.

If inappropriate documentation and updates are identified during the credentialing information integrity audit, consequences will be determined based on the severity of the issue. These may include, but are not limited to:

- Coaching/mentoring
- Implementation of a Performance Improvement Action Plan
- Disciplinary action

G. Information Integrity Training

Alameda Health System will conduct training to the credentialing and enrollment staff on inappropriate documentation and updates to the credentialing information as defined in this policy.

Training will be provided annually to all existing staff and upon new hire orientation for any new staff. Documentation of training material and attendance will be kept on file in the medical staff office.

H. Confidentiality and Information Security

In accordance with the AHS/AH medical staff bylaws and policies, medical staff records are confidential and access is limited to duly appointed officers and committees of the medical staff.

Medical Staff services personnel are granted access to the credentialing database in accordance with their assigned user role defined in this policy. Electronic files are primarily maintained within the credentialing database; however, supporting materials may also be electronically stored in a network folder, accessible to all medical staff

personnel. Personnel shall secure all confidential information when not in use. Workstations shall be in physically secure areas and computer screens should be positioned to prevent viewing form unauthorized individuals.

File location/storage and release of credentials information to third parties is addressed in the medical staff policy titled "Access to Medical Staff Records". Any historical, hard copies files are stored in on or off-site locations in locked files accessible by the Vice President of Physician Services, or designee.

In addition to the annual training for information integrity, medical staff services personnel are provided with orientation to the location and security of credentialing files, and all relevant polices, upon hire. Existing medical staff service personnel are oriented to updates and revisions of any relevant policies. All medical staff services personnel annually attest to maintain the confidentiality and protection of such information during and after employment.

Alameda Health System secures and backs-up electronic information in accordance with system-wide policies. Medical staff credentialing files are maintained indefinitely. Disposal of any duplicate or erroneous credentialing information would be deleted (electronically) or shredded (physical, paper) in a secure shredding bin.

References:

1. AHS/AH Medical Staff Bylaws
2. AHS/AH Medical Staff policy titled "Access to Medical Staff Records"
3. AHS Information Security System-wide policies titled:
   - Information System Access Policy
   - Information Systems Activity Review
   - Information Security Risk Management
   - AHS Remote Access to Information Systems
   - Acceptable Use of Information Systems Policy

		AHS	AH
Credentials Committee	**Date:**	**11/13/25**	
Medical Executive Committee	**Date:**	**11/19/25**	**11/14/25**
QPSC	**Date:**	**11/19/25**	
Board of Trustees	**Date:**		

Alameda Health System

MEDICAL STAFF CREDENTIALING AND PRIVILEGING OF PROVIDERS

Department	Medical Staff	***Effective Date***	5/2011
Campus	AHS, AH	***Date Revised***	5/2011, 6/2014, 6/2017, 6/2019, 2/2020, 1/2022, 4/2022; 4/2023; 5/2023; 10/2023; 11/2023; 2/2024; 3/2024; 3/2025; 4/2025; 8/2025; 11/2025
Unit	Medical Staff	***Next Scheduled Review***	11/2028
Manual	Medical Staff	***Author***	Manager, Medical Staff Services
Replaces the following Policies:		***Responsible Person***	Chief of Staff

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

Purpose

As an extension of the Alameda Health System (AHS) and Alameda Hospital (AH) Medical Staff Bylaws this policy will establish the mechanism for gathering relevant data, which involves the collection, verification and assessment of applicant information that will serve as the basis for decisions regarding credentialing and privileging of licensed practitioners and Advanced Practice Providers (APP), collectively referred to herein as "provider",who provide patient care services within the Alameda Health System.

Policy Statement

It is the policy of the AHS/AH Medical Staff to ensure that licensed practitioners and APPs meet minimum credentialing, privileging and performance standards for membership and/or privileges/practice prerogatives as outlined in the Medical Staff Bylaws and policies. The credentialing process is performed jointly where applicable, however, membership appointments and granting of privileges are independently recommended to the Governing Body by the respective Medical Staff.

All applications for appointment and/or reappointment to the Medical Staff/Advanced Practice Provider, and requests for clinical privileges, will be evaluated based on critical parameters: current licensure; education and relevant training; and experience, ability, and current competence to perform the requested privilege(s). Any applications that meet the application criteria during the verification process shall be categorized in accordance with policy.

Credentialing is required for all physicians (medical or osteopathic), dentists, podiatrists, or clinical psychologists as well as those advanced practice providers approved by the Board of Trustees, which include acupuncturists, audiologists, optometrists, nurse practitioners, certified registered nurse anesthetists, certified nurse midwives and physician assistants.

Nondiscriminatory Statement and Audit Process

The AHS and AH Medical Staff credentialing, and privileging process acts in compliance with all federal and state and local laws and regulations governing discrimination involving patients, employees, vendors, visitors and other individuals and entities associated or involved with AHS. This policy reaffirms the commitment of the AHS Medical Staff and AH Medical Staff to maintaining a discrimination-free credentialing and privileging process.

The AHS and AH Medical Staff will not engage in discrimination or harassment of any person employed or seeking employment or medical staff credentialing or patient care within AHS on the basis of race, color, natural origin, age, disability, religion, sexual orientation, gender identity, gender expression, physical or mental disabilities, medical condition, pregnancy, HIV status, ancestry, marital status, citizenship, or status as a covered veteran or the type of procedure patients in which the provider specializes. The Medical Staff does not retaliate against a person for pursuing their right under this policy and/or for the purpose of investigatory proceedings. Non-discriminatory information is available in alternative forms of communication to meet the needs of persons with sensory impairments.

The AHS and AH Medical Staff will not discriminate against a licensed provider solely on the basis of a civil judgment, criminal conviction, or another professional disciplinary action in another state if the judgment, conviction, or professional disciplinary action is solely based on the application of another state's law that interferes with a person's right to receive care that would be lawful if provided in California

On an annual basis, each member of the AHS and AH Credentials Committee will sign a confidentiality statement that will include an affirmative statement that all decisions are made in a non-discriminatory manner.

The Medical Staff Services Department will monitor through periodic audits of credentials files and provider complaints about possible discrimination, by performing audits of decisions recommended by the Credentials Committee. The findings will be reported to the Credentials Committee and the Medical Executive Committee on an annual basis to protect against discrimination and to maintain a nondiscriminatory credentialing process.

Procedure

All applications for appointment, reappointment, and requests for clinical privileges are processed as described below. The initial application process requires completion of a pre-application step prior to the initial application being issued. Telemedicine credentialing by proxy will be processed in accordance with policy.

Applicants will provide an attestation that all information submitted for credentialing and privileging is accurate and agree to immediately report any change in status of the information maintained in the Credentials files.

If any submitted items differ from information received through the verification process, the applicant will be required to resolve discrepancies. This may require further consultation between the applicant and the Department Chair or Division Chief.

Applications for membership and clinical privileges will be processed and verified as indicated herein.

Pre-Application

A pre-application will be issued via email to potential applicants requesting staff membership and/or clinical privileges. The pre-application will be used to determine if the applicant meets the basic qualification for medical staff membership/advanced practice provider status as delineated in the Medical Staff Bylaws, Rules, and Policies.

Potential applicants will be provided instructions outlining the basic requirements to apply for membership and/or privileges along with a link to an electronic pre-application. Once the pre-application is submitted a cursory review of the applicants' qualifications will be performed including review of the following:

1. Professional license(s); including all states and other jurisdictions
2. Medical Board of California License Verification System (LVS) – Health Facility/Peer Review Reporting Form (805 report)
3. Drug Enforcement Administration (DEA) registration, if applicable
4. National Provider Identifier Registry (NPI)
5. National Practitioner Data Bank (NPDB)self-query
6. Office of Inspector General (OIG) exclusion database
7. System for Award Management (SAM) exclusion list
8. Department of Health Care Services (DHCS) Medi-Cal Providers Suspended and Ineligible Provider list
9. California Secretary of State Business look-up
10. Centers for Medicare and Medicaid Services (CMS) Opt Out List
11. Internet search query

The applicant will be notified if they do not meet criteria and the initial application will not be released. Such action shall not give rise to hearing and appeal rights pursuant to the Medical Staff Bylaws, nor require reporting to the National Practitioner Data Bank and/or licensing body. If a potential applicant believes that they meet the criteria, that individual must submit evidence to substantiate such, in writing, to the Medical Staff within thirty (30) days after notice that criteria was not met.

If the applicant meets criteria, instructions and a link to the portal to access the initial application packet and privilege forms approved by the Medical Executive Committee will be sent. The communication will outline the time frame and basic requirements for processing the request.

Initial Application for Appointment

Providers who meets criteria to apply for membership and/or privileges must submit a complete application along with copies of other documents as applicable including, but not limited to, the following:

1. California Medical License (copy required)
2. Out of State License, if applicable
3. DEA registration, if applicable
4. Other relevant certificates or permits (i.e., PALS, BLS/ACLS, Fluoroscopy, etc.)
5. Diploma, Education and Training Certificates
6. Curriculum vitae (CV) / Resume
7. Educational Commission for Foreign Medical Graduates (ECFMG) certificate, if applicable
8. Board Certification or Advanced Practice Provider National Certification
9. NPI Number
10. Evidence of current and any prior malpractice coverage of $1 million per occurrence/$3 million aggregate
11. Malpractice Insurance Declaration of Coverage for the past 10 years (recent graduates must provide malpractice during their residency)
12. Copy of a California State-issued photo identification (i.e., driver's license). The name on this document will be used as the provider's official name of record.
13. Privilege Request, if applying for privileges, which shall include any relevant documentation to support the qualifying criteria
14. Procedure or clinical case log activity for the last two years
15. Application fee
16. Immunization/Vaccines in accordance with policy
17. Written documentation explaining gaps in education, practice and work history of 90 days or more Covering provider(s)

The following forms must be completed and signed:

1. Background Investigation Acknowledgement Form
2. Information Release/Acknowledgment
3. AHS/AH Medical Staff Sharing Agreement
4. Confidentiality and Security Agreement
5. Confidentiality Agreement form for Medical Staff Affairs
6. Medical Staff Quality and Assessment and Peer Review Agreement
7. Information Services (IS) Epic Training Data Collection Form
8. Electronic Signature authorization
9. Photography and Videotaping Attestation
10. Medicare and Tricare Acknowledgement
11. Professional Code of Conduct Agreement
12. Attestation Questionnaire: including applicant attesting to perform privileges as requested, lack of present illegal drug use, history of loss of license and/or felony convictions, and history of loss of limitation of privileges or disciplinary activity.
13. Relevant APP agreements and standardized procedures as applicable.

The applicant's identity must be verified via presentation of an original government-issued identification document prior to appointment/granting of privileges.

Reappointments

Reappointment to the Medical Staff and requesting of clinical privileges shall occur within a period not to exceed 24 months. The provider shall be required to submit a complete application along with copies of documents as applicable including, but not limited to, the following:

1. New Malpractice Insurance Declaration of Coverage not currently on file
2. Any new, relevant licensure or certification not currently on file
3. An update CV/Resume, if applicable
4. Privilege Request, if applying for privileges, which shall include any relevant documentation to support the qualifying criteria
5. Reappointment application fee

The following forms must be completed and signed.

1. Background Investigation Acknowledgement
2. Information release/acknowledgment
3. Sharing agreement
4. Confidentiality and Security Agreement
5. Confidentiality Agreement form for Medical Staff Affairs
6. Medical Staff Quality and Assessment and Peer Review Agreement
7. Professional Code of Conduct Agreement
8. Attestation Questionnaire: including applicant attesting to perform privileges as requested, lack of present illegal drug use, history of loss of license and/or felony convictions, and history of loss of limitation of privileges or disciplinary activity.
9. Relevant APP agreements and standardized procedures as applicable.

Reappointment Applications will be sent via the Practitioner Portal to provider approximately four (4) months prior to their appointment expiration date and are expected to be completed on-line and submitted within 60 days.

Medical Staff Services sends reappointment applications as outlined in the Medical Staff Bylaws. Communication templates are outlined in Attachment A.

If the provider fails to submit a completed application by the date as stated on the written notice, a final reminder will be made to the provider, which includes an attempt to reach the provider via phone call. Failure to do so shall be deemed as a voluntarily resignation of membership and/or privileges. The procedural rights set forth in the Medical Staff Bylaws shall not apply to voluntary resignation.

Verification and Processing

When the application for appointment or reappointment is submitted, a review for completeness is performed by Medical Staff Services. If additional information is required, or if questions are left blank, the applicant is contacted and informed that processing will not begin until the application is entirely complete. The applicant is responsible for providing the information to satisfy the process, including resolution of any discrepancies. Failure to submit the requested

information within thirty (30) days shall be considered a withdrawal of the application. Such withdrawal shall not give rise to hearing and appeal rights pursuant to the Bylaws. In accordance with the Bylaws, the Medical Staff will not take action on an application that is not "complete".

All information gathered on the application will be verified by the primary source (when applicable). Primary source may include oral verification which requires a dated, signed note in the credentialing file stating who at the primary source verified the item, and the date and time of verification.

The following queries, along with the applicable source/location, will be conducted:

1. California Professional License/Professional Licenses from Other States
   Current California State professional licensure must be obtained by direct confirmation from the appropriate licensing board via the California Department of Consumer Affairs Licensing Board Website. Other State Medical and Professional Boards for active professional licenses will be verified with the relevant State Board.

2. DEA Certification
   All providers must have a valid DEA certificate, with a California address, with the exception of Pathologists. For Advanced Practice Providers, DEA requirements are based on scope of service. Providers who are required to have a DEA, must have an unexpired DEA, without limited schedules or an out of state address, otherwise privileges shall be suspended until evidence of a valid DEA is verified. Primary source verification is obtained via the DEA Controlled Substances Act Registration Information Database.

3. Fluoroscopy or Radiography Certification
   A copy of the permit/certification is required for all radiologists and non-radiologists who will be using fluoroscopy equipment in the operating rooms or other procedure areas. Radiography Certificate is not acceptable as a Fluoroscopy Certificate. Temporary primary source verification will be obtained via the California Department of Public Health (CDPH) Radiologic Health Branch (RHB).

   Medical Staff Services shall provide a monthly report to Radiology and Perioperative Services of all providers with a valid Fluoroscopy certificate.

4. Hospital Affiliations and/or Work History
   Written verification of ten (10) years of clinical work history from hospitals or other health care organization affiliations is required for initial appointment and the prior two (2) years for reappointment. Verifications must be received directly from the organization or their designated third party.

   If verification of an affiliation is not obtained after three attempts with the applicant's assistance, including a phone call to the facility, the file may then move through the evaluation process without verification. In such instance, a file note will be recorded.

5. Graduation from Medical/Professional School and Completion of Residencies and Fellowships
   Verification of medical/professional school graduation and completion of residency and fellowship training may be obtained from the institution(s) where the training was completed, and/or an agency that is deemed a primary source verification, such as the American Medical Association (AMA) Physician Masterfile or American Osteopathic Association (AOA) Physician Database, National Student Clearing House (NSCH) (upon confirmation the organization uses NSCH as their 3rd party) or Federation of State Medical Boards (FSMB) for closed residency programs or state licensing agency, if the state verifies.

   Foreign Medical Graduates from schools of medicine other than those in the United States and Canada must present evidence of certification by the Education Commission for Foreign Medical Graduates (ECFMG) or successful completion of a fifth pathway, or successful passing of the Foreign Medical Graduate Examination in the Medical Sciences (FMGEMS). Verification of foreign graduation will be conducted.

6. Board Certification
   Board Certification is verified querying the American Board of Medical Specialties on-line database, American Osteopathic Association (AOA), or primary source verification directly from the certification board.

   Advanced Practice Registered Nurses and Physician Assistants are required to maintain national certification by any of the following bodies:
   - American Academy of Nurse Practitioners (AANP)
   - American Nurses Association – American Nurses Credentialing Center (ANCC)
   - Pediatrics Nursing Certification Board (PNBC)
   - National Certification Corporation (NCC) for Nurse Practitioner certification
   - American Association of Critical-Care Nurses (AACN)
   - American Midwifery Certification Board (AMCB)
   - National Board of Certification & Recertification for Nurse Anesthetist (NBCRNA)
   - National Commission on Certification of Physician Assistants (NCCPA)

7. Current, Adequate Malpractice Insurance
   Professional Liability Insurance coverage and the amount of coverage must be verified directly with the carrier.

8. Professional Liability Claims History
   Verification of ten (10) years of claims history for new appointments and the previous two (2) years for reappointments must be obtained from the current and/or previous carriers. If after three (3) attempts with the applicants' assistance, including a phone call to the facility, the insurance carrier does not respond, the NPDB will be used as primary source verification. The NPDB query may be used as evidence of settlement and judgment history.

9. Background Checks
   Background checks will be conducted on all applicants at the time of initial appointment and reappointment in accordance with state and federal laws. Applicants must consent to this

process by signing and submitting the Notice Regarding Background Check Investigation. Failure to complete this form shall result in the application being deemed incomplete.

Signature on the Notice Regarding Background Investigation acknowledges and authorizes Medical Staff Services to search the following databases:

- Social Security Number (SSN) Trace and Death Index
- Maiden & Alias Name Search
- Criminal Records Search – Federal, State and County Levels
- National Wants and Warrants
- National Sex Offender Registry
- General Services Administration (GSA)
- U.S. Government Terrorist List/Office of Foreign Assets Control (OFAC)

10. National Practitioner Data Bank (NPDB)
    The NPDB must be queried for all new appointments, reappointments and at the time of the request for additional privileges. Each query to the NPDB is facility specific therefore there will be a query for every facility to which the provider is applying. All providers will be enrolled in the NPDB Continuous Query and will be reviewed at initial appointment, reappointment, temporary privileges, and request for additional privileges.

11. Medicare/Medicaid Sanctions
    Sanction verifications for Medicare and Medicaid will be obtained via Sanctions Exclusions Report published by the Office of Inspector General (OIG) and Excluded Parties List System (EPLS) for all new appointments and reappointments.

12. Centers for Medicare & Medicaid Services (CMS) Opt Out
    CMS will be queried for all new appointments and reappointments to confirm whether a provider has opted out of participating in the Medicare program.

13. Professional References
    Three (3) professional references for providers with the same credentials are required for new applicants and two (2) for reappointments. For reappointments, the Department Chair or an AHS Division Chief may serve as the peer reference. These references must be from individuals familiar with a provider's work, either via direct clinical observations or through a close working relationship within the prior two years. For an Advanced Practice Provider (APP) one of the references should be from a physician within the same department that has direct observation of care provided.

14. Continuing Medical Education
    A statement documenting Continuing Medical Education must be included with the application for appointment or reappointment or a signed statement indicating that the provider has met or exceeded continuing medical education requirements for licensure. Courses must reflect appropriate training for the specialty and privileges requested and meet any state-mandated CME requirements.

15. Provider Enrollment
    For applicants who are assigning billing, collected information will be distributed to health plans as required for purposes of billing and enrollment. Providers may be required to complete various payor-specific forms. Provider Enrollment has access to the information in the Medical Staff Services database for the purpose of providing accurate credentialing information to health plans and for the publishing of provider directories.

16. Ongoing Professional Practice Evaluation (OPPE)
    Ongoing Professional Practice Evaluation (OPPE) is the continuous evaluation of provider's performance. Information contained in OPPE reports are factored into the decision to maintain existing clinical privilege(s), to revise, or to revoke an existing clinical privilege prior to or at the time of reappointment.

17. Additional Information
    Departments and Clinical Services may also require additional documentation or standards. Privilege criteria is defined in the specialty-specific privilege request forms.
    Other information as deemed necessary may also be collected and considered at the request of the Medical Executive Committee or designee.

18. Timeliness of Information
    The established processing time is estimated at 60-90 days following receipt of completed application. Applications for Behavioral Health providers will be assessed for completion and verification of qualifications within 60 days of receipt of an application. Such applicants will be notified within seven (7) business days of receipt and confirmation of whether the application is complete. An application must be signed within 120 days of Credentials Committee review. The attestation must be signed within 180 days of Credentials Committee review. Verification of licensure, board certification, sanctions, current work history, malpractice claims history must be verified within 120 days of Credentials Committee review.

Requests for Modification of Privileges

Providers may request a modification of additional privileges at any time. These requests are handled as follows:

1. The provider must complete the request for a modification of privileges request and privilege form along with any supporting documentation regarding training or experience, as required.

2. The following primary source verification will be conducted:
   - CA Medical or Professional License(s)
   - LVS 805 Report
   - NPDB

3. FPPE/Proctoring shall be considered by the Department Chair at the time of a request for additional privileges.

4. The privileges requested and supporting documentation is made available to the appropriate Division Chief and/or Department Chair/designee for review and recommendation to the Credentials Committee with final review and recommendation for approval by the Medical Executive Committee (MEC) to the Governing Board.

Appointment/Privilege Approval Notifications

Following Board approval, providers will be issued a Board approval notification letter outlining the approved membership and privileges within ten (10) business days of the Quality Professional Services Committee (QPSC)/Board determination.

Application Fees

Providers are required to submit an application fee for membership and/or privileges. An application is incomplete until payment is received. Application fees are non-refundable once the submitted application has been received and processing has started. Reappointment fees are applied in full, regardless of the reappointment term.

1. Medical Staff Fees:
    a. AHS/AH application fee for Temporary Privileges ONLY of $100.00.
    b. AHS application fee of $300.00 and reappointment fee of $500.00.
    c. AH application fee of $300.00 and reapplication fee of $500.00.

2. Advanced Practice Provider (APP) e.g., PA, NP, etc. Fees:
    a. AHS application fee of $150.00 and a reappointment fee of $150.00.
    b. AH application fee of $200.00 and a reappointment fee of $200.00.

3. Providers who apply for membership or privileges at more than one Medical Staff within Alameda Health System the provider will receive a 50% discount of their initial application and/or reappointment fees at the second facility.

AHS and AH Category Assessments

The number(s) of patient care activities for the associated status categories are defined in the AHS/AH Medical Staff Bylaws. During the reappointment process, each applicant's clinical care activity reports will be reviewed to determine accurate category assignment.

Voluntary Resignation

Providers who wish to resign their Medical Staff membership and/or privileges shall complete a Voluntary Resignation form.

Medical Staff Services will process the voluntary resignation and complete the necessary steps for deactivation of Alameda Health System computer access. The provider will attest that their charting and medical records for any care provided will be completed on or before their voluntary resignation (H&Ps, procedure notes, orders, discharge summaries). In addition, they will acknowledge that their AHS network logon and all application access will be automatically deactivated on the indicated date of their voluntary resignation. Any changes to the voluntary resignation date or a desire to rescind this resignation MUST be communicated verbally and in writing to the Medial Staff Office and the Department Chair. Failure to communicate any

changes in dates will result in the resignation being effective as of the date on the Voluntary Resignation Form and all systems access will cease as outlined in the deactivation process.

PROVIDER RIGHTS TO AMEND APPLICATION AND REVIEW CREDENTIALS FILE

Providers have the right to correct erroneous information obtained throughout the credentialing process. If any submitted items differ substantially from documentation disclosed through the verification process, the provider will be notified, asked to resolve this discrepancy, and expected to do so within thirty (30) days of the request. All identified and/or requested amendments will be included in the provider's file for consideration.

Providers are allowed access to their own credentials files as outlined in the respective Medical Staff policy.

Providers have a right to be informed of the status of their application. Upon submission of an application, an auto-generated email confirming receipt is sent to the provider. Initial applicants are provided with an estimated board appointment date. Applicants may request the status of their application via email or phone call to the medical staff office. Contact information for medical staff services is provided in application correspondence and is posted on the intranet. A representative of the medical staff office will respond within three (3) business days.

RELATED DOCUMENTS
Alameda Health System and Alameda Hospital Medical Staff Bylaws, Rules & Regulations, Privilege Forms, Policies and Procedures

Approvals:

		AHS	AH
Credentials Committee	**Date:**	**11/13/25**	
Medical Executive Committee	**Date:**	**11/19/25**	**11/14/25**
QPSC	**Date:**	**11/19/25**	
Board of Trustees	**Date:**		

Medical Staff Credentialing and Privileging of Providers
Attachment A

The email templates below will be used at the point where the Credentials Coordinators stop any additional work on collecting an application for reappointment.

The provider will receive two courtesy reminder emails with language in the second reminder as follows:

Subject Line: **Action Needed** Application for Reappointment AHS / AH

Reappointment Failure to Submit Application Reminder: *Used for the second notice that a reappointment application was not submitted.*

Dear (insert provider's name),

This is a second reminder to notify that your application for reappointment to the <Alameda Health System/Alameda Hospital> Medical Staff has not been received. It has been 20 days since the initial notification to apply for reappointment was sent. Your application for reappointment is due within 35 days from the date of initial notification. Should your application not be submitted, it will be considered a voluntary resignation of medical staff membership and privileges at <Alameda Health System/Alameda Hospital>.

Following voluntary resignation, you will be required to reapply for membership and privileges via initial application for appointment. If you have any questions, please contact the Medical Staff Services Department at <Alameda Health System/Alameda Hospital>.

Sincerely,

Medical Staff Services
AHS Phone: 510-437-6535
SLH Phone: 510-297-5404
AH Phone: 510-814-4035
Email: medicalstaff@alamedahealthsystem.org

If the provider fails to submit a completed application in the timeframe outlined on the written notice, a final reminder will be made to the provider by telephone requesting communication with Medical Staff Services within 24 hours. Failure to do so shall be deemed to have voluntarily resigned their Medical Staff membership. The procedural rights set forth in the Medical Staff Bylaws shall not apply to a voluntary resignation under this section.

The following two email templates would be the standard work when sending email communication to address applications for reappointment which have not been submitted after three (3) automated efforts. If an application for reappointment has been started and is in progress, the applicant will be sent The Partial Action on Application for Reappointment notification.

Subject Line: **Final Notice** Application for Reappointment AHS / AH
Cc: Department Chair, Division Chief (if applicable), Credentials Committee Chair(s), MSS Director, Manager

Regular Failure to Submit Email: *Used for the final notice that an application was not submitted, and patient care is ending.*

Dear (insert provider's name),

Medical Staff Services has not received your application for reappointment to the Medical Staff of Alameda Health System and/or Alameda Hospital.

The invitation to the online application portal was sent on month/date/year, and the application remains at 0% complete. The following reminders were sent to your email(s) on file, on the below dates:

- First reminder – month/date/year
- Second reminder - month/date/year
- Third reminder – month/date/year

As of today's date, you have exceeded the 35-day application for reappointment period, as outlined in the invitation to apply for reappointment. Per the Medical Staff Bylaws, failure to submit a completed application for reappointment with all supporting or requested documentation shall result in automatic termination of your Medical Staff Membership and/or Privileges.

In effect, this results in termination of membership and/or privileges as a voluntary resignation from the Alameda Health System Medical Staff.

As of month/date/year, your Medical Staff Membership and/or Privileges at Alameda Health System will expire, with no patient care permitted.

Please contact your Department Chair, regarding the above.

Partial Action on Application for Reappointment: *Used only if the Department Chair wants them to stay on staff or they are close to having the application completed.*

Subject Line: **Final Notice Requiring Action** Application for Reappointment AHS / AH
Cc: Department Chair, Division Chief if applicable, Credentials Committee Chair(s), MSS Director, Manager

Dear (insert provider's name)

Medical Staff Services has not received your application for reappointment to the Medical Staff of Alameda Health System and/or Alameda Hospital.

The invitation to the online application portal was sent on month/date/year, and the application remains at 14% complete. The following reminders were sent to your email(s) on file, on the below dates:

- First reminder – month/date/year
- Second reminder - month/date/year
- Third reminder – month/date/year

As of today's date, you have exceeded the 35-day application for reappointment period, as outlined in the invitation to apply for reappointment. Per the Medical Staff Bylaws, failure to

submit a completed application for reappointment with all supporting or requested documentation shall result in automatic termination of your Medical Staff Membership and/or Privileges.

In effect, this results in termination of membership and/or privileges as a voluntary resignation from the Alameda Health System Medical Staff.

Please consider this our final attempt to collect your application for reappointment for processing, which if not received by COB month/date/year, will result in expiration of Medical Staff Membership and/or Privileges.

As of month/date/year, your Medical Staff Membership and/or Privileges at Alameda Health System will expire, with no patient care permitted.

Please contact your Department Chair, regarding the above.

Alameda Health System

MEDICAL STAFF ONGOING MONITORING AND EVALUATION OF ACTIONS RELATED TO PROVIDERS

Department	AHS Medical Staff	***Effective Date***	3/2022
Campus	AHS, AH	***Date Revised***	8/2023; 3/2025; 4/23/25; 11/19/25
Unit	All	***Next Scheduled Review***	11/2028
Manual	Medical Staff	***Author***	Manager, Medical Staff Services
Replaces the following Policies:		***Responsible Person***	Chief of Staff

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

Purpose

This policy describes the ongoing monitoring process the Alameda Health System (AHS) and Alameda Hospital (AH) Medical Staffs follow in response to alerts related to a member or privileged provider of the Medical Staff or Advanced Practice Providers, by establishing a systematic process for reviewing and evaluating such events.

Policy Statement

To ensure the quality and safety of care, the Alameda Health System Medical Staff office conducts ongoing monitoring and review of any sanctions, complaints and adverse events between credentialing cycles for Medical Staff members or privileged providers.

The ongoing review process is designed to ensure allegations and reports are reviewed timely, objectively and that actions taken are considered and instituted where appropriate to comply with the Medical Staff Bylaws and to maintain safety of care delivered to patients. Any data or information as part of the medical staff oversight and review process, are protected by California Evidence Code section 1157. Pertinent information identified in the review process shall be factored into decisions regarding what actions will be taken.

Procedure

Ongoing monitoring of provider sanctions, complaints and adverse events between credentialing cycles will be monitored via the following mechanisms:

1. Basic Responsibilities of Medical Staff
   Providers are required to notify the Medical Staff in writing within seven (7) days of any of the events listed in the Medical Staff Bylaws Section captioned “Basic Responsibilities of Medical Staff. The foregoing includes, but is not limited to, events related to their licensure, certification, registration, loss of membership, restriction or denial of privileges, employment, inability to provide care for more than 30 days, liability insurance, participation in federally funded health care organizations, professional liability suits, mental/physical health, felony or misdemeanor.

2. Licensing Boards
    a. **California Medical Board**: Medical Staff office personnel receives and reviews the Board's proactive disclosure notifications of actions via periodic, automated emails from the Medical Board of California subscription (MBC-ACTIONS@SUBSCRIBE.DCALISTS.CA.GOV).
    b. **California Osteopathic Medical Board:** Medical Staff office personnel receives and reviews the Board's proactive disclosure notifications of actions via periodic, automated emails from the Medical Board of California subscription (OMBC-GENERAL@SUBSCRIBE.DCALISTS.CA.GOV)
    c. **Dental Board of California**: The Dental Board of California publishes monthly information "Hot Sheets" (summaries of board enforcement actions). The report is retrieved monthly and cross-referenced to identify affiliated providers. (https://www.dbc.ca.gov/consumers/hotsheets.shtml).
    d. **California Physician Assistant Board**: The Department of Consumer Affairs Physician Assistant Board publishes monthly information regarding administrative disciplinary actions. The report is retrieved monthly and cross-referenced to identify affiliated providers. (https://pab.ca.gov/consumers/disciplinaryactions.shtml)
    e. **California Board of Psychology**: Medical Staff office personnel receives and reviews the Board's proactive disclosure notifications of actions via periodic, automated emails from the Board of Psychology (LISTSERV@SUBSCRIBE.DCALISTS.CA.GOV)
    f. **California Board of Podiatric Medicine:** The Podiatric Medical Board of California publishes Recent Disciplinary Actions reports for actions against their licentiates (https://pmbc.ca.gov/consumers/dispsumm.shtml). The report is retrieved monthly and cross-referenced to identify affiliated providers.
    g. **California Board of Optometry**: The Department of Consumer Affairs California State Board of Optometry publishes citations and disciplinary actions against their licentiates (https://www.optometry.ca.gov/consumers/2025_disciplinary.shtml). The report is retrieved monthly and cross-referenced to identify affiliated providers.
    h. **Acupuncture Board:** The Department of Consumer Affairs California State Acupuncture Board publishes citations and disciplinary actions against their licentiates (https://www.acupuncture.ca.gov/consumers/board_actions.shtml). The report is retrieved monthly and cross-referenced to identify affiliated providers.
    i. **California Board of Registered Nurses:** Advanced Practice nurses are enrolled in the National Council of State Boards of Nursing, Inc., Nursys electronic verification system using their registered nurse license number. Medical Staff office personnel receives and reviews the Board's proactive disclosure notifications of disciplinary actions via periodic, automated emails from Nursys for enrolled nurses. (https://www.nursys.com/EN/ENDefault.aspx)

    The providers listed on these notices/reports are cross-referenced against AHS/AH affiliated providers to identify matches, if any.

3. National Practitioner Databank (NPDB)
   All providers are enrolled in the NPDB Continuous Query. Enrolled practitioners are continuously monitored, and an alert is emailed when a new report is received or an existing report is revised, corrected, or voided. The credentialing database interfaces with the NPDB to automatically receive NPDB reports.

4. Federal and State Exclusions
   Monthly provider rosters are uploaded to Verify Comply (vendor platform solution for comprehensive exclusion screening services) to screen for exclusions in all US States and Federal databases. Databases include the following:
   a. U.S. HHS OIG List of Excluded Individuals and Entities (LEIE)
   b. U.S. GSA System for Award Management (SAM)
   c. Suspended/Excluded Providers for All States
   d. U.S. Dept of the Treasury Office of Foreign Assets Control (OFAC)
   e. CMS Opt Out NPI Only

Review and findings of each of the above notices/reports are logged. Any provider matches are addressed in accordance with this policy.

If the action triggers an automatic action, such as an automatic termination, suspension or restriction of membership and/or privileges under the Medical Staff Bylaws, the automatic action shall be immediately imposed in accordance with the Bylaws.

Actions will be evaluated as follows:
1. Reports will be sent to the Department Chair/Division Chief (if applicable) along with any supporting information.
2. The Division Chief (if applicable)/Department Chair (if no Division Chief) will review what is reported and assess if further information is required from the provider. If further information is required, the provider will be sent a letter that requires additional information. The response will be reviewed by the Department Chair/Division Chief (if applicable). Upon completing a review of what is reported and any response, the Department Chair/Division Chief (if applicable) will complete an Action Assessment Form (Attachment A to document their review of the report and recommend the next steps.)
3. If the Chief/Chair is uncertain how to address a situation, the Chief/Chair may refer information to Credentials and/or Medical Executive Committee for further review and recommendation.
4. Documentation related to the report will be maintained in the provider's credentialing file.
5. Actions will be logged and reported to the Credentials Committee.

Quality of Care complaints/concerns will be facilitated in accordance with the Medical Staff Peer Review policy.

Behavior concerns/complaints will be facilitated in accordance with Medical Staff Professionalism and Conduct policy.

Reporting Requirements:

In accordance with the California Business and Professions Code §805, a report must be filed for physicians and podiatrists within 15 days after one of the following actions occurs:

1. Denial or rejection of privileges or membership for a medical disciplinary cause or reason;
2. Revocation of privileges or membership for a medical disciplinary cause or reason;
3. Restrictions imposed, or voluntarily accepted, on privileges or membership for a total of 30 days or more within any 12 month period for medical disciplinary reasons;
4. If a resignation, leave of absence, withdrawal or abandonment of application or for renewal of privileges occurs after receiving notice of a pending investigation initiated for a medical disciplinary cause or reason;
5. Summary suspension of staff privileges or membership is imposed for a period in excess of 14 days.

In accordance with the California Business and Professions Code §805.01, a report of a final decision or recommendation to terminate, revoke, summarily suspend or restrict privileges or membership must be filed for physicians, physician assistants and podiatrists within 15 days if the reason for the investigation was one of the following:

1. Incompetence, or gross or repeated deviation from the standard of care involving death or serious bodily injury to one or more patients, to the extent or in such a manner as to be dangerous or injurious to any person or to the public. This paragraph shall not be construed to affect or require the imposition of immediate suspension pursuant to Section 809.5.
2. The use of, or prescribing for or administering to himself or herself, any controlled substance; or the use of any dangerous drug, as defined in Section 4022, or of alcoholic beverages, to the extent or in such a manner as to be dangerous or injurious to the licentiate, any other person, or the public, or to the extent that such use impairs the ability of the licentiate to practice safely.
3. Repeated acts of clearly excessive prescribing, furnishing, or administering of controlled substances or repeated acts of prescribing, dispensing, or furnishing of controlled substances without a good faith effort prior examination of the patient and medical reason therefor. However, in no event shall a physician and surgeon prescribing, furnishing, or administering controlled substances for intractable pain, consistent with lawful prescribing, be reported for excessive prescribing and prompt review of the applicability of these provisions shall be made in any complaint that may implicate these provisions.
4. Sexual misconduct with one or more patients during a course of treatment or an examination

In accordance with the California Business and Professions Code §805.08, a report must be filed with 15 days of receiving a written allegation of sexual abuse or sexual misconduct by a provider.

In accordance with the National Practitioner Databank, a report must be submitted for physicians and dentists within 30 days of one of the following occurrences:

1. Professional review actions - based on reasons related to professional competence or conduct - adversely affecting clinical privileges for a period longer than 30 days.
2. Voluntary surrender or restriction of clinical privileges while under, or to avoid, an investigation

Approvals

		AHS Core	AH
Credentials Committee	**Date:**	**11/13/25**	
Medical Executive Committee	**Date:**	**11/19/25**	**11/14/25**
QPSC	**Date:**	**11/19/25**	
Board of Trustees	**Date:**		

Attachment A

Alameda Health System Medical Staff Action/Allegation/Accusation Assessment Form

Date: _____

Provider Name: _____

Report of action/allegation/accusation made by or received from: _____
Reported on: _____

Brief summary of report: _____

Division Chief (if applicable)/Department Chair Recommendation:

As Chair of the Provider's Department or Division Chief, I have reviewed the reported action/allegation/accusation and recommend the following:

☐ No action at this time.
☐ Track/Trend and/or monitor for final outcome.
☐ Request additional information from the provider.
☐ Refer to QRC/Peer Review.
☐ Initiate FPPE.
☐ Refer to Well-Being Committee
☐ Limit/restrict privileges and/or membership (refer to MEC)
☐ Refer to the Credentials Committee and/or Medical Executive Committee for further review/recommendation.
☐ Other

Explanation/details supporting the above recommendation(s):

_____
_____
_____
_____

_____	_____	_____
Name	Signature	Date

This is a quality improvement/peer review document of the hospital. It includes privileged and confidential information which is protected from disclosure pursuant to California Evidence Code, Section 1157 and other provisions of state and federal law.

Alameda Health System

MEDICAL STAFF ROUTINE FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE) / PROCTORING

Department	Medical Staff	***Effective Date***	12/07
Campus	AHS. AH	***Date Revised***	12/07, 3/2011, 6/2014, 6/2017, 6/2019, 6/2022, 11/2025
Unit	All	***Next Scheduled Review***	11/2028
Manual	Medical Staff	***Author***	Manager, Medical Staff Services
Replaces the following Policies:		***Responsible Person***	Chief of Staff

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

Purpose

To establish mechanisms and define the process for satisfying the routine focused professional practice evaluation (FPPE) / proctoring requirements of the Alameda Health System (AHS) and Alameda Hospital (AH) Medical Staffs.

Proctoring as described in this policy is designed to meet the intent of Joint Commission Standards related to FPPE at the time of initial privileges or the granting of new privileges. This policy does not address FPPE/Proctoring for cause, which is based upon identified concerns with a particular individual's care or conduct, which is addressed in accordance with the applicable Medical Staff bylaws and policy.

Policy

It is the policy of the AHS and AH Medical Staffs to require FPPE/proctoring anytime privileges are initially granted.

1. FPPE/proctoring
    a. FPPE/proctoring requirements are outlined on each privilege delineation form, representing the minimum required number of cases to be proctored. At the discretion of the Department Chair/designee, additional proctoring may be assigned when there is not enough activity to represent the scope of privileges granted.
    b. FPPE/proctoring may include both concurrent, direct observation of any care/ procedure performed, and/or retrospective review of medical care via medical record review
    c. A proctor who is not providing direct clinical care is not required to have a California medical license. The proctor must, however, have a valid medical license in at least one state. If the proctor is participating in direct clinical care, he or she must hold similar privileges.
    d. FPPE/proctoring information is used as part of the Medical Staff's Peer Review program..

2. FPPE/Proctoring is required for:
    a. Upon initial granting of privileges for all providers .
        i. Proctoring for providers who have recently (within the prior two years) completed an AHS residency/fellowship program may be reduced at the discretion of the Department Chair or designee accompanied by documentation of relevant activity and verified competency by the Program Director.Approved requests for new/additional privileges from existing Medical Staff/Advanced Practice Providers (APP)..
    b. Upon granting of temporary privileges.
    c. External proctoring evaluations from another Joint Commission (TJC) accredited hospital or from a TJC/AAACH accredited Surgery Center may be used to supplement.

3. FPPE/Proctoring may be required at the discretion of the Medical Executive Committee:
    a. As a condition for privilege renewal for privileges performed so infrequently that assessment of current competence is not feasible.
    b. Whenever the Medical Executive Committee determines that additional information is needed to assess a practitioner's current competence.

4. FPPE/Proctoring by qualified practitioners who are not currently members of the AHS or AH Medical Staff must be appointed as Administrative Staff.

<u>Assignment of Proctors</u>

1. All members of the Medical Staff/APP who have themselves completed FPPE/proctoring and hold unrestricted privileges to perform the procedures and/or manage the clinical cases to be proctored.

2. FPPE/Proctoring may be performed by Medical Staff/APP members who hold related privileges sufficiently similar to the privileges being proctored to allow them to make prudent and informed judgments regarding competence.

3. If no member of the Medical Staff/APP possessing the requisite expertise is available to serve as a proctor, arrangements may be made by the Department Chair/Designee for FPPE/proctoring by a qualified practitioner who is not currently a member of the Medical Staff.

4. All proctors will be assigned by the Department Chair/Designee at the time of review and recommendation for privileges to the Medical Executive Committee.

5. Whenever reasonably possible, both a primary proctor and an alternate proctor will be assigned to assure timely availability. More than two proctors may be assigned at the discretion of the Department Chair/Designee.

Scope and Timeliness of FPPE/Proctoring

1. All basic and advanced FPPE/proctoring requirements may be met through direct observation of procedures and/or concurrent chart review of clinical care.

2. Subject to emergencies exceptions, both basic and advanced FPPE/proctoring should include the "first" cases performed by the practitioner in each category requiring proctoring.

3. If the practitioner who is subject to FPPE/proctoring requirements provides emergency care without concurrent FPPE/proctoring, the practitioner shall promptly report the case to both the proctor for review and the Director of Medical Staff Services, who will notify the Department Chair/Designee or Chief of Staff to review if the emergency necessitated proceeding without a proctor.

Supplemental Proctoring from an External Source

External proctoring may be used to supplement local proctoring for providers with limited activity; however, supplemental data must not replace the internal process of capturing data at the facility where the privileges are held.

Completion of FPPE/Proctorship

FPPE/proctoring is not considered complete until such recommendation by the Medical Executive Committee has been approved by the Board of Trustees.

Failure to Satisfactorily Complete FPPE/Proctoring Requirements

If a provider fails to satisfy the basic FPPE/proctoring requirements solely because of the failure to perform the required number of cases, the provider will remain under proctoring until sufficient activity is achieved.

Procedure

Department Chair/Designee

1. Provide the names of the primary, alternative, and other proctors at the time the chairperson recommends clinical privileges.
2. Assure that providers are proctored in a timely and in accordance with assignments.
3. Address any unfavorable or questionable evaluations.
4. Intervene at the request of the proctor or provider being proctored when there is a conflict regarding appropriate care.
5. Submit recommendation for release of proctoring upon satisfactory completion of assigned proctoring, upon review and acceptance of proctored evaluations.

Medical Staff Services Duties

1. Notify the provider of their assigned proctor(s) and proctoring plan.
2. Notify the proctor when they have been designated as the proctor.
3. Report proctoring activity to the Credentials Committee.

FPPE/Proctored Practitioner Duties

1. Assure that the first procedures or medical admissions and the first performance of any procedures are proctored in a timely manner.
2. Notify the proctor of each case where care is to be evaluated and do so in sufficient time to allow the proctor to observe or review concurrently. For elective surgical or invasive procedures where direct observation is required, the practitioner must secure agreement from the proctor to attend the procedure before the procedure is scheduled. If an emergency situation exists and the practitioner must admit and treat a patient, the practitioner must notify the proctor as soon as is reasonably possible to continue with the concurrent FPPE/proctoring process..
3. Provide the proctor with the patient's clinical history, pertinent physical findings, pertinent laboratory and x-ray results, the planned course of treatment or management and the rational for its use.

Proctor Duties

1. Directly observe the procedure being performed and/or concurrently observe medical management by reviewing the medical record and complete the appropriate FPPE/proctoring form.
2. The proctoring evaluation must be completed on the approved form and shall include an evaluation of the provider's performance of patient care, medical clinical knowledge, practiced based learning, interpersonal and communication skills, professionalism, system-based practice and an overall impression.
3. Make reasonable accommodation to be available for cases that require direct observation or concurrent review.
4. Direct observation of procedures or medical admissions may be continued beyond the minimum FPPE/proctoring requirements, if needed, until the proctor has observed a sufficient number of cases to make an informed judgment regarding the clinical performance of the individual being proctored. A request for additional FPPE/proctoring requirements may be made by the proctor and submitted to the Department Chair for review and approval.
5. While the proctor's primary responsibility is to observe care and evaluate performance, if the proctor reasonably believes that intervention is warranted to prevent harm to the patient, the proctor may take whatever action is reasonably necessary to protect the patient. The proctor is authorized at the proctor's sole discretion to delay, postpone, or terminate any proposed treatment and/or procedure pending immediate notice to the Department Chair/Designee and/or Chief of Staff.
6. In procedural FPPE/proctoring, a proctor may act as a surgical assistant for the provider being proctored. If the proctor acts as surgical assistant, the proctor then has the responsibilities of an assistant to the patient.

7. The FPPE/proctor must assure the confidentiality of the FPPE/proctoring evaluation form. The FPPE/proctor evaluation forms should be timely submitted to the Medical Staff Services Office. Proctoring evaluations should not be attached to the patient's medical record and copies should not be kept by the proctor.

FPPE/Proctoring Forms

Approved FPPE/proctoring evaluation forms are to be utilized when documenting FPPE/proctoring activities/evaluation.

Approvals

		AHS	AH
Credentials Committee	**Date:**	**11/13/25**	
Medical Executive Committee	**Date:**	**11/19/25**	**11/14/25**
QPSC	**Date:**	**11/19/25**	
Board of Trustees	**Date:**		

Alameda Health System

STANDARDIZED PROCEDURES FOR ADVANCED PRACTICE PROVIDERS IN THE DEPARTMENT OF SURGERY

Department	Surgery/Trauma Dept	***Effective Date***	3/2013
Campus	Highland	***Date Revised***	2/2013; 8/2024; 11/2025
Unit	Inpatient/Outpatient	***Next Scheduled Review***	11/2028
Manual	Interdisciplinary Practice	***Author***	Juan Casillas, NP
Replaces the following Policies:		***Responsible Person***	Chief of Staff

Procedure Statement

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

Purpose

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

Application

1. In addition to general requirements set forth and described in the Medical Staff Bylaws, Rules and Regulations, policies and privileges forms, the following criteria shall specifically apply to any APPs applying for privileges in the department of Surgery:
   a. Current Advanced Cardiac Life Support (ACLS) Certification

Conditions and Standards of Practice

1. **General Conditions**
   a. The Advanced Practice Provider (APP) shall render all care within the standards provided in this document.
   b. The APP shall provide all care in accordance with the laws and regulations of the State of California, and with the Bylaws and Regulations of the Medical Staff and the Department of 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 he/she 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. 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. Head/Neuro trauma
    ii. Facial trauma
    iii. Neck trauma
    iv. Chest trauma
    v. Abdominal trauma
    vi. Extremity trauma
    vii. Blunt trauma
    viii. 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 he/she has 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 surgery computer based format followed by all providers in the Department of Surgery.

3. **Emergency Care**

The APP may perform life sustaining measures, whenever necessary. This includes, but is not limited to those found in the Advanced Cardiac Life Support text and in the Advanced Trauma Life Support text.

4. **Procedures and Minor Surgeries**

a. APP at time of hire will need to demonstrate competency in each of the basic surgery/trauma skills. Advanced procedures require proctoring and advanced attending approval before procedure is initiated in the trauma patient. The APP will follow existing surgery department protocols for each procedure done in the trauma patient, including sterile procedure, sedation, observation and confirmatory testing.
b. For procedures that require consent APP will be responsible for obtaining informed consent from the patient
c. At the completion of the procedure the APP will write a procedure note that includes and complications and the name of the attending Surgery Physician.
d. The following list of procedures APP can do for trauma patients once granted privileges and demonstrated competency by direct observation or documented prior work experience.

i. Surgery/trauma procedures
   - Anesthesia, local infiltration, regional blocks
   - Nasal Packing, ant/posterior
   - Foreign Body removal from the cornea
   - Arthrocentesis
   - Joint aspiration/injection
   - Fracture treatment/splinting and casting
   - Joint reductions/simple closed fracture reductions
   - Debridement, Suture repair of wounds
   - Debridement and care of burns
   - Incision and drainage of hematoma or abscess
   - Wound Care, including complex
   - Treatment of nail avulsion, paronychia
   - Arterial puncture
   - Arterial Line
   - Central Venus Line
   - Biopsy: skin/muscle
   - Excision of skin and subcutaneous lesions
   - Thoracentesis
   - Paracentesis
   - IV catheterization
   - Foley catheter placement

ii. Advanced procedures, performed only at Highland Hospital, requiring proctoring in the ED/ICU/OR/PACU/Floors and patient specific pre-approval and supervision by the surgical attending for each patient.
   - Suprapubic catheter insertion
   - Endotracheal intubations
   - Chest tube insertion and removal
   - Venous cut down
   - First Assistant in the Operating Room (certification required for NPs)
   - Vascular Surgery: Bedside endovenous procedures (e.g., varicose veins)
   - Vascular Surgery: Dialysis access procedures (e.g., percutaneous balloon fistuloplasty)
   - Vascular Surgery: ultrasound performance and interpretation
   - Moderate Sedation (requires competency assessment)

iii. Procedures requiring additional training and proctoring.
   - Ultrasound: Proof of competency (confirmation of active privileges at another organization) or fellowship training OR participation in training remote/asynchronous and in-person through Alameda Health System with concurrent proctoring.

5. **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.

6. **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, Surgery Department protocols or current texts/articles on Trauma Care found in the Department of Surgery.

7. **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 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:

i. General
   - Full thickness burns
   - Shock
   - Probable or proven malignancy
   - Unresponsiveness

ii. Dermatology
   - Laceration involving nerve, tendon, muscle, artery, joint

iii. Eye
   - Diplopia
   - Papilledema
   - Foreign body
   - Vision loss

iv. ENT/Respiratory
   - Abnormal CXR
   - Head and neck masses
   - Respiratory distress and tachypnea
   - Hoarseness/voice loss

v. Cardiovascular
   - Abnormal EKG
   - Leg ulcers
   - Aneurysm
   - Bruit
   - Peripheral edema, new
   - Chest pain, new or changed
   - Pulmonary edema
   - Syncope
   - Heart murmur, not functional; new or changed

vi. Gastrointestinal
   - Peritonitis

- Organomegaly
- Abdominal distention
- Persistent vomiting/diarrhea
- Abdominal pain, persistent or severe

vii. Genitourinary
- GU Trauma

viii. Obstetrics
- Pregnant victim of trauma

ix. Musculoskeltal
- Radicular pain/weakness
- Unstable sprain
- Fractures

x. Hematology
- Anemia
- Unexplained abnormal lab test

xi. Neuro/Psych
- Acute change in mental status/behavior
- Acute sensory, strength or coordination change
- Suicidal ideation
- New onset or uncontrolled seizures
- Pupil changes
- Severe headache

8. **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.

9. **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.

10. **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.

11. **References/Resources**

- AHS/AH Medical Staff Bylaws
- Medical Staff Advanced Practice Provider policy and procedure manual
- Medical Staff Privilege forms
- Nurse Practice Act in the California Business and Professions Code
- Physician Assistant Practice Act
- References that define Standard of care for the 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:

	AHS	**AH**
Interdisciplinary Practice Committee	10/29/25	
Credentials Committee	11/13/25	
Medical Executive Committee	11/19/25	11/14/25
QPSC	11/19/25	
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: _____

Alameda Health System

STANDARDIZED PROCEDURES FOR ADVANCED PRACTICE PROVIDERS IN THE DEPARTMENT OF SURGERY

Department	Surgery/Trauma Dept	***Effective Date***	3/2013
Campus	Highland	***Date Revised***	2/2013; 8/2024; 11/2025
Unit	Inpatient/Outpatient	***Next Scheduled Review***	11/2028
Manual	Interdisciplinary Practice	***Author***	Juan Casillas, NP
Replaces the following Policies:		***Responsible Person***	Chief of Staff

Procedure Statement

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

Purpose

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

Application

1. In addition to general requirements set forth and described in the Medical Staff Bylaws, Rules and Regulations, policies and privileges forms, the following criteria shall specifically apply to any APPs applying for privileges in the department of Surgery:
   a. Current Advanced Cardiac Life Support (ACLS) Certification

Conditions and Standards of Practice

1. **General Conditions**
   a. The Advanced Practice Provider (APP) shall render all care within the standards provided in this document.
   b. The APP shall provide all care in accordance with the laws and regulations of the State of California, and with the Bylaws and Regulations of the Medical Staff and the Department of 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 he/she 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. 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. Head/Neuro trauma
    ii. Facial trauma
    iii. Neck trauma
    iv. Chest trauma
    v. Abdominal trauma
    vi. Extremity trauma
    vii. Blunt trauma
    viii. 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 he/she has 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 surgery computer based format followed by all providers in the Department of Surgery.

3. **Emergency Care**

The APP may perform life sustaining measures, whenever necessary. This includes, but is not limited to those found in the Advanced Cardiac Life Support text and in the Advanced Trauma Life Support text.

4. **Procedures and Minor Surgeries**

a. APP at time of hire will need to demonstrate competency in each of the basic surgery/trauma skills. Advanced procedures require proctoring and advanced attending approval before procedure is initiated in the trauma patient. The APP will follow existing surgery department protocols for each procedure done in the trauma patient, including sterile procedure, sedation, observation and confirmatory testing.
b. For procedures that require consent APP will be responsible for obtaining informed consent from the patient
c. At the completion of the procedure the APP will write a procedure note that includes and complications and the name of the attending Surgery Physician.
d. The following list of procedures APP can do for trauma patients once granted privileges and demonstrated competency by direct observation or documented prior work experience.

i. Surgery/trauma procedures
   - Anesthesia, local infiltration, regional blocks
   - Nasal Packing, ant/posterior
   - Foreign Body removal from the cornea
   - Arthrocentesis
   - Joint aspiration/injection
   - Fracture treatment/splinting and casting
   - Joint reductions/simple closed fracture reductions
   - Debridement, Suture repair of wounds
   - Debridement and care of burns
   - Incision and drainage of hematoma or abscess
   - Wound Care, including complex
   - Treatment of nail avulsion, paronychia
   - Arterial puncture
   - Arterial Line
   - Central Venus Line
   - Biopsy: skin/muscle
   - Excision of skin and subcutaneous lesions
   - Thoracentesis
   - Paracentesis
   - IV catheterization
   - Foley catheter placement

ii. Advanced procedures, performed only at Highland Hospital, requiring proctoring in the ED/ICU/OR/PACU/Floors and patient specific pre-approval and supervision by the surgical attending for each patient.
   - Suprapubic catheter insertion
   - Endotracheal intubations
   - Chest tube insertion and removal
   - Venous cut down
   - First Assistant in the Operating Room (certification required for NPs)
   - Vascular Surgery: Bedside endovenous procedures (e.g., varicose veins)
   - Vascular Surgery: Dialysis access procedures (e.g., percutaneous balloon fistuloplasty)
   - Vascular Surgery: ultrasound performance and interpretation
   - Moderate Sedation (requires competency assessment)

iii. Procedures requiring additional training and proctoring.
   - Ultrasound: Proof of competency (confirmation of active privileges at another organization) or fellowship training OR participation in training remote/asynchronous and in-person through Alameda Health System with concurrent proctoring.

5. **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.

6. **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, Surgery Department protocols or current texts/articles on Trauma Care found in the Department of Surgery.

7. **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 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:

i. General
   - Full thickness burns
   - Shock
   - Probable or proven malignancy
   - Unresponsiveness

ii. Dermatology
   - Laceration involving nerve, tendon, muscle, artery, joint

iii. Eye
   - Diplopia
   - Papilledema
   - Foreign body
   - Vision loss

iv. ENT/Respiratory
   - Abnormal CXR
   - Head and neck masses
   - Respiratory distress and tachypnea
   - Hoarseness/voice loss

v. Cardiovascular
   - Abnormal EKG
   - Leg ulcers
   - Aneurysm
   - Bruit
   - Peripheral edema, new
   - Chest pain, new or changed
   - Pulmonary edema
   - Syncope
   - Heart murmur, not functional; new or changed

vi. Gastrointestinal
   - Peritonitis

- Organomegaly
- Abdominal distention
- Persistent vomiting/diarrhea
- Abdominal pain, persistent or severe

vii. Genitourinary
- GU Trauma

viii. Obstetrics
- Pregnant victim of trauma

ix. Musculoskeltal
- Radicular pain/weakness
- Unstable sprain
- Fractures

x. Hematology
- Anemia
- Unexplained abnormal lab test

xi. Neuro/Psych
- Acute change in mental status/behavior
- Acute sensory, strength or coordination change
- Suicidal ideation
- New onset or uncontrolled seizures
- Pupil changes
- Severe headache

8. **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.

9. **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.

10. **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.

11. **References/Resources**

- AHS/AH Medical Staff Bylaws
- Medical Staff Advanced Practice Provider policy and procedure manual
- Medical Staff Privilege forms
- Nurse Practice Act in the California Business and Professions Code
- Physician Assistant Practice Act
- References that define Standard of care for the 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:

	AHS	**AH**
Interdisciplinary Practice Committee	10/29/25	
Credentials Committee	11/13/25	
Medical Executive Committee	11/19/25	11/14/25
QPSC	11/19/25	
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: _____

Alameda Health System

MEDICAL STAFF CREDENTIALING SYSTEM CONTROLS

Department	AHS Medical Staff	***Effective Date***	4/2022
Campus	AHS, AH	***Date Revised***	
Unit	All	***Next Scheduled Review***	4/2025
Manual	Medical Staff	***Author***	Director of Medical Staff Services
Replaces the following Policies:		***Responsible Person***	Chief Medical Officer

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

Purpose

This purpose of this policy is to describe the ongoing monitoring process the Alameda Health System (AHS) and Alameda Hospital (AH) Medical Staffs follow for storing, modifying, and securing credentialing information.

Policy Statement

Alameda Health System and Alameda Hospital Medical Staffs require that Medical Staff Services monitor compliance with the Credentials Systems Control policy and procedures. The systems controls requirements align with the Medical Staff Bylaws in that any data or information as part of the credentialing process, are protected by California Evidence Code section 1157. Access to the data and information contained in the credentialing and privileging database is limited and access to the electronic credentials file is outlined in the Medical Staff Bylaws.

Procedure

1. **Primary source verification information (NCQA CR 1.C.1.)**
   Credentialing applications, supporting documents and verifications are received via (electronic application, online portal, mail, email, fax, internet web site or web crawler). All documents are dated electronically when they are received and reviewed by Credentialing Staff. File progress is tracked via internal credentialing checklist in the electronic database workflows. All files are stored in locked cabinets, confidential share drives and/or password protected databases.

2. **Tracking modifications (NCQA CR 1.C.2.)**
   If a modification needs to be made to credentialing information, the credentialing system will automatically document the date the modification was made, and who made the modification within the credentialing system. Electronic Audit files maintain a record of when the information was modified, how the information was modified and who made the modification. The Audit also maintains before and after values of each field, date/time stamps and information on who made the

change. Modifications may be made when updated credentials information is acquired. File notes may be included in the appropriate section in the credentialing system.

3. **Authorization to modify information (NCQA CR 1.C.3)**
   - **a.** Credentialing Coordinators and Provider Enrollment staff are assigned user roles within the credentialing database which based on areas of responsibility as defined in their job description. Each user role is assigned specific read/write system access as needed to perform their duties which may include adding, modifying, and deleting information. Additionally, the Medical Staff Services office employs both a Database Administrator and Sr. System Analyst who both have administrative access to the database and perform routine maintenance and data validation within the credentialing software.
   - **b.** Verification information may be modified by Credentialing Coordinators, Enrollment Coordinators, or Managers when verification information changes – examples include but are not limited to (see below). If credentialing information changes, new verifications will be obtained, date stamped by the credentialing software and stored in the provider's electronic credentialing file.
     - i. Updates to expired licensure or other documents
     - ii. Changes/updates to education, training, or privileges
     - iii. To correct data entry errors
     - iv. Duplicate profiles
     - v. Documents appended to incorrect provider profile

4. **Securing information (NCQA CR 1.C.4)**
   - **a. Limiting physical access to Credentialing Information:** Physical access includes information on servers, hardware, and physical records credentials files. Hard copy data (any printed confidential/ sensitive document or file) must be stored out of sight and not be accessible to anyone who does not have a business need to view the contents. Credentialing staff shall secure all practitioner files and information when not in process and during non-work hours in locked cabinets in a restricted area that is only accessible to authorized staff. Workstations are in physically secure areas. Computer screens should be positioned to prevent viewing by unauthorized individuals. All password-based systems on workstations must mask, suppress, or otherwise obscure the passwords so that unauthorized persons are not able to observe them. Authorized users are prohibited from allowing others to access computer systems or restricted areas with their account, password, badge, or unique ID information. The IT department enforces 2 level authentication for access to the network and requires password resets every six months or can be modified by the staff at any time. IT security policy states that you use strong passwords and never write them down. All credentialing users must first have a unique AHS Network ID and password established before they can be added to the Credentialing system using single sign-on authentication. Users are disabled and passwords removed from the credentialing system by the MSS DBA, and network access is removed by

the IT Security team when a user has left the organization.

b. Release of Credentialing Information:

i. Credentialing information regarding any member or applicant to the Medical Staff shall, to the fullest extent permitted by law, be confidential and protected from disclosure pursuant to California Evidence Code 1157. Dissemination of such information and records shall only be made where expressly required by law, to other peer review bodies for peer review purposes, pursuant to officially adopted policies of the Alameda Health System Medical Staff and Alameda Hospital Medical Staff.

ii. Access to medical staff records shall be limited to duly appointed officers and committees of the medical staff for the sole purpose of discharging medical staff responsibilities and subject to the requirements that confidentiality be maintained.

iii. Requests for release of information from Risk Management, corporate attorney, Credentialing Committee Chair, Department Chair, etc. will be reviewed with the Medical Staff Officers and the Medical Staffs' legal counsel. If approval for release of information occurs, reasonable efforts will be made to notify the impacted provider(s) prior to disclosure of information to attorney(s).

iv. Regulatory or accreditation agencies - access will require direct supervision by the Medical Staff Director /Credentialing Manager to ensure no data is accessed without authorization.

v. Third parties or organizations (health plans, MCOs, etc.) with whom delegate is contracted. Every credentialed provider is required to submit a signed authorization and release of information form as part of their credentialing and recredentialing processes.

5. **Credentialing Process audit for factors 1-4 (NCQA CR 1.C.5)**

This section describes how Alameda Health System Medical Staff Services monitors compliance with the AHS/AH policies and procedures for credentialing system controls that address factors 1-4 at least annually and takes appropriate actions when applicable.

a. Frequency and methods of monitoring activities.

The monitoring process must occur at least annually, however the AHS or AH Medical Staff can request a review audit of credentialing modifications more frequently. These audits will be performed by one of the System Administrators, i.e. Senior System Analyst in the Medical Staff Services Department. These audits may include but are not limited to the following:

i. A description of the system functionality that prevents or disallows modifications of credentialing information.

ii. If the CR system allows modifications only under specific circumstances, an annual process for identifying all changes to established policies within the past 12 months and then updating the system controls accordingly.

iii. A review of automatic system alerts or flags for modifications or events in real time and a separate process for annually testing the performance of the system's automatic alerts or flags.

b. When auditing is used as the method for monitoring, sampling using the "5% or 50 files" audit method, with a minimum of 10 credentialing files and 10 recredentialing files shall occur. If fewer than 10 practitioners were credentialed or recredentialed since the last annual audit, the organization audits will audit 100% of the credentialing and recredentialing files.

c. Annual review of job roles and current user access to ensure system access is still appropriate for the role requirements.

d. Monthly, quarterly, semiannual, or annual review of all modifications made to credentialing data to confirm accuracy and appropriateness using the electronic system's audit trail function reporting capability.

e. Credentialing, privileging, and enrollment are paperless processes that have very limited paper documents due to requirements for wet signatures. For paper documents/files, leadership conducts periodic walk-throughs of the department to ensure confidential/sensitive documents are being handled and stored properly during and after business hours – i.e., in locked drawers/filing cabinets, not left on workstations, etc.

f. Incorporate review of data modifications/changes/updates to credentialing data (both electronic and paper as applicable) into file Q&A process. Assess for accuracy, appropriateness, compliance with policies. Findings will be documented and stored in a network folder.

g. Credentialing staff and anyone who has access to credentialing information is required to sign an annual confidentiality form. These forms will be stored in a Medical Staff Services folder.

6. **Credentialing System Controls Oversight (NCQA CR 1.D)**

At a minimum, an annual monitoring report will be required to show compliance with our Credentialing System Controls policies, procedures shall be reported to the AHS and AH Credentials Committee and Medical Executive Committee. The report will need to include:

a. A review of all modifications that did not meet the policies and procedures
   i. Conduct a qualitative and quantitative analysis of all modifications that did not meet policies.
   ii. Actions taken to address any modifications that did not meet established policy.
   iii. Implement quarterly monitoring when there are elements that did not meet the policies and procedures and provide written documentation in a report of this review.

b. The report shall include the person/role/title of the person performing the monitoring.

c. The report shall include the person/role/title of the person who has oversight of the monitoring process if different from who performs monitoring.

d. **<u>Oversight Reports:</u>**
   i. Credentialing System Controls Oversight Report – this template will be included in the request for documents at the time of the annual oversight assessment.

ii. **Monitoring and Reporting of Inappropriate Modifications** this template will be included in the request for documents at the time of the annual oversight assessment. AHS would need to submit this report if inappropriate modifications were identified. MSS will continue to monitor the report until it demonstrates improvement for three consecutive quarters. If improvement isn't demonstrated for at least one finding, all quarterly reports will be submitted to the MSS Director.

Approvals

		AHS Core	AH
Credentials Committee	**Date:**	**4/14/22**	**4/12/22**
Medical Executive Committee	**Date:**	**4/20/22**	**4/15/22**
QPSC	**Date:**	**4/20/22**	
Board of Trustees	**Date:**	**5/11/2022**	

ALAMEDA HEALTH SYSTEM

November 19, 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:** A4

Meeting Date: November 19, 2025

Item Description: Medical Staff Application Forms and Specialty Privilege Forms

COMMITTEE ACTION: Approval of revised Medical Staff Application and Privilege Forms

Background:
The specialty privilege form(s) listed in the analysis section are revised privileges forms, designed to offer a systematic approach for care across our facilities (AHS, SLH, AH) as applicable. Pre-application forms are updated to include the required elements for evaluating eligibility for receipt of an initial application. The resignation form is updated to allow collaboration with AHS employment and contracting teams.

Analysis:
The Medical Staff application includes questionnaires intended to collect documentation used in the decision-making process for credentialing applicants that are applying to the Medical Staff.

Whether new or revised, the Medical Staff privilege forms are updated through a succinct process using best practice and clinical evidence.

Board Action Requested:
Approval of application form revisions, resignation form revision and revised privilege forms, that offer a system-wide approach for credentialing and privileging providers that support patient care at AHS.

Revised Privilege Forms for AHS & AH:
- Anesthesiology
- Radiology
- Surgery Advanced Practice Provider

Revised Governing Documents/Forms for AHS & AH:

- Medical Staff and APP Pre-application
- Pre-Application Consent Acknowledgement
- Medical Staff and APP Voluntary Resignation form

Anesthesiology

Delineation of Privileges

Applicant's Name:

Instructions:

1. Click the **Request** checkbox to request a group of privileges such as *Core Privileges* or a *Special Privileges*.
2. Uncheck any privileges you do not want to request in that group.
3. Check off any special privileges you want to request.
4. Sign form electronically and submit with any required documentation.

Required Qualifications	
Membership	Meet all requirements for Medical Staff membership.
Education/Training	For initial applicants, effective January 1, 2020, completion of an ACGME or AOA accredited Residency training program in Anesthesiology.
Continuing Education	Attestation to 25 Category I CME credits per year directly related to the practice of the specialty of Anesthesiology. **OR** Applicants requesting subspecialty privileges only in Pain Medicine or Anesthesia Critical Care Medicine must meet the required qualifications indicated for those privileges.
Certification	Current certification or board eligibility in Anesthesiology by the American Board of Anesthesiology or by the American Osteopathic Board of Anesthesiology. **AND** Applicant must be active in the MOC (maintenance of certification) program for Anesthesiology (waived for providers currently Board Eligible or who hold Lifetime Board Certification Status). **OR** Applicants requesting subspecialty privileges only in Pain Medicine or Anesthesia Critical Care Medicine must meet the required qualifications indicated for those privileges.
Clinical Experience (Initial/Reappointment)	Applicant must provide documentation of provision of anesthesiology clinical services (200 cases) representative of the scope and complexity of the privileges requested during the previous 24 months (waived for applicants who completed training during the previous year). **OR** Applicants requesting subspecialty privileges only in Pain Medicine or Anesthesia Critical Care Medicine must meet the required qualifications indicated for those privileges.
Additional Qualifications	Applicant must be party to the agreement for any contractual exclusive services.

REQUIRED - Anesthesiology Core Privileges

Description: Plan and administer anesthesia care for patients with all anesthesia classifications. Provision of pain relief and maintenance or restoration, of a stable condition during and immediately following a surgical procedure or an obstetric or diagnostic procedure. Assess risk of the patient undergoing surgery and optimize the condition of the patient prior to, during, and after surgery. The preoperative, intraoperative, and postoperative care of patients undergoing surgery and related invasive procedures.

Request		***Request all privileges listed below.***
AHS Core	AH	Click **shaded blue check box** to Request all privileges. Uncheck any privileges you do not want to request.
☐	☐	☐ **- Currently granted privileges**
		General Cognitive Privileges
☐	☐	Admitting/Attending Privileges (including Adolescents 14-21 years of age)
☐	☐	Assessment of patients within the perioperative period
☐	☐	Medical management of patients during the perioperative period
☐	☐	Management of post anesthetic recovery including procedural pain
☐	☐	Airway management consultation and treatment
☐	☐	Pain management consultation and treatment
		Anesthesia and Analgesia
☐	☐	Supervise and administer general anesthesia
☐	☐	Supervise and administer regional anesthesia
☐	☐	Supervise and administer neuraxial anesthesia
☐	☐	Monitored Anesthesia Care
☐	☐	Assessment, consultation, and preparation of patients for anesthesia
☐	☐	Consultation and treatment of acute and perioperative pain
☐	☐	Monitoring and maintenance of normal physiology and fluid status during perioperative period, including the post anesthetic recovery
		Obstetrical Anesthesia and Analgesia
☐	☐	Assessment of fetal status and possible maternal co-morbidity; development of an anesthetic care plan that is integrated with the surgical and obstetric care plan and that includes provision for peri-operative fetal monitoring; development of a plan for possible emergency Cesarean delivery if appropriate; provision for postoperative analgesia; and collaboration with the obstetrician in the development of a plan to prevent preterm birth
☐	☐	Supervision and administration of regional neuraxial and general anesthesia to women during pregnancy and the puerperium
		Procedures
☐	☐	Airway management including, but not limited to, endotracheal intubation, double lumen tube placement, LMA placement
☐	☐	Management of cardiac and pulmonary resuscitation
☐	☐	Ultrasound-guided procedures including nerve blocks and line placement
☐	☐	Arterial line placement
☐	☐	Central venous line placement
☐	☐	Intraosseous line placement
☐	☐	Cricothyrotomy/emergency airway management/surgical airway
		Other Procedures (optional)

☐	☐	Jet ventilation

☐	☐	PA catheter insertion
☐	☐	Insertion of temporary pacemaker for life-threatening arrhythmias

Focused Professional Practice Evaluation (FPPE)/Routine Proctoring Requirements		
AHS Core	**AH**	
☐	☐	
☐	☐	Review of first three (3) cases.

Anesthesia Transesophageal Echocardiography (TEE) Privileges

Description: TEE education must be based upon the training objectives for advanced perioperative echocardiography of the American Society of Echocardiography and the Society of Cardiovascular Anesthesiologists outlined in "Guidelines for Training in Perioperative Echocardiography". These criteria do not confirm the skills necessary to make diagnosis that may alter the surgical plan. If a basic exam suggests a change in the operative plan the diagnosis needs to be supported by review with an advanced level anesthesia TEE provider, Cardiologist, or Cardiothoracic Surgeon.

Qualifications	
Education/Training	For initial applicants, effective January 1, 2020, completion of an ACGME or AOA accredited Residency training program in Anesthesiology. **OR** Documentation of completion of basic perioperative TEE examination through the ASA or National Board of Echocardiography.
Clinical Experience (Initial)	Documentation of performance of 10 successful probe placements and TEE examinations supervised by a Cardiothoracic Surgeon, Cardiologist, or Advanced Level Anesthesia TEE provider.
Clinical Experience (Reappointment)	Attestation to ongoing clinical practice performing TEE examinations.

Request		***Request all privileges listed below.***
AHS Core	**AH**	Click **shaded blue check box** to Request all privileges. Uncheck any privileges you do not want to request.
☐	☐	☐ **- Currently granted privileges**
☐	☐	Transesophageal Echocardiography (TEE)

Focused Professional Practice Evaluation (FPPE)/Routine Proctoring Requirements		
AHS Core	AH	
☐	☐	
☐	☐	Retrospective review of three (3) cases

Pain Medicine

Qualifications	
Education/Training	For initial applicants, effective January 1, 2020, completion of an ACGME or AOA accredited Residency training program in Anesthesiology. **AND** Completion of an ACGME or AOA accredited Fellowship training program in Anesthesia Pain Medicine.
Continuing Education	Attestation to 25 Category I CME credits per year directly related to the practice of the specialty of Pain Medicine (waived for applicants who have completed training during the previous 24 months).
Certification	Current certification in Anesthesiology by the American Board of Anesthesiology or by the American Osteopathic Board of Anesthesiology. **AND** Current certification or board eligibility in Pain Medicine by the American Board of Anesthesiology or subspecialty certification in Pain Medicine by the American Osteopathic Board of Anesthesiology. **AND** Applicant must be active in the MOC (maintenance of certification) program for Pain Medicine (waived for providers currently Board Eligible).
Clinical Experience (Initial/Reappointment)	Applicant must provide documentation of provision of pain medicine services (50 cases) representative of the scope and complexity of the privileges requested during the previous 24 months (waived for applicants who completed training during the previous 2 years).
Additional Qualifications	Fluoroscopy Privileges: Current California Fluoroscopy Certificate/Permit, in accordance with Title 17, Article 1, section 30463, required for fluoroscopy use any time in or outside of operating area; radiology technician cannot be used in lieu of individual licensed provider.

Request		***Request all privileges listed below.***
AHS Core	AH	Click **shaded blue check box** to Request all privileges. Uncheck any privileges you do not want to request.
☐	☐	☐ **- Currently granted privileges**
		General Cognitive Privileges
☐	☐	Admitting/Attending Privileges (including Adolescents 14-21 years of age)
☐	☐	Assessment of patients within the perioperative period

☐	☐	Medical management of patients during the perioperative period
☐	☐	Management of post anesthetic recovery including procedural pain
☐	☐	Airway management consultation and treatment
☐	☐	Pain management consultation and treatment
		Pain Medicine Procedures
☐	☐	Major joint and bursae injections, without fluoroscopy
☐	☐	Major joint and bursae injections, with fluoroscopy (Current California Fluoroscopy Certificate/Permit required)
☐	☐	Trigger point injections
☐	☐	Scar neuroma injections
☐	☐	Injections with Botox
☐	☐	Infusion therapy with IV lidocaine and/or ketamine
☐	☐	Inpatient and outpatient pain management consultation and follow-up office visits
☐	☐	Cryoanalgesia, Radiofrequency ablation, without fluoroscopy
☐	☐	Cryoanalgesia, Radiofrequency ablation, with fluoroscopy (Current California Fluoroscopy Certificate/Permit required)
☐	☐	Peripheral and neuraxial nerve blocks, including diagnostic nerve blocks, without fluoroscopy
☐	☐	Peripheral and neuraxial nerve blocks, including diagnostic nerve blocks, with fluoroscopy (Current California Fluoroscopy Certificate/Permit required)
☐	☐	Sympathetic blocks and ablation, without fluoroscopy
☐	☐	Sympathetic blocks and ablation, with fluoroscopy (Current California Fluoroscopy Certificate/Permit required)
☐	☐	Spinal Cord Stimulator trial and implantation, with fluoroscopy (Current California Fluoroscopy Certificate/Permit required)
☐	☐	Dorsal Root Ganglion Stimulation trial and implantation (Current California Fluoroscopy Certificate/Permit required)
☐	☐	Peripheral Nerve Stimulation trial and implantation (Current California Fluoroscopy Certificate/Permit required)
☐	☐	Epidural/Intrathecal Infusion Pump Internal
☐	☐	Epidural injections: cervical, thoracic, lumbar, and caudal, with fluoroscopy (Current California Fluoroscopy Certificate/Permit required)
☐	☐	Cranial nerve blocks including Trigeminal nerve block, without fluoroscopy
☐	☐	Cranial nerve blocks including Trigeminal nerve block, with fluoroscopy (Current California Fluoroscopy Certificate/Permit required)
☐	☐	Minimally Invasive Lumbar Decompression (MILD) procedure (Current California Fluoroscopy Certificate/Permit required)
☐	☐	Kyphoplasty (Current California Fluoroscopy Certificate/Permit required)

Focused Professional Practice Evaluation (FPPE)/Routine Proctoring Requirements		
AHS Core	**AH**	
☐	☐	
☐	☐	Concurrent review of first three (3) clinic visits.
☐	☐	Concurrent review of first three (3) procedures.
☐	☐	Concurrent review of first three (3) inpatient pain consults.

Anesthesia Critical Care Medicine

Qualifications	
Education/Training	For initial applicants, effective January 1, 2020, completion of an ACGME or AOA accredited Residency training in Anesthesiology. **AND** Completion of an ACGME or AOA accredited Fellowship training program in Anesthesia Critical Care Medicine.
Continuing Education	Attestation to 25 Category I CME credits per year (waived for applicants who have completed training during the previous 24 months).
Certification	Current certification in Anesthesiology by the American Board of Anesthesiology or by the American Osteopathic Board of Anesthesiology. **AND** Current Certification or board eligibility in the examination process leading to certification in Critical Care Medicine by the American Board of Anesthesiology, or subspecialty certification in Critical Care Medicine by the American Osteopathic Board of Anesthesiology. **AND** Applicant must be active in the MOC (maintenance of certification) program for Anesthesia Critical Care Medicine (waived for providers currently Board Eligible).
Clinical Experience (Initial/Reappointment))	Applicant must provide documentation of provision of Anesthesia Critical Care services (50 cases) representative of the scope and complexity of the privileges requested during the previous year (waived for applicants who completed training during the previous 2 years).

Request		***Request all privileges listed below.***
AHS Core	**AH**	Click **shaded blue check box** to Request all privileges. Uncheck any privileges you do not want to request.
☐	☐	☐ **- Currently granted privileges**
☐	☐	Airway management including intubation, laryngoscopy
☐	☐	Fiberoptic bronchoscopy, without fluoroscopy
☐	☐	Ventilator management (all modes)
☐	☐	Cavity drainage including thoracentesis, paracentesis and pericardiocentesis with or without image guidance
☐	☐	Wound care including wound closure; selection of specialized dressings; drain insertion and removal; I & D superficial soft tissue mass; and the use of local anesthetics, basic and regional blocks, debridement, minor surgical excisions, and skin biopsy
☐	☐	Lumbar puncture with or without intrathecal injection, without fluoroscopy
☐	☐	Placement and management of arterial lines, central venous lines, dialysis catheters, and pulmonary artery catheters with or without image guidance
☐	☐	Needle and tube thoracostomy
☐	☐	Elective cardioversion
☐	☐	Placement of percutaneous cavitary catheter
☐	☐	Percutaneous Dilatational Tracheostomy (PDT)
☐	☐	IV immunoglobulin therapy
☐	☐	Abdominal paracentesis
☐	☐	Hyperalimentation
☐	☐	Critical care consultation and ongoing assessment and treatment

Focused Professional Practice Evaluation (FPPE)/Routine Proctoring Requirements		
AHS Core	AH	
☐	☐	
☐	☐	Review of first three (3) cases.

Moderate/Deep (Procedural) Sedation

Description: Moderate Sedation/Analgesia ("Conscious Sedation") is a drug-induced depression of consciousness. No interventions are required to maintain a patent airway, spontaneous ventilation is adequate and cardiovascular function is maintained.

Qualifications	
Clinical Experience (Initial)	Applicant must provide documentation of provision of clinical services representative of the scope and complexity of the privileges requested during the previous year (waived for applicants who completed training during the previous year). **OR** Documentation of participation and completion of approved training through Alameda Health System Chair of Procedural Sedation Committee.
Additional Qualifications	Current ACLS certification (waived for applicants requesting Anesthesiology Core Privileges). **AND** Completion of AHS Procedural Sedation Competency, initially and at time of reapplication.

Request		***Request all privileges listed below.***
AHS Core	AH	Click **shaded blue check box** to Request all privileges. Uncheck any privileges you do not want to request.
☐	☐	☐ **- Currently granted privileges**
☐	☐	Moderate Sedation
☐	☐	Deep Sedation

Focused Professional Practice Evaluation (FPPE)/Routine Proctoring Requirements		
AHS Core	AH	
☐	☐	
☐	☐	Three (3) Moderate/Deep Sedation case reviews. Concurrent evaluation required for providers without recent clinical experience.

Telemedicine Privileges Inpatient or Outpatient Care

Description: These privileges are intended to support existing specialty privileges for physicians and Advanced Practice Providers who are not otherwise classified as Telemedicine ONLY providers.

Qualifications	
Qualifications	Clinical services are limited to only those aspects of existing privileges granted that can be provided remotely.

Request		***Request all privileges listed below.***
AHS Core	**AH**	
		Click **shaded blue check box** to Request all privileges. Uncheck any privileges you do not want to request.
☐	☐	☐ **- Currently granted privileges**
☐	☐	Telehealth initial and follow up consultations
☐	☐	Virtual Check-ins
☐	☐	E-Visits

Acknowledgment of Applicant

I have requested only those privileges for which by education, training, current experience, and demonstrated competency I believe that I am competent to perform and that I wish to exercise at Alameda Health System hospital(s) and I understand that:

A. In exercising any clinical privileges granted, I am constrained by applicable Hospital and Medical Staff policies and rules applicable generally and any applicable to the particular situation.

B. Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of the Medical Staff Bylaws or related documents.

Practitioner's Signature _____ Date _____

Department Chair Recommendation - Privileges

I have reviewed the requested clinical privileges and supporting documentation and make the following recommendation(s):

Privilege	Condition/Modification/Deletion/Explanation

Department Chair Recommendation - FPPE Requirements

Signature of Chief/Designee

Date

Signature of Department Chair/Designee

Date

Submit

Radiology

Delineation of Privileges

Applicant's Name:

Instructions:

1. Click the **Request** checkbox to request a group of privileges.
2. Uncheck any privileges you do not want to request in that group.
3. Check off any special privileges you want to request.
4. Sign form electronically and submit with any required documentation.

Required Qualifications	
Membership	Meet all requirements for Medical Staff membership.
Education/Training	Completion of an ACGME or AOA accredited residency training program in Diagnostic Radiology. **OR** Completion of an ACGME accredited residency in Interventional Radiology (integrated program).
Certification	Current certification or board eligibility in the examination process leading to certification in Diagnostic Radiology or Interventional Radiology and Diagnostic Radiology by the American Board of Radiology or primary certification in Diagnostic Radiology by the American Osteopathic Board of Radiology.
Clinical Experience (Initial/Reappointment)	Applicant must provide documentation of provision of diagnostic radiology services representative of the scope and complexity of the privileges requested during the previous 24 months (waived for applicants who completed training during the previous year).
Radiology Certificate/Permit	Current California Radiology Supervisor and Operator Certificate required to operate state registered X-ray equipment and to supervise state authorized radiologic technologists, X-ray technicians, and students.

Description: These privileges are intended to support existing specialty privileges for physicians and Advanced Practice Providers who are not otherwise classified as Telemedicine ONLY providers.

Qualifications	
Qualifications	Clinical services are limited to only those aspects of existing privileges granted that can be provided remotely.

Request		***Request all privileges listed below.***
AHS Core	**AH**	Click **shaded blue check box** to Request all privileges. Uncheck any privileges you do not want to request.
☐	☐	☐ **- Currently granted privileges**
☐	☐	Telehealth initial and follow up consultations
☐	☐	Virtual Check-ins
☐	☐	E-Visits

Core Privileges in Radiology

Description: Diagnostic radiology encompasses image-based diagnosis and image-guided therapeutic techniques, and includes but is not limited to: computed tomography (CT); interventional procedures; magnetic resonance imaging (MRI); medical physics; nuclear radiology and molecular imaging; radiography/fluoroscopy; ultrasonography; and radiology quality and safety. Diagnostic radiology educational content includes, but is not limited to, diagnostic imaging and related image-guided interventions in the following 10 categories: breast; cardiac; gastrointestinal; musculoskeletal; neurologic; pediatric; reproductive and endocrine; thoracic; urinary; and vascular.

Request		***Request all privileges listed below.***
AHS Core	**AH**	Click **shaded blue check box** to Request all privileges. Uncheck any privileges you do not want to request.
☐	☐	☐ **- Currently granted privileges**
		Select, Perform, and Interpret
☐	☐	Diagnostic imaging, including x-rays and bone density scans
☐	☐	Diagnostic ultrasound
☐	☐	Diagnostic CT (computed tomography) and CTA (computed tomography angiography)
☐	☐	MRI (magnetic resonance imaging) and MRA (magnetic resonance angiography)
☐	☐	Image guided procedures including contrast studies of the gastrointestinal and genitourinary systems; arthrography; lumbar puncture; discography; myelography; and cisternography
☐		Diagnostic nuclear medicine studies
☐		Supervision of the preparation, administration, and use of sodium iodide I-131 for therapeutic purposes

Focused Professional Practice Evaluation (FPPE)/Routine Proctoring Requirements

AHS Core	AH	
☐	☐	
☐	☐	Ten (10) overreads representative of the scope and complexity of privileges that have been granted.

Breast Imaging and Invasive Privileges

Description: Select, perform, and interpret imaging and invasive procedures related to the detection and treatment of cancer of the breast.

Qualifications

Clinical Experience (Initial/Reappointment) Applicant must provide documentation from residency/fellowship program director confirming that applicant is trained and qualified to perform breast imaging and invasive procedures.

OR

Applicant must provide documentation of provision of clinical services representative of the scope and complexity of privileges requested during the previous 24 months.

Request		*Request all privileges listed below.*
AHS Core	AH	Click **shaded blue check box** to Request all privileges. Uncheck any privileges you do not want to request.
☐	☐	☐ **- Currently granted privileges**
		Select, Perform, and Interpret
☐	☐	Mammography, diagnostic or screening
☐	☐	Diagnostic breast imaging consultation which may include diagnostic mammography or other imaging studies
☐	☐	Magnetic resonance guided biopsy with placement of breast localization device(s) and imaging of the biopsy specimen
☐	☐	Ultrasound guided biopsy with placement of breast localization device(s) and imaging of the biopsy specimen
☐	☐	Stereotactic guided biopsy with placement of breast localization device(s) and imaging of the biopsy specimen

Focused Professional Practice Evaluation (FPPE)/Routine Proctoring Requirements		
AHS Core	AH	
☐	☐	
☐	☐	Three (3) overreads representative of the scope and complexity of privileges that have been granted.

Interventional Radiology Privileges

Description: Interventional radiology focuses on diagnostic and therapeutic aspects of patient care through expertise in diagnostic imaging, image-guided, minimally invasive procedures, and the evaluation and clinical management of patients with conditions amenable to these methods.

Qualifications	
Education/Training	Completion of an ACGME or AOA accredited fellowship program in Interventional Radiology. **OR** Completion of an ACGME accredited residency in Interventional Radiology (integrated program). **OR** . Applicants for initial privileges who completed an ACGME or AOA residency training program in Diagnostic Radiology prior to January 1, 2010, must provide recent experience documentation in Interventional Radiology at initial request for determination of eligibility by the Department of Radiology Chair. Grandfathered for providers who were granted privileges prior to January 1, 2026.

Certification Current certification or board eligibility in the examination process leading to certification in Interventional Radiology and Diagnostic Radiology by the American Board of Radiology or subspecialty certification in Vascular and Interventional Radiology by the American Osteopathic Board of Radiology

OR

Current certification in Diagnostic Radiology by the American Board of Radiology or by the American Osteopathic Board of Radiology.

Clinical Experience (Initial/Reappointment) Applicant must provide documentation of provision of vascular and interventional radiology services representative of the scope and complexity of the privileges requested during the previous 24 months (waived for applicants who completed training during the previous year).

Special Privileges Qualifications Applicant must provide documentation of performance of two cases during the previous 24 months for each requested privilege.

Additional Qualification Moderate Sedation Privileges are required for Interventional Radiology privileges. Applicant must be currently granted or request Moderate Sedation to qualify.

Request		***Request all privileges listed below.***
AHS Core	**AH**	Click **shaded blue check box** to Request all privileges. Uncheck any privileges you do not want to request.
☐		☐ **- Currently granted privileges**
☐		Pre- and Post procedure clinical evaluation and management of patients
		Perform and interpret percutaneous and vascular procedures
☐		Angiography, venography, fistulography, and lymphangiography
☐		Image guided biopsy and drainage procedures (excludes breast)
☐		Image guided procedures including contrast studies of the gastrointestinal and genitourinary systems; arthrography; lumbar puncture; discography; myelography; and cisternography.
☐		Therapeutic vascular radiology procedures (excludes intracranial and carotids) including angiography; balloon angioplasty with or without stenting; atherectomy; thrombectomy and/or thrombolysis (excluding pulmonary arteriograms with intervention); vascular embolization including transarterial chemoembolization; AV fistula creation or revision; IVC filter insertion and management; and endovascular aneurysm repair
		Image guided ablation procedures – all modes
☐		Percutaneous transcatheter retrieval of intravascular foreign body
☐		Image guided procedures including percutaneous tube placement; fluid and cyst aspiration; nephrostomy; biliary drainage; venous sampling; gastrostomy tube placement; transcervical fallopian tube recanalization, and other procedures requiring the same or similar techniques and skills
☐		Transcatheter genitourinary procedures involving calculus extraction or fragmentation, stent placement, stricture dilation, clot removal, or reduction of prostate enlargement
		Special Privileges (see additional qualification requirements)
☐		Insertion and management of transvenous intrahepatic portosystemic shunts (TIPS), including venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract recannulization/dilatation, stent placement and all associated imaging guidance
☐		Transarterial radioembolization
☐		Pulmonary arteriograms with intervention
☐		Balloon occluded retrograde transvenous obliteration (BRTO)

☐		Neuroendovascular angiography
☐		Intracranial therapies including embolization and vessel infusion therapy
☐		Percutaneous vertebroplasty (with cement) or vertebral augmentation (kyphoplasty)

Focused Professional Practice Evaluation (FPPE)/Routine Proctoring Requirements		
AHS Core	**AH**	
☐	☐	
☐		Concurrent observation of one (1) major invasive procedure.
☐		Three (3) retrospective chart reviews that are representative of the scope and complexity of privileges that have been granted.

Moderate (Procedural) Sedation

Description: Moderate Sedation/Analgesia ("Conscious Sedation") is a drug-induced depression of consciousness. No interventions are required to maintain a patent airway, spontaneous ventilation is adequate and cardiovascular function is maintained.

Qualifications	
Clinical Experience (Initial)	Applicant must provide documentation of provision of clinical services representative of the scope and complexity of the privileges requested during the previous year (waived for applicants who completed training during the previous year). **OR** Documentation of participation and completion of approved training through Alameda Health System Chair of Procedural Sedation Committee.
Additional Qualifications	Current ACLS certification. **AND** Completion of AHS Procedural Sedation Competency, initially and at the time of reapplication.

Request		***Request all privileges listed below.***
AHS Core	**AH**	Click **shaded blue check box** to Request all privileges. Uncheck any privileges you do not want to request.
☐	☐	☐ **- Currently granted privileges**
☐		Moderate Sedation

Focused Professional Practice Evaluation (FPPE)/Routine Proctoring Requirements		
AHS Core	**AH**	
☐	☐	

☐	☐	Three (3) Moderate/Deep Sedation case reviews. Concurrent evaluation required for providers without recent clinical experience.

Acknowledgment of Applicant

I have requested only those privileges for which by education, training, current experience, and demonstrated competency I believe that I am competent to perform and that I wish to exercise at Alameda Health System hospital(s) and I understand that:

A. In exercising any clinical privileges granted, I am constrained by applicable Hospital and Medical Staff policies and rules applicable generally and any applicable to the particular situation.

B. Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of the Medical Staff Bylaws or related documents.

Practitioner's Signature

Date

Department Chair Recommendation - Privileges

I have reviewed the requested clinical privileges and supporting documentation and make the following recommendation(s):

Privilege	Condition/Modification/Deletion/Explanation

Department Chair Recommendation - FPPE Requirements

Signature of Department Chair/Designee

Date

Submit

Surgery - Advanced Practice Providers

Delineation of Privileges

Applicant's Name:

Instructions:

1. Click the **Request** checkbox to request a group of privileges such as *Core Privileges* or a *Special Privileges*.
2. Uncheck any privileges you do not want to request in that group.
3. Check off any special privileges you want to request.
4. Sign form electronically and submit with any required documentation.

Required Qualifications	
Licensure	Physician Assistant: Licensed as a Physician Assistant by the Physician Assistant Board of California. **OR** Nurse Practitioner: Licensed as a registered nurse by the California Board of Registered Nursing AND license certification as a Nurse Practitioner by the California Board of Registered Nursing.
Education/Training	Physician Assistant: Successful completion of a Physician Assistant Education program which meets the requirements required for licensure and Physician Assistant Certification. **OR** Nurse Practitioner: Master's or Doctoral Degree in Nursing and successful completion of a graduate program for the education and preparation of nurse practitioners or meet the training/education requirements according to Title 16, Article 8, Section 1482; BPC Section 2834-2837.
Continuing Education	Attestation of 100 hours of continuing education credits in the past two (2) years relevant to the privileges requested.
Certification	Physician Assistant: Certification by the National Commission on Certification of Physician Assistants (NCCPA). **OR** Nurse Practitioner: Certification by the by the American Nurses Credentialing Center (ANCC), American Academy of Nurse Practitioners Certification Board (AANP), or American Association of Critical-Care Nurses (AACN).
Clinical Experience (Initial/Reappointment)	Recent training and/or clinical experience is required for all applicants for appointment and reappointment. Recent clinical experience is defined as having performed at least 200 surgical cases or procedures in a Joint Commission accredited hospital or hospital based ambulatory setting in the past two (2) years.
Additional Qualifications	Physician Assistant: Practice Agreement/Delegation of Services Agreement. Nurse Practitioner: California Nurse Practitioner Furnishing Number. **AND** Signed Standardized Procedure

Supervising Physician Agreement
Current DEA registration
Current ACLS certification

COGNITIVE PRACTICE PREROGATIVES

Description: Privileges available to the Advanced Practice Provider (PA or NP) working in the Department of Surgery.

Request		***Request all privileges listed below.***
AHS Core	AH	Click **shaded blue check box** to Request all privileges. Uncheck any privileges you do not want to request.
☐	☐	☐ **- Currently granted privileges**
☐	☐	Obtain patient's medical history and perform a physical examination
☐	☐	Conduct the initial and ongoing assessment of the patient's medical and physical status: Adolescent
☐	☐	Conduct the initial and ongoing assessment of the patient's medical and physical status: Adult
☐	☐	Order, conduct, interpret labs, x-rays, and other diagnostic studies
☐	☐	Counsel patients and their families on health promotion, diagnosis, and management options
☐	☐	Facilitate and initiate referrals to appropriate health care agencies and arranging for community resources
☐	☐	Administer, provide, or transmit drug orders or devices according to protocols and the requirements in the Advanced Practice Provider policy manual and Standardized Procedures

Focused Professional Practice Evaluation (FPPE)/Routine Initial Proctoring		
AHS Core	AH	
☐	☐	
☐	☐	Five (5) retrospective case reviews that are representative of the scope and complexity of privileges requested.

PROCEDURAL PRACTICE PREROGATIVES

Request		***Request all privileges listed below.***
AHS Core	AH	Click **shaded blue check box** to Request all privileges. Uncheck any privileges you do not want to request.
☐	☐	☐ **- Currently granted privileges**
☐	☐	Anesthesia, local infiltration, regional blocks
☐	☐	Nasal Packing, anterior/posterior
☐	☐	Foreign Body removal from the cornea
☐	☐	Arthrocentesis
☐	☐	Joint aspiration/injection
☐	☐	Fracture treatment, splinting, and casting
☐	☐	Debridement, Suture repair of wounds

☐	☐	Debridement and care of burns

☐	☐	Incision and drainage of hematoma or abscess
☐	☐	Wound Care, including complex
☐	☐	Treatment of nail avulsion, paronychia
☐	☐	Arterial Puncture
☐	☐	Arterial Line
☐	☐	Central Venous Line
☐	☐	Thoracentesis
☐	☐	Paracentesis
☐	☐	IV Catheterization
☐	☐	Foley catheter placement
☐	☐	Biopsy: skin/muscle
☐	☐	Excision of skin and subcutaneous lesions
☐	☐	Joint reductions/simple closed fracture reductions

Focused Professional Practice Evaluation (FPPE)/Routine Initial Proctoring		
AHS Core	**AH**	
☐	☐	
☐	☐	Three (3) retrospective case reviews that are representative of the scope and complexity of privileges requested.

HIGHLAND HOSPITAL ONLY - ADVANCED PROCEDURAL PRACTICE PEROGATIVES

Qualifications	
First Assistant Qualifications	First Assistant: Nurse Practitioner - Registered Nurse First Assistant (RNFA) certification

Request		***Request all privileges listed below.***
AHS Core	**AH**	Click **shaded blue check box** to Request all privileges. Uncheck any privileges you do not want to request.
☐		☐ **- Currently granted privileges**
☐		Suprapubic catheter insertion
☐		Endotracheal intubations
☐		Chest tube insertion and/or removal
☐		Venous cut down
☐		First Assistant in the operating room (RNFA certification required for NPs)

Focused Professional Practice Evaluation (FPPE)/Routine Initial Proctoring		
AHS Core	AH	
☐	☐	
☐	☐	Two (2) concurrent case reviews for suprapubic catheter insertion.
☐	☐	Two (2) concurrent case reviews for endotracheal intubation.
☐	☐	Two (2) concurrent case reviews for chest tube insertion and/or removal.
☐	☐	Two (2) concurrent case reviews for venous cut down.
☐	☐	Two (2) concurrent case reviews for First Assistant in OR.

HIGHLAND HOSPITAL ONLY - VASCULAR SURGERY

Request		***Request all privileges listed below.***
AHS Core	AH	Click **shaded blue check box** to Request all privileges. Uncheck any privileges you do not want to request.
☐		☐ **- Currently granted privileges**
☐		Bedside endovenous procedures (e.g., varicose veins)
☐		Dialysis access procedures (e.g., percutaneous ballon fistuloplasty)
☐		Vascular ultrasound performance and interpretation

Focused Professional Practice Evaluation (FPPE)/Routine Initial Proctoring		
AHS Core	AH	
☐	☐	
☐	☐	Two (2) concurrent case reviews for bedside endovascular procedures.
☐	☐	Two (2) concurrent case reviews for dialysis access procedures.
☐	☐	Two (2) concurrent case reviews for vascular ultrasound.

HIGHLAND HOSPITAL ONLY - POINT OF CARE ULTRASOUND (POCUS)

Description: HIGHLAND HOSPITAL ONLY- ADVANCED PRACTICE PREROGATIVES

Qualifications	
Qualifications	Proof of competency (confirmation of active privileges at another organization) or fellowship training. **OR** Participation in training remote/asynchronous and in-person through Alameda Health System with concurrent proctoring.

Request		*Request all privileges listed below.*
AHS Core	AH	Click **shaded blue check box** to Request all privileges. Uncheck any privileges you do not want to request.
☐		☐ **- Currently granted privileges**
		POCUS PRIVILEGES
☐		Soft Tissue Ultrasound
☐		Hepatobiliary Ultrasound
☐		Trans-abdominal Ultrasound of the Female Pelvis
☐		Deep Venous Thrombosis (DVT)
☐		Focused Assessment with Sonography for Trauma (FAST)
		ADVANCED POINT OF CARE ULTRASOUND (POCUS)
☐		Line placement (Peripheral)
☐		Line placement (Central)
☐		Bedside Echo (screening)
☐		Lung Ultrasound
☐		Advanced US guided nerve blocks

Focused Professional Practice Evaluation (FPPE)/Routine Initial Proctoring		
AHS Core	AH	
☐	☐	
☐	☐	Five (5) retrospective case reviews for Soft Tissue Ultrasound.
☐	☐	Five (5) retrospective case reviews for Hepatobiliary Ultrasound.
☐	☐	Five (5) retrospective case reviews for Trans-abdominal Ultrasound of the Female Pelvis.
☐	☐	Five (5) retrospective case reviews for Deep Venous Thrombosis (DVT).
☐	☐	Five (5) retrospective case reviews for FAST.
☐	☐	Five (5) concurrent case reviews that are representative of the scope and complexity of the Advanced Point of Care Ultrasound privileges requested.

Moderate (Procedural) Sedation

Description: Moderate Sedation/Analgesia ("Conscious Sedation") is a drug-induced depression of consciousness. No interventions are required to maintain a patent airway, spontaneous ventilation is adequate and cardiovascular function is maintained.

Qualifications	
Education/Training	The applicant must provide documented evidence of training and supervised experience. **OR** Documentation of participation and completion of approved training through Alameda Health System Chair of Procedural Sedation Committee.
Clinical Experience (Initial)	Applicant must provide documentation of moderate services during the previous year (waived for applicants who completed training during the previous year).
Clinical Experience	Applicant must provide documentation of moderate sedation services during the previous 24

(Reappointment) months.

Additional Qualifications Current ACLS certification

AND

Completion of AHS Procedural Sedation Competency, initially and at time of reapplication

Request		***Request all privileges listed below.***
AHS Core	**AH**	Click **shaded blue check box** to Request all privileges. Uncheck any privileges you do not want to request.
☐	☐	☐ **- Currently granted privileges**
☐	☐	Moderate Sedation

Focused Professional Practice Evaluation (FPPE)/Routine Initial Proctoring		
AHS Core	**AH**	
☐	☐	
☐	☐	Concurrent review of two (2) cases of administration of moderate sedation.

TELEMEDICINE PRIVILEGES INPATIENT OR OUTPATIENT CARE

Description: These privileges are intended to support existing specialty privileges for physicians and Advanced Practice Providers who are not otherwise classified as Telemedicine ONLY providers.

Qualifications

Qualifications Clinical services are limited to only those aspects of existing privileges granted that can be provided remotely.

Request		***Request all privileges listed below.***
AHS Core	**AH**	Click **shaded blue check box** to Request all privileges. Uncheck any privileges you do not want to request.
☐	☐	☐ **- Currently granted privileges**
☐	☐	Telehealth initial and follow up consultations
☐	☐	Virtual Check-ins
☐	☐	E-Visits

Acknowledgment of Applicant

I have requested only those privileges for which by education, training, current experience, and demonstrated competency I believe that I am competent to perform and that I wish to exercise at Alameda Health System hospital(s) and I understand that:

A. In exercising any clinical privileges granted, I am constrained by applicable Hospital and Medical Staff policies and rules applicable generally and any applicable to the particular situation.

B. Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of the Medical Staff Bylaws or related documents.

Practitioner's Signature

Date

Department Chair Recommendation - Privileges

I have reviewed the requested clinical privileges and supporting documentation and make the following recommendation(s):

Privilege	Condition/Modification/Deletion/Explanation

Department Chair Recommendation - FPPE Requirements

Signature of Chief/Designee

Date

Signature of Department Chair/Designee

Date

Submit

Basic Information	
Practitioner Information	
Name (F,M,L):	
Middle initial:	
Last Name:	
Degree:	
Date of birth:	
Social Security Number:	
Gender:	
Home Phone:	
Cell Phone:	
Personal Email:	
Current Practice Locations	
Practice Location Lookup (Select a Practice Location from the dropdown):	
Practice Location :	
Address:	
Address 2:	
City/State/Zip:	
State:	
Zip Code:	
Phone:	
Group Name:	

Alameda Health System (AHS) Affiliation
Have you had prior affiliation with any AHS location (i.e., clinical rotation at Highland Hospital)? ■ Yes ■ No

Work Background	
Professional Licensure/Registrations	
California State License	
ID Type:	
ID Number:	
State:	
Issue Date:	
Expiration Date:	
Field of Licensure:	
DEA Number	
ID Type:	
ID Number:	
DEA Schedule:	
State:	
Issue Date:	
Expiration Date:	
Field of Licensure:	
NPI Number	

ID Type: ID Number: Field of Licensure:

Educational Commission for Foreign Medical Graduates (ECFMG), if applicable

ID Type:
ID Number:
DEA Schedule:
State:
Issue Date:
Expiration Date:
Field of Licensure:

Out of State License

ID Type:
ID Number:
DEA Schedule:
State:
Issue Date:
Expiration Date:
Field of Licensure:

Driver's License or ID (U.S. State Issued)

ID Type:
ID Number:
State:
Issue Date:
Expiration Date:

ID Type:
ID Number:
DEA Schedule:
State:
Issue Date:
Expiration Date:
Field of Licensure:

Keep this for additional licenses/certs.

Education and Training

Board Certifications

Name of Issuing Board:
Specialty Name:
Date Certified:
Year Recertified:
Expiration Date:
Certified:
Primary:
If not certified, describe your intent for certification and date of anticipated certification.:

Attestation Questions

Current Questions

Current Status, Training & Certification, Medicare/Medi-Cal Status	
○ Yes ○ No	1. Do you have a current, active professional California license to practice medicine?
○ Yes ○ No	2. Are you currently board certified or actively completing the board certification process for the specialty in which you are seeking clinical privileges through an ABMS recognized Board? For Advanced Practice Providers: Are you currently certified by the AANP, ANCC, PNBC, NCC, AACN, AMCB, NBCRNA, or NCCPA?
○ Yes ○ No	3. Do you currently have professional liability insurance that covers all of the privileges you will be requesting with at least $1,000,000 per occurrence and $3,000,000 aggregate?
○ Yes ○ No	4. : For Physicians: Have you successfully completed an ACGME or AOA accredited residency program; For Advanced Practice Providers: Have you successfully completed an accredited program required for licensure?
○ Yes ○ No	5. Have you established or plan to establish a residence and/or office within a reasonable distance of the hospital to provide continuous care for your patients commensurate with your practice privileges?

If you answer "No" to question 6 or "Yes" to questions 7 or 8, please provide an explanation.

○ Yes ○ No	6. Have you actively practiced clinical medicine during the prior two (2) years? **Explanation**
○ Yes ○ No	7. Is your professional California license subject to suspension (whether or not stayed), or subject to limitations, conditions, probation, sanction and/or requirements for monitoring or a chaperone? **Explanation**
○ Yes ○ No	8. Have you ever been, or are you currently, ineligible for payment by the Medicare and/or Medicaid (e.g. Medi-Cal in California) program as a result of (1) a felony conviction, which includes a no contest plea and a withhold of felony adjudication, and/or (2) a conviction of Medicare, Medicaid or insurance fraud and abuse, payment of civil money penalties for same, exclusion or other adverse actions taken from such programs (e.g. OIG, GSA)? **Explanation**

Documents	
Forms & Information	
Pre-Application Consent Acknowledgment:	☐ I have read and agree with the Consent Acknowledgment.
Pre-Application Attestation-101518:	☐ I have completed the online Pre-Appointment Attestations Questionnaire.
Upload Documents	
Copy of Current Pocket State License or Wall Certificate:	
DEA Registration:	
Driver's License or ID (U.S. State Issued):	
NPDB - PDS Report Disclosure (https://www.npdb.hrsa.gov/ext/selfquery/SQHome.jsp):	
Department Chair/Medical Director Written Request:	
Professional Color headshot photo (passport size):	
Other Documents:	

Review and Submit
Submit

ALAMEDA HEALTH SYSTEM and ALAMEDA HOSPITAL MEDICAL STAFFS
CONSENT ACKNOWLEDGMENT

I understand that (1) completing this questionnaire in no way obligates the Hospital and/or Medical Staff to afford me Medical Staff membership or privileges, (2) this questionnaire will be reviewed to assess if I meet the criteria to apply for Medical Staff membership and clinical privileges, (3) a decision that I do not meet the criteria to receive an application to apply for Medical Staff membership and clinical privileges is not an evaluation of my current competence, character, ethics and other qualifications, and (4) if I meet the criteria to apply for membership and privileges, I then am required to submit an application for membership and privileges that may require some duplication of documents or information and the Medical Staff then would evaluate my qualifications.

I understand and agree that I have the burden of producing information the Medical Staff deems necessary for a proper evaluation of my current competence, character, ethics, and other qualifications, and for resolving any doubts about such qualifications. To accomplish this, I have provided the information requested within this document and agree to provide such other information as may be requested by the Medical Staff at any time during the Request for Application process. I also agree that if the information submitted is no longer accurate and complete, to submit to the Medical Staff within thirty (30) days an update that includes such current and complete information.

I understand that if I do not submit this completed Request for Application along with the required supporting documents within thirty (30) days after I am sent the Request for Application, or if any information determined by Medical Staff as necessary to deem this Request for Application complete is not received within thirty (30) days after the request for such additional information is sent to me, this request for application automatically shall be considered void, no further processing shall take place, and this Request for Application shall be deemed withdrawn.

To the maximum extent permitted by law, I hereby release from liability any and all representatives of the Alameda Health System and its Medical Staff for their acts performed in connection with evaluating my request for Medical Staff membership and privileges at Alameda Health System To the maximum extent permitted by law, I hereby release from liability any and all individuals and organizations who provide information to representatives of Alameda Health System or its Medical Staff concerning my professional competence, ethics, character, and other qualifications, and I hereby consent to the release of such information.

With my signature, I affirm that I reviewed all of the information and documentation submitted in this Request for Application and that it is truthful and accurate. I understand that providing any false or misleading information in this Request for Application shall result in me not meeting criteria to receive an application, without any rights to further processing of that Request for Application. I understand that if I am found eligible to receive an application but during the application process information arises that was not revealed or conflicts with information provided in the Request for Application, the application will automatically be withdrawn without any rights to further processing. I understand that if the application for appointment is not returned to Medical Staff Services within thirty (30) days, I will be required to resubmit a pre-application for reconsideration.

Signature: _____ Date: _____

Signature #1 on true

Medical Staff/APP Voluntary Resignation Form

I hereby formally submit my voluntary resignation from the Medical Staff(s) listed below.

☐ *Alameda Health System ☐ Alameda Hospital

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

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

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

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

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

- □ Layoff / Reduction in Workforce
- □ Resignation / Termination of Employment
  (Notice: this completed form will be shared with AHS Human Resources)
- □ No longer with contracted group
  (Notice: this completed form will be shared with AHS Contracting Services)
- □ No longer utilize AHS Facilities
- □ Moved out of state
- □ Retired from practice
- □ Other _____

Provider's Printed Name	Department / Specialty	Medical Group Name *(if applicable)*

Provider's Signature	Date

Submit your completed form via email **medicalstaff@alamedahealthsystem.org** or fax: (510) 379-7440

Any request to change or rescind this voluntary resignation **MUST** be communicated verbally and in writing to the Medial Staff Office and your Division Chief/Department Chair prior to the date specified above.

You will receive a letter that confirms your voluntary resignation of membership and/or privileges after the resignation has been accepted by the Board. For any questions, please contact Medical Staff Services at (510) 437-6535.

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

Last updated 11/2025

REPORT/DISCUSSION: Medical Staff Reports

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

November 19, 2025

Berenice Perez, MD, AHS Chief of Staff

Cathy Pyun, DO, AH Chief of Staff

Overview

- Education: Medical Staff Responsibilities
- Peer Review Redesign Taskforce
- Committee Reports
  - Credentials Committee
  - Clinical Practice Council
  - Quality and Safety Committee
  - Disaster Action Response Team (DART)
  - Continuing Medical Education Committee
  - Graduate Medical Education Committee
- Resources Engagement After Care in the Hospital (REACH)
- Department of Obstetrics, Midwifery and Gynecology (OMG)

Alameda Health System and Alameda Hospital Medical Staffs

Medical Executive Committee Meeting – 11/19/25

COMPLIANCE:
Medical Staff Responsibilities

Jennifer Jackson – Manager, Medical Staff Services

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

Alameda Hospital and Skilled Nursing

Laws

- California Code of Regulations (CCR) Title 22
  - § 70703 – Organized Medical Staff

    Define the structure and responsibilities of a hospital's organized medical staff, which is responsible for patient care quality and must include physicians, dentists, and podiatrists. The medical staff must adopt written bylaws governing appointments, privileges, and appeals, and is required to have a physician available for emergencies. These rules also address how the staff works with other departments, such as having committees responsible for recommending medical privileges and developing policies
  - § 70705 – Licensure
  - § 70706 – CIDP, non-physician privileging, standardized procedures
- California Business and Professions Code
  - § 2282.5 – Self Governance
  - § 805 – Reporting of disciplinary actions
  - § 2282 – Professional Standards
  - § 2054 – Unauthorized use of titles
  - § 2282.5 – Prohibiting inducements
- California Evidence Code § 1157 - Protects confidentiality of peer review

Medical Staff Bylaws

- Compliance with Bylaws is crucial for the proper functioning and legal standing of the Medical Staff organization. Bylaws ensure consistent and agreed-upon (Medical Staff and Board approved) governance of the Medical Staff Organization.

- Rules and Regulations, Policies, and Forms further describe or detail the expected application/operation of the “rules”.

- Non-compliance may result in remedial, disciplinary, or automatic action depending on the occurrence.

Basic Responsibilities

Except for the Honorary, Emeritus and Administrative Staff, the ongoing responsibilities of each member of the Medical Staff and/or clinical privilege holder include:

a. FPPE/proctoring for new privileges.

b. Quality patient care

c. Abiding by the Medical Staff Bylaws, Rules & Regulations and Policies and Procedures.

d. Discharging in a responsible and cooperative manner such reasonable responsibilities and assignments imposed on the member by virtue of Medical Staff membership including committee assignments.

e. Timely preparing and completing medical records for all patients to whom the member provides care in the Health System.

f. Abiding by the lawful ethical principles of the California Medical Association or other applicable professional association.

g. Aiding in any Medical Staff approved educational programs for medical students, interns, resident physicians, resident dentists, staff physicians and dentists, nurses and other personnel although members who choose not to participate in professional graduate educational programs shall not be subject to denial of Medical Staff membership and privileges.

h. Working cooperatively with members, nurses, Health System administration and others so as to create a working environment conducive to quality patient care;

i. Providing continuing coverage for their patients as required by the Medical Executive Committee;

j. Refusing to engage in fee splitting or in improper inducements for patient referral;

k. Participating in continuing education programs as required by the Medical Executive Committee;

l. Participating in such emergency service coverage or consultation panels as may be required by the Medical Staff;

m. Cooperating in performance improvement activities and the accreditation process;

n. Serving as a proctor or other peer reviewer, and otherwise participating in medical staff peer review as reasonably requested;

o. Discharging such other staff obligations as may be lawfully established from time to time by the Medical Staff or Medical Executive Committee;

p. Providing information to or testifying on behalf of the Medical Staff or accused practitioner regarding any matter under investigation pursuant to these Bylaws, or which is the subject of a hearing pursuant to Article 9;

Basic Responsibilities (cont.)

q. Notify the Chief of Staff in writing no later than seven (7) calendar days from the occurrence of any of the following and providing such additional information as may be requested, regarding each of the following:

1. The revocation, limitation, or suspension of their professional license or DEA registration, any court order to cease or restrict their professional practice, any reprimand or other disciplinary action taken by any state or federal governmental agency relating to their professional license, or the imposition of terms of probation by any state.
2. Loss, summary suspension or summary restriction or denial of staff membership or privileges at any hospital or other health care institution, whether temporary or permanent.
3. Change in employment status such as termination and/or administrative leave.
4. To maintain quality and safety for our patients, if the individual Staff member or APP has been unable to provide clinical care for more than thirty (30) days they must notify the Department Chair or Division Chief and the Medical Staff Office in writing five (5) working days in advance of resuming clinical care within our health system.
5. Lapse, cancellation or change of professional liability coverage including any change of carrier or amount of coverage.
6. Receipt of a quality inquiry letter, an initial sanction, or notice of the commencement of an investigation, the filing of charges relating to health care matters or exclusion from any federally funded health care organization including Medicare or Medicaid (Medi-Cal), or other action by a Medicare peer review organization, the Department of Health Human Services, or any law enforcement agency or health regulatory agency of the United States or the State of California.
7. Receipt of notice of the filing of any suit against the practitioner alleging professional liability in connection with the treatment of any patient.
8. The development of any mental or physical condition or other situation that could compromise the practitioner's ability to perform the functions associated with their clinical privileges in a safe and effective manner.
9. The filing of any criminal misdemeanor or felony charges, including but not limited to DUI charges.

r. Protecting and preserving the confidentiality of patient health, services, and payment information consistent with federal and state confidentiality laws and the confidentiality policies of Alameda Health System.

Corrective Action

Corrective action is considered when reliable information indicates a provider may have exhibited acts, demeanor or conduct that is likely to be:

1. detrimental to patient safety or to the delivery of quality patient care within the hospital;
2. unethical or unprofessional, including but not limited to violations of patient privacy;
3. contrary to the Medical Staff Bylaws, Medical Staff rules or regulations, Medical Staff policies or the policies of the Health System that have been approved by the Medical Executive Committee; or
4. below applicable professional standards

Following the investigation of such, the MEC may take the following action:

a. determining no corrective action be taken and retaining the information;

b. deferring action for a reasonable time where circumstances warrant;

c. issuing letters of admonition, censure, reprimand, or warning, although nothing herein shall be deemed to preclude Department Chairs or Division Chiefs from issuing informal written or oral warnings outside of the mechanism for corrective action. In the event such letters are issued, the affected member may make a written response which shall be placed in the member's file;

d. recommending the imposition of terms of probation or special limitation on continued Medical Staff membership or exercise of clinical privileges, including, without limitation, requirements for co-admissions, mandatory consultation, or monitoring;

e. recommending reduction, modification, suspension or revocation of clinical privileges;

f. recommending reductions of membership status or limitation of any prerogatives directly related to the member's delivery of patient care;

g. recommending suspension, revocation or probation of Medical Staff membership;

h. taking summary action to restrict or suspend clinical privileges; and

i. taking other actions deemed appropriate under the circumstances.

Automatic Actions

Automatic Suspension

- Licensure, DEA, required certification/licensure expiration
- Felony charge
- Failure to appear/respond to meeting request
- Incomplete Medical Record
- Expired/Lack of malpractice
- Exclusion from Federal Health Care program
- Failure to follow Medical Staff Bylaws, rules/regulations, policies
- Failure to provide required information (i.e., physical/mental exam, documentation related to disciplinary action elsewhere)
- Failure to pay dues/assessments
- No longer party to an exclusive contract

Automatic Resignation

- Privilege Suspension for more than 60 days
- Failure to reappoint (incomplete reappointment)

Medical Staff Peer Review Redesign Taskforce Update November 3, 2025

Restructure Peer Review

- Consolidate peer review into a single, centralized PEC to improve case reviews and avoid multiple bodies with overlapping function
- Rebrand as “Physician Excellence Committee” (PEC) will handle formal peer case reviews, focusing on physician care rather than system issues
- Establishment of Department indicators

Peer Case Review Policy

- System issues (i.e., hospital-wide issues) should be extracted from the peer review process
- Only cases with potential inappropriate care are discussed during meetings; others are approved via a consent agenda
- Feedback is gathered from physicians with questions (both open and closed-ended) to understand their perspective and rate the care provided

Peer Case Review Indicators

- Two types of indicators: basket (general) and specific (department-focused), with each department selecting 3-5 specialty-specific indicators
- Indicators need to be clearly defined with inclusion/exclusion criteria, and tailored to the department’s needs
- Quality Department to vet cases against indicators established by the Medical Staff and assign to PEC members for review

Next Steps

- Finalize peer case review policy and process, case review worksheet, and case review indicators
- Update the department-specific indicators and update any over-identification or missed cases based on the current indicator system
- Review OPPE and FPPE to assess how they can improve the peer review system
- 12/4 meeting will focus on finalizing PEC membership and structure, and reviewing the policies for peer case review, ongoing professional practice evaluation (OPPE) and forced professional practice evaluation for concern (FPPE-C)

Credential Committee

Credentials and Privileges **APPROVAL**

The committee reviewed the credential files of the initial applicants, temporary privileges, and reappointments and recommended approval for Medical Staff membership and clinical privileges as listed. Additional credentialing activity, including leave of absences, completion of proctoring, additional privileges, category/staff status changes, and resignations was also reviewed and approved.

- 13 Initial Appointments
- 38 Reappointments
- 3 Requests for Leave of Absence/2 Requests to Return from Leave of Absence
- 3 Completions of FPPE/Proctoring and 1 Category Advancement
- 14 Privilege Modifications
- 2 Category Changes
- 24 Resignations

Credentials Committee

Medical Staff Documents:

- Medical Staff and Advanced Practice Provider (APP) Pre-application (revision)
- Pre-Application Consent Acknowledgement
- Medical Staff and Advanced Practice Provider (APP) Voluntary Resignation Form

Policies:

- Medical Staff Credentialing and Privileging of Providers
- Medical Staff Ongoing Monitoring and Evaluation of actions Related to Providers
- Medical Staff Routine Focused Professional Practice Review (FPPE)/Proctoring
- Name Change: Medical Staff Routine Focused Professional Practice Evaluation (FPPE)/Proctoring
- Medical Staff Credentialing Information Integrity and Data Security
- Retire/Replace: Medical Staff Credentialing Systems Control

Privileges:

- Anesthesiology (existing form updated)
- Radiology (existing form updated)
- Surgery Advanced Practice Providers (existing form updated)

Clinical Practice Council

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

- **22 medication protocols, policies and plans**
  - Immediate Use Compounding Policy for Nursing Personnel
  - Controlled Substance Management Policy (33916-1)
  - Pharmaceutical Waste Policy (34443-1)
  - System Pharmacy Scope Of Service Policy (34439-1)
  - ~~Subanesthetic Ketamine Use for Pain or Withdrawal Clinical Practice Guidelines (34486-1)~~
  - CEM MED Code Policy
  - AHS Fire Safety Management Plan
  - Conducting Monthly Tests of Emergency Diesel Generators
  - Emergency Generator Failure
  - Malignant Hyperthermia
  - HR Section 4.00 - Policy 4.21 Annual Competencies
  - HR Section 2.00 - Policy 2.51 Personal Leave of Absence
  - HR Section 1.00 – Policy 1.26 Rehire or Reinstatement to Employment
  - Phenobarbital Monotherapy for Alcohol Withdrawal Order Panel
  - Antimicrobial Stewardship Committee Approved Recommendations
  - AHS ONCBCN DOSE-ADJUSTED R-EPOCH (ETOPOSIDE - PREDNISONE - VINCRISTINE - CYCLOPHOSPHAMIDE - DOXORUBICIN + RITUXIMAB), 21 DAY CYCLES - HIV-RELATED LYMPHOMA
  - AHS ONCBCN USTEKINUMAB EVERY 12 WEEKS
  - AHS ONCBCN Pembrolizumab + GVD (Gemcitabine/VinORELBine/Liposomal DOXOrubicin) – Hodgkin Lymphoma
  - Benadryl Drug Monograph
  - ~~SBAR: Ketamine Order Panel Change Request~~
  - System Injectable Medication List
  - SBAR on VTE Prophylaxis

Quality and Patient Safety

Patient Safety Committee

- October 2025 Report
  - RCAs, operational issues that affect quality and patient safety

Quality Steering Committee

- October 2025 Report
  - Monitoring
    - OKR/KPI Dashboards
    - Performance Improvement Team Reporting

Alameda Health System
Disaster Action Response Team
Report to
Medical Executive Committee

M. Kelley Bullard, MD

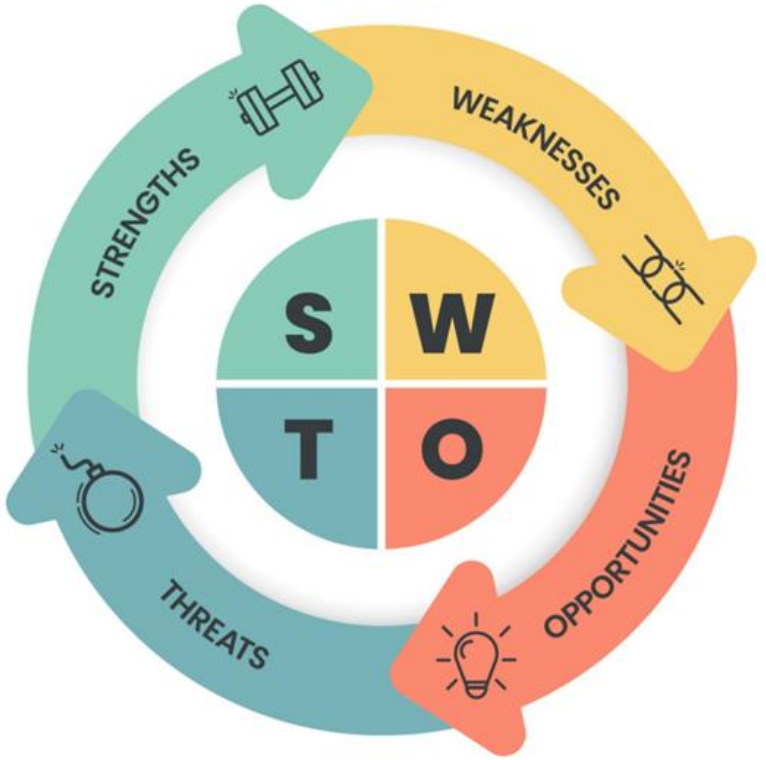
November 19, 2025

Disaster Action Response Team Report

The focus of DART is to build infrastructure solely for disasters that involve mass casualties.

As the processes are built, we train staff with scenario-based drills.

Next: Strengths, Weaknesses, Opportunities, Threats for DART in 2025



Disaster Action Response Team Report

Support Needed

- **Patient Care:**
  - Areas of Care Model: all patient facing staff need training
  - Partner with Environmental Health and Safety – Dyad Clinical and Operational processes to choreograph a response (e.g. active shooter)

- **Operations:**
  - Environmental Health and Safety – Strengthen operational / clinical liaison for standard work
  - Administrative support to build sustainable processes

Alameda Health System
Continuing Medical Education (CME) Committee
Semi-Annual Report to
Medical Executive Committee

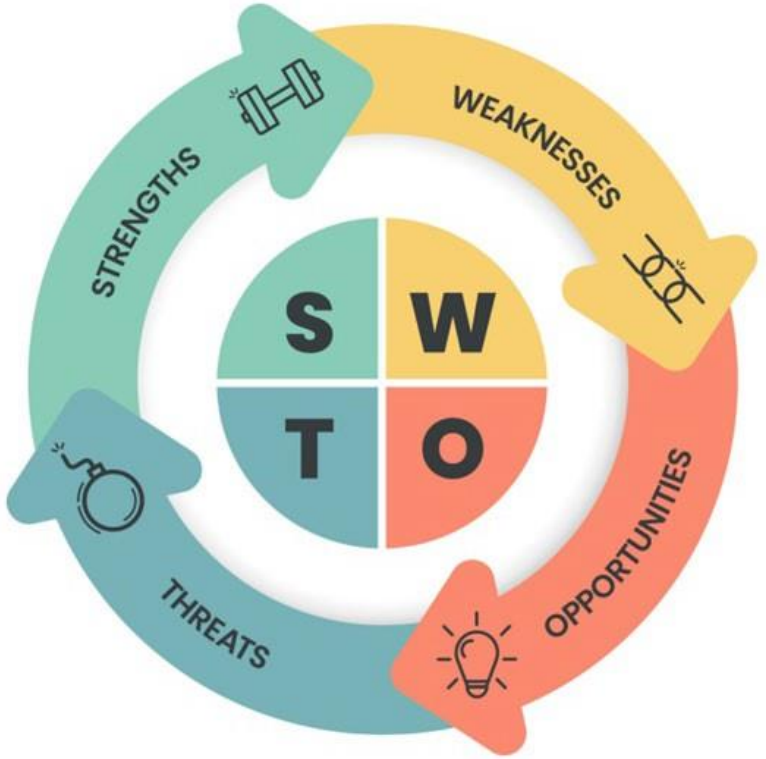
Pamela Simms-Mackey, MD, FAAP
Jena Resner, MD

November 19, 2025

Continuing Medical Education Report

CME Mission

The Continuing Medical Education (CME) Program at Alameda Health System (AHS) supports the institutional mission of caring, healing, teaching, and serving all by providing independent, valid, relevant and evidence-based education designed to address the practice gaps and educational needs of AHS physicians and medical staff in order to advance their competence, strategies, skills and professionalism in the delivery of compassionate and high quality patient care.



CME Committee Composition

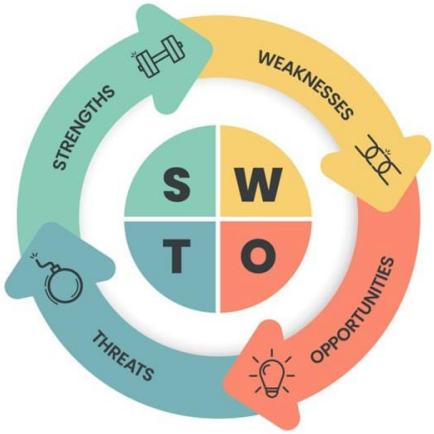
Name (Physicians)	Title	Dept/Program
Benny Liu, MD	Chair, CME Committee Interim Chief of Division of Gastroenterology and Hepatology	Medicine/Gastroenterology
Pamela Simms-Mackey, MD	Chair, Pediatrics DIO & Chief of GME	Pediatrics
Julie Gesch, MD	Emergency Medicine Faculty Medical Director Clinical Simulation	Emergency Medicine
Ayemoethu Ma, MD	Breast Surgeon Director Breast Surgery	Surgery

Name (Staff)	Title	Dept/Program
Ken Coelho	ADIO and Director of GME/CME	Graduate Medical Education (GME)
Satira Dalton	VP Physician Services	Medical Staff Services
Jena Resner, MD	CME Manager (non-voting)	Continuing Medical Education (CME)
Sherlana Springer-Sanders	CME Coordinator (non-voting)	Continuing Medical Education (CME)

CME Committee Report – Cont.

Strengths

- CME Program under multidisciplinary physician leadership has continued to be reaccredited by ACCME/CMA for a 4-year term (May 2024-2028) and remains in good standing.
- American Board of Pediatric (ABP) Maintenance of Certificate (MOC) points are now awarded for Pediatric Grand Rounds
- CME sessions in 2025 have increased along with expanded department collaborations with **175** CME sessions conducted, awarding **177** CME credits (hours of education) with **4500** cumulative attendees (learners) of which **77%** are physicians and **23%** other medical staff**,** in alignment with AHS mission of teaching.
- **12** regularly scheduled weekly and monthly CME activities conducted across **12** clinical departments. Education focus is on clinical updates, professionalism and addressing healthcare disparities and implicit bias, in alignment with AHS mission of caring and serving all. Regular departmental CME supports physician and staff wellness and team building.
- **136** unique speakers/presenters in 2025 includes AHS attending physicians, staff, resident physicians and students, as well as guest faculty from other institutions.

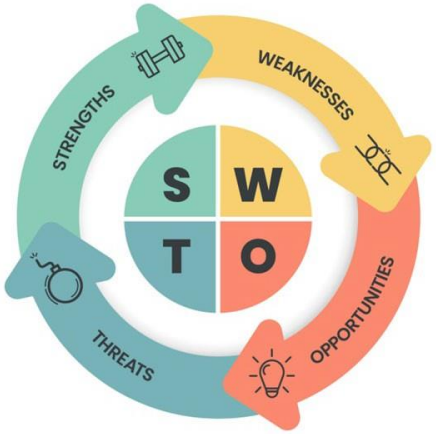


CME Committee Report – Cont.

Strengths continued

Goals Achieved

- **98%** of attendees indicate plans to make one or more change or improvement in practice after attending CME activity. [Detailed reports and examples provided to dept. chairs and planners]
- **95%** indicate on follow up evaluation they made one or more change or improvement in practice after attending a prior session. [Detailed reports and examples sent to each dept.]
- **99%** rated CME sessions as overall, “outstanding” or “good.” Comments are enthusiastic for content and speakers.
- Evaluations show that CME activities and the CME program overall are meeting the CME mission to improve patient care practices.
- Continued compliance with the CME standards independent from commercial influence.



Alameda Health System
Graduate Medical Education
Semi-Annual Report to
Medical Executive Committee

Pamela Simms-Mackey, MD, FAAP

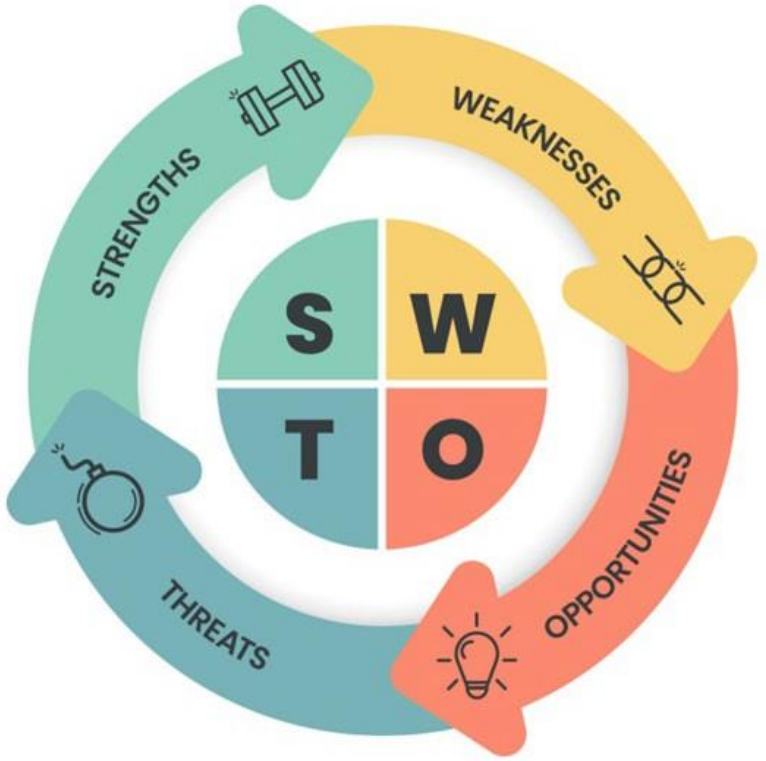
DIO/Chief of GME

November 19, 2025

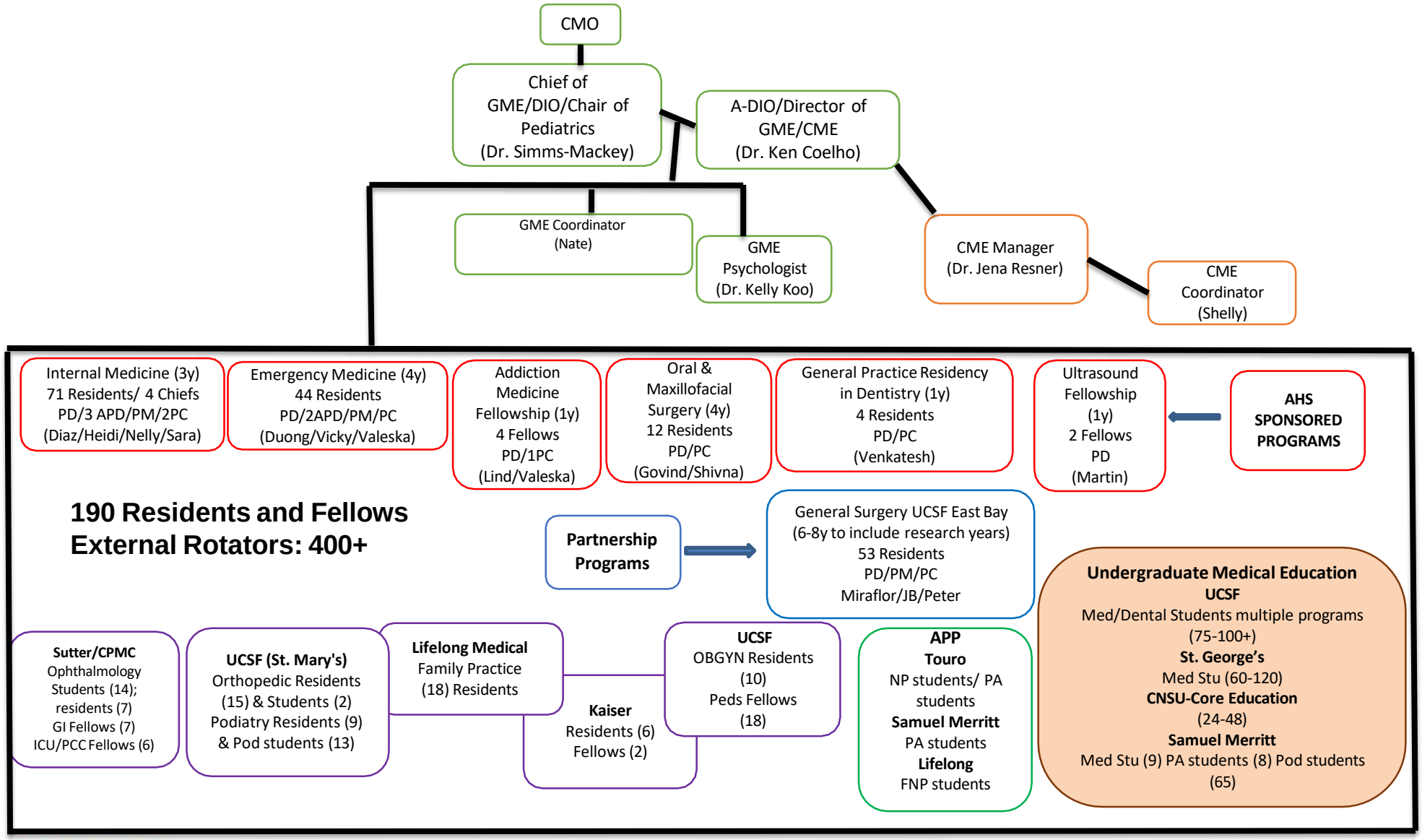
Graduate Medical Education Report

GME Mission

The Graduate Medical Education Department at Alameda Health System-Highland Hospital provides oversight and support for our training programs to recruit clinicians who reflect our world today and provide the highest quality education and training in delivering care to the underserved and working to eliminate healthcare disparities, while creating a learning environment committed to the institutional mission of Caring, Healing, Teaching, Serving ALL.



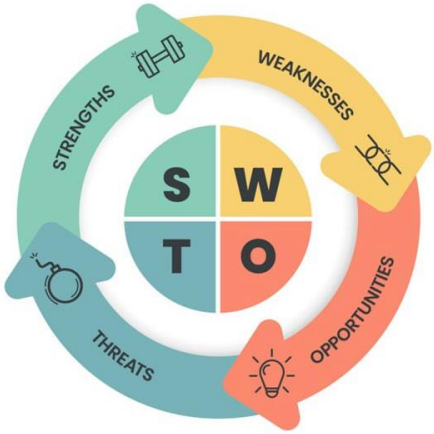
Graduate Medical Education Organizational Chart



Graduate Medical Education Report – Cont.

Strengths

- All programs in good standing with no ACGME or CODA citations
- Addiction Medicine expansion grant 2->4 fellows
- Addiction Medicine successful ACGME site visit
- Institutional Support
- Sharing of knowledge across programs
- Robust educational curriculum with respect to eliminating healthcare disparities and preparation for careers working with underserved populations.
- Residents/Fellows
  - National presentations, competitions
  - Matching into competitive fellowships
  - Pipeline to Medical Staff
- Obtaining CalMedForce and Song Brown Grants annually (cumulative over $20,000,000)



ALAMEDA HEALTH SYSTEM

REACH

Resources and Engagement After Care in the Hospital

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

Feedback

"This is great! Thank you so much for calling I feel cared for, I didn't know this even existed"

"Thank you so much for listening, I really appreciate the call."

"If you guys are doing all of this, then maybe I should transfer my care to Highland"

"Thank you for calling. I really appreciated that!"

"I appreciate you talking through everything and going over my labs and imaging..."

"Thank you for being kind enough for thinking about me and my health even when I'm not in the hospital"

"I can't believe you are helping me"
(after spending more than 45 mins calling pharmacy)

Department of Obstetrics, Midwifery, and Gynecology (OMG)

ALAMEDA HEALTH SYSTEM

Alameda Hospital Medical Staff

- The Medical Executive Committee met in November 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

REPORT/DISCUSSION: Quality Reports

BOT Executive Summary: Quality Report
Ana Torres, Vice President of Quality
November 20, 2025

Key Point 1: The table below summarizes the performance of the metrics on the 2026 FYTD (through September) QPSC OKR report.

Key Result	Performance		
	Met goal	≥ Baseline	Did not meet goal
Total Patient Harms		✓	
Sepsis Bundle Compliance		✓	
Sepsis Mortality (O/E)			✓
Readmission, All Cause			✓
Wait for New Appointment – Specialty Clinics	Metric is still being developed.		
Wait for New Appointment – Primary Clinics			
ED Boarding – Community Hospitals		✓	
ED Boarding- Highland Hospital			✓
HRSN Screening	✓		
Likelihood to Recommend	✓		

Note: YTD Data is inclusive of August for all metrics except HRSN.

HARMS

Harms were reported in the following categories: Surgical Site Infections, Falls with Injury, Hospital Acquired Pressure Injuries (HAPI), and Behavioral Events with Injury. There are performance improvement teams actively working on implementing evidence-based practices and monitoring processes to ensure effectiveness of actions taken.

SEPSIS BUNDLE COMPLIANCE

The sepsis bundle compliance is one percentage point from meeting the goal. To further improve performance, the sepsis performance improvement team identified two workflow issues that were addressed in an Epic upgrade in late September.

SEPSIS MORTALITY

There are ongoing efforts to improve the sepsis mortality ratio. All mortalities are reviewed to identify potential care gaps and to determine whether the mortality was related to sepsis or a comorbidity. There are also efforts to improve the documentation of comorbidities.

READMISSIONS

The All Cause 30-day Readmission Rate did not meet the goal. Readmission reduction efforts include improving discharge teaching and addressing the site-specific cause of readmission. Alameda Hospital has the highest readmission rate due to a higher prevalence of elderly patients and patients admitted from SNFs. The Improvement plan includes: engaging patients

and families in palliative care, partnering with community SNFs, and conducting discharge education for patients admitted with congestive heart failure.

WAIT TIME FOR NEW APPOINTMENT – Specialty & Primary
This metric is still under review and validation.

ED BOARDING
The ED Boarding times are being addressed by the systemwide Throughput Steering Committee. The committee has expanded to include the following five taskforces:

- Access to Primary / Specialty / Operating Room
- Throughput and Readmissions
- Surge Red Process
- System Bed Capacity
- Length of Stay / Care Coordination.

Health-Related Social Needs (HRSN)
The HRSN Screening met the goal. Patients that screen positive for one of HRSN are connected with community services via FindHelp.

LIKELIHOOD TO RECOMMEND:
The Likelihood to Recommend metric met the goal. This metric measures the Likelihood to Recommend in Acute Care, Emergency Department and Ambulatory Surgery. The improvement plan focuses on addressing responsiveness of staff, leader rounding, the discharge communication process which addresses several patient satisfaction areas, reinforcement of GIFT, and standards of behavior with accompanying customer service in-service training.

Key Point 2: There were no regulatory surveys in October 2025.

FY 2026 QPSC OKR Dashboard

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

Safe Care - Caring, Healing, Teaching All		Performance			Goals		
OBJECTIVES	KEY RESULTS	Aug 2025	FY26 YTD	FY2025 Actual	Improvement	Benchmark	Accountable Leaders
Provide safe care	Total Patient Harms*	24	79	410	204	164	R. Lofton, L. Laurent
	Bundle Compliance Sepsis Early Management	72.73%	74%	55%	75%	88%	R. Lofton, L. Laurent
	Sepsis Mortality O/E Ratio	1.05	1.07	1.05	1.00	0.93	R. Lofton, L. Laurent
Timely, Effective, and Efficient Care							
OBJECTIVES	KEY RESULTS	Aug 2025	FY26 YTD	FY2025 Actual	Improvement	Benchmark	Accountable Leaders
Promote wellbeing	All Cause 30-day readmission rate	13.23%	12.34%	12.26%	11.69%	11.12%	D. Littlepage, A. Wu
Provide accessible care	% of Specialty Clinics with an average of less than or equal to 15 days for New Patients Appointments*	28%		11.76%		80%	T. Amoruwa, P. Mack
	% of Adult Primary Care Clinics with an average of less than or equal to 10 days for New Patients Appointments *	0%		0%		100%	T. Amoruwa, P. Mack
	ED Boarding Time for Admitted Patients Community Hospital	2:20	2:27	3:10	2:12	1:30	R. Lofton, A.Wu
	ED Boarding Time for Admitted Patients Highland	8:23	8:39	8:25	8:28	4:00	R. Lofton, A. Wu
Equitable Care							
OBJECTIVES	KEY RESULTS	Aug 2025	FY26 YTD	FY2025 Actual	Improvement	Benchmark	Accountable Leaders
Serving all: Deliver equitable care	Health-related Social Needs Assessment Completed on Inpatients	83.50%	84.00%	64.58%	81.95%	89.40%	R. Lofton
	% of Inpatients positive for at least 1 Health-related Social Need	29.10%	30.00%	NA			
Patient-Centered Care							
OBJECTIVES	KEY RESULTS	Aug 2025	FY26 YTD	FY2025 Actual	Improvement	Benchmark	Accountable Leaders
Be the most welcoming system to receive care	Likelihood to recommend care composite	76.40%	76.17%	72.54%	73.54%	79.67%	R. Lofton, A. Ng

Fiscal Year Starts in July 1 and Ends June 30

FY26 YTD is results from July 2025 to FY26YTD

* AHS' ultimate goal is Zero Hospital Acquired Harm

Fiscal Year 2025

OKR Metric Definitions for QPSC

Metric	Definition	GOAL	
		Improvement	Benchmark
Patient Harm	The number of potential health-care acquired patient harms Includes: CLABSI, CAUTI, MRSA BSI, C-Diff, SSI for Acute Med-Surg/Critical Care, and Patient Falls with injuries, Hospital Acquired Pressure Injuries and Behavior Events that result in Injury for all areas (practically, not inclusive of ambulatory)	353 50% gap reduction to the 50th Percentile	293 NHSN 2022 50th Percentile
Bundle Compliance Sepsis Early Management	A set of guidelines that hospitals use to manage patients with severe sepsis or septic shock. The guidelines focus on early recognition and intervention to save lives and limbs. This is an "all-or-nothing" measure, meaning that hospitals must adhere to all elements of the bundle to receive credit. Follows CMS/TJC SEP 1 Definition	CMS National 7/2023-6/2024 75th Percentile	CMS National 7/2023-6/2024 95th Percentile
Sepsis Mortality O/E Ratio	The observed to expected (O:E) sepsis mortality ratio is a comparison of the actual number of sepsis-related deaths in a hospital (observed) to the predicted number of deaths (expected). Performance is considered better than expected if the O:E ratio is less than 1, and worse than expected if the ratio is greater than 1. A lower O:E ratio indicates that more people are surviving conditions that would otherwise be fatal.	NA	1.04 National Mean per Vizient
All-cause 30 day Readmissions Rate	Percentage of inpatient acute med-surg encounters, regardless of payer type, with an unplanned readmission to any AHS facility within 30 days for any cause among encounters for acute care inpatients with a principal discharge diagnosis/procedure for a clinical classification category in the Cardiorespiratory, Cardiovascular, Medicine, Neurology, or Surgery/Gynecology cohort. *Note:* This measure approximates, but likely does not match, the value of the	11.56% 50% gap reduction to the 50th Percentile CMS Hospital Compare	11.12% 50th Percentile CMS Hospital Compare
% of Specialty Clinics with an average of less than or equal to 15 days for New Patients Appointments*	The average of days between when a new patient to AHS requests an appointment with a specialty to the day of appointment. This metric tracks the percentage of clinics that are, on average, less than or equal to 15 business days		80% of clinics have a monthly average equal to or less than 15 business days
% of Adult Primary Care Clinics with an average of less than or equal to 10 days for New Patients Appointments *	The average of days between when a new patient to AHS requests an appointment with a primary care to the day of appointment. This metric tracks the percentage of clinics that are, on average, less than or equal to 10 business days		100% of clinics have a monthly average equal to or less than 10 business days
ED Boarding Time Time in ED from Decision to Admit to Inpatient Bed	Median time from Decision to Admit to departure from the emergency department for admitted patients. Decision to Admit = First Admit Disposition Admit = Time patient admitted to Inpatient Unit	2:20 Community Hospitals: 50% gap closure to pre=pandemic performance	1:30 Community Hospitals: Pre-pandemic Performance 4:00 Highland:
Rate of Inpatients screened for health-related social needs (food, housing, transportation, safety, utilities) ↑	The percentage of inpatient acute medical/surgical admissions where the patient is screened for social determinents of health: food insecurity, housing, transportation, safety and utilites	75% Internal Benchmark: Best Performing Campus rate for FY24	90% Internal Benchmark: Monthly Rate achieve by Best Performing Campus
Rate of patients who reported they would “definitely” recommend AHS	Percentage of patients who would recommend AHS (includes rehab, acute, ambulatory, ED, outpatient surgery, dental, radiology)	78.78% 2% Improvement over FY24 Baseline	79.16% 75th Percentile for Inpatient Med Surg 50th Percentile for all other areas based on Press Ganey National Database

QPSC BOT Executive Summary: Post-Acute Quality Report
Richard Espinoza, NHA, CAO Post-Acute Services
11/19/25

Key Point 1: **Quality Star ratings – Overall, Health Inspection, Quality Measures, Staffing: al 5 stars – all sites**

All AHS SNF/SA sites are Overall 5-star CMS rated, QM 5 star rated, Health inspection 5 star rated and staffing 5 star rated – perfect score card for all sites

Key Point 2: **CDPH visits:**

4 visits – 1 for Park Bridge, 2 for Fairmont and 1 for South shore – all pending

Key Point 3: **US News and World Report – Best Nursing Homes 2026:**

All AHS SNF/SA units were recognized and rated Best Long-Term Care from US News in November. The AHS SNF/SA sites were recognized by Newsweek for Best Nursing Homes 2026 in October

Key Point 4: **ARU Press Ganey Detail scores:**

Continued efforts with the patient experience team in increasing the n number. Overall score of 94.05 (91% is goal) and likelihood of recommending 91.67 (100% is goal). The team has an action plan for the scores less than 100% as part of their QAPI plan.

Key Point 5: **ARU Monthly Standard Metrics**:

3 falls – no injuries
0 Catheter Associated Urinary Tract Infection
0 Clostridium Difficile (C-diff)
0 med errors
0 HAPI (Hospital Associated Pressure Injuries)

DISCUSSION: Harm - Falls and HAPI

No Written Materials

Agenda Item D Falls and HAPI

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.

DISCUSSION: QIP Audit Results

Board of Trustees Executive Summary: QIP – Audit and Submission, 2024.

Natalie Curtis, MD

Medical Director of Value Based Care

November 19th, 2025

Key Points

The Quality Incentive Program (QIP) is a complex, increasingly difficult, pay-for-performance quality program worth ~$60M/year

- Supplemental funding accounts for ~36% of AHS's overall revenue and includes dollars from QIP
    - Funds are in our base budget, if program targets are not met, then AHS experiences a funding loss
- These programs exist to support a shift to high-value, low-acuity, preventative services
    - 70% of metrics lie within ambulatory care services
    - Increasing accountability to reduce racial inequities
- Measures follow the California Department of Health Care Services' (DHCS) Strategic Plan
    - Bold Goals – DHCS priorities centered around closing disparity gaps in maternal-child health outcomes and behavioral health screening and treatment
    - Increasingly, targets must be achieved overall and for disparity subpopulations

AHS successfully completed audit activities for the CY2024 QIP Report and DHCS's review of the audit was accepted

- AHS Bi-Annual Audits Conducted by DHCS - Increased scrutiny on data integrity that carries financial risk
- Audit includes comprehensive review of the data source code for metric logic, patient level data review, evaluation of AHS's management of practitioner data, tracking of data by race/ethnicity

AHS Achieved a Quality Score of 100% for CY 2024 and will receive 100% of allocated supplemental funding

- AHS was the top performer among all healthcare systems achieving the highest number of performance targets compared to other systems
- Through driving improvement AHS has been recognized for its performance in domains of maternal/perinatal health, pediatrics, and equity
    - The Safety Net Institute invited AHS to share best practices related to advancing maternal and child health based on the success of our midwife run Pregnancy Assessment Clinic

- For work related to health equity, AHS will be a recipient of the 2024 Quality Leader Awards for breast cancer screening improvement and collaborative co-design. The (QLA) is an annual recognition program by the California Health Care Safety Net Institute (SNI) and the California Association of Public Hospitals and Health Systems (CAPH) to honor innovative and high-quality initiatives in California's public health care systems

Agenda Item C1 OKRs

Alameda Hospital FY 2026 Detailed Quality OKR and KPI Dashboard

Vision: Alameda Health System will be recognized as a world-class patient and family centered system of care that promotes wellness, eliminates disparities and optimized the health of our diverse communities.

Safe Care - Caring, Healing, Teaching All			Performance			FY26 Goals	
OBJECTIVES	KEY RESULTS	Detailed KPIs	Aug 2025	FY26 YTD	FY25 Actual	Improvement	Benchmark
Provide safe care	Eliminate Patient Harms	Total Patient Harms	3	4	27	24	14
		CLABSI # Events/SIR	0/0	0/0	0/0	0/0.317	0/0
		CAUTI # Events/SIR	0/0	0/0	1/0.56	0/.55	0/.264
		MRSA # Events/SIR	0/0	0/0	0/0	0/0.658	0/0.335
		C. Difficile # Events/SIR	0/TBD	0/0	5/0.75	3/.58	2/.346
		SSI # Events/SIR	0/0	0/0	1/1.23	1/1.324	0/.849
		Falls with Injury/% Per 1000 Days	1/0.96	1/0.48	10/0.53	9/0.477	3/0.24
		Reportable HAPI #/% per 1000 Discharges	1/4.31	1/2.16	0/0	0/0	0/0
		Behavior Events with Physical Injury	1/0.96	2/0.96	10/0.76	9/0.684	8/0.608
		HAPI all Stages #/% per 1000 Discharges	6/25.862	9/19.44	50/18.22	45/16.398	40/14.576
		Serious Safety Events (F or Greater)	0	1	0		
	Reduce Mortality from Sepsis	Sepsis Mortality Observed:Expected & Total Deaths	NA	0.73	1.04	1	0.93
		Bundle Compliance Sepsis Early Management	100.00%	94.12%	77.00%	0.75	0.88
	Embed Critical Behaviors	Hand Hygiene Compliance	83.68%	76.34%	82.62%		95%

Fiscal Year Starts in July 1 and Ends June 30

FY26 YTD is results from July 2025 to Aug 2025

Timely, Effective, and Efficient Care			Performance			FY26 Goals	
OBJECTIVES	KEY RESULTS	Detailed KPIs	Aug 2025	FY26 YTD	FY25 Actual	Improvement	Benchmark
Promote wellbeing	Provide the right care at the right time	All Cause 30-Day Readmission Rate	16.67%	15.11%	14.82%	11.69%	11.12%
Provide accessible care	Minimize Time Spent Waiting for our Patients	ED Boarding Time for Admitted Patients	2:35	2:29	2:55	2:12	1:30
Equitable Care			**Performance**			**FY26 Goals**	
OBJECTIVES	KEY RESULTS	Detailed KPIs	Aug 2025	FY26 YTD	FY25 Actual	Improvement	Benchmark
Serving all: Deliver equitable care	Health-related social needs recognized and addressed	Health-related social needs assessment completed on inpatients	68.80%	63.90%	49.50%	82%	89%
		% of patients that screened positive for at least 1 Health-related social needs	11.00%	9.00%	NA		
Patient-Centered Care			**Performance**			**FY26 Goals**	
OBJECTIVES	KEY RESULTS	Detailed KPIs	Aug 2025	FY26 YTD	FY25 Actual	Improvement	Benchmark
Be the most welcoming system to receive care	Optimize performance regarding patient experience	Likelihood to recommend Acute	73.37%	75.77%	62.99%	63.89%	71.10%
		Likelihood to recommend ED	66.67%	70.30%	64.40%	65.40%	71.60%
		Communication with Nurses	69.96%	70.74%	69.60%	70.60%	79.90%
		Communication with Providers	71.68%	72.18%	75.91%	76.91%	79.20%

Fiscal Year Starts in July 1 and Ends June 30

FY26 YTD is results from July 2025 to Aug 2025

Fiscal Year 2025

OKR Metric Definitions for QPSC

Metric	Definition	GOAL	
		Improvement	Benchmark
Patient Harm	The number of potential health-care acquired patient harms Includes: CLABSI, CAUTI, MRSA BSI, C-Diff, SSI (Colon, C-Section, Gallbaldder, Hysteretomy, Spinal Fusion. Small Bowel)for Acute Med-Surg/Critical Care, and Patient Falls with injuries, Reportable Hospital Acquired Pressure Injuries and Behavior Events that result in Injury for all areas (practically, not inclusive of ambulatory)	HAI equal to or better than 75th percentile Falls, HAPI, Behavior Events 10% reduction	HAI equal to or better than 50th percentile Falls, HAPI, Behavior Events 20% reduction
CLABSI # Events/ SIR	A primary bloodstream infection (that is, there is no apparent infection at another site) that develops in a patient with a central line in place . #: Number of infections that occurred SIR: Standardized Infection Ratio compares the actual number of infections to the predicted number of infections. The predicted number is risk adjusted. Results less 1 are desirable	NHSN National 25th Percentile	NHSN National 10th Percentile
CAUTI # Events/ SIR	an infection of the urinary tract caused by a tube (urinary catheter) that has been placed to drain urine from the bladder. #: Number of infections that occurred SIR: Standardized Infection Ratio compares the actual number of infections to the predicted number of infections. The predicted number is risk adjusted. Results less 1 are desirable	NHSN National 50th Percentile	NHSN National 25th Percentile
MRSA # Events/ SIR	Potential hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA) staph infection that is difficult to treat because of resistance to some antibiotics. #: Number of infections that occurred .Serving as a proxy measure tied to patient days, reflecting the hospital's ability to prevent transmission and invasive infection rather than serving as a confirmed clinical diagnosis. NHSN defines hospital-onset (HO) as the first positive laboratory test for an organism collected on or after hospital day 4 of admission, which reasonably attributes the event to the hospitalization	NHSN National 50th Percentile	NHSN National 25th Percentile
C. Difficile # Events/ SIR	Potential hospital acquired infection that causes diarrhea and colitis (an inflammation of the colon). #: Number of infections that occurred This serves as a proxy for infection risk in the hospital rather than a confirmed diagnosis. Hospital-onset (HO) is defined as the first positive laboratory test for an organism collected on or after hospital day 4 of admission, which reasonably attributes the event to the hospitalization	NHSN National 75th Percentile	NHSN National 50th Percentile
SSI # Events/ SIR	an infection that occurs after a Colon, C-Section, Gallbaldder, Hysteretomy, Spinal Fusion, Small Bowel surgery in the part of the body where the surgery took place. Excludes superficial infections. Attributed to date of procedure. #: Number of infections that occurred attributed to month procedure performed SIR: Standardized Infection Ratio compares the actual number of infections to the predicted number of infections. The predicted number is risk adjusted. Results less 1 are desirable	NHSN National 75th Percentile	NHSN National 50th Percentile
Falls with Injury/ # % Per 1000 Days	Patient Fall reported via Midas Safety Alert. # of Events / Rate: Number of events divided by number of patient days times 1000	10% improvement as compared to Fiscal Year 2025	NDNQI 25th Percentile
Reportable HAPI #/% per 1000 Discharges	Hospital Acquired Pressure Ulcers Stage 3 or 4 ulcer, acquired after admission to a health facility, excluding progression from Stage 2 to Stage 3 if Stage 2 was recognized upon admissionreported via Midas Safety Alert. This includes deep tissue injuries and unstageable pressure injuries that progress to a stage 3 or 4. # of Events / Rate: Number of events divided by number of patient discharges times 1000	10% improvement as compared to Fiscal Year 2025	20% improvement as compared to Fiscal Year 2025
Behavior Events with Physical Injury	Behavior events that resulted in physicial injury via Midas Safety Alerts # of Events/Rate: Number of events divided by number of patient days times 1000	10% improvement as compared to Fiscal Year 2025	20% improvement as compared to Fiscal Year 2025
HAPI #/ % per 1000 DCs	Hospital Acquired Pressure Ulcers reported via Midas Safety Alert. # of Events / Rate: Number of events divided by number of patient discharges times 1000	10% improvement as compared to Fiscal Year 2025	20% improvement as compared to Fiscal Year 2025
Serious Safety Events (F or Greater)	Midas Safety Alerts where an event occurred that may have contributed to or resulted in temporary harm to any involved parties and required initial or prolonged hospitalization	NA	Zero

Fiscal Year 2025

OKR Metric Definitions for QPSC

Metric	Definition	GOAL	
		Improvement	Benchmark
Sepsis Mortality O/E Ratio	The observed to expected (O:E) sepsis mortality ratio is a comparison of the actual number of sepsis-related deaths in a hospital (observed) to the predicted number of deaths (expected). Performance is considered better than expected if the O:E ratio is less than 1, and worse than expected if the ratio is greater than 1. A lower O:E ratio indicates that more people are surviving conditions that would otherwise be fatal.	Observed Mortality equal to Expected Mortality	Vizient National FY2025 50th Percentile
Bundle Compliance Sepsis Early Management	A set of guidelines that hospitals use to manage patients with severe sepsis or septic shock. The guidelines focus on early recognition and intervention to save lives and limbs. This is an "all-or-nothing" measure, meaning that hospitals must adhere to all elements of the bundle to receive credit. Follows CMS/TJC SEP 1 Definition	CMS National 7/2023-6/2024 75th Percentile	CMS National 7/2023-6/2024 95th Percentile
Hand Hygiene Compliance	Hand hygiene is a leading way to reduce the spread of pathogens in healthcare settings. It includes: Washing hands with soap and water and Using an antiseptic handrub. Hand hygiene compliance is the percentage of times that a person performs hand hygiene when an opportunity arises. It's calculated by dividing the number of hand hygiene actions performed by the total number of opportunities.		The level of adherence crucial for patient safety and preventing healthcare-associated infections.
All-cause 30 day Readmissions Rate	Percentage of inpatient acute med-surg encounters, regardless of payer type, with an unplanned readmission to any AHS facility within 30 days for any cause among encounters for acute care inpatients with a principal discharge diagnosis/procedure for a clinical classification category in the Cardiorespiratory, Cardiovascular, Medicine, Neurology, or Surgery/Gynecology cohort. *Note:* This measure approximates, but likely does not match, the value of the corresponding CMS readmission measure.	50% gap reduction to the 50th Percentile CMS Hospital Compare	50th Percentile CMS Hospital Compare
NTSV Cesarean Section Rate	he NTSV C-section rate is the percentage of live babies born to women in their first pregnancy who meet the following criteria: Born at or after 37 weeks gestation Singleton (no twins or more) In the vertex presentation (no breech or transverse positions)	QIP Target: 10% gap closure between AHS CY2024 performance and 90th Percentile	90th Percentile
ED Boarding Time Time in ED from Decision to Admit to Inpatient Bed	Median time from Decision to Admit to departure from the emergency department for admitted patients. Decision to Admit = First Admit Disposition Admit = Time patient admitted to Inpatient Unit	**Community Hospitals:** 50% gap closure to pre=pandemic performance **Highland:** 50% gap closure to TJC benchmark	**Community Hospitals:** Pre-pandemic Performance **Highland:** TJC guidance for max boarding time
Rate of Inpatients screened for health-related social needs (food, housing, transportation, safety, utilities) ↑	The percentage of inpatient acute medical/surgical and behavioral health admissions where the patient is screened for all 5 social determinents of health: food insecurity, housing, transportation, safety and utilites	10% improvement as compared to Fiscal Year 2025	20% improvement as compared to Fiscal Year 2025
% of patients that screened positive for at least 1 Health-related social needs	The percentage of inpatient acute medical/surgical and behavioral health admissions where the patient screened positive for 1 or more health-related social needs: food insecurity, housing, transportation, safety and utilites	NA - Establishing Baseline	NA-Establishing Baseline
Acute: Rate of patients who reported they would “definitely” recommend AHS	Percentage of discharged inpatients who would recommend AHS	1% improvement as compared to Fiscal Year 2025	**Community Hospitals:** National 50th Percentile **Highland:** National 75th Percentile
Same Day Surgery:Rate of patients who reported they would “definitely” recommend AHS	Percentage of same day surgery patients who would recommend AHS	1% improvement as compared to Fiscal Year 2025	National 50th Percentile
Emergency: Rate of patients who reported they would “definitely” recommend AHS	Percentage of Emergency patients who would recommend AHS	1% improvement as compared to Fiscal Year 2025	National 50th Percentile

Fiscal Year 2025

OKR Metric Definitions for QPSC

Metric	Definition	GOAL	
		Improvement	Benchmark
Communication with Nurses	A domain of HCAHPS which measures patients' perceptions of how well patients feel that their nurses: explained things clearly, listened carefully, and treated the patient with courtesy and respect. Percent of surveyed Inpatient discharges where patient response was highest of the scale	1% improvement as compared to Fiscal Year 2025	National 50th Percentile
Communication with Providers	A domain of HCAHPS which measures patients' perceptions of how well patients feel that their provider(s): explained things clearly, listened carefully, and treated the patient with courtesy and respect. Percent of surveyed Inpatient discharges where patient response was highest of the scale	1% improvement as compared to Fiscal Year 2025	**Community Hospitals:** National 50th Percentile **Highland:** National 90th Percentile

Ambulatory FY 2026 Detailed Quality OKR and KPI Dashboard

Vision: Alameda Health System will be recognized as a world-class patient and family centered system of care that promotes wellness, eliminates disparities and optimized the health of our diverse communities.

Safe Care - Caring, Healing, Teaching All			Performance			FY26 Goals		
OBJECTIVES	KEY RESULTS	Detailed KPIs	Aug 2025	FY26 YTD	FY25 Actual	Improvement	Benchmark	Accountable Leaders
Provide safe care	Eliminate Patient Harms	Total Patient Harms	0	0	1	1	0	R. Lofton
		Behavior Events with Physical Injury	0	0	1	1	0	
		Serious Safety Events (F or Greater)	0	0	0	1	0	R. Lofton
	Embed Critical Behaviors	Hand Hygiene Compliance	94.31%	92.65%	82.84%		95%	

Timely, Effective, and Efficient Care			Performance			FY26 Goals		
OBJECTIVES	KEY RESULTS	Detailed KPIs	Aug 2025	FY26 YTD	FY25 Actual	Improvement	Benchmark	Accountable Leaders
Promote wellbeing	Provide the right care at the right time	All Cause 30-Day Readmission Rate	8.83%	11.11%	12.26%	11.56%	11.12%	
		MyChart Activation Rate	36.00%	36.00%	27.00%			
	Find and treat conditions early	Breast Cancer Screening	59.48%		59.48%	60.27%	63.48%	Natalie Curtis
		Cervical Cancer Screening	48.60%		46.44%	49.64%	67.46%	Natalie Curtis
		Colorectal Cancer Screening	61.04%		61.68%	57.98%	57.98%	Natalie Curtis
	Achieve the best health outcomes	Glycemic status assessment of patients with diabetes	30.67%		31.16%	29.94%	27.01%	Natalie Curtis
		Controlling High Blood Pressure	64.79%		63.82%	63.86%	72.75%	Natalie Curtis
		Child and Adolescent Well-Care Visits	51.53%		49.99%	49.85%	64.74%	Natalie Curtis

Fiscal Year Starts in July 1 and Ends June 30

FY26 YTD is results from July 2025 to Aug 2025

Timely, Effective, and Efficient Care (continued)	Performance	FY26 Goals

OBJECTIVES	KEY RESULTS	Detailed KPIs	Aug 2025	FY26 YTD	FY25 Actual	Improvement	Benchmark	Accountable Leaders
	Minimize Time Spent Waiting for our Patients	TNAA Primary Care - Return	0	0	10	10	2	
		TNAA Specialty Care -Return	1	1	7	15	2	
		% of Specialty Clinics with an average of less than or equal to 15 days for New Patients Appointments*	28.13%		11.76%		80%	T.Amoruwa, P. Mack
		% of Adult Primary Care Clinics with an average of less than or equal to 10 days for New Patients Appointments *	0.00%		0%		100%	T.Amoruwa, P. Mack
Equitable Care			Performance			FY26 Goals		
OBJECTIVES	KEY RESULTS	Detailed KPIs	Aug 2025	FY26 YTD	FY25 Actual	Improvement	Benchmark	Accountable Leaders
Serving all: Deliver equitable care	Health-related social needs recognized and addressed	Health-related social needs referrals placed	29%	30%	NA			
Patient-Centered Care			Performance			FY26 Goals		
OBJECTIVES	KEY RESULTS	Detailed KPIs	Aug 2025	FY26 YTD	FY25 Actual	Improvement	Benchmark	Accountable Leaders
Be the most welcoming system to receive care	Optimize performance regarding patient experience	Likelihood to recommend (Dental)	67.11%	67.29%	62.51%	63.51%	79.10%	Holly Garcia
		Likelihood to recommend (Primary/Specialty)	76.90%	77.56%	73.18%	74.18%	80.00%	Holly Garcia
		Communication with Care Provider (Primary/Specialty)	76.50%	77.52%	76.48%	77.48%	83.20%	Holly Garcia
Fiscal Year Starts in July 1 and Ends June 30								
*Preliminary Data								FY26 YTD is results from July 2025 to Aug 2025

Highland FY 2026 Detailed Quality OKR and KPI Dashboard

Vision: Alameda Health System will be recognized as a world-class patient and family centered system of care that promotes wellness, eliminates disparities and optimized the health of our diverse communities.

Safe Care - Caring, Healing, Teaching All			Performance			FY26 Goals	
OBJECTIVES	KEY RESULTS	Detailed KPIs	Aug 2025	FY26 YTD	FY25 Actual	Improvement	Benchmark
Provide safe care	Eliminate Patient Harms	Total Patient Harms	3	12	136	108	66
		CLABSI # Events/SIR	0/0	0/0	0/0	2/.317	0/0
		CAUTI # Events/SIR	0/0	0/0	8/0.94	4/.55	2/.264
		MRSA # Events/SIR	0/0	0/0	2/0.97	1/.658	0/0.335
		C. Difficile # Events/SIR	1/TBD	1/0	18/0.67	15/.579	9/.346
		SSI # Events/SIR	0/0	4/2.97	36/2.35	20/1.32	12/.849
		Falls with Injury/% Per 1000 Days	1/0	2/0	36/0.44	32/0.396	13/0.24
		Reportable HAPI #/% per 1000 Discharges	1/0.95	1/0.49	0/0	0/0	0/0
		Behavior Events with Physical Injury	0/0	4/0.41	36/0.63	32/0.567	28/0.504
		HAPI all Stages #/% per 1000 Discharges	11/10.446	11/5.37	78/7.01	70/6.309	62/5.608
		Serious Safety Events (F or Greater)	2	3	11		
	Reduce Mortality from Sepsis	Sepsis Mortality Observed:Expected & Total Deaths	NA	0.87	1.10	1	0.93
		Bundle Compliance Sepsis Early Management	75.00%	60.00%	57.94%	75%	88%
	Embed Critical Behaviors	Hand Hygiene Compliance	91.40%	93.59%	89.36%		95%

Fiscal Year Starts in July 1 and Ends June 30

FY25 YTD is results from July 2024 to Aug 2025

Highland FY 2026 Detailed Quality OKR and KPI Dashboard

Timely, Effective, and Efficient Care			Performance			FY26 Goals	
OBJECTIVES	KEY RESULTS	Detailed KPIs	Aug 2025	FY26 YTD	FY25 Actual	Improvement	Benchmark
Promote wellbeing	Provide the right care at the right time	All Cause 30-Day Readmission Rate	8.68%	10.64%	11.27%	11.69%	11.12%
	Achieve the best health outcomes	NTSV Cesarean Section Rate	NA	N/A	22.60%	22.17%	22%
Provide accessible care	Minimize Time Spent Waiting for our Patients	ED Boarding Time for Admitted Patients	8:23	8:39	12:57	8:28	4:00
Equitable Care			Performance			FY26 Goals	
OBJECTIVES	KEY RESULTS	Detailed KPIs	Aug 2025	FY26 YTD	FY25 Actual	Improvement	Benchmark
Serving all: Deliver equitable care	Health-related social needs recognized and addressed	Health-related social needs assessment completed on inpatients	85.60%	80.00%	76.00%	82%	89%
		% of patients that screened positive for at least 1 Health-related social needs	11.00%	11.00%	NA		
Patient-Centered Care			Performance			FY26 Goals	
OBJECTIVES	KEY RESULTS	Detailed KPIs	Aug 2025	FY26 YTD	FY25 Actual	Improvement	Benchmark
Be the most welcoming system to receive care	Optimize performance regarding patient experience	Likelihood to recommend Acute	86.22%	84.61%	76.10%	77.35%	78.30%
		Likelihood to recommend ED	61.04%	60.40%	58.28%	59.36%	71.60%
		Likelihood to recommend Amb Surg	75.68%	78.02%	77.82%	81.43%	86.70%
		Communication with Nurses	80.91%	80.35%	73.68%	74.68%	79.90%
		Communication with Providers	88.33%	86.40%	82.93%	83.93%	93.60%
Fiscal Year Starts in July 1 and Ends June 30			FY26 YTD is results from July 2025 to Aug 2025				

Fiscal Year 2025

OKR Metric Definitions for QPSC

Metric	Definition	GOAL	
		Improvement	Benchmark
Patient Harm	The number of potential health-care acquired patient harms Includes: CLABSI, CAUTI, MRSA BSI, C-Diff, SSI (Colon, C-Section, Gallbaldder, Hysteretomy, Spinal Fusion. Small Bowel)for Acute Med-Surg/Critical Care, and Patient Falls with injuries, Reportable Hospital Acquired Pressure Injuries and Behavior Events that result in Injury for all areas (practically, not inclusive of ambulatory)	HAI equal to or better than 75th percentile Falls, HAPI, Behavior Events 10% reduction	HAI equal to or better than 50th percentile Falls, HAPI, Behavior Events 20% reduction
CLABSI # Events/ SIR	A primary bloodstream infection (that is, there is no apparent infection at another site) that develops in a patient with a central line in place . #: Number of infections that occurred SIR: Standardized Infection Ratio compares the actual number of infections to the predicted number of infections. The predicted number is risk adjusted. Results less 1 are desirable	NHSN National 25th Percentile	NHSN National 10th Percentile
CAUTI # Events/ SIR	an infection of the urinary tract caused by a tube (urinary catheter) that has been placed to drain urine from the bladder. #: Number of infections that occurred SIR: Standardized Infection Ratio compares the actual number of infections to the predicted number of infections. The predicted number is risk adjusted. Results less 1 are desirable	NHSN National 50th Percentile	NHSN National 25th Percentile
MRSA # Events/ SIR	Potential hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA) staph infection that is difficult to treat because of resistance to some antibiotics. #: Number of infections that occurred .Serving as a proxy measure tied to patient days, reflecting the hospital's ability to prevent transmission and invasive infection rather than serving as a confirmed clinical diagnosis. NHSN defines hospital-onset (HO) as the first positive laboratory test for an organism collected on or after hospital day 4 of admission, which reasonably attributes the event to the hospitalization	NHSN National 50th Percentile	NHSN National 25th Percentile
C. Difficile # Events/ SIR	Potential hospital acquired infection that causes diarrhea and colitis (an inflammation of the colon). #: Number of infections that occurred This serves as a proxy for infection risk in the hospital rather than a confirmed diagnosis. Hospital-onset (HO) is defined as the first positive laboratory test for an organism collected on or after hospital day 4 of admission, which reasonably attributes the event to the hospitalization	NHSN National 75th Percentile	NHSN National 50th Percentile
SSI # Events/ SIR	an infection that occurs after a Colon, C-Section, Gallbaldder, Hysteretomy, Spinal Fusion, Small Bowel surgery in the part of the body where the surgery took place. Excludes superficial infections. Attributed to date of procedure. #: Number of infections that occurred attributed to month procedure performed SIR: Standardized Infection Ratio compares the actual number of infections to the predicted number of infections. The predicted number is risk adjusted. Results less 1 are desirable	NHSN National 75th Percentile	NHSN National 50th Percentile
Falls with Injury/ # % Per 1000 Days	Patient Fall reported via Midas Safety Alert. # of Events / Rate: Number of events divided by number of patient days times 1000	10% improvement as compared to Fiscal Year 2025	NDNQI 25th Percentile
Reportable HAPI #/% per 1000 Discharges	Hospital Acquired Pressure Ulcers Stage 3 or 4 ulcer, acquired after admission to a health facility, excluding progression from Stage 2 to Stage 3 if Stage 2 was recognized upon admissionreported via Midas Safety Alert. This includes deep tissue injuries and unstageable pressure injuries that progress to a stage 3 or 4. # of Events / Rate: Number of events divided by number of patient discharges times 1000	10% improvement as compared to Fiscal Year 2025	20% improvement as compared to Fiscal Year 2025
Behavior Events with Physical Injury	Behavior events that resulted in physicial injury via Midas Safety Alerts # of Events/Rate: Number of events divided by number of patient days times 1000	10% improvement as compared to Fiscal Year 2025	20% improvement as compared to Fiscal Year 2025
HAPI #/ % per 1000 DCs	Hospital Acquired Pressure Ulcers reported via Midas Safety Alert. # of Events / Rate: Number of events divided by number of patient discharges times 1000	10% improvement as compared to Fiscal Year 2025	20% improvement as compared to Fiscal Year 2025
Serious Safety Events (F or Greater)	Midas Safety Alerts where an event occurred that may have contributed to or resulted in temporary harm to any involved parties and required initial or prolonged hospitalization	NA	Zero

Fiscal Year 2025

OKR Metric Definitions for QPSC

Metric	Definition	GOAL	
		Improvement	Benchmark
Sepsis Mortality O/E Ratio	The observed to expected (O:E) sepsis mortality ratio is a comparison of the actual number of sepsis-related deaths in a hospital (observed) to the predicted number of deaths (expected). Performance is considered better than expected if the O:E ratio is less than 1, and worse than expected if the ratio is greater than 1. A lower O:E ratio indicates that more people are surviving conditions that would otherwise be fatal.	Observed Mortality equal to Expected Mortality	Vizient National FY2025 50th Percentile
Bundle Compliance Sepsis Early Management	A set of guidelines that hospitals use to manage patients with severe sepsis or septic shock. The guidelines focus on early recognition and intervention to save lives and limbs. This is an "all-or-nothing" measure, meaning that hospitals must adhere to all elements of the bundle to receive credit. Follows CMS/TJC SEP 1 Definition	CMS National 7/2023-6/2024 75th Percentile	CMS National 7/2023-6/2024 95th Percentile
Hand Hygiene Compliance	Hand hygiene is a leading way to reduce the spread of pathogens in healthcare settings. It includes: Washing hands with soap and water and Using an antiseptic handrub. Hand hygiene compliance is the percentage of times that a person performs hand hygiene when an opportunity arises. It's calculated by dividing the number of hand hygiene actions performed by the total number of opportunities.		The level of adherence crucial for patient safety and preventing healthcare-associated infections.
All-cause 30 day Readmissions Rate	Percentage of inpatient acute med-surg encounters, regardless of payer type, with an unplanned readmission to any AHS facility within 30 days for any cause among encounters for acute care inpatients with a principal discharge diagnosis/procedure for a clinical classification category in the Cardiorespiratory, Cardiovascular, Medicine, Neurology, or Surgery/Gynecology cohort. *Note:* This measure approximates, but likely does not match, the value of the corresponding CMS readmission measure.	50% gap reduction to the 50th Percentile CMS Hospital Compare	50th Percentile CMS Hospital Compare
NTSV Cesarean Section Rate	he NTSV C-section rate is the percentage of live babies born to women in their first pregnancy who meet the following criteria: Born at or after 37 weeks gestation Singleton (no twins or more) In the vertex presentation (no breech or transverse positions)	QIP Target: 10% gap closure between AHS CY2024 performance and 90th Percentile	90th Percentile
ED Boarding Time Time in ED from Decision to Admit to Inpatient Bed	Median time from Decision to Admit to departure from the emergency department for admitted patients. Decision to Admit = First Admit Disposition Admit = Time patient admitted to Inpatient Unit	**Community Hospitals:** 50% gap closure to pre=pandemic performance **Highland:** 50% gap closure to TJC benchmark	**Community Hospitals:** Pre-pandemic Performance **Highland:** TJC guidance for max boarding time
Rate of Inpatients screened for health-related social needs (food, housing, transportation, safety, utilities) ↑	The percentage of inpatient acute medical/surgical and behavioral health admissions where the patient is screened for all 5 social determinents of health: food insecurity, housing, transportation, safety and utilites	10% improvement as compared to Fiscal Year 2025	20% improvement as compared to Fiscal Year 2025
% of patients that screened positive for at least 1 Health-related social needs	The percentage of inpatient acute medical/surgical and behavioral health admissions where the patient screened positive for 1 or more health-related social needs: food insecurity, housing, transportation, safety and utilites	NA - Establishing Baseline	NA-Establishing Baseline
Acute: Rate of patients who reported they would “definitely” recommend AHS	Percentage of discharged inpatients who would recommend AHS	1% improvement as compared to Fiscal Year 2025	**Community Hospitals:** National 50th Percentile **Highland:** National 75th Percentile
Same Day Surgery:Rate of patients who reported they would “definitely” recommend AHS	Percentage of same day surgery patients who would recommend AHS	1% improvement as compared to Fiscal Year 2025	National 50th Percentile
Emergency: Rate of patients who reported they would “definitely” recommend AHS	Percentage of Emergency patients who would recommend AHS	1% improvement as compared to Fiscal Year 2025	National 50th Percentile

Fiscal Year 2025

OKR Metric Definitions for QPSC

Metric	Definition	GOAL	
		Improvement	Benchmark
Communication with Nurses	A domain of HCAHPS which measures patients' perceptions of how well patients feel that their nurses: explained things clearly, listened carefully, and treated the patient with courtesy and respect. Percent of surveyed Inpatient discharges where patient response was highest of the scale	1% improvement as compared to Fiscal Year 2025	National 50th Percentile
Communication with Providers	A domain of HCAHPS which measures patients' perceptions of how well patients feel that their provider(s): explained things clearly, listened carefully, and treated the patient with courtesy and respect. Percent of surveyed Inpatient discharges where patient response was highest of the scale	1% improvement as compared to Fiscal Year 2025	**Community Hospitals:** National 50th Percentile **Highland:** National 90th Percentile

John George FY 2026 Detailed Quality OKR and KPI Dashboard

Vision: Alameda Health System will be recognized as a world-class patient and family centered system of care that promotes wellness, eliminates disparities and optimized the health of our diverse communities.

Safe Care - Caring, Healing, Teaching All			Performance			FY26 Goals		
OBJECTIVES	KEY RESULTS	Detailed KPIs	Aug 2025	FY26 YTD	FY25 Actual	Improvement	Benchmark	Accountable Leaders
Provide safe care	Eliminate Patient Harms	Total Patient Harms	11	15	69	62	55	P. Espeseth R. Delaney
		Falls with Injury/% Per 1000 Days	4/1.99	4/0.86	16/0.59	14	12	R. Delaney
		Behavior Events with Physical Injury	7/3.48	11/2.36	53/1.96	48	42	P. Espeseth R. Delaney
		Serious Safety Events (F or Greater)	0	0	1	0	0	P. Espeseth R. Delaney
Patient-Centered Care			**Performance**			**FY26 Goals**		
OBJECTIVES	KEY RESULTS	Detailed KPIs	Aug 2025	FY26 YTD	FY25 Actual	Improvement	Benchmark	Accountable Leaders
Be the most welcoming system to receive care	Optimize performance regarding patient experience	Overall Rating of Care	54.31%	51.51%	57.67%	58.67%	67.50%	P. Espeseth R. Delaney

Fiscal Year Starts in July 1 and Ends June 30

FY26 YTD is results from July 2025 to Performance

Fiscal Year 2025

OKR Metric Definitions for QPSC

Metric	Definition	GOAL	
		Improvement	Benchmark
Total Patient Harms	The number of potential health-care acquired patient harms Includes: Patient Falls with injuries, H Behavior Events that result in Injury	10% reduction compared to FY25 overall	20% reduction compared to FY25 overall
Falls with Injury/% Per 1000 Days	Patient Fall reported via Midas Safety Alert. # of Events / Rate: Number of events divided by number of patient days times 1000	10% reduction compared to FY25 overall	20% reduction compared to FY25 overall
Behavior Events with Physical Injury	Behavior events that resulted in physicial injury via Midas Safety Alerts # of Events/Rate: Number of events divided by number of patient days times 1000	10% reduction compared to FY25 overall	20% reduction compared to FY25 overall
Serious Safety Events (F or Greater)	Risk Events that are given a significance of F or Greater		
Overall Rating of Care	A question on the Behavioral Health Dashboard which measures patients' perceptions of how well patients feel that their overall care experience was Percent of surveyed discharges where patient response was highest of the scale (Top Box Score)	1% improvement over FY25 score	2% improvement over FY25 score

San Leandro Hospital FY 2026 Detailed Quality OKR and KPI Dashboard

Vision: Alameda Health System will be recognized as a world-class patient and family centered system of care that promotes wellness, eliminates disparities and optimized the health of our diverse communities.

Safe Care - Caring, Healing, Teaching All			Performance			FY26 Goals	
OBJECTIVES	KEY RESULTS	Detailed KPIs	Aug 2025	FY26 YTD	FY25 Actual	Improvement	Benchmark
Provide safe care	Eliminate Patient Harms	Total Patient Harms	3	9	45	32	21
		CLABSI # Events/SIR	0/0	0/0	0/0	0/0.317	0/0
		CAUTI # Events/SIR	0/0	0/0	0/0	0/0.55	0/0.264
		MRSA # Events/SIR	0/0	0/0	2/4.12	0/0.658	0/0.335
		C. Difficile # Events/SIR	1/TBD	1/0	13/2.07	3/0.58	2/0.346
		SSI # Events/SIR	0/0	0/0	2/1.19	2/1.324	1/0.849
		Falls with Injury/% Per 1000 Days	1/1.22	3/1.54	11/0.56	9/0.504	3/0.24
		Reportable HAPI #/% per 1000 Discharges	0/0	2/4.2	6/0	7/2.295	6/2.04
		Behavior Events with Physical Injury	1/1.22	3/1.54	11/0.78	9/0.603	8/0.536
		HAPI all Stages #/% per 1000 Discharges	2/9.13	10/21.01	64/20.4	57/18.36	51/16.32
		Serious Safety Events (F or Greater)	1	1	1		
	Reduce Mortality from Sepsis	Sepsis Mortality Observed: Expected	NA	1.89	1.08	1	0.93
		Bundle Compliance Sepsis Early Management	60.00%	54.55%	59.24%	75%	88%
	Embed Critical Behaviors	Hand Hygiene Compliance	92.92%	92.07%	94.46%		95%

Fiscal Year Starts in July 1 and Ends June 30

FY26 YTD is results from July 2025 to Aug 2025

Timely, Effective, and Efficient Care			Performance			FY26 Goals	
OBJECTIVES	KEY RESULTS	Detailed KPIs	Aug 2025	FY26 YTD	FY25 Actual	Improvement	Benchmark
Promote wellbeing	Provide the right care at the right time	All Cause 30-Day Readmission Rate	10.94%	12.69%	12.73%	11.69%	11.12%
Provide accessible care	Minimize Time Spent Waiting for our Patients	ED Boarding Time for Admitted Patients	1:57	2:24	2:55	2:12	1:30
Equitable Care			**Performance**			**FY26 Goals**	
OBJECTIVES	KEY RESULTS	Detailed KPIs	Aug 2025	FY26 YTD	FY25 Actual	Improvement	Benchmark
Serving all: Deliver equitable care	Health-related social needs recognized and addressed	Health-related social needs assessment completed on inpatients	91.00%	91.20%	92.30%	82%	89%
		% of patients that screened positive for at least 1 Health-related social needs	11.00%	11.00%	NA		
Patient-Centered Care			**Performance**			**FY26 Goals**	
OBJECTIVES	KEY RESULTS	Detailed KPIs	Aug 2025	FY26 YTD	FY25 Actual	Improvement	Benchmark
	Optimize performance regarding patient experience	Likelihood to recommend Acute	86.40%	76.57%	67.39%	68.39%	71.10%
		Likelihood to recommend ED	63.41%	70.93%	58.67%	59.67%	71.60%
		Likelihood to recommend Amb Surg	88.24%	82.22%	76.92%	77.92%	86.70%
		Communication with Nurses	75.55%	73.66%	72.60%	73.60%	79.90%
		Communication with Providers	83.07%	77.53%	77.85%	78.85%	79.20%

Fiscal Year Starts in July 1 and Ends June 30

FY26 YTD is results from July 2025 to Aug 2025

Fiscal Year 2025

OKR Metric Definitions for QPSC

Metric	Definition	GOAL	
		Improvement	Benchmark
Patient Harm	The number of potential health-care acquired patient harms Includes: CLABSI, CAUTI, MRSA BSI, C-Diff, SSI (Colon, C-Section, Gallbaldder, Hysteretomy, Spinal Fusion. Small Bowel)for Acute Med-Surg/Critical Care, and Patient Falls with injuries, Reportable Hospital Acquired Pressure Injuries and Behavior Events that result in Injury for all areas (practically, not inclusive of ambulatory)	HAI equal to or better than 75th percentile Falls, HAPI, Behavior Events 10% reduction	HAI equal to or better than 50th percentile Falls, HAPI, Behavior Events 20% reduction
CLABSI # Events/ SIR	A primary bloodstream infection (that is, there is no apparent infection at another site) that develops in a patient with a central line in place . #: Number of infections that occurred SIR: Standardized Infection Ratio compares the actual number of infections to the predicted number of infections. The predicted number is risk adjusted. Results less 1 are desirable	NHSN National 25th Percentile	NHSN National 10th Percentile
CAUTI # Events/ SIR	an infection of the urinary tract caused by a tube (urinary catheter) that has been placed to drain urine from the bladder. #: Number of infections that occurred SIR: Standardized Infection Ratio compares the actual number of infections to the predicted number of infections. The predicted number is risk adjusted. Results less 1 are desirable	NHSN National 50th Percentile	NHSN National 25th Percentile
MRSA # Events/ SIR	Potential hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA) staph infection that is difficult to treat because of resistance to some antibiotics. #: Number of infections that occurred .Serving as a proxy measure tied to patient days, reflecting the hospital's ability to prevent transmission and invasive infection rather than serving as a confirmed clinical diagnosis. NHSN defines hospital-onset (HO) as the first positive laboratory test for an organism collected on or after hospital day 4 of admission, which reasonably attributes the event to the hospitalization	NHSN National 50th Percentile	NHSN National 25th Percentile
C. Difficile # Events/ SIR	Potential hospital acquired infection that causes diarrhea and colitis (an inflammation of the colon). #: Number of infections that occurred This serves as a proxy for infection risk in the hospital rather than a confirmed diagnosis. Hospital-onset (HO) is defined as the first positive laboratory test for an organism collected on or after hospital day 4 of admission, which reasonably attributes the event to the hospitalization	NHSN National 75th Percentile	NHSN National 50th Percentile
SSI # Events/ SIR	an infection that occurs after a Colon, C-Section, Gallbaldder, Hysteretomy, Spinal Fusion, Small Bowel surgery in the part of the body where the surgery took place. Excludes superficial infections. Attributed to date of procedure. #: Number of infections that occurred attributed to month procedure performed SIR: Standardized Infection Ratio compares the actual number of infections to the predicted number of infections. The predicted number is risk adjusted. Results less 1 are desirable	NHSN National 75th Percentile	NHSN National 50th Percentile
Falls with Injury/ # % Per 1000 Days	Patient Fall reported via Midas Safety Alert. # of Events / Rate: Number of events divided by number of patient days times 1000	10% improvement as compared to Fiscal Year 2025	NDNQI 25th Percentile
Reportable HAPI #/% per 1000 Discharges	Hospital Acquired Pressure Ulcers Stage 3 or 4 ulcer, acquired after admission to a health facility, excluding progression from Stage 2 to Stage 3 if Stage 2 was recognized upon admissionreported via Midas Safety Alert. This includes deep tissue injuries and unstageable pressure injuries that progress to a stage 3 or 4. # of Events / Rate: Number of events divided by number of patient discharges times 1000	10% improvement as compared to Fiscal Year 2025	20% improvement as compared to Fiscal Year 2025
Behavior Events with Physical Injury	Behavior events that resulted in physicial injury via Midas Safety Alerts # of Events/Rate: Number of events divided by number of patient days times 1000	10% improvement as compared to Fiscal Year 2025	20% improvement as compared to Fiscal Year 2025
HAPI #/ % per 1000 DCs	Hospital Acquired Pressure Ulcers reported via Midas Safety Alert. # of Events / Rate: Number of events divided by number of patient discharges times 1000	10% improvement as compared to Fiscal Year 2025	20% improvement as compared to Fiscal Year 2025
Serious Safety Events (F or Greater)	Midas Safety Alerts where an event occurred that may have contributed to or resulted in temporary harm to any involved parties and required initial or prolonged hospitalization	NA	Zero

Fiscal Year 2025

OKR Metric Definitions for QPSC

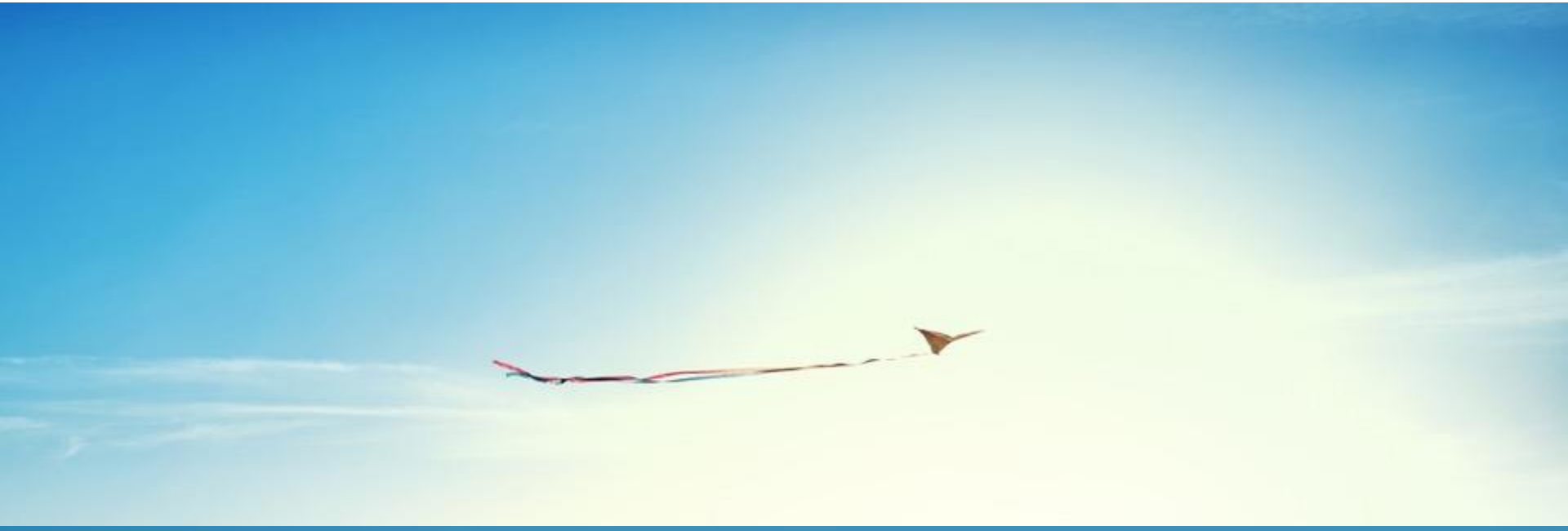
Metric	Definition	GOAL	
		Improvement	Benchmark
Sepsis Mortality O/E Ratio	The observed to expected (O:E) sepsis mortality ratio is a comparison of the actual number of sepsis-related deaths in a hospital (observed) to the predicted number of deaths (expected). Performance is considered better than expected if the O:E ratio is less than 1, and worse than expected if the ratio is greater than 1. A lower O:E ratio indicates that more people are surviving conditions that would otherwise be fatal.	Observed Mortality equal to Expected Mortality	Vizient National FY2025 50th Percentile
Bundle Compliance Sepsis Early Management	A set of guidelines that hospitals use to manage patients with severe sepsis or septic shock. The guidelines focus on early recognition and intervention to save lives and limbs. This is an "all-or-nothing" measure, meaning that hospitals must adhere to all elements of the bundle to receive credit. Follows CMS/TJC SEP 1 Definition	CMS National 7/2023-6/2024 75th Percentile	CMS National 7/2023-6/2024 95th Percentile
Hand Hygiene Compliance	Hand hygiene is a leading way to reduce the spread of pathogens in healthcare settings. It includes: Washing hands with soap and water and Using an antiseptic handrub. Hand hygiene compliance is the percentage of times that a person performs hand hygiene when an opportunity arises. It's calculated by dividing the number of hand hygiene actions performed by the total number of opportunities.		The level of adherence crucial for patient safety and preventing healthcare-associated infections.
All-cause 30 day Readmissions Rate	Percentage of inpatient acute med-surg encounters, regardless of payer type, with an unplanned readmission to any AHS facility within 30 days for any cause among encounters for acute care inpatients with a principal discharge diagnosis/procedure for a clinical classification category in the Cardiorespiratory, Cardiovascular, Medicine, Neurology, or Surgery/Gynecology cohort. *Note:* This measure approximates, but likely does not match, the value of the corresponding CMS readmission measure.	50% gap reduction to the 50th Percentile CMS Hospital Compare	50th Percentile CMS Hospital Compare
NTSV Cesarean Section Rate	he NTSV C-section rate is the percentage of live babies born to women in their first pregnancy who meet the following criteria: Born at or after 37 weeks gestation Singleton (no twins or more) In the vertex presentation (no breech or transverse positions)	QIP Target: 10% gap closure between AHS CY2024 performance and 90th Percentile	90th Percentile
ED Boarding Time Time in ED from Decision to Admit to Inpatient Bed	Median time from Decision to Admit to departure from the emergency department for admitted patients. Decision to Admit = First Admit Disposition Admit = Time patient admitted to Inpatient Unit	**Community Hospitals:** 50% gap closure to pre=pandemic performance **Highland:** 50% gap closure to TJC benchmark	**Community Hospitals:** Pre-pandemic Performance **Highland:** TJC guidance for max boarding time
Rate of Inpatients screened for health-related social needs (food, housing, transportation, safety, utilities) ↑	The percentage of inpatient acute medical/surgical and behavioral health admissions where the patient is screened for all 5 social determinents of health: food insecurity, housing, transportation, safety and utilites	10% improvement as compared to Fiscal Year 2025	20% improvement as compared to Fiscal Year 2025
% of patients that screened positive for at least 1 Health-related social needs	The percentage of inpatient acute medical/surgical and behavioral health admissions where the patient screened positive for 1 or more health-related social needs: food insecurity, housing, transportation, safety and utilites	NA - Establishing Baseline	NA-Establishing Baseline
Acute: Rate of patients who reported they would “definitely” recommend AHS	Percentage of discharged inpatients who would recommend AHS	1% improvement as compared to Fiscal Year 2025	**Community Hospitals:** National 50th Percentile **Highland:** National 75th Percentile
Same Day Surgery:Rate of patients who reported they would “definitely” recommend AHS	Percentage of same day surgery patients who would recommend AHS	1% improvement as compared to Fiscal Year 2025	National 50th Percentile
Emergency: Rate of patients who reported they would “definitely” recommend AHS	Percentage of Emergency patients who would recommend AHS	1% improvement as compared to Fiscal Year 2025	National 50th Percentile

Fiscal Year 2025

OKR Metric Definitions for QPSC

Metric	Definition	GOAL	
		Improvement	Benchmark
Communication with Nurses	A domain of HCAHPS which measures patients' perceptions of how well patients feel that their nurses: explained things clearly, listened carefully, and treated the patient with courtesy and respect. Percent of surveyed Inpatient discharges where patient response was highest of the scale	1% improvement as compared to Fiscal Year 2025	National 50th Percentile
Communication with Providers	A domain of HCAHPS which measures patients' perceptions of how well patients feel that their provider(s): explained things clearly, listened carefully, and treated the patient with courtesy and respect. Percent of surveyed Inpatient discharges where patient response was highest of the scale	1% improvement as compared to Fiscal Year 2025	**Community Hospitals:** National 50th Percentile **Highland:** National 90th Percentile

Agenda Item C2 Post Acute



ALAMEDA HEALTH SYSTEM

Post-Acute Quality Report 11/19/25

Richard Espinoza, NHA, CAO Post-Acute Services

CMS Overall Quality 5 Star Rating

5 stars every category for all sites

Care Compare Five-Star Ratings of Nursing Homes

Provider Rating Report for October 2025

Ratings for Alameda County Medical Center D/P SNF (056479) San Leandro, California			
Overall Quality	**Health Inspection**	**Quality Measures**	**Staffing**
★★★★★	★★★★★	★★★★★	★★★★★

Care Compare Five-Star Ratings of Nursing Homes

Provider Rating Report for October 2025

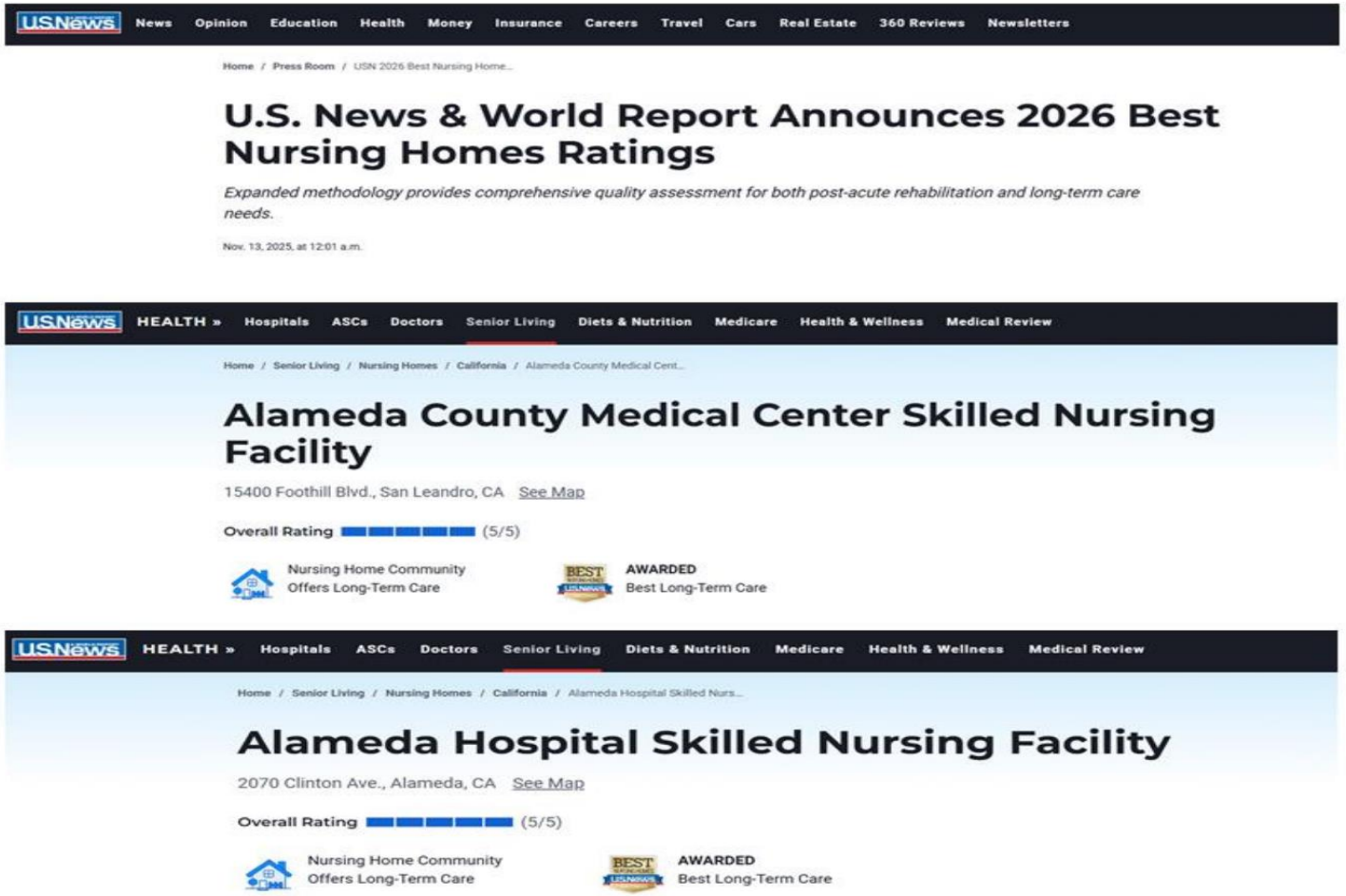
Ratings for Alameda Hospital D/P SNF (555381) Alameda, California			
Overall Quality	**Health Inspection**	**Quality Measures**	**Staffing**
★★★★★	★★★★★	★★★★★	★★★★★

CDPH/CMS Visits

- CDPH visits: 4 visits

- Park Bridge: 1 pending outcome
- Fairmont: 2 pending outcome
- South shore: 1 pending outcome

US News and World Report
Best Nursing Homes 2026



U.S.News | News | Opinion | Education | Health | Money | Insurance | Careers | Travel | Cars | Real Estate | 360 Reviews | Newsletters

Home / Press Room / USN 2026 Best Nursing Home...

U.S. News & World Report Announces 2026 Best Nursing Homes Ratings

Expanded methodology provides comprehensive quality assessment for both post-acute rehabilitation and long-term care needs.

Nov. 13, 2025, at 12:01 a.m.

U.S.News | HEALTH » | Hospitals | ASCs | Doctors | Senior Living | Diets & Nutrition | Medicare | Health & Wellness | Medical Review

Home / Senior Living / Nursing Homes / California / Alameda County Medical Cent...

Alameda County Medical Center Skilled Nursing Facility

15400 Foothill Blvd., San Leandro, CA See Map

Overall Rating (5/5)

Nursing Home Community Offers Long-Term Care

AWARDED Best Long-Term Care

U.S.News | HEALTH » | Hospitals | ASCs | Doctors | Senior Living | Diets & Nutrition | Medicare | Health & Wellness | Medical Review

Home / Senior Living / Nursing Homes / California / Alameda Hospital Skilled Nurs...

Alameda Hospital Skilled Nursing Facility

2070 Clinton Ave., Alameda, CA See Map

Overall Rating (5/5)

Nursing Home Community Offers Long-Term Care

AWARDED Best Long-Term Care

ARU Press Ganey Details

PressGaney

New Query

Generated: 11/14/2025 12:55 PM ET
Received Date Range: 10/1/2025 - 10/31/2025
Alameda Health System (11797)

Inpatient Rehabilitation

Questions	Mean	n
Overall	94.05	3
Nurses Overall	91.67	3
Courtesy and respect of nurses	91.67	3
Nurses kept you informed	91.67	3
Physical Therapy Overall	95.83	3
Courtesy and respect of PT	100.00	3
PT expl treatmt/progress	91.67	3
Occupational Therapy Overall	100.00	2
Courtesy and respect of OT	100.00	2
OT expl treatmt/progress	100.00	2
Speech Therapy Overall	83.33	3
Courtesy and respect of ST	83.33	3
ST expl treatmt / progress	83.33	3
Rehabilitation Doctors Overall	100.00	3
Courtesy and respect of doctors	100.00	3
Doctors kept you informed	100.00	3
Discharge Overall	100.00	3
Care team explained discharge plans	100.00	3
Training given re home care	100.00	3
Personal Issues Overall	89.58	3
Staff concern for privacy	91.67	3
Your feeling of safety and security	91.67	3
Staff concern for questions/worries	91.67	3
Staff promptness: resp. to requests	83.33	3
Overall Assessment Overall	93.75	3
Staff worked together care for you	83.33	3
Staff prepared to function at home	100.00	3
Overall rating of care	100.00	3
Likelihood of recommending	91.67	3

ARU Monthly Quality Metrics

October 2026 Metrics ARU	Actual	Goal
Falls	3	0
Fall %	3.30%	less than 5% - strech of 0
CAUTI	0	0
C-DIFF	0	0
Med Error	0	0
HAPI	0	0
Workplace Violence	0	0

- 3 falls for the month
- Goal – less than 5% - stretch goal is to be at zero as best as possible
- 0 CAUTI
- 0 C-Diff
- 0 Med Errors
- 0 HAPI
- 0 Workplace Violence

Thank you

Questions?

Agenda Item E, QIP

ALAMEDA HEALTH SYSTEM

Quality Incentive Program – 2024 Audit and Submission

Natalie Curtis, MD - Medical Director Value Based Care

Executive Summary

- **The Quality Incentive Program (QIP) is a complex, increasingly difficult, pay-for-performance quality program worth ~$60M/year (funds are in our base budget, if we don't meet, then funding loss)**

- **Supplemental funding accounts for ~36% of AHS's overall revenue and includes dollars from QIP**

- **These programs exist to support population health for AHS's assigned lives**
  - Shift to high-value, low-acuity, preventative services
  - Increasing accountability to reduce racial inequities

- **QIP and its predecessor "PRIME" have catalyzed transformational change at AHS to improve care quality**

QIP's Portfolio includes 56 Metrics worth ~$60 Million

Primary Care - Pediatrics

- Well-child visits (baby, child/adol)
- Lead screening
- Immunizations (child, adolescent)
- Weight assessment & counseling
- Developmental screening
- Developmental screening (Black/AA)

Primary Care – Preventative Care

- BMI screening & follow-up
- Breast cancer screening
- Colorectal cancer screening
- Colorectal screening (Black/AA)
- Cervical cancer screening
- Influenza immunization
- Chlamydia screening
- HIV screening
- Adult Immunization Status

Primary Care – Chronic Disease Management

- Asthma control
- Blood pressure control
- Diabetes control
- Diabetes control (Latinx/Black/AA)
- Diabetes eye exam
- Diabetes kidney health evaluation
- HIV viral load suppression
- Statin therapy for CV disease
- Advanced care planning

Behavioral Health

- Depression screening & follow-up
- Depression response & remission
- Follow-up for substance use (from ED & high-intensity settings)
- Pharmacotherapy for opioid use
- Tobacco screening & counseling
- Concurrent Use of Opioids & BDZs
- Use of Opioids at High Dosage
- Follow-up after ED for Mental Illness

Maternal & Perinatal Health

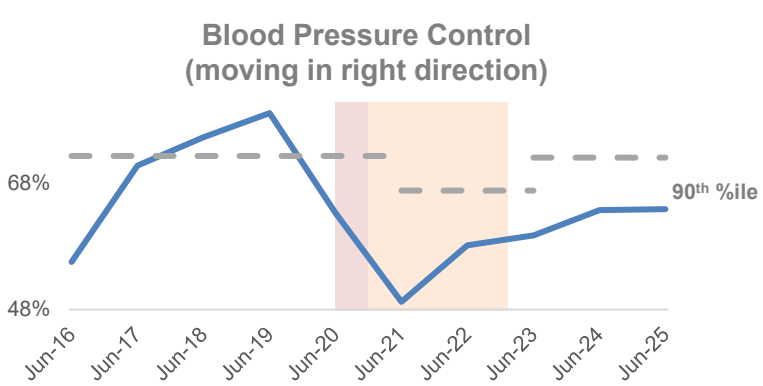
- Cesarean birth
- Exclusive breastmilk feeding
- Timely prenatal & postpartum care
- Prenatal Immunizations
- Prenatal Depression Screening
- Postpartum Depression Screening

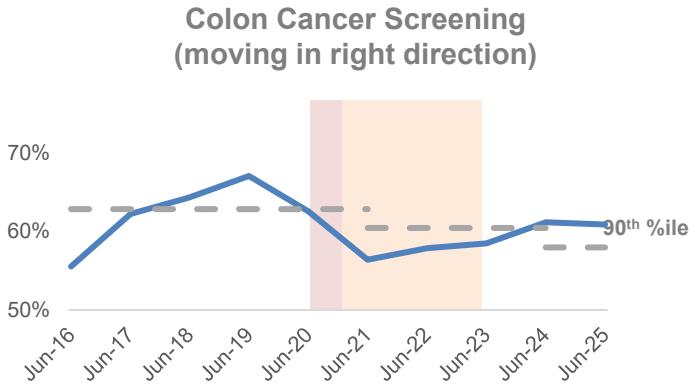
Acute Care & Resource Stewardship

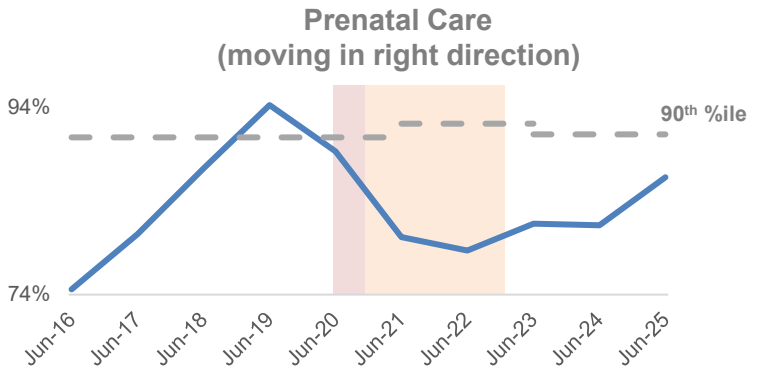
- ED use of CT for head trauma
- Pharmacotherapy for COPD
- Readmissions
- Stroke: Discharge on antithrombotic
- CAD: Antiplatelet & ACE/ARB
- Heart failure: use of ACE/ARB
- Imaging for low back pain
- Antibiotics for URIs, acute bronchitis
- Prevention of central line associated bloodstream infections (CLABSI)
- Hospital-acquired c difficile
- Surgical site infection
- Perioperative VTE prophylaxis

Of 56 available metrics, (~70%) are exclusively based on ambulatory performance, (~13%) rely on both ambulatory and acute (ED, inpatient) performance, and (~17%) rely exclusively on inpatient performance.

AHS's Journey towards Continuous Quality Improvement





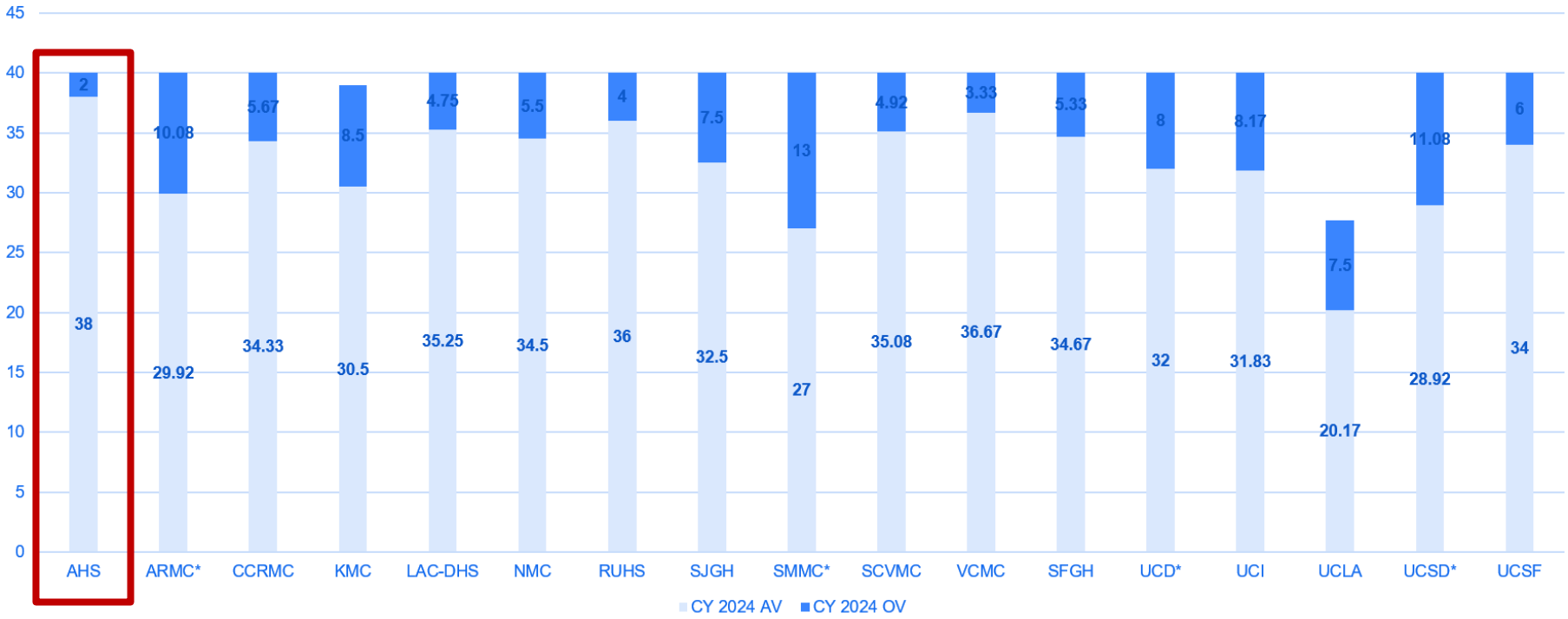


EHR migration COVID-19 (pre-vaccine)

ALAMEDA HEALTH SYSTEM

Data is collected from prior PRIME submissions years including QIP 3.5 (period of PRIME transitioning to QIP), plus current QIP data

AHS Top Performer for CY24
100% Quality Score



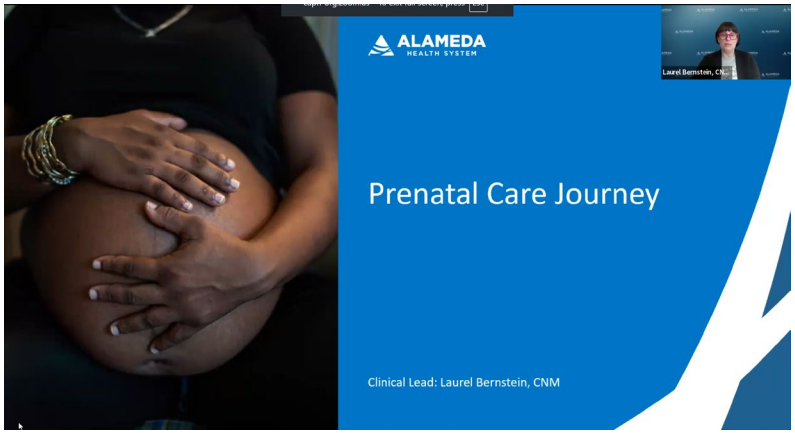
AHS as a Leader In Quality

CY2023 QIP Top Performer

CY2023 QLA Pediatrics

CY2024 QLA Equity

AHS invited to share improvement work and best practices related to prenatal care among other public hospital systems



Questions

Added Complexity: QIP Requires Ongoing Analytics & Improvement Efforts

Total Measure Set = 56 metrics. Required to report on 40:

- 20 **priority** (required) metrics & 20 **elective** metrics (AHS choose out of remaining 36)
- New measures added every year and yearly metric specification revisions

Increasingly Difficult Target Re-calculations

- Systems must meet a "minimum threshold" (the 25th percentile)
- Then, increasingly close the gap to the 90th percentile *each year*

Metrics encompass <u>all</u> (seen and unseen) Medi-Cal managed care assigned lives.

- ~55% of AHS assigned MCMC patients have not been seen by primary care in last 24 months

Measures follow DHCS Strategic Plan

- Bold Goals – DHCS priorities centered around closing disparity gaps in maternal-child health outcomes and behavioral health screening and treatment
- Increasingly, targets must be achieved overall and for disparity subpopulations

Bi-Annual Audits Conducted by DHCS*

- Increased scrutiny on data integrity that carries financial risk

CY24 Performance Summary

- 17 metrics above the 90th percentile benchmark
- Our top performing metrics are: