QUALITY PROFESSIONAL SERVICES COMMITTEE MEETING

Wednesday, January 28, 2026
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

Members of the public may also participate at the following ZOOM Meeting Link:[1]
https://alamedahealthsystem.zoom.us/j/9361457125?pwd=4JnAmhDnBaLgY4GWf4PQBwp3w0Puy2.1&omn=85708728143
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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.

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

OPEN SESSION / ROLL CALL

PUBLIC COMMENT

A. Chair's Report
Covering the Uninsured: Considerations for California as It Prepares for Coverage Losses
Lilavati Indulkar, Chair

B. ACTION: Consent Agenda

B1. Approval of the Minutes of the November 19, 2025 Quality Professional Services Committee Meeting

B2. Recommendation to the Board of Trustees for approval of the AHS Medical Staff Policies and Procedures listed below:

AHS and AH Medical Staff:

- 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)
- CEM MED Code Policy
- AHS Fire Safety Management Plan
- Conducting Monthly Tests of Emergency Diesel Generators
- Emergency Generator Failure
- Malignant Hyperthermia
- Continuous Peripheral Nerve Blocks Using Infusion Pumps Policy
- PREPARATION AND ADMINISTRATION OF IV CONTRAST MEDIA IN CT & MRI
- PREPARATION AND ADMINISTRATION OF Oral Contrast Policy
- Subanesthetic Ketamine Use for Pain or Withdrawal Clinical Practice Guidelines
- Patient Identification Policy
- Master Clock Policy

- Red Flag Identity Theft Policy
- Registered Dietitian Nutritionist (RDN) Competency Policy
- Swallowing Screen, Nursing Bedside Policy
- Hemodialysis Patient Management

B3. Recommendation to the Board of Trustees for approval of the AHS Medical Staff Policies and Procedures listed below:

AHS and AH Medical Staff:

- Medical Staff Temporary Privileges

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

Revised Privilege Forms for AHS & AH:

- Radiology – Multifacility
- Neurological Surgery - AHS

Recommendation: Motion to Approve

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

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. CLOSED SESSION

E1. Consideration of Confidential Medical Staff Credentialing Reports
Chief of Staff, AHS Medical Staff
Chief of Staff, AH Medical Staff

E2. Regulatory Affairs, Risk Management, Patient Safety
[Health and Safety Code 101850(ai) (1)]

(Reconvene to Open Session)

F. OPEN SESSION

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

ADJOURNMENT

ADDENDUMS

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.

Covering the Uninsured: Considerations for California as It Prepares for Coverage Losses

SEPTEMBER 2025

CHCF Issue Brief

by Len Finocchio, DrPH

Covering the Uninsured: Considerations for California as It Prepares for Coverage Losses

After over a decade of expanding coverage and achieving the lowest uninsured rate ever in the state, California now faces the possibility of millions of people losing health care coverage due to state and federal policy changes, especially those with low incomes and those with unsatisfactory immigration status (UIS). State policymakers and leaders from the health care delivery system, including health plans, providers, and counties, may need to rethink and possibly redesign what safety-net health care services look like for people who are uninsured. These will be challenging conversations involving eligibility, benefits, systems of care, and financing.

To inform that dialogue, this paper:

- Provides a concise overview of how California achieved its lowest-ever uninsured rate over the last decade through policy changes like the Affordable Care Act and Medi-Cal expansions to Californians regardless of immigration status.
- Describes pre–Affordable Care Act approaches to providing coverage and health care services to people who were uninsured.
- Raises high-level considerations for policymakers and delivery system leaders and experts that should be part of discussions when planning for if and how the state can provide health care services to newly uninsured Californians, particularly those with lower incomes.

Background: How California Achieved Its Lowest-Ever Uninsured Rate

Since Congress passed the Patient Protection and Affordable Care Act (ACA) in 2010, the percentage of Californians without health insurance has dropped from 15% in 2013 to 8% in 2024.[1] This rise in insurance coverage is due primarily to the implementation of key ACA components in California: adopting the optional Medicaid expansion for adults without dependents, establishing a state-based health benefit exchange (Covered California) for individuals and small businesses, and enforcing health insurance consumer protections. These major changes led to dramatic growth in health care coverage for Californians with lower incomes: Medi-Cal enrollment has grown from 8.4 million people in 2013 to 15 million today, and a decade after its launch, Covered California now insures 2 million people.[2] Table 1 below shows the number of enrollees in each of the Medi-Cal expansion groups described in the section above. See Appendix A for expansion enrollment population by county.

California's commitment to achieving universal coverage also extends to people with UIS. According to a study by the Bay Area Council, 1.5 million of California's 2.3 million immigrants with UIS make up 8% of the state's workforce and contribute $23 billion annually in state, federal, and local taxes.[3] Yet immigrants with UIS have the highest rate of uninsurance.[4]

Research shows that people without insurance face serious barriers to care:[5]

- They are less likely to have a regular doctor or health clinic.
- They delay getting care because of cost concerns.
- They experience more preventable hospitalizations.
- They have poorer health overall.

Studies show that Medicaid expansions save lives. Research found that expanding Medicaid reduced deaths among adults with low incomes by 21%. This life-saving impact was seen across all age groups, including younger adults.[6]

Figure 1. Timeline of Insurance Coverage Expansions in California, 2010–24

- **2010:** Bridge to Reform Section 1115 demonstration waiver and Low-Income Health Program
- **2013:** Healthy Families Program transitions into Medi-Cal
- J**anuary 2014:** ACA Optional Medicaid Adult Expansion
- **January 2014:** California Health Benefit Exchange
- **May 2016:** Medi-Cal expansion to all income-eligible children and youth under 19
- **January 2020:** Medi-Cal expansion to all income-eligible people age 19–26
- **May 2022:** Medi-Cal expansion to all income-eligible people over 50
- **January 2024:** Medi-Cal expansion to all income-eligible people age 26–49
- **January 2024:** Elimination of the asset test as Medi-Cal eligibility requirement
- **January 2026:** Enrollment moratorium for UIS adults 19 and older in full-scope Medi-Cal
- **January 2026:** Reinstate asset test as a Medi-Cal eligibility requirement

Note: *UIS* is unsatisfactory immigration status.

Sources: "Medi-Cal Facts and Figures Almanac, 2024 Edition, CHCF, June 2024; California Section 1115 Comprehensive Demonstration Project Waiver. A Bridge to Reform: A Section 1115 Waiver Proposal (PDF), DHCS, June 3, 2010; Healthy Families Program Transition to Medi-Cal: Final Comprehensive Report (PDF), DHCS, February 4, 2014; S.B. 1, 2013–14 Leg., Reg. Sess. (Cal. 2014); "California's Health Benefit Exchange," Covered California, accessed July 2, 2025; S.B. 75, 2015–16 Leg., Reg Sess. (Cal. 2016); A.B. 133, 2021–22 Leg., Reg. Sess. (Cal. 2021); and A.B. 116, 2025–26 Leg., Reg. Sess. (Cal. 2025)."

Table 1. Medi-Cal Expansion Populations, May 2025

POPULATION	ENROLLMENT
ACA Medicaid Expansion	
Expansion adults	5,065,200
Children under 19 with UIS	
Children under 19	217,550
Adults with UIS	
Adults 19–25	152,912
Adults 26–49	849,349
Adults 50+	445,707
Total adults with UIS	**1,447,968**

Note: *UIS* is unsatisfactory immigration status.

Sources: *2025–26 May Revision: Department of Health Care Services Highlights* (PDF), California Department of Health Care Services, May 14, 2025, 8; "SB 75 - Full Scope Medi-Cal for All Children," California Health and Human Services Agency (CalHHS), last updated August 13, 2025; "Young AE (19–25) Population (by County)," CalHHS, last updated August 13, 2025; "Age 26–49 AE Population (by County)," CalHHS, last updated August 13, 2025; and "Older AE (50 and Over) Population (by County)," CalHHS, last updated August 13, 2025.

Learning from Programs Past: Health Care Services Programs for the Uninsured Before the ACA

Before the ACA and other expansions of Medi-Cal, California and its 58 counties had a confusing patchwork of programs to provide a range of services to the uninsured. Each program was unique in its design, benefits covered, eligibility requirements, financing, and other features, and few counties provided care for Californians with UIS. These pre-ACA programs can be sorted into three groups: state programs, hospital charity care and discount programs, and county programs. Many of these programs remain operational today. The descriptions below are complemented by an overview in Appendix B.

State Programs

Over time, the state implemented several programs targeting narrow groups of people who were uninsured. Examples include:

- Major Risk Medical Insurance Program
  - The Major Risk Medical Insurance Program (MRMIP) was narrowly focused and provided health insurance for California residents unable to obtain insurance in the individual health insurance market due to preexisting conditions (before the ACA, individual market plans could deny coverage because an applicant had a preexisting condition).
  - Eligible adults could not have had Medicare or been eligible for Medi-Cal but denied coverage due to a preexisting condition in the preceding 12 months.
  - Eligible people were subject to a three-month waiting period before receiving minimum essential coverage (excluding dental and vision services) and had monthly premiums, an annual deductible, cost sharing, and a lifetime cap.
  - Services were provided through contracted health plans. Funding came largely from the state General Fund, with some portion temporarily provided through the Pre-Existing Condition Insurance Plan created by the Affordable Care Act.[7]
  - As of January 1, 2025, per Senate Bill 159, coverage through MRMIP was terminated and enrollees were transitioned to Covered California.[8]
- Restricted Scope Medi-Cal
  - Provides a limited set of benefits (e.g., emergency and pregnancy-related services) to those not meeting eligibility requirements. Restricted scope Medi-Cal remains available today.
  - Funding comes from both the state General Fund and federal financial participation.[9]
- Medi-Cal Presumptive Eligibility
  - Provides full-scope benefits through fee-for-service providers for up to 60 days for those self-attesting to selected eligibility requirements with no documentation required. Enrollment is done electronically through selected providers. The program limits the number of times presumptive eligibility benefits can be received: twice in 12 months for children, once in 12 months for adults, once per pregnancy for pregnant people.
  - Medi-Cal presumptive eligibility has evolved over the years and remains available today.
  - Funding for Medi-Cal presumptive eligibility benefits come from the state General Fund and federal financial participation.[10]
- Breast and Cervical Cancer Treatment Program
  - Provides coverage for cancer treatments to eligible low-income California residents diagnosed with breast or cervical cancer. The program remains available to the eligible today.
  - Funding comes from the state General Fund and federal financial participation.[11]
- Family Planning, Access, Care, and Treatment
  - Provides comprehensive family planning and reproductive health services at no cost to eligible low-income Californians through a network of enrolled providers. The program remains available today.
  - Funding comes from the state General Fund and federal financial participation.[12]

- Low-Income Health Program
  - As part of the 2010 Bridge to Reform 1115 demonstration waiver of the California Department of Health Care Services (DHCS) leading up to the ACA Medicaid expansion, 54 counties participated in the Low-Income Health Program (LIHP) managed by DHCS.[13]
  - County participation in LIHP was voluntary for counties and included two programs for which eligibility had to follow Medicaid eligibility rules: the Medicaid Coverage Expansion (MCE) for those with incomes below 133% of the federal poverty level (FPL) and the Health Care Coverage Initiative (HCCI) for those with income above 133% FPL but below 200% FPL.
  - LIHP programs offered a core set of benefits (e.g., outpatient and acute inpatient hospital services, prescription medications, physical therapy) through MCE and HCCI and several additional benefits through MCE (e.g., minimum mental health services, nonemergency medical transportation). Counties used local funds to claim federal matching to finance services and administration. LIHP did not cover residents with UIS. At its peak, county LIHP programs provided services to some 650,000 California residents.
  - The LIHP program ended after the launch of Medi-Cal expansion in January 2014 and LIHP enrollees were transitioned into Medi-Cal.

Hospital Charity Care and Discount Payment Programs

While not an organized program, state laws providing guidelines for hospital "charity care" programs have been in place for decades. Since 2007, acute care, psychiatric, and specialty hospitals must provide information to the uninsured about available charity care, discounted payment programs, and government-sponsored health insurance. Recent laws, generally called Hospital Fair Pricing policies, have clarified eligibility requirements for hospital charity care and discount programs, increased standardization of billing and collections, and added other consumer protections. Starting January 1, 2025, hospitals must offer financial assistance to those without insurance with incomes up to 400% FPL.[14]

County Programs for the Uninsured

Before the ACA, counties had wide discretion to provide services to medically indigent adults (MIA) as required by their Welfare and Institutions Code Section 17000 obligation as the "provider of last resort."[15] Some counties had more than one program for uninsured adults. A 2019 paper from Insure the Uninsured Project offers a detailed resource of these programs by county, many of which remain operational but have adapted programmatic features since the various Medi-Cal expansions described above.[16] As described in that brief, there were four models of MIA programs:

- Provider counties that use county-operated hospitals and clinics to provide services.
- Payer counties that contract with or pay private hospitals, clinics, and providers to deliver care.
- Hybrid counties that provide some services through county clinics but contract other services to private hospitals.
  - County Medical Services Program for 35 counties with populations under 300,000 that contracts with a provider network (see the longer description below). The program is still operational.

Eligibility for these programs varied by age group, family income, and immigration status, and many had specific periods for eligibility to receive services (e.g., from several months to a full year). Benefits varied by county and program, and they ranged from primary care and preventive services only to extensive benefits, including inpatient hospital care, pharmacy, behavioral health, and dental services. Financing these

MIA programs were a combination of county General Funds and state realignment funds provided to counties for this and other related purposes.

One example of these programs is My Health LA. It was an outgrowth of the Los Angeles County LIHP program Healthy Way LA and provided primary and specialty care for residents of Los Angeles County age 26–49 with incomes at or below 138% FPL and who were not eligible for other coverage. Participants were required to have a medical home to coordinate and manage their care. Enrollees received services from a network of contracted clinics as well as Los Angeles Department of Health Services clinics and hospitals. My Health LA was operational from October 2014 to January 31, 2024, when the program ended due to the Medi-Cal expansion, and its 87,000 enrollees were transitioned to Medi-Cal.[17]

Continuing County Programs Post-ACA Implementation

Many counties continue to operate their MIA programs, though several have closed completely. These programs are not standardized and have varying program eligibility requirements, services provided, and other features. Some do not cover the immigrants with UIS who are ineligible for Medi-Cal. Most have evolved their eligibility and other program features since the Medi-Cal expansions to offer services to those not income-eligible for Medi-Cal. Most remaining programs make it clear that they are not offering insurance coverage. With the ACA optional expansion of Medi-Cal, the state and counties passed AB 85 in 2013 redirecting realignment funds away from county indigent programs to CalWORKs grant increases.[18] See Appendix C for a description of counties with operational programs.

Two examples of these county-based programs are the County Medical Services Program and Healthy San Francisco.

The County Medical Services Program

The County Medical Services Program (CMSP) continues to operate in 35 mostly small and rural counties, providing health coverage for uninsured low-income, indigent adults age 21–64 with incomes under 300% FPL who are not otherwise eligible for other publicly funded health care programs, notably Medi-Cal. A governing board sets policy for the program, and each county contracts with CMSP to provide services in that county.[19]

The CMSP does cover residents with UIS. The covered benefits, while broad, are not comprehensive (e.g., pregnancy-related services and long-term care are not included).[20]

Services are subject to prior authorization and medical necessity requirements, a share of cost, and some benefit limits. Interested people enroll through county health and human services departments.

Starting in 2020, the CMSP added the Connect to Care program offering preventive health services and prescription drugs, with enrollment directly through participating community providers such as clinics and pharmacies.

Healthy San Francisco

- Healthy San Francisco was established in 2007 and covers San Francisco residents age 18 and older with income up to 500% of the FPL who are uninsured and ineligible for Medi-Cal or Medicare.
- The program offers a wide range of services, including primary and preventive care, prescription drugs, inpatient services, and mental health services from the network of providers.
- Healthy San Francisco is funded through fees imposed on local businesses and patient copayments.
- Participants have a medical home and receive services from a network composed of San Francisco Department of Public Health clinics, San Francisco

Community Clinic Consortium clinics, and other providers within the City and County of San Francisco.

Issues, Considerations, and Questions for Providing Health Care Services to the Uninsured

After over a decade of expanding coverage and achieving the lowest uninsured rate ever in the state, California now faces the possibility, due to state and federal policy changes, of nearly four million people losing health care coverage, especially those with low incomes or UIS.[21] State policymakers and leaders from the health care delivery system, including health plans, providers, and counties, may need to rethink and possibly redesign what safety-net health care services look like for people who are uninsured. These will be challenging conversations, involving discussions around eligibility, health care services, systems of care, and financing. This will require discussions among state and county policymakers, Medi-Cal leadership, managed care plans, hospitals, clinics and other providers, advocates, and Medi-Cal enrollees who may face a transition. Table 2 lists a few high-level issues, considerations, and questions that could be addressed during those discussions.

Table 2. Issues, Considerations, and Questions for Providing Health Care Services to the Uninsured

ISSUE	CONSIDERATIONS AND QUESTIONS
Values	▸ What values and goals would frame these discussions and decisionmakings? ▸ How will the state protect the health of uninsured Californians, regardless of immigration status? ▸ How could this be an innovative opportunity to build upon the universal coverage system that the state has built up over the past decade? ▸ Is it the goal of this effort to provide every income-eligible uninsured Californian, regardless of immigration status, the same coverage as full-scope Medi-Cal, including physical care, behavioral health care, prescription drugs, long-term care, In-Home Supportive Services, and dental services? ▸ Or is it the goal to provide a limited set of services designed to keep people as healthy as possible? ▸ Is it a goal to provide these same services statewide? Or to allow counties to choose different programs, eligibility requirements, and services?
Leadership and governance	▸ How should these health care services be governed? ▸ The statewide Medi-Cal program has systematically taken most of the responsibility for the health care coverage of low-income uninsured people back from counties since 2014. Should the state maintain this responsibility? ▸ How will or could these responsibilities be shared by the state and counties, safety-net hospitals and clinics, private hospitals and providers, employers and individuals?
Adapting or building upon previous or existing coverage programs	▸ How should a program for this population be structured? ▸ What past or existing state and county programs could be adapted or used as models to provide meaningful health and other services to uninsured Californians (e.g., LIHP, CMSP, Healthy Way LA, Healthy San Francisco, MRMIP)? ▸ What new and innovative approaches to programs might offer coverage or services to California's uninsured? ▸ Would health care services require premiums, copayments, or a share of cost? If so, would these vary based on family size, age, income? Who would collect these? ▸ Would eligibility and enrollment processes be uniform across the state and counties?

Health care services	➤ Which health care and other services should be provided? ➤ Would services be extensive or limited? ➤ Primary care and prevention only? Prescription drugs? Long-term care? Dental care? ➤ Should behavioral health services be included? Hospital inpatient services? ➤ Should covered services mirror the "minimum essential coverage" provided in Covered California and Medi-Cal? ➤ To what degree would new or expanded programs be required to keep existing Medi-Cal providers?
Financing and realignment	➤ How should these health care services be financed? ➤ Should the state dedicate General Fund and other resources specifically to providing services to the uninsured? ➤ Should the state decide to once again "realign" responsibility for the uninsured back to counties, and how would costs be determined (e.g., number of uninsured served, health care services covered, age)? ➤ Would such a realignment to counties create a state mandate? How would the state and counties share costs? ➤ Would existing realignment statutes and formulas need to be renegotiated or amended? If so, how? ➤ Should employers participate financially in supporting coverage for employees? If so, how? Would it vary based on the size of the business?
Minimizing harmful impact on people	➤ How will establishing or adapting programs for the uninsured minimize negative impacts on those who transition out of Medi-Cal? ➤ For current Medi-Cal enrollees who drop from coverage, how would continuity of care be addressed as they move to a different program or change providers? Would existing Medi-Cal continuity of care policies apply? ➤ Would the state, counties, and providers engage in a planning process to facilitate such transitions? ➤ How would the recent Medi-Cal unwinding and managed care plan transition inform such planning and implementation?

"Notes: *LIHP* is Low Income Health Program; *CMSP* is County Medical Services Program; *MRMIP* is Major Risk Medical Insurance Program."

Conclusion

As California grapples with an evolving coverage landscape, this paper offers a foundation for informed, forward-looking policy and delivery-system planning. By reflecting on past successes and anticipating future challenges, it aims to support efforts to protect and reimagine care for the state's most vulnerable residents.

Appendix A. Medi-Cal Expansion Populations, May 2025 and August 2024

COUNTY	SB 75 CHILDREN	AGE 19–25	AGE 26–49	AGE 50+	ACA EXPANSION ADULTS*	TOTAL
Alameda	10,884	8,100	34,751	14,536	181,032	249,303
Alpine	†	†	‡	†	96	96
Amador	16	11	94	38	2,862	3,021
Butte	389	228	1,199	535	28,167	30,518
Calaveras	33	19	121	74	4,503	4,750
Colusa	135	75	303	166	2,538	3,217
Contra Costa	7,271	4,781	17,912	7,485	109,706	147,155
Del Norte	25	‡	95	78	3,578	3,776
El Dorado	274	151	1,010	411	14,104	15,950
Fresno	6,475	4,270	19,464	7,871	156,436	194,516
Glenn	184	116	587	272	3,440	4,599
Humboldt	193	156	978	322	21,913	23,562
Imperial	338	102	699	336	26,478	27,953
Inyo	48	27	148	95	1,716	2,034
Kern	6,647	4,401	22,895	9,964	131,818	175,725
Kings	764	522	2,112	986	18,749	23,133
Lake	586	273	1,274	381	10,095	12,609
Lassen	12	‡	58	29	2,533	2,632
Los Angeles	66,641	49,553	311,750	200,863	1,480,597	2,109,404
Madera	1,314	963	5,640	1,907	22,484	32,308
Marin	1,952	2,152	7,038	1,978	20,497	33,617
Mariposa	11	‡	55	22	2,069	2,157
Mendocino	642	342	2,087	780	14,039	17,890
Merced	2,125	1,318	7,019	2,704	40,027	53,193
Modoc	35	16	72	23	1,034	1,180

COUNTY	SB 75 CHILDREN	AGE 19–25	AGE 26–49	AGE 50+	ACA EXPANSION ADULTS*	TOTAL
Mono	63	41	233	87	1,317	1,741
Monterey	3,965	3,830	20,351	5,968	51,329	85,443
Napa	816	573	2,436	1,168	11,017	16,010
Nevada	128	78	525	187	10,707	11,625
Orange	14,734	9,955	61,444	35,888	373,166	495,187
Placer	738	376	2,102	744	25,339	29,299
Plumas	19	15	44	20	1,842	1,940
Riverside	9,931	6,001	38,114	20,345	314,980	389,371
Sacramento	6,214	3,818	20,717	7,823	197,282	235,854
San Benito	307	206	1,145	455	6,219	8,332
San Bernardino	8,712	5,122	34,641	19,495	299,244	367,214
San Diego	10,391	6,001	37,292	22,228	370,813	446,725
San Francisco	4,568	4,295	16,782	6,589	97,612	129,846
San Joaquin	4,210	2,336	14,125	5,429	85,817	111,917
San Luis Obispo	1,116	835	3,252	1,034	23,000	29,237
San Mateo	7,190	5,559	23,669	9,456	60,207	106,081
Santa Barbara	4,106	4,278	17,852	4,900	52,823	83,959
Santa Clara	12,876	8,356	43,625	21,384	156,282	242,523
Santa Cruz	916	907	5,035	2,030	28,683	37,571
Shasta	138	73	417	145	19,391	20,164
Sierra	‡	‡	‡	‡	225	225
Siskiyou	104	28	249	109	5,562	6,052
Solano	2,277	1,436	6,732	2,815	47,887	61,147
Sonoma	2,615	1,725	9,177	3,937	47,960	65,414
Stanislaus	4,168	2,182	12,204	5,001	73,675	97,230
Sutter	556	367	1,986	659	12,033	15,601

COUNTY	SB 75 CHILDREN	AGE 19–25	AGE 26–49	AGE 50+	ACA EXPANSION ADULTS*	TOTAL
Tehama	433	243	1,228	513	8,018	10,435
Trinity	‡	‡	48	‡	1,863	1,911
Tulare	4,127	2,652	15,290	6,825	86,914	115,808
Tuolumne	‡	17	71	25	4,857	4,970
Ventura	4,046	3,448	17,844	7,051	86,748	119,137
Yolo	676	393	2,268	1,078	19,913	24,328
Yuba	416	190	1,090	463	10,197	12,356
Statewide	**217,550**	**152,912**	**849,349**	**445,707**	**4,893,433**	**6,188,489**

* The ACA Expansion Adult enrollment figure here differs from that in Table 1, as this source with county data has August 2024 figures.

† County not included in the dataset.

‡ Cell suppressed due to small numbers.

Sources: "Medi-Cal Adult Full Scope Expansion Programs," California Health and Human Services Agency (CalHHS), August 13, 2025; "SB 75 - Full Scope Medi-Cal for All Children," CalHHS, last updated August 13, 2025; "Certified Eligible Individuals, by Aid Code, 2010 to the Most Recent Reportable Month," CalHHS, last updated August 13, 2025; and "Medi-Cal Certified Eligibles Data by Month with Demographics, by Aid Category," CalHHS, last updated July 3, 2025

Appendix B. County and State Programs for the Uninsured

PROGRAM	ELIGIBILITY	BENEFITS	COST SHARING	PROVIDERS	STATUTES AND OTHER RESOURCES
County Programs					
County medically indigent adult programs (see Appendix C) have wide discretion to provide services to uninsured adults. Large counties typically have their own programs. Smaller counties participate in CMSP. **Financing.** County General Fund and some state realignment funds. **Status.** Many medically indigent adult programs have closed. Those still operational have adapted eligibility and other features to adapt to Medi-Cal expansions (see Appendix A).	Varies by county but typically not eligible for Medi-Cal or other insurance coverage. **Income eligibility.** Ranges from <100% of the federal poverty limit (FPL) to <500% FPL. Some counties include an asset test. **Age eligibility.** Varies by county: no age restriction, over 19, 19–64, and under 64. **Immigration status restriction.** Varies by county.	Varies by county. A few counties provide extensive benefits but most provide limited or moderate coverage, such as prevention and primary care services; some offer specialty care, mental health, and dental. Some counties offer discount programs to support payment for services.	Varies by county and could include premiums, copays, and deductibles.	Models of medically indigent adult programs: ▸ Provider counties that use county-operated hospitals and clinics ▸ Payer counties that contract with or pay private hospitals, clinics, and providers ▸ Hybrid counties that provide services through county clinics but contract other services to private hospitals.	California Welfare and Institutions Code Section 17000[22]

PROGRAM	ELIGIBILITY	BENEFITS	COST SHARING	PROVIDERS	STATUTES AND OTHER RESOURCES
Low-Income Health Program (LIHP) was a voluntary county-funded program administered by the county health department or social services agency. LIHP included two components distinguished by family income level: Medicaid Coverage Expansion (MCE) and Health Care Coverage Initiative (HCCI). **Financing.** County funds with federal reimbursement. CMS-approved claims process for counties to receive federal reimbursement for LIHP costs. **Status.** Programs transferred enrollees into Medi-Cal in January 2014 and subsequently closed.	Ineligible for Medicaid and Children's Health Insurance Program, not pregnant. For MCE, a person may have other health insurance as long as they meet the other program requirements for enrollment. For HCCI, a person must not have other health coverage and must meet all other program requirements for enrollment. **Income eligibility.** For MCE, family income at or below 133% FPL. For HCCI, family income above 133% and up to 200% FPL. **Age eligibility:** 19–64. **Immigration status restriction.** Required proof of US citizenship or satisfactory immigration status.	LIHP programs offered a core set of benefits (e.g., outpatient and acute inpatient hospital services, prescription medications, lab services, physical therapy) through MCE and HCCI and several additional benefits through MCE (e.g., minimum mental health services, nonemergency medical transportation). Both MCE and HCCI program also provided care coordination.	No	Varied by county but largely existing safety-net providers. Enrollees were assigned to a medical home.	Bridge to Reform Section 1115 Medicaid Demonstration waiver (PDF)[23]
County Medical Services Program (CMSP) provides health coverage for uninsured low-income, indigent adults not eligible for other publicly funded health care programs. CMSP serves 35 small and rural counties with populations under 300,000. **Status.** CMSP has been operational since 1983 and still offers services to eligible people.	Residents not eligible for publicly funded health care programs, notably Medi-Cal. **Income eligibility.** Under 300% FPL. **Age eligibility.** Adults 21–64. **Immigration status restriction.** None.	**Connect to Coverage program.** Routine preventive care, some mental health services, and prescription drugs. Maximum prescription drug benefit of $1,500. **CMSP benefit.** Broad but not comprehensive (e.g., pregnancy-related and long-term care services are excluded). Services are subject to prior authorization, medical necessity requirements, and some benefit limits.	Copays for prescriptions in the Connect to Coverage program and share of cost for some services (depending on income).	Contracted community health clinics and hospitals.	Welfare & Institutions Code Sections 16809 et seq.[23] CMSP Governing Board Regulations (PDF) [24]

PROGRAM	ELIGIBILITY	BENEFITS	COST SHARING	PROVIDERS	STATUTES AND OTHER RESOURCES
Statewide Programs					
California Major Risk Medical Insurance Program (MRMIP) provided health insurance for residents unable to obtain insurance in the individual health insurance market due to preexisting conditions. **Financing.** State funds with temporary ACA funding through Pre-Existing Condition Insurance Plan program. **Status.** Terminated January 1, 2025.	Unable to obtain other coverage. Enrollment subject to a maximum enrollment cap and waiting list. **Income eligibility.** No. **Age eligibility.** No. **Immigration status restriction.** Must be California resident.	Comprehensive but no dental or vision coverage. **Other features.** Covered enrollee dependents.	Yes. Premium, $500 deductible (not applied to certain preventive services), out-of-pocket maximum, $75,000 annual cap, $750,000 lifetime cap.	Contracted health plans.	Welfare and Institutions Code Section 15870[25] Terminated in SB 159[26]
Restricted Scope Medi-Cal provides a limited set of benefits. It may also be referred to as "Emergency Medi-Cal." **Financing.** State General Fund and federal financial participation. **Status.** Available to all eligible people.	**Income eligibility.** Same income and other requirements as Medi-Cal eligibility. **Immigration status restriction.** Must be California resident.	Provides emergency and pregnancy-related services to those not meeting eligibility requirements.	No	All enrolled Medi-Cal providers.	
Medi-Cal Presumptive Eligibility ▶ Children's ▶ Hospital ▶ Pregnant People **Financing.** State General Fund and federal financial participation. **Status.** Available to all eligible people.	Self-attestation to: ▶ California residency ▶ Not enrolled in Medi-Cal ▶ Within household income limits ▶ Not exceeded Presumptive Eligibility enrollment period limitations **Age eligibility.** Under 19 for children. **Immigration status restriction.** Must be California resident. Enrollment is digital, through selected providers.	Provides full-scope benefits for children and adults through fee-for-service providers for up to 60 days. Provides limited scope coverage for selected outpatient prenatal services. The program limits number of times presumptive eligibility benefits can be received: ▶ Twice in 12 months for children ▶ Once in 12 months for adults ▶ Once per pregnancy for pregnant people	No	Enrolled providers for presumptive eligibility enrollment and services and fee-for-service providers.	Children's Presumptive Eligibility[27] Hospital Presumptive Eligibility[28] Presumptive Eligibility for Pregnancy[29]

PROGRAM	ELIGIBILITY	BENEFITS	COST SHARING	PROVIDERS	STATUTES AND OTHER RESOURCES
Breast and Cervical Cancer Treatment Program (BCCTP) **Financing.** State General Fund and federal financial participation. **Status.** Available to all eligibles.	Diagnosis of breast or cervical cancer requiring treatment. **Income eligibility.** Monthly income less than $5,360 for a family of four. **Immigration status restriction.** Must be California resident.	Cancer treatments for eligible low-income California residents diagnosed with breast or cervical cancer who do not have insurance.	No	All enrolled Every Woman Counts providers for screening and diagnosis.[30] Other enrolled Medi-Cal providers for treatment.	BCCTP home page[31]
Family Planning, Access, Care, and Treatment (FPACT) **Financing.** State General Fund and federal financial participation. **Status.** Available to all eligibles.	Medical need for family planning. **Age eligibility.** No. Must be able to get pregnant or cause a pregnancy. **Income eligibility.** At or below 200% FPL. **Immigration status restriction.** Must be California resident.	Provides comprehensive family planning and related services to people who qualify.	No	All enrolled FPACT providers.	FPACT home page[32]

PROGRAM	ELIGIBILITY	BENEFITS	COST SHARING	PROVIDERS	STATUTES AND OTHER RESOURCES
Hospital Charity Care and Discount Payment Programs					
Hospital Charity Care and Discount Payment Programs. Acute care, psychiatric, and specialty hospitals must provide information about charity care, discounted payment programs, and government health insurance. Recent Hospital Fair Pricing policies have clarified eligibility requirements, increased standardization of billing and collections, and added consumer protections. **Status.** Numerous current laws with oversight by the California Department of Health Care Access and Information.	Hospitals must offer financial assistance to those without insurance with incomes up to 400% FPL. Assets may not be considered for eligibility determination.	Not coverage but instead episodic hospital-based services.	Patients may still incur costs if eligible for discounted payments. Hospitals must limit discount payments to the amount the hospital would expect to receive for providing services from Medicare or Medi-Cal, whichever is greater.	All acute care, psychiatric, and specialty hospitals.	A.B. 2297 (Chapter 511, Statutes of 2024)[33] S.B. 1061 (Chapter 520, Statutes of 2024)[34] A.B. 1020 (Chapter 473, Statutes of 2021)[35]

Appendix C. Counties with Operational Medically Indigent Adult Programs

This appendix presents information about medically indigent adult programs in 23 large counties that are not part of the County Medical Services Program (CMSP). All the programs listed in this appendix are operational unless otherwise noted. Although some programs remain operational with policies, applications, and provider contracts in place, they have been "dormant" in that there have been few, in any, enrollees and claims submitted in recent years (e.g., Merced, Placer). Where available, links to the program landing page and other resources are provided.

- **Methodology.** The authors reviewed county program websites and validated operational status via phone call or email inquiries. For some counties, the authors reached out to county administrators for additional validation, program information, or both. For most programs, deep validation of each element was not undertaken beyond what is posted online or shared in communications, and how these programs are financed was not assessed. Some program features may be different.
- **Benefits/services.** Services provided vary widely but generally group into three coverage categories: (1) limited — selected outpatient services, but no or limited inpatient hospital services; (2) moderate — numerous outpatient services and inpatient hospital services, but no dental or mental health services; and (3) extensive — wide array of outpatient services, inpatient hospital services, and dental and/or mental health services. Most programs make clear that the coverage is not health insurance.
- **Eligibility requirements.** All programs require county residency for eligibility and that applicants are ineligible for Medi-Cal, Medicare, Covered California, and other health insurance coverage. Some programs require an eligible medical condition or diagnosis. Some programs offer coverage or service eligibility for a specified time of several months to a full year. Counties also vary in whether their programs cover residents with unsatisfactory immigration status.
- **Costs.** Counties vary widely in terms of copayments or cost sharing that may be charged to enrollees for services. Costs may also vary depending on family income.

COUNTY PROGRAM NAME	BENEFITS/SERVICES ▸ LIMITED ▸ MODERATE ▸ EXTENSIVE	ELIGIBILITY REQUIREMENTS ▸ AGE ▸ FAMILY INCOME ▸ ASSET LIMIT	COSTS ▸ COPAYMENTS ▸ COST SHARING	COVERS RESIDENTS WITH UIS?	PROGRAM RESOURCES
Alameda Health Program of Alameda County (HPAC)[36]	Extensive ▸ Preventive and routine care ▸ Urgent care ▸ Specialty care ▸ Prescription drugs ▸ Radiology ▸ Laboratory services ▸ Hospital inpatient services ▸ Emergency services ▸ Mental health services ▸ Dental services ▸ Medical equipment and supplies ▸ Ambulance and nonemergency transportation	Age ▸ 19 and over Income ▸ ≤200% FPL	Copayments <138% FPL: ▸ None >138%–150% FPL: ▸ Emergency: $35 ▸ Outpatient: $10 ▸ Inpatient: $100 ▸ Pharmacy: $5 per prescription, $50 max per visit ▸ Special procedures: $100 >150%–200% FPL: ▸ Emergency: $50 ▸ Outpatient: $15 ▸ Inpatient: $100 ▸ Pharmacy: $5 per prescription, $50 max per visit ▸ Special procedures: $100	Yes	Brochure (PDF)[37] Participant Handbook (PDF)[38]

COUNTY PROGRAM NAME	BENEFITS/SERVICES ▸ LIMITED ▸ MODERATE ▸ EXTENSIVE	ELIGIBILITY REQUIREMENTS ▸ AGE ▸ FAMILY INCOME ▸ ASSET LIMIT	COSTS ▸ COPAYMENTS ▸ COST SHARING	COVERS RESIDENTS WITH UIS?	PROGRAM RESOURCES
Contra Costa Contra Costa Basic Health Care Program[39]	Extensive ▸ Advice nurse ▸ Physical exams ▸ Allergy injections and testing ▸ Bloodwork ▸ Emergency dental ▸ Basic dental (age 5–14) ▸ Diabetic testing and supplies ▸ Durable medical equipment ▸ Emergency and urgent care ▸ Family planning services ▸ Hearing test ▸ Hemodialysis (acute) ▸ Hospitalization ▸ Immunizations ▸ Outpatient care ▸ Over-the-counter and prescription medications on preferred drug list ▸ Sterilization ▸ Supplies, disposable	Age ▸ All ages Income ▸ ≤300% FPL	Cost sharing Annual cost sharing based on income for a family of four: ▸ 100%–200% FPL: $0 ▸ 201%–250% FPL: $120 per adult, $60 per child ▸ 251%–300% FPL: $240 per adult, $180 per child	Yes	FAQ (PDF)[40] List of services[41] Cost sharing table (PDF)[42]

COUNTY PROGRAM NAME	BENEFITS/SERVICES ▸ LIMITED ▸ MODERATE ▸ EXTENSIVE	ELIGIBILITY REQUIREMENTS ▸ AGE ▸ FAMILY INCOME ▸ ASSET LIMIT	COSTS ▸ COPAYMENTS ▸ COST SHARING	COVERS RESIDENTS WITH UIS?	PROGRAM RESOURCES
Fresno Fresno County Medically Indigent Services Program (MISP)[43]	Moderate ▸ Emergency services ▸ Adult primary care ▸ Specialty care (e.g., cardiology, ob/gyn, neurology) ▸ Inpatient hospitalization ▸ Outpatient surgery ▸ X-rays, CT scans, MRIs ▸ Laboratory services ▸ Home health ▸ Pharmacy services ▸ Physical and occupational therapy	Age ▸ 19–64 Income ▸ ≤224% FPL Asset limit ▸ $3,300 (family of four)	Cost sharing Based on income (example for a household of four): ▸ $0–$2,743: no share of cost ▸ $2,744–$4,453: share of cost	No	Share of cost fact sheet (PDF)[44]

COUNTY PROGRAM NAME	BENEFITS/SERVICES ▸ LIMITED ▸ MODERATE ▸ EXTENSIVE	ELIGIBILITY REQUIREMENTS ▸ AGE ▸ FAMILY INCOME ▸ ASSET LIMIT	COSTS ▸ COPAYMENTS ▸ COST SHARING	COVERS RESIDENTS WITH UIS?	PROGRAM RESOURCES
Kern Kern Medical Wellness Program[45]	Limited ▸ Physician services (including specialty care and outpatient clinics) ▸ Cardiology ▸ Pulmonology ▸ Urology ▸ Women's health ▸ Neurology ▸ Endocrinology ▸ Generic prescription drugs ▸ Emergency care services ▸ Radiology/imaging services ▸ Orthopedics ▸ Physical therapy ▸ Wellness/health education ▸ Laboratory services ▸ Physical therapy	Age ▸ 19–64 Income ▸ ≤138% FPL	Cost sharing ▸ Percentage of the cost depends on the specific service and the member's program plan.	Yes	
Los Angeles My Health LA (PDF)[46]	Program closed January 31, 2024				

COUNTY PROGRAM NAME	BENEFITS/SERVICES ▸ LIMITED ▸ MODERATE ▸ EXTENSIVE	ELIGIBILITY REQUIREMENTS ▸ AGE ▸ FAMILY INCOME ▸ ASSET LIMIT	COSTS ▸ COPAYMENTS ▸ COST SHARING	COVERS RESIDENTS WITH UIS?	PROGRAM RESOURCES
Merced Medical Access Program	Moderate ▸ Primary care ▸ Outpatient specialty care ▸ Basic emergency care ▸ General acute care ▸ Ob/gyn services ▸ Intensive care ▸ Coronary care ▸ Clinical laboratory ▸ Radiology ▸ Pharmacy	Age ▸ 21–64 years old Income ▸ ≤100% FPL Other criteria ▸ Medical need must be established	Cost sharing ▸ No	No	
Monterey Esperanza Program	Program closed in 2024				
Orange Medical Safety Net Program[47]	Limited ▸ Immediate treatment of life- or limb-threatening urgent and emergent conditions ▸ Hospital care (inpatient and outpatient) ▸ Emergency ambulance transportation ▸ Nonemergency ambulance ▸ Physical therapy ▸ General x-rays, ultrasounds, MRIs, CT scans, diagnostic mammo-grams, and other diagnostics ▸ Laboratory services	Age ▸ 19–64 Income ▸ >138%–200% FPL ▸ $3,300 (family of four)	Copayments* ▸ Minute clinic: $20 ▸ Urgent care: $75 ▸ Lab test: $45 ▸ Specialist visit: $70 ▸ Emergency room visit: $300 ▸ Inpatient admission: $300 * See patient handbook for complete list of copayments.	No	Patient handbook (PDF)[48]

COUNTY PROGRAM NAME	BENEFITS/SERVICES ▸ LIMITED ▸ MODERATE ▸ EXTENSIVE	ELIGIBILITY REQUIREMENTS ▸ AGE ▸ FAMILY INCOME ▸ ASSET LIMIT	COSTS ▸ COPAYMENTS ▸ COST SHARING	COVERS RESIDENTS WITH UIS?	PROGRAM RESOURCES
Placer Medical Care Services Program (MCSP)[49]	Extensive ▸ Preventive and primary care services ▸ Pharmacy ▸ Chronic illness treatment ▸ Specialty care ▸ Inpatient hospitalization ▸ Mental health ▸ Dental services	Age ▸ 21–64 Income ▸ <100% FPL	Cost sharing ▸ Depends on income	No	
Riverside Riverside County MISP[50]	Limited ▸ For people who suffer trauma or have other emergency needs ▸ Financial assistance program	Age ▸ 21–64 Income ▸ ≤200% FPL	Copayments If income >100% FPL: ▸ $2 per prescription ▸ $5 per outpatient visit, such as doctors or special visits ▸ $10 per emergency room visit ▸ Eligibles with income that's 100%–200% FPL may qualify with a share of cost	Yes	Run through Riverside University Health System[51]
Sacramento Sacramento County MISP[52]	Moderate ▸ Primary care ▸ Specialty care ▸ Pharmacy ▸ Emergency ▸ Hospital ▸ Ancillary services ▸ Some services require prior authorization	Age ▸ 21–64 Income ▸ 138%–400% FPL	Cost sharing ▸ Share of cost if income >138% FPL ▸ Some share of cost for pharmacy	No	

COUNTY PROGRAM NAME	BENEFITS/SERVICES ▸ LIMITED ▸ MODERATE ▸ EXTENSIVE	ELIGIBILITY REQUIREMENTS ▸ AGE ▸ FAMILY INCOME ▸ ASSET LIMIT	COSTS ▸ COPAYMENTS ▸ COST SHARING	COVERS RESIDENTS WITH UIS?	PROGRAM RESOURCES
San Bernardino Arrowhead Regional Medical Center[53]	Limited ▸ Financial assistance through charity care and discounted payment plan at Arrowhead Regional Medical Center	▸ Uninsured (self-pay) OR ▸ High medical costs AND income ≤400% FPL	Cost sharing ▸ Depends on income	Yes	Fact sheet (PDF)[54]
San Diego San Diego County Medical Services[55]	Moderate ▸ Outpatient ▸ Inpatient ▸ Pharmacy ▸ Dental ▸ Emergency room ▸ Specialty physician referrals	Age ▸ 21–64 Income ▸ ≤165% FPL ▸ <165% can apply for hardship and may have share of cost	Copayments ▸ None	No	Patient handbook (PDF)[56]
San Francisco Healthy San Francisco[57]	Extensive ▸ Preventive, routine, and specialty care ▸ Prescription medicines ▸ Laboratory services and tests ▸ Hospital care ▸ Mental health care ▸ Alcohol and substance use treatment ▸ Ambulance services ▸ Family planning services	Age ▸ 18+ Income ▸ ≤500% FPL	Participant fees ▸ Quarterly fees based on income range from $0 to $450 Point of service copayment ▸ Based on income	Yes	
San Joaquin Medical Financial Assistance program[58]	Limited ▸ Charity care and discount payment program for hospital outpatient and inpatient services	Age ▸ 19 and older Income ▸ ≤400% FPL	Cost sharing ▸ Depends on income	Yes	Application (PDF)[59] Financial Assistance Policy (PDF)[60]

COUNTY PROGRAM NAME	BENEFITS/SERVICES ▸ LIMITED ▸ MODERATE ▸ EXTENSIVE	ELIGIBILITY REQUIREMENTS ▸ AGE ▸ FAMILY INCOME ▸ ASSET LIMIT	COSTS ▸ COPAYMENTS ▸ COST SHARING	COVERS RESIDENTS WITH UIS?	PROGRAM RESOURCES
San Luis Obispo MISP program[61]	Limited ▸ Services provided through community health centers ▸ Primary care ▸ Pharmacy ▸ Some diagnostic laboratory tests, x-rays, and ultrasounds ▸ Emergency hospital services	Age ▸ 19–64 Income ▸ 138%–250% FPL Asset limit ▸ Must meet asset limit	Cost sharing ▸ Monthly share of cost varies based on household income and Maintenance Need Level	No	Share of cost fact sheet[62]
San Mateo Access and Care for Everyone (ACE)[63]	Moderate ▸ Preventive care ▸ Prescription medicines ▸ Hospital visits ▸ Mental health ▸ Eye care ▸ Hospice ▸ Short-term skilled nursing ▸ Emergency dental ▸ Medical transportation	Age ▸ 19–64 Income ▸ ≤200% FPL	Copayments ▸ $360 application fee ▸ $360 annual participant fee ▸ $15 copays for most ▸ Copayments may be waived depending on income ▸ $1,000 annual out-of-pocket maximum	Yes	Participant handbook (PDF)[64]
Santa Barbara Indigent Care Program (ICP)[65]	Limited ▸ Primary care and specialty outpatient services provided through Santa Barbara County Health Care Centers ▸ Hospital inpatient services after application for charity care ▸ Limited pharmaceutical benefits	Age ▸ 18–64 Income ▸ <100% FPL	Cost sharing ▸ Varies based on income and household size	No	Board of Supervisors actions to change ICP program[66] Potential funding sources for uninsured patients[67]

COUNTY PROGRAM NAME	BENEFITS/SERVICES ▸ LIMITED ▸ MODERATE ▸ EXTENSIVE	ELIGIBILITY REQUIREMENTS ▸ AGE ▸ FAMILY INCOME ▸ ASSET LIMIT	COSTS ▸ COPAYMENTS ▸ COST SHARING	COVERS RESIDENTS WITH UIS?	PROGRAM RESOURCES
Santa Clara Primary Care Access Program (PCAP)[68] and Healthcare Access Program (HAP)[69]	Limited ▸ Primary and preventive care ▸ Laboratory ▸ Mammography and radiology ▸ Pharmacy ▸ Some specialty services ▸ Financial assistance for inpatient and emergency care in HAP program	Age *PCAP* ▸ 19 and older *HAP* ▸ 18 and older Income *PCAP* ▸ ≤650% FPL *HAP* ▸ ≤650% FPL: sliding scale financial assistance	Copayments *PCAP* May apply for some services *HAP* Sliding scale financial assistance: ▸ <400% FPL: 100% charity care ▸ 401%–650% FPL: discounted payment between 70% and 25%	Yes	PCAP services (PDF)[70] HAP notice[71]
Santa Cruz Medi-Cruz[72]	Limited ▸ By referral from primary care physician only ▸ Specialty services covered: ▸ Dermatology ▸ Enterology ▸ Gastroenterology ▸ Ob/gyn ▸ Nephrology ▸ Neurology ▸ Orthopedics ▸ Urology	Age ▸ 19+ Income ▸ 139%–160% FPL Residency ▸ Resident for at least 6 months Other criteria ▸ Must have a medical need covered by the program	Copayments ▸ None	Yes	Services not covered[73]

COUNTY PROGRAM NAME	BENEFITS/SERVICES ▸ LIMITED ▸ MODERATE ▸ EXTENSIVE	ELIGIBILITY REQUIREMENTS ▸ AGE ▸ FAMILY INCOME ▸ ASSET LIMIT	COSTS ▸ COPAYMENTS ▸ COST SHARING	COVERS RESIDENTS WITH UIS?	PROGRAM RESOURCES
Stanislaus Stanislaus County Indigent Health Care Program[74]	Moderate ▸ Primary care ▸ Specialty care ▸ Urgent care ▸ Inpatient services ▸ Emergency room ▸ Laboratory and diagnostic services ▸ Pharmacy ▸ Dental care	Age ▸ 21–65 Income ▸ ≤171% FPL (21–29 yrs) ▸ ≤198% FPL (30–39 yrs) ▸ ≤226% FPL (40–49 yrs) ▸ ≤251% FPL (50–59 yrs) ▸ ≤279% FPL (60–64 yrs) Asset limits ▸ $2,000 for individuals ▸ $3,000 for households Other criteria ▸ Prior authorization for some services	Cost sharing ▸ Yes	No	
Tulare Tulare County Medical Services	Limited ▸ Outpatient services ▸ Physician services ▸ Nonemergency hospital outpatient and inpatient ▸ Emergency medical services ▸ Laboratory and radiology ▸ Pharmacy and supplies dispensed by hospital ▸ Physical and speech therapy ▸ Podiatry	Age ▸ 21–65 Income ▸ ≤275% FPL Asset limits ▸ Net value ▸ Personal property ▸ Vehicle Other criteria ▸ Medical need and prior authorization for services	Cost sharing ▸ $0 if income ≤135% FPL Copayments ▸ $5 copayment minimum	No	

COUNTY PROGRAM NAME	BENEFITS/SERVICES ▸ LIMITED ▸ MODERATE ▸ EXTENSIVE	ELIGIBILITY REQUIREMENTS ▸ AGE ▸ FAMILY INCOME ▸ ASSET LIMIT	COSTS ▸ COPAYMENTS ▸ COST SHARING	COVERS RESIDENTS WITH UIS?	PROGRAM RESOURCES
Ventura County Health Care Agency programs[75]	Limited ▸ Outpatient and inpatient services provided by Ventura County Health Care Agency clinics and hospitals ▸ Programs: ▸ Self-pay discount ▸ Charity care ▸ Sliding fee discount payments	Age ▸ No age restriction Income ▸ ≤400% FPL Other criteria ▸ Self-pay patient ▸ High medical costs ▸ Medically necessary services	Cost sharing ▸ Yes ▸ Amount varies depending on program eligibility	Yes	Discount Payment Program Policy (PDF)[76] Charity Care Program Policy (PDF)[77] Sliding Fee Scale Program Policy(PDF)[78]

Note: *UIS* is unsatisfactory immigration status; *FPL* is federal poverty level.

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49. "Medical Care Services Program," Placer County Department of Human Services.
50. "Medically Indigent Services Program," Riverside County Department of Public Social Services.

51. "Medically Indigent Services Program," Riverside University Health System.
52. "County Medically Indigent Services Program," Sacramento County Department of Health Services.
53. "*Help Paying Your Bill*," Arrowhead Regional Medical Center.
54. *Help Paying Your Bill* (PDF), Arrowhead Regional Medical Center.
55. "*County Medical Services (CMS)*," San Diego County Health and Human Services Agency.
56. *County of San Diego County Medical Services Patient Handbook* (PDF), San Diego County Health and Human Services Agency, November 2022.
57. "Healthy San Francisco," San Francisco Department of Public Health.
58. "Help Paying Your Bill," San Joachin General Hospital.
59. *Financial Assistance Application Form* (PDF), San Joaquin General Hospital.
60. *San Joaquin General Hospital Financial Assistance Policy* (PDF), San Joaquin General Hospital, effective date June 4, 2025.
61. "Medically Indigent Services Program (MISP)," County of San Luis Obispo Health Agency.
62. Share of Cost Fact Sheet (PDF), County of San Luis Obispo Health Agency.
63. "Access and Care for Everyone (ACE)," Health Plan of San Mateo.
64. *San Mateo County Access and Care for Everyone 2018 Participant Handbook* (PDF), last updated March 27, 2019.
65. "Indigent Care Program," Santa Barbara County Public Health Department.
66. "Agenda Item 19-00186," Santa Barbara County Board of Supervisors, March 5, 2019.
67. "Potential Funding Sources for Uninsured Patients," Santa Barbara County Public Health Department.
68. "Primary Care Access Program (PCAP): Program Description," County of Santa Clara.
69. "Get Help Paying Your Bill with the Healthcare Access Program (HAP)," County of Santa Clara Health System.
70. *Primary Care Access Program (PCAP) Description of Services* (PDF), County of Santa Clara, last revised November 8, 2022.
71. *Help Paying Your Bills* (PDF), County of Santa Clara Health System, last updated January 2025.
72. "*MediCruz Program*," County of Santa Cruz Health Services Agency.
73. *To Applicants of Medi-Cruz* (PDF), County of Santa Cruz Health Services Agency.
74. "Indigent Health Care Program," Stanislaus County.
75. "How to Get Help Paying for Your Care," Ventura County Health Care Agency.
76. *110.032 Discount Payment Program Policy* (PDF), Ventura County Health Care Agency, last revised October 10, 2023.
77. *110.030 Charity Care Policy* (PDF), Ventura County Health Care Agency, last revised May 3, 2023.
78. *Sliding Fee Discount Payment Program Policy* (PDF), Ventura County Health Care Agency, last revised March 2023.

About the Author

Len Finocchio, DrPH, is an independent policy expert, researcher, and consultant focused on Medicaid and safety-net programs.

About the Foundation

The California Health Care Foundation (CHCF) is an independent, nonprofit philanthropy that works to improve the health care system so that all Californians have the care they need. We focus especially on making sure the system works for Californians with low incomes and for communities who have traditionally faced the greatest barriers to care. We partner with leaders across the health care safety net to ensure they have the data and resources to make care more just and to drive improvement in a complex system.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

ACTION: Consent Agenda

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

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 5:01 pm

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

ABSENT: Lilavati Indulkar, MD, Excused

PUBLIC COMMENT: None

Trustee Garrett asked if there was any public comment on the consent agenda, Ms. Jojola Gonsalves said there was none.

A. ACTION: Consent Agenda

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

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.

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

Ms. Jojola Gonsalves said that in agenda item E of the minutes, she changed the word "matrix" to "correlation" in the first paragraph.

Trustee moved Linton and Trustee Moss 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, Linton, Moss
NAYS: None
ABSTENTION: None

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

Trustee Garrett spoke briefly about the Doc of the Day program and the REACH program and his appreciation for the work that went into these important initiatives.

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

Trustee Garrett said he appreciated the report and was looking forward to a deeper dive in a future meeting.

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

Trustee Linton said, referring to the Quality Leader Awards, it was absolutely outstanding to get these results. Dr. Curtis said the good data was key. They tried to be systematic about applying A3 thinking to the improvement work. They were very intentional about collaborating with stakeholders and subject matter experts.

Trustee Garrett said Dr. Indulkar was interested in having a discussion at a future meeting about how they could maintain these results if they lost the QIP funding given the pending Federal cuts. Dr. Curtis said they had their kickoff meetings in person, and they invited people from the State to share their expectations given this climate. The QIP changes would not go into effect until 2028. They hoped there would be changes in policy before then to help offset the cuts.

Mr. Azizi said that Trustee Moss's medical credentials were agendized for agenda item F1 and that Trustee Moss would recuse himself from that item. He also announced that they were waiting on one of the other officers to arrive so they could have quorum once Trustee Moss was recused.

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. <u>CLOSED SESSION</u>

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. Trustee Fox arrived and voted along with Trustees Garrett and Linton to approve Trustee Moss's credentials. The Committee then considered the remaining credentialing reports for each of the medical staffs and approved credentials/privileges for fully qualified practitioners recommended by the medical staffs. No other reportable actions were taken.

ADJOURNMENT 6:10 PM

Alameda Health System			CPC Executive Summary to AHS and AH Medical Executive Committee(s) – November 2025			
Policies and Procedures				Chairs: Kelley Bullard, MD & Wacheera Davis, DNP, MSN, BSN, RN, MBA		
TOPIC or TITLE OF POLICY	**Document Owners**	**Summary of Changes**	**Last Approved Date**	**Next review date after BOT approval**	**Purpose**	**History of Review Committee**
AHS System Wide Policies & Procedures						
Immediate Use Compounding Policy for Nursing Personnel	Priya Patel, PharmD	• New policy to support unit based immediate use compounding • System P&T 10/2025 • Consent item - Policy		11/2028		• System P&T 10/2025 • CPC 11/6//2025 • MEC 11/19/2025
Controlled Substance Management Policy (33916-1)	Priya Patel, PharmD	• TJC Triennial Review – no changes • System P&T 10/2025 • Consent item – Policy		11/2028		• System P&T 10/2025 • CPC 11/6//2025 • MEC 11/19/2025
Pharmaceutical Waste Policy (34443-1)	Priya Patel, PharmD	• TJC Triennial Review – minor changes • System P&T 10/2025 • Consent item – Policy		11/2028		• System P&T 10/2025 • CPC 11/6//2025 • MEC 11/19/2025
System Pharmacy Scope Of Service Policy (34439-1)	Priya Patel, PharmD	• TJC Triennial Review - no changes • System P&T 10/2025 • Consent item – Policy		11/2028		• System P&T 10/2025 • CPC 11/6//2025 • MEC 11/19/2025
CEM MED Code Policy	Sammy Hodroge MD | ED Medical Director	• To create a standardized process for activating and managing a medical resuscitation in the community emergency departments. There is a current "Code 3" response but it is not codified.		11/2028		• CPC 11/6//2025 • MEC 11/19/2025
AHS Fire Safety Management Plan	James Helena	• Revised • No verbiage changes, this is up for renewal. Please note the template has not been changed since this was already progress in the system and the policy is in review status for the CPC. •		11/2028		• CPC 11/6//2025 • MEC 11/19/2025

Alameda Health System			CPC Executive Summary to AHS and AH Medical Executive Committee(s) - November 2025			
Policies and Procedures				Chairs: Kelley Bullard, MD & Wacheera Davis, DNP, MSN, BSN, RN, MBA		
TOPIC or TITLE OF POLICY	**Document Owners**	**Summary of Changes**	**Last Approved Date**	**Next review date after BOT approval**	**Purpose**	**History of Review Committee**
Conducting Monthly Tests of Emergency Diesel Generators	James Helena	• Revised		11/2028		• CPC 11/6//2025 • MEC 11/19/2025
Emergency Generator Failure	James Helena	• Revised		11/2028		• CPC 11/6//2025 • MEC 11/19/2025
Malignant Hyperthermia	Lisa Burden	• Renewal; No revisions.		11/2028		• CPC 11/6//2025 • MEC 11/19/2025
HR Section 4.00 - Policy 4.21 Annual Competencies	Sara McElfresh	• This policy has been revised to reflect the implementation of the new LMS system, incorporate updated information regarding notification of non-compliance per Legal's recommendations for clarity, and outline the process for addressing non-compliance among temporary and registry employees.		11/2028		• CPC 11/6//2025 • MEC 11/19/2025
HR Section 2.00 - Policy 2.51 Personal Leave of Absence	Sara McElfresh	• Revised document---Revised eligibility requirements and edited sections to simplify language noted in policy. All edits were reviewed/approved by AHS Legal Team (Jonathan Su).		11/2028		• CPC 11/6//2025 • MEC 11/19/2025
HR Section 1.00 – Policy 1.26 Rehire or Reinstatement to Employment	Sara McElfresh	• Transferred to new template – adding Scope and reviewed to make sure that information is accurate to current operations		11/2028		• CPC 11/6//2025 • MEC 11/19/2025

Alameda Health System			CPC Executive Summary to AHS and AH Medical Executive Committee(s) – January 2026			
Policies and Procedures				Chairs: Kelley Bullard, MD & Wacheera Davis, DNP, MSN, BSN, RN, MBA		
TOPIC or TITLE OF POLICY	**Document Owners**	**Summary of Changes**	**Last Approved Date**	**Next review date after BOT approval**	**Purpose**	**History of Review Committee**
AHS System Wide Policies & Procedures						
Continuous Peripheral Nerve Blocks Using Infusion Pumps Policy	Dr. Prakash/Dr. Eric Kim	• Add CADD pump use for peripheral nerve blocks on the inpatient side • System P&T approval 11/2025 • Pain and Addiction Committee approval 11/2025 • Consent Item - PolicyTech		01/2029		• System P&T 11/2025 • CPC 12/4//2025 • MEC 1/21/2026
PREPARATION AND ADMINISTRATION OF IV CONTRAST MEDIA IN CT & MRI	Fredrick D. Lee II, RT (R), Ed.D., CRA, FACHE	• Need formal approval of dept specific policy for TJC • System P&T approval 11/2025 • Submitted to CPC by P&T		01/2029		• System P&T 11/2025 • CPC 12/4//2025 • MEC 1/21/2026
PREPARATION AND ADMINISTRATION OF Oral Contrast Policy	Fredrick D. Lee II, RT (R), Ed.D., CRA, FACHE	• Need formal approval of dept specific policy for TJC • System P&T approval 11/2025 • Submitted to CPC by P&T		01/2029		• System P&T 11/2025 • CPC 12/4//2025 • MEC 1/21/2026
Subanesthetic Ketamine Use for Pain or Withdrawal Clinical Practice Guidelines	Lauren Roller, PharmD/Dr. Anderson	• Change Max IV Push dose from 50mg to 30mg • Add IBW for dosing of Ketamine • System P&T 10/2025 • Pain and Addiction 10/2025 • Consent item – Clinical Practice Guidelines • Returning to MEC		01/2029		• System P&T 10/2025 • CPC 11/2025 • MEC 11/2025 and 1/21/2026
PATIENT IDENTIFICATION POLICY	Dawn Anderson MSN, MBA, HCM	• REVISED		01/2029		• CPC 12/4//2025 • MEC 1/21/2026
Master Clock Policy	James Helena	• Renewal Only • No verbiage changes		01/2029		• CPC 12/4//2025 • MEC 1/21/2026

Alameda Health System			CPC Executive Summary to AHS and AH Medical Executive Committee(s) - January 2026			
Policies and Procedures				Chairs: Kelley Bullard, MD & Wacheera Davis, DNP, MSN, BSN, RN, MBA		
TOPIC or TITLE OF POLICY	**Document Owners**	**Summary of Changes**	**Last Approved Date**	**Next review date after BOT approval**	**Purpose**	**History of Review Committee**
Red Flag Identity Theft Policy	Akemi Renn, CHC, CHPC, CPC	• New		01/2029		• CPC 12/4//2025 • MEC 1/21/2026
Registered Dietitian Nutritionist (RDN) Competency Policy	Rosylan M Rojas | MS, RD	• Revised • This policy was due for review. A policy statement was added, and the format was updated to align with the current AHS Policy Template. • Language revised to be more concise.		01/2029		• CPC 12/4//2025 • MEC 1/21/2026
Swallowing Screen, Nursing Bedside Policy	Ginger Manss, DNP, RN	• Revised • Added Policy statement, Scope, and responsibilities as they were missing from previous version; Added pertinent definitions; Clarified process by deleting double negatives and the YES or NO statement; Added statement that if patient fails a swallow screen and subsequently has status improvement, may be re-screen with a physician order; Updated references. • KEYWORDS –to include in the PolicyTech search function: Dysphagia Screen		01/2029		• CPC 12/4//2025 • MEC 1/21/2026

Alameda Health System			CPC Executive Summary to AHS and AH Medical Executive Committee(s) - January 2026			
Policies and Procedures				Chairs: Kelley Bullard, MD & Wacheera Davis, DNP, MSN, BSN, RN, MBA		
TOPIC or TITLE OF POLICY	**Document Owners**	**Summary of Changes**	**Last Approved Date**	**Next review date after BOT approval**	**Purpose**	**History of Review Committee**
Hemodialysis Patient Management	Berlinia E. Leonor | MSN, BSN, RN	• REVISED • The revised hemodialysis patient management policy incorporates the SBAR (Situation, Background, Assessment, Recommendation) framework as a standardized communication tool for handoffs between the primary nurse and the hemodialysis nurse. This method requires the primary nurse to clearly articulate the situation of the patient, detailing patient current clinical condition related to hemodialysis treatment, including access points and vital sign parameters. The nurse will also provide relevant background information and conduct a comprehensive assessment of the patient's condition, addressing neurological, respiratory, genitourinary, gastrointestinal systems, as well as any lines, wounds, and critical lab results. Finally, the nurse will offer recommendations for necessary interventions following hemodialysis and ensure safe transport back to the designated patient floor.		01/2029		• CPC 12/4//2025 • MEC 1/21/2026

ALAMEDA HEALTH SYSTEM	Policy	
	Immediate-Use Compounding Policy for Nursing Personnel	**29958 1**
	LEVEL ☐ System ☐ Site	EFFECTIVE DATE: 1/2026

Purpose
To outline the process and requirements for compounding immediate-use sterile preparations (CSPs) by nursing personnel in accordance with USP <797> guidelines. This policy ensures patient safety, regulatory compliance, and aseptic technique.

Scope
This policy applies to all licensed nursing personnel authorized and trained to prepare immediate-use CSPs in acute care, procedural, and emergency settings outside of a pharmacy cleanroom.

Definitions
- Compounding: Involves mixing more than three components or altering a product beyond simple reconstitution or mixing.
- Immediate-Use Compounding: Preparation of a sterile medication for a specific patient in urgent situations when delays would harm the patient, and pharmacy services or cleanroom facilities are not accessible.
- Beyond-Use Date (BUD): The date/time by which a compounded preparation must begin administration.
- CSP (Compounded Sterile Preparation): A medication prepared by combining, mixing, or altering components under sterile conditions.

Policy
Nurses may perform immediate-use sterile compounding only when all the following criteria are met:

A. Eligibility
   a. The medication is required urgently or during times when the pharmacy is not accessible (e.g., nights, weekends).
   b. The preparation involves no more than three different sterile components. More than one vial of the same drug is considered one product.
   c. Hazardous drugs (e.g., antineoplastics) are not eligible for immediate-use preparation.
   d. The preparation is for one patient only, for immediate administration.

Procedure

A. Preparation Requirements
   a. Only one immediate-use CSP may be prepared at a time.
   b. Perform preparation in a clean, uncluttered, and designated functionally separate area.
   c. Wash hands thoroughly before preparation.
   d. Use aseptic technique to prevent contamination.
   e. Discard any unused contents of single-dose vials or containers immediately after compounding.

B. Labeling – all CSP's must be labelled with:
   a. Names and amounts of all active ingredients.
   b. Initials of the nurse who prepared it.
   c. BUD (must begin within 1 hour of preparation).

C. Documentation & Administration
   a. Begin administration within 1 hour of preparation.
   b. If administration has not started within this time, discard the preparation.
   c. Document preparation time, administration time, components used, and preparer initials in the patient's chart.

Training and Competency

A. All nurses performing immediate-use compounding must complete initial training on aseptic technique and USP <797> standards.
B. Annual competency assessments will be documented but do not require media fill or fingertip testing.

Compliance and Monitoring

A. Nursing supervisors and infection prevention personnel will monitor adherence to this policy.
B. Non-compliance will result in re-education and may limit privileges for immediate-use compounding.

References

A. USP <797> Pharmaceutical Compounding—Sterile Preparations (2023)
B. CDC Safe Injection Practices

		System	AHS Core	AH
Pharmacy Department	DATE:	10/2025		
Nursing Department	DATE:	10/2025		
System Pharmacy & Therapeutics	DATE:	10/2025		
Clinical Practice Committee	DATE:	11/2025		
Board of Trustees	DATE:	01/2026		

ALAMEDA HEALTH SYSTEM

CONTROLLED SUBSTANCE MANAGEMENT POLICY

Effective Date	1/2026	***Date Revised***	Not Approved Yet
Document Owner	PRIYA PATEL (MGR SYS MED SAFETY-CLIN PHARM)	***Next Scheduled Review***	1/2029
Executive Responsible	DIRECTOR, PHARMACY		

PURPOSE

The organization shall have controls in place that meet all DEA and State Board Requirements for controlled substances and for other medications deemed to have high potential for diversion.

DEFINITIONS

- Controlled Substances (CS): Any medication defined by the DEA as a Scheduled Medication in Class I, II, III, IV, or V.
- Narcotics: All a subset of controlled substances that produce sedation or drowsiness effect.

POLICY

A. ***Security***

a. Storage

i. Any area containing CS shall remain secure at all times. CS should never be left unattended.

ii. All CS for inpatient use shall be secured in a designated automating dispensing machine (ADM) or in a locked, irremovable cart/cabinet.

iii. CS will not be stocked in any ancillary unlocked areas.

iv. Each pharmacy will remain securely locked. Only designated pharmacy staff shall have access to the securely locked area.

v. The pharmacy, including medication preparation, dispensing, and storage areas will be designated as a "Restricted Area." Access shall be granted only to pharmacy staff and those authorized by a staff pharmacist. No access by non-pharmacy personnel will be permitted unless a licensed pharmacist is in the pharmacy, (a pharmacist must remain in the pharmacy during the presence of non-pharmacy personnel).

vi. In the Pharmacy, controlled substances must be securely stored within the designated controlled substance pharmacy storage area. Only a pharmacist or pharmacy technician shall have access to controlled substances in the pharmacy.

vii. All controlled substances (Schedules II-V) will be secured in a designated Automated Dispensing Machine (ADM) or a lockable cabinet. The Director of Pharmacy/Pharmacist in Charge (DOP/PIC) will maintain a list of all prescribers (as authorized by state regulations) and personnel authorized to handle controlled substances, inclusive of pharmacists, pharmacy technicians,

nurses, nurse anesthetists/practitioners, physician assistants, and physicians. Records shall be maintained for a minimum period of 2 years following cessation of employment.

b. Access
    i. Access to CS storage areas will only be accessible to authorized staff.
    ii. Automated dispensing machine access shall only be through Biometric Identification (BIO-ID)
    iii. If BIO-ID is unavailable, and ADM passwords must be used, the passwords will be set to expire every 90 days
    iv. For all sites and units with automated dispensing machine the blind count process will be used when CS are stocked and removed. The blind count process is when the automated dispensing machine user is required to manually count the remaining product and enter this information as part of the transaction. The user is not provided with the tallied count of remaining medication.
    v. Automated dispensing machine and non- automated dispensing machine access is removed promptly for terminated employees.
    vi. Patient specific CS infusions (e.g. PCA's, epidurals, large volume continuous infusions) are enclosed in a locked box.
    vii. CS brought in by a patient that cannot be returned home are considered Patient Own Medication will be stored in a locked area of the pharmacy.

B. ***Pharmacy Ordering and Receiving of Controlled Substances***
    a. General requirements
        i. Ordering and receiving of CS scheduled II may be completed by either of the two processes outlined in Section B Controlled Substance Ordering System (CSOS -preferred) or Section C (use of DEA 222 forms) or a combination of both processes.
        ii. The registrant of the DEA renewal is the person of record for the Power of attorney for the site.
        iii. Pharmacist in Charge will determine maximum number of staff/managers who that person will grant the Power of Attorney authority to execute orders for CS Scheduled II drugs.
        iv. The registrant will complete DEA paperwork to give these staff/managers power of attorney authority. If a pharmacist in charge changes and/or the DEA renewal registrant changes, all new power of attorney paperwork for staff/managers must be completed prior to execution of CII order forms. Power of Attorney authority and paperwork are maintained on site at the pharmacy.
        v. Monthly Record of Controlled Substance Purchases. The Pharmacy Director or Administrator must maintain the purchasing summary available from drug wholesalers, or a written history of all controlled substance purchases made by the facility for the month, sorted by date.
    b. Use of the Controlled Substance Ordering System to Purchase Controlled Substances, Schedule medications.
    c. Campuses are encouraged to adopt the electronic CSOS process for ordering control

substances.

d. Control of DEA 222 Forms and Registration Certificate
    i. DEA 222 forms used to order Schedule II if CSOS is not available
    ii. Authority**:** Upon receipt of the DEA 222 form from the Drug Enforcement Agency (DEA), the PIC or designee must record each DEA form 222 into a control log to document all forms received into the pharmacy.
    iii. Security**:** Unused DEA 222 forms will be stored in a secured area (e.g. vault, locked drawer) and only accessible by those individuals authorized to order controlled substances for schedules II.
    iv. **NO PRE-SIGNING of DEA 222** Forms allowed. DEA 222 forms should only be signed by the authorized agent only as orders are placed. Blank forms should never be pre-signed.
    v. Execution**:** Care should be taken when filling out a DEA 222 form so that no erasures or alterations are made anywhere on the form. If a mistake is made, void all copies of the form and maintain the voided copy in your records. The Suppliers Copy 1 and DEA Copy 2 are sent to the drug wholesaler/supplier and Purchasers Copy 3 retained in the pharmacy.
    vi. Ordering and Receiving of Controlled Substances: should be performed by different individuals whenever possible, including at least one pharmacist. Two employees will sign out DEA 222 forms or forms are kept in CII safe.
    vii. Reconciliation**:** The receiving process must include reconciliation of controlled substances against the packing slip or invoice accompanying the order as well as the DEA 222 ordering form.
        1. When Schedule II drugs are delivered/received, a pharmacist must verify the order immediately against the invoice, prior to signing the delivery receipt and releasing the courier. Pharmacy personnel must be in attendance for receipt of any delivery or delivery cannot be accepted.
        2. Reconciliation of the DEA 222 form will be completed within 24 hours
        3. The quantity received and date will be filled in on all DEA 222 forms
        4. The quantity received and date and signatures will be filled in on the invoice.
        5. The filled-out DEA 222 form will be attached to the original corresponding invoice and filed separately for 7 years.
        6. The medications are then logged into the automated dispensing machine for secure storage.

viii. Discrepancies**:** In case of any order discrepancy, shortage or breakage, the wholesaler must be notified and the incident documented on the packing slip/invoice.

1. Incomplete or Partial Schedule II Orders and Filing DEA Form 222
    a. If the DEA Form 222 is not complete (i.e. part of the order has not been received), the form and the invoice(s) shall be filed in a pending file until the balance of the order is received.
    b. At the time of the receipt of the additional order, the accompanying invoice(s) must be attached to the DEA Form 222 and invoice(s) from the pending file must also be attached to complete the documentation as outlined above.
    c. Upon the completion of the DEA Form 222, updates to the DEA Form 222 Log and Controlled Substance Perpetual Inventory Record, the DEA Form 222 shall be attached to the applicable invoice(s) and filed numerically in a secure retrievable file, as prescribed by state and/or federal statute/law. OR
    d. If the vendor is unable to fill an order in its entirety, do not backorder. If unavailable the pharmacist will note "0 (zero)" quantity, date and sign the DEA Form 222. The Schedule-II controlled substances will then be reordered on a new DEA Form 222.
    e. Pharmacist receives medications, match amount against ordered quantity, Form 222 and invoice.
    f. Reconciliation of inventory is done, and receipt is signed by receiving pharmacist. The medications are then logged into automated dispensing machines for secure storage.
    g. Any unfilled narcotic orders will not be signed off as being received. The outstanding, unfilled order will then be matched with a later invoice when that item is subsequently delivered.
    h. All of the above records are then stapled together and stored in the CII medication file.

C. ***Preparation and Distribution of Controlled Substances within the Hospital***

a. Tamper evident packaging is utilized for CS prepared by pharmacy
b. Automated dispensing machines are utilized in patient care areas for the distribution of CS and are interfaced with the electronic patient profile in those units that profiled machines will be used to limit access only to medications ordered for a specific patient.
c. Bar code scanning is utilized when replenishing automated dispensing machines whenever possible.
d. The number of CS on override status in profiled automated dispensing machines are minimized (e.g. one-time injectables for emergencies)
e. For CS delivered to patient care areas, two staff members must be involved (e.g., pharmacist orders the drug, technician sends the drug).
f. Manual deliveries to non- automated dispensing machines must be co-signed by the

receiving RN and documentation is kept in the pharmacy.

g. Only a pharmacist and pharmacy technician will distribute controlled substances from the pharmacy stock to the nursing unit/OR suite.
h. Controlled substances stock will be replenished daily during pharmacy operating hours, or as needed.
i. Routinely used controlled substances will be stocked on each unit per established par levels based on regular usage evaluation or collaboration with nursing personnel.

D. ***Ordering and Prescribing***

a. Prescribing of CS is limited to only those who have a current and verified DEA registration with controlled substance prescribing privileges. Registrants may include physicians, other Licensed Independent Practitioner (LIP) or APP (Advanced Practice Professional).
b. The hospital shall have medical staff bylaws or a policy that shall specify the requirements for an LIP or APP with control substance prescribing privileges to have a verified and current DEA registration.

E. ***Administration***

a. Only healthcare providers operating within the scope of their practice may administer CS.
b. The individual retrieving CS from an automated dispensing machine /locked storage area is also the person that administers the medication. Exceptions may include emergencies.
c. Scheduled medication removal and administration should occur within 60 minutes of order
d. Unscheduled/PRN medication administration should occur within 30 min of removal
e. PCA syringe administration should have two licensed personnel verifying order and verification of amount

F. ***Waste and Destruction of CS***

a. Waste
    i. Waste should occur at time of removal or within 30 minutes of removal and documented in the automated dispensing machine when possible
    ii. A witness is required for all waste in the automated dispensing machines and those disposed of in the controlled substance waste bins (e.g. Rx Destroyer)
    iii. Waste should occur in limited access-controlled substance waste bins
    iv. For waste of CS Patches, staff is to wear gloves, fold with sticky side's together and cut patch. Dispose of the cut patch into the appropriate limited access-controlled substance waste bin.
b. Destruction:
    i. Any CS approaching expiration will be removed from stock documented in the CS Destruction Log and kept segregated from other stock.
    ii. Expired meds will be destroyed using the "Reverse Distributor" process.

G. ***Inventory of CS***

a. **Pharmacy**

i. The Pharmacist-in-Charge, or a designated pharmacist will be involved with the quarterly controlled substance inventory reconciliation

1. Full physical count of all CII quantities within the pharmacy, which excludes hospital unit ADMs
2. Reconciliation
    a. Perform a physical count, not an estimate, of all quantities of federal C-II controlled substances.
    b. Review all acquisitions and dispositions of federal C-II controlled substances since the last inventory reconciliation report.
    c. Compare (a) and (b) to determine if there are any variances.
    d. All records used to compile each inventory reconciliation report shall be maintained in the pharmacy or clinic for at least 3 years in a readily retrievable form;
    e. Possible causes of overages shall be identified in writing and incorporated into the inventory reconciliation report.
3. Inventory Reconciliation reports must be dated and signed by the person performing the inventory and countersigned by the Consultant Pharmacist, PIC or clinic professional director.

ii. Annual Perpetual Inventory Count includes inventory of all controlled substances in the facility performed once a year. The inventory of the controlled substances must include the following:

1. Name and location of the hospital
2. DEA #
3. Time/date of inventory
4. Opening/close business
5. Beginning date of stocking of the control drug inventory

iii. Controlled substances waiting to be destroyed will be sequestered and segregated while waiting for reverse distribution.

b. **Nursing**

i. Unit automated dispensing machines

1. Depending on the campus and the automated dispensing machine functionality, either of the two will occur:
    a. Two licensed nursing staff members will be involved with both the end of shift accessed only CS inventory count and the weekly inventory count of all CS
    b. Two licensed nursing staff members will be involved with end of shift count inventory.

H. ***Record Keeping of CS***

a. Most controlled substance records need to be maintained on site for the prescribed DEA storage timelines (e.g., inventory records) of 3 years.
b. Record keeping of inventories and invoices for controlled substances will be kept

separate for CI & CII, CIII-CV and non-controlled drugs.

c. Pharmacy must keep a record of all records from the Reverse Distribution Company for a minimum of 2 years.

I. ***Monitoring***

d. A "Compare Report" to identify stock removal and delivery will be reviewed, validated and signed off by the pharmacist for reconciliation as the delivery of the CS occurs.

e. Non-profiled automated dispensing machine will require monthly random auditing to reconcile physician order with Controlled substance automated dispensing machine removal and administration.

f. Undocumented controlled substance waste reports will be generated and reconciled

g. All automated dispensing machine CS Discrepancies shall be resolved by the involved nurse(s) and nurse manager before change of shift. No licensed staff is to be dismissed until the discrepancy is resolved. Discrepancies that cannot be resolved are jointly reviewed by pharmacy and nursing leadership.

h. Metrics will be tracked and trended to MERT

i. Any discrepancies shall be submitted into the AHS Safety Alert.

J. ***Reporting CS losses***

a. A pharmacy or clinic shall report in writing identified losses and known causes to the following regulatory bodies:

i. State Board of Pharmacy within 30 days of discovery unless the cause of the loss is theft, diversion, or self-use in which case the report shall be made within 14 days of discovery.

ii. DEA for any theft or significant loss of any controlled substance within one business day of discovery of such loss or theft.

b. If the pharmacy or clinic is unable to identify the cause of the loss, further investigation shall be undertaken to identify the cause and actions necessary to prevent additional losses of controlled substances.

REFERENCES

1. Title 16 State Board of Pharmacy CCR 1715.65 Inventory Reconciliation Report of Controlled Substances

2. Drug Enforcement Administration: 1-800-882-9539 and www.deadiversion.usdoj.gov.

3. US Dept of Justice: DEA Division. Pharmacist Manual: An Informational Outline of the Control Substance Act. (http://www.deadiversion.usdoj.gov/pubs/manuals/pharm2/pharm_manual.pdf)

4. California State Board of Pharmacy. Current Year Lawbook for Pharmacy. (http://www.pharmacy.ca.gov/laws_regs/lawbook.pdf)
5. Reducing Controlled Substances Diversion in Hospitals

(http://www.chpso.org/sites/main/files/file-attachments/controlled_substance_diversion.pdf)

APPROVALS

		System	Alameda	AHS/Highland/John George/San Leandro
Department	**Date:**	10/2025		
Pharmacy and Therapeutics (P&T)	**Date:**	10/2025		
Clinical Practice Council (CPC)	**Date:**	11/2025		
Medical Executive Committee	**Date:**	11/2025		
Board of Trustees	**Date:**	01/2026		

ALAMEDA HEALTH SYSTEM

PHARMACEUTICAL WASTE

Effective Date	1/2026	***Date Revised***	10/2025
Document Owner	MGR SYS MED SAFETY-CLIN PHARM	***Next Scheduled Review***	1/2029
Executive Responsible	BOT, QPSC, DIRECTOR – PHARMACY, CAO, CNE, CMO		

Purpose

To ensure Pharmaceutical waste is segregated, contained, transported, treated and disposed of in accordance with federal, state, county and city regulations.

Policy

1. The Department of Pharmacy Services shall serve as a resource for up-to-date information on pharmaceutical waste management.
2. Pharmacy is responsible for identification and categorization of all pharmaceuticals that may become Resource Conservation and Recovery Act (RCRA) hazardous pharmaceutical waste.
3. Each patient care unit and department is responsible for appropriate handling, storage and disposal of pharmaceutical waste products that is generated from the medication use process.
4. Pharmaceutical waste containers will be labeled with a start date and a 90 day beyond use date.
5. When the container is full or one week before it reaches 90 day limit, the container will be sealed with provided seals and EVS contacted to have the container moved to the secured storage area for removal and incineration by an outside vendor.
6. The pharmaceutical waste may be stored on site at the hospital for up to 1 year from start date before transporting to a site for incineration. The transportation of the waste must be recorded using a Department of Health Service (DHS) approved medical waste tracking document.

Definition

Pharmaceutical waste is any partially used medication (more than trace amounts) in IV infusion containers, tubing, syringes, ampules or vials. Pharmaceutical waste also includes tablets, capsules, oral solutions, suppositories, topical products, patches and inhalers.

Procedure

1. **Acceptable for Sewering:** IV solutions containing normal saline, lactate, nutrients such as dextrose, vitamins and electrolytes such as potassium. These IV solutions shall be drained down the sewer and the IV containers and tubing discarded in the regular trash after removal of patient identifiers on IV label.

2. **NOT Acceptable for Sewering:** Hazardous waste and non-hazardous waste as regulated under the Resource Conservation and Recovery Act (RCRA). This includes both liquid and solid pharmaceuticals and all controlled substances.

3. Pharmaceutical waste containers will be provided to patient care areas for waste management. Containers will be placed in point of use areas and secured as in the management of any sharps container. Pharmaceutical waste is segregated from other types of medical wastes and contained in sturdy leak-proof containers labeled on the top and sides with the words, "**INCINERATION ONLY"**. Each container will be labeled with the type of waste to be placed inside (see below).

   Segregation of pharmaceutical wastes shall follow the guidelines as outlined in AHS System Waste Chart and per instructions provided in epic.
   1. This guideline will be posted adjacent to the pharmaceutical waste bins
      a. **Pharmaceutical waste in WHITE/CREAM/BEIGHE bins with BLUE/PURPLE tops:** IV containers, tubing, syringes, vials and ampules containing medications (except RCRA waste), tablets, capsules, topical products and inhalers (except RCRA – Aerosol waste).
      b. .
      c. **RCRA waste in BLACK bins with WHITE tops:** Hazardous waste. RCRA items will be labeled "RCRA" by Epic (Table 1). Special BLACK RCRA bins included P-listed (for warfarin only) and Aerosol (for metered dose inhalers (HFA), aerosol sprays, foams, topical sprays (except Thrombin which can go into regular Pharmaceutical waste bin).
      d. **Chemotherapy/Biotherapy Waste in YELLOW bins with WHITE tops:** anything that has trace or is empty chemotherapy/biotherapy IV bags, vials and syringes.
      e. When pharmaceutical waste bins are full or reaching the 6 month limit, call EVS for pick up and replacement.
      f. EVS will obtain and store pharmaceutical waste bin supplies from Central Supply and replace the bins as needed.

4. **Controlled substance** waste must be a witnessed disposal and documented on the medication administration record by both individuals and disposed of in RxDestroyer.
   a. Tablets/capsules/suppositories- drop into RxDestroyer and dispose of packaging into the regular trash**.**
   b. Syringes- Drain the liquid from the IV containing controlled substances into the RxDestroyer
   c. Vials/Ampules - Draw or pour the contents into the container and discard the vial or ampule into the regular trash**.**
   d. Patches- Drop patches into container and discard packaging.
   e. DO NOT place syringes, vials/ampules, packaging or non-controlled substance in RxDestroyer
   f. Oral solutions- pour remaining contents in the. RxDestroyer and place empty medication cups or bottles in regular trash after removing patient identifiers
   g. IV bags- cut IV bag to drain out any remaining contents in the **RxDestoryer and** remove patient identifiers and dispose the IV bag and tubing in the regular trash

5. Transportation and Storage:
   a. Filled, labeled, and tightly covered pharmaceutical waste containers shall be transported to the designated area by EVS.
   b. EVS shall store and dispose the pharmaceutical waste according to guidelines defined by the EVS Department.

<u>References</u>

www.epa.gov/epawaste/inforesources/online/index.htm

www.epa.gov/osw/hazard/wastetypes/universal/pharm.htm

Approvals

		SYSTEM	HH/FM/JG/SLH	AH
System P&T	Date:	10/2025		
Clinical Practice Committee	Date:			
Medical Executive	Date:			
BOT	Date:		2	

Table 1:

Label	Description
P	P-listed hazardous pharmaceutical waste
	Other “compatible” hazardous wastes, including those

	categorized as PharmE Hazardous® (Note: the term "compatible" means the items will not react with one another and can safely be shipped in the same container.)
AERO	Ignitable aerosols and pressurized aerosols which need to be shipped separately from other hazardous waste
OXID	Silver nitrate applicators or other oxidizers which might appear on the floor in a finished dosage form and are UNUSED when discarded
ACID	Corrosive acid items, which might be stocked in a finished dosage form
BASE	Corrosive bases, which might be stocked in a finished dosage form
BIO	Biohazardous items, such as those derived from blood products or a live attenuated virus

Controlled Substance Wastage Guide

Please check the AHS Waste Chart for applicable items

- For Deactivation of Liquid or Solid Drug only, Not Packaging or Containers –

Yes! **Put these items in the Rx Destroyer Container**

IVs: Drain the liquid from the IV containing controlled substances into the container

Syringes: Purge the contents into the container and place the empty syringe into a sharps container

Vials/Ampoules: Draw or pour the contents into the container and discard the vial or ampule according to hospital policy

Patches: Drop patches into container and discard packaging according to hospital policy

Pills, Tablets, and Capsules: Drop into container and discard packaging according to hospital policy

No. **Don't put these items in the Rx Destroyer**

Syringes, vials/ampoules, packaging

Drugs other than controlled substances

Please **screw on cap** when not adding controlled substances to Rx Destroyer container. If the container is full before the service technician replaces it, please contact **Environmental Services.**

WASTE MANAGEMENT

SUSTAINABILITY SERVICES

AHS SYSTEM WASTE CHART

Special Radioactive Waste	Biohazardous Waste / Red Bags	Sharps Waste Container	Pharmaceutical Waste Container (White with Blue/Purple Top)	Chemotherapy Waste Container (Yellow with White Top)	Pathology Waste Container (Gray)	RCRA Hazardous Waste (Black with White Top)	Regular Trash	Batteries	Controlled Substances
									
	BLOOD/BODILY Fluids	**SYRINGES, GLASS, NEEDLES, ETC.**	**MEDICATIONS THAT CANNOT BE REUSED**	**TRACE AMOUNTS CHEMOTHERAPY**	**TISSUE/SPECIMENS**	**BULK AMOUNTS CHEMOTHERAPY & HAZARDOUS MEDICATIONS**	Items that are NOT SATURATED or NOT DRIPPING with blood or body fluids.		All Controlled Substances that are open full or partial doses
Call as Needed for Any Disposal Related Questions Radiation Safety Officer 510 437-4744 or ext. 44744 Urine, stool, Peritoneal Dialysis Fluid. Acceptable to flush bloody urine and stool down the sewer.	Items that still hold blood, or are **SATURATED** or **DRIPPING** with **BLOOD** or **BODILY FLUIDS**, and will not cut or puncture.	- Disposable needles - All syringes – with or without needles - Scalpels, blades, and razors - Staples and wire - Disposable Stainless steel instruments such as scissors, forceps, staple removers - Pipettes, Lancets, glass slides, or glass tubes - Blood tubes - Broken glass	- Ampules and vials - Pills and capsules - Ointments, paste, creams - -IV Bags, tubing, syringes *if containing medication* - inhaled dry powders (Advair diskus) ***Exceptions*** - IV bags containing only electrolytes/ fluids can be sewered. - metered dose inhalers with propellant - those need to go into Aerosol black bins All empty IV bag/tubing place in regular trash with patient information removed 	- Trace or Empty chemo IV bags, vials, syringes - anything that has touched chemo - PPE- includes masks - cleaning products (i.e. paper towels) **UNUSED or LARGE AMOUNTS OF CHEMO** **Return to Pharmacy**	- Surgical specimens - Human tissue - Placentas - Amniotic fluid	• Chemo that is pourable (greater than trace amounts), Chemo tablets hazardous medications (see list below) - **Insulin** - **All Hormonal** - **Nicotine products** - **Warfarin** - **Epinephrine** - **Physotigmine products** - **Flu vaccine with thimersol** - **Metered Dose inhalers with propellant (Albuterol, Ipratropium)** - **Fasiodex** - **Gastrografin** - **Iodine** - **Isopropyl Alcohol** - **Lice Treatment** - **Omnipaque** - **Tetanus/Diptheria vaccine** - **Visipaque** **P-listed Bin** - **Warfarin** **Aerosol Bin** - **HFA, Aerosol Sprays, Foams, Topical Sprays (Except Terbinafine (Black/Trash) and Thrombin (White/Trash))**  	- Dressings - Gloves - Gowns - Masks - Diapers - Band aids - Office waste - Plastics - Food	Place batteries in designated containers Pick up by Engineering Department	- Open full or partial tablets /capsules/suppositories - Open partial injections- dispose syringe and contents or partially used vial or ampule - Oral solutions- pour remaining contents in the **RxDestroyer** and place empty medication cups or bottles in regular trash after removing patient identifiers

ALAMEDA HEALTH SYSTEM

SYSTEM PHARMACY SCOPE OF SERVICE

Site	Alameda Health System	***Previous Revision Dates***	
Effective Date	1/2026	***Date Revised***	10/2025
Document Owner	MGR SYS MED SAFETY-CLIN PHARM	***Next Scheduled Review***	1/2029
Executive Responsible	Please Fill In		
Approvals	BOT, QPSC		

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

Purpose

Pharmacy Services at Alameda Health System utilizes the guidance and direction described in the health system's Mission, Vision, and Core Values as its Scope of Practice.

Policy
The Department of Pharmacy Services shall provide the highest quality of pharmaceutical care available through a philosophy of "Best Practice".

Best practice is defined at AHS as focusing on medication therapy that is:

- Safe
- Individual Patient-focused Outcome
- Collaborative and Inter-disciplinary
- Evidence Based (current)
- Cost-effective
- Patient Care Centered

The scope of pharmacy services will be provided in accordance with laws, rules, regulations, and recognized standards and practice guidelines. The following organizations are used to guide the practice of pharmacy at AHS:

- American Society of Health-system Pharmacists (ASHP)
- American Pharmaceutical Association (APhA)
- The Joint Commission (TJC)
- California Boards of Pharmacy, Nursing, and Medicine
- California Department of Public Health (CDPH)
- Centers for Medicare and Medicaid (CMS)
- Food and Drug Administration (FDA)
- Drug Enforcement Agency (DEA)
- Institute for Safe Medication Practices (ISMP)
- USP 795/USP 797/USP 800
- NIOSH

Scope of Pharmacy Services:

Provision of Pharmaceutical Care

Pharmaceutical care is provided to all patients through compounding and dispensing medication, monitoring of patient medication therapy, provision of medication information to professional staffs, and patient medication education. Specific services may include:

- Establishing policies and practices concerning selection, storage, ordering, dispensing, administering, monitoring, waste and evaluation of effectiveness of medications.
- Identifying high-risk medications and establishing methods to reduce harm.
- Reviewing medication orders for appropriateness and efficacy.
- Evaluating potential medication interactions.
- Packaging, labeling, and dispensing medications and other pharmaceutical preparations to patient care areas consistent with current recommended practices.
- Use of a bar-coded unit-dose automated medication distribution system whenever possible.
- Compounding sterile preparations that meet USP 797/USP 800, federal, and state requirements. Scan barcoded medications during compounding whenever possible.
- Assessing patient medication therapy for potential problems such as adverse drug reactions, drug interactions, inappropriate dose or dosing interval, administration routes, duration and allergy.
- Ensuring rational and appropriate antibiotic therapy based on labs, culture and sensitivity results along with any adjustments to hepatic and renal dysfunction
- Monitoring, reporting, and assessing adverse drug events.
- Monitor medication use and identify opportunities for improvement in cooperation with the Pharmacy and Therapeutics Committee
- Provide medication therapy management and laboratory ordering/monitoring per protocol under physician collaborative practice agreements.
- Participate in education programs for the staff of the health system.
- Drug accountability for all drugs
- Participation in drug usage evaluations in conjunction with the nursing and medical staff.
- Identification and communication to the appropriate prescriber on patient specific significant drug/drug, drug/laboratory test, drug/food or diet, or drug/disease interactions.
- Provide age-specific and "off-label" drug information to health care providers and patients.
- Evaluation and inspection of emergency drug supplies.
- Participation on multidisciplinary institutional committees to improve overall performance of the hospital.
- Pharmaceutical services will be available by pharmacy staff on a 24 hour basis (AHS or remote)
- For Adult patients, Pharmacy staff shall provide adult unit doses, individual adult intravenous and parenteral nutrition solutions; and shall also provide continuous drug surveillance per Pharmacy Therapeutic Drug Monitoring Policy.
- For NICU/Ped's patients, Pharmacy staff shall provide neonatal unit doses, individual neonatal intravenous and parenteral nutrition solutions, neonatal nutritional products in clearly marked containers and shall also provide continuous drug surveillance per Pharmacy Therapeutic Drug Monitoring Policy.

Hospital Pharmacy Services

- Pharmacokinetic Service
- Anticoagulation Service
- Antimicrobial Stewardship Program
- Renal Dosing
- IV to PO conversions
- Therapeutic Interchange
- Total parenteral nutrition monitoring
- Therapeutic Drug Monitoring/Lab Monitoring
- Rounding with the Medical Teams
- Medication therapy reviews
- Code attendance
- Audits/Quality Assurance

Pharmacy and Therapeutics Committee
The Director of Pharmacy Services or designee serves as co-chair of the Pharmacy and Therapeutics Committee along with a member of the medical staff.

Committee activities include:

- Develop and implement system-wide policies and procedures for medication use within AHS
- Develop and maintain a formulary of approved medications for AHS including therapeutic interchanges, formulary restrictions, formulary guidelines, clinical pathways, drug use evaluations and medication use algorithms.
- Participate in activities related to the review and evaluation of medication use
- Develop and review medication order sets
- Monitoring the use of non-formulary drugs
- Review shortages in the medication supply chain that will require substitution
- Establish standards and protocols for the use of investigational drugs and medications in clinical trials
- Communicate decisions to the medical staff, pharmacy staff, and patient care areas.
- Ensure appropriateness and quality of pharmaceutical care by using a comprehensive performance improvement process for monitoring

Medication Error Reduction Team (MERT)
The Director of Pharmacy Services or designee serves as co-chair of MERT along with a member of the medical staff.

Committee activities include

- Track and Trend medication related occurrences to identify areas of improvement
- Define and review adverse drug events (medication errors, adverse drug events, incompatibilities)
- Assess effectiveness of the implementation of the Medication Error Reduction Plan

Medication Therapy Management
Medication therapy is reviewed by a pharmacist at the time of order validation or order entry and collection of home medication lists for high risk patients.

Medication therapy management includes monitoring and intervention protocols designed to promote positive patient outcomes. Medication therapies targeted for specific monitoring include those that are high volume, potentially problem prone, and/or possess a narrow therapeutic index.
These include but are not limited to:

- Therapeutic dose monitoring (i.e. aminoglycosides, vancomycin, warfarin, etc)
- IV to PO conversions
- Adverse drug reaction monitoring
- Creatinine clearance review and renal dose adjustments
- Total parenteral nutrition monitoring
- Medication use evaluations
- Clinical Pharmacist driven medication titration for chronic disease management per protocol
- Clinical Pharmacist based antimicrobial stewardship
- New Oral OAC/Argatroban monitoring

Drug Information
The Department of Pharmacy Services provides medication information and education to providers via newsletters, in-service education programs, the pharmacy website, and patient specific medication information.

The pharmacy department participates in the orientation of new health-system employees.

The pharmacy department also provides education and information to the medical staff via presentations at various medical committees, newsletters, the pharmacy intervention program, the antibiogram and empiric dosing guidelines, and patient specific information as requested.

Hours of Operation
Pharmacy services are provided twenty-four (24) hours per day, seven days a week, either on-site or via remote services.

Staffing
Pharmacy staff may include but not limited to:

- Director of Pharmacy
- Pharmacy Managers and Supervisors
- Clinical Pharmacist Specialists
- Informatics Pharmacist/Pharmacy technician
- Staff Pharmacists
- Certified Pharmacy Technicians
- Pharmacy Technicians
- Pharmacy Clinical Coordinator
- Pharmacy Buyer

The Director of pharmacy services will identify the core staffing requirements of the department and the method used to modify staffing when needed. Workload is monitored and evaluated on an ongoing basis and staffing adjusted.

The pharmacy department has an ASHP-accredited residency training program and a Touro University-affiliated residency training program. The department also precepts student on Introductory and Advanced Pharmacy Practice Experiences (IPPE and APPE) with accredited colleges of pharmacy. Students/Residents are oriented to dispensing and clinical responsibilities, participate in medication therapy monitoring, provide in-services to nursing and pharmacy staff, and complete projects pertinent to the practice of pharmacy.

Staff Development
Educational and training programs are available to pharmacy staff by AHS, area experts and are also provided by the clinical pharmacy staff. Annual competencies and competency exam upon hiring are assigned and assessed. These include topics such as but not limited to:

1. Adult Enteral Nutrition (ASHP)
2. Adult Patients for RPh (ASHP)
3. Adult Patients for Technicians (ASHP)
4. Adverse Drug Reaction Reporting (ASHP)
5. Aminoglycoside Dosing (ASHP)
6. Antibiotic Streamlining (ASHP)
7. Compounding Hazardous Drugs(ASHP)
8. Compounding Nonsterile Preparations (ASHP)
9. Compounding Sterile Preparations (ASHP)
10. Controlled Substances (ASHP)
11. Geriatric Patient for Technicians (ASHP)
12. Geriatric Patient for RPh (ASHP)
13. IV to Oral Therapy Conversion (ASHP)
14. Med Area Inspection (ASHP)

15. Med Dosing Hepatic Dysfunction (ASHP)
16. Med Dosing Renal Dysfunction (ASHP)
17. Medication Safety (ASHP)
18. Neonatal and Infant patients for RPh (ASHP)
19. Neonatal and Infant patients for Technicians (ASHP)
20. Obstetric Patients (ASHP)
21. Oncology Patients (ASHP)
22. Oral Anticoagulant Therapy (ASHP)
23. Pain Management (ASHP)
24. Parental Anticoagulant Therapy (ASHP)
25. Patient Counseling (ASHP)
26. Peds and Adolescent Patients for RPh (ASHP)
27. Peds and Adolescent Patients for Technician (ASHP)
28. Pharmaceutical Waste (ASHP)
29. Psychiatric Medications (ASHP)
30. Repackaging Medications (ASHP)
31. Adult Parenteral Nutrition
32. Aseptic Technique Competency
33. Chemotherapy Technician Test
34. Pharmacy Calculations
35. AHS Controlled Substance Diversion Education

References

Title 22 (70269) Pharmaceutical Services
TJC MM 03.01.01
California State Board of Pharmacy Law

Approvals:

		Alameda	HGH/FM/JG	San Leandro
System Pharmacy Leadership	**Date:**	**10/2025**		
System Pharmacy and Therapeutics Committee	**Date:**	**10/2025**		
Clinical Practice Committee	**Date:**	**11/2025**		
Medical Executive Committee	**Date:**	**11/2025**		
Board of Trustees	**Date:**	**01/2026**		

	Policy	
ALAMEDA HEALTH SYSTEM	**Document Title: CEM Med Code Policy (Community Emergency Medicine – Alameda and San Leandro Hospitals)**	**Version 1**
	Level ☐ System X Site	**Effective Date:** 1/2026 **Next Review Date: 1/2029**
	Document Owner: Dr. Sammy Hodroge, ED Medical Director	

Purpose:

To establish a standardized process for activating and managing a Medical Resuscitation Code ("Med Code") in the Emergency Department (ED) for critically ill patients requiring immediate multi-disciplinary intervention, including ED care team, respiratory therapy, phlebotomy, and radiology.

1. Scope

This policy applies to all staff in the ED, including physicians, advanced practice providers (APPs), nurses, respiratory therapists, phlebotomists, radiology technologists, unit clerks, and hospital operators.

2. Definitions

- Med Code: An emergency activation for critically ill patients requiring immediate bedside resuscitation with a multidisciplinary team.
- Critical Illness**:** Any patient who is unstable, ill-appearing, or in need of immediate life-saving interventions.

3. Inclusion Criteria

- Any critically ill patient in the San Leandro or Alameda Hospital Emergency Department requiring immediate resuscitation and the services of the ED care team (physician, nurse, technician), respiratory therapy, phlebotomy, and radiology.
- Patients may be self-presenting or arrive via EMS (any code 1, 2, or 3 ringdown).

4. Exclusion Criteria

- None.

5. Activation Process

- Need for resuscitation identified – ill-appearing patient arriving by private vehicle, or any unstable EMS ringdown.
- Physician, APP, or ED nursing requests Med Code activation.

- Unit clerk, ED nurse, or physician/APP calls 5-5555 to alert hospital operator.

- Hospital operator activates Med Code by overhead page three times, e.g.:
  - "Med Code, ED, ETA 3 minutes"
  - "Med Code, ED, Room 5"
- Med Code team — including physician, ED nurses, ED technician, respiratory therapist, phlebotomist, and radiology technologist— responds immediately to the bedside. The team is de-escalated as appropriate by the physician.

6. Med Code Team Composition

- ED Physicians / APPs
- ED Nurses (minimum 2)
- ED Technicians
- Respiratory Therapist
- Phlebotomist
- Radiology Technologist (with portable imaging equipment)

7. Roles & Responsibilities

- Physician/APP: Lead resuscitation efforts, manage airway, activate and deactivate the Med Code, communicate with team
- Nurses: IV Access, medication administration, patient monitoring, documentation
- Technicians: Assist with procedures, equipment setup
- Respiratory Therapist: Respiratory support
- Phlebotomist: Obtain labs, blood cultures as indicated
- Radiology Technologist: Provide portable imaging at bedside promptly

8. Equipment & Supplies

- Portable X-ray machine (Radiology)
- Blood draw kits (Phlebotomy)
- Airway management and resuscitation equipment (ED/RT)
- Medication and IV supplies (Nursing)

- ECG and Lucas Device as needed (ED Technician)
- PPE (ED)

9. Documentation

- Designated nurse or physician documents key events and interventions in the EMR.

ALAMEDA HEALTH SYSTEM

AHS FIRE SAFETY MANAGEMENT PLAN

Site	Alameda Health System	***Previous Revision Dates***	8/2012, 6/2015, 6/2018
Effective Date	8/2012	***Date Revised***	10/25
Document Owner	DIR, FACILITIES SERVICES	***Next Scheduled Review***	10/28
Executive Responsible	COORDINATOR		

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

PURPOSE

The purpose of the Alameda Health System's (AHS) Fire Safety Management Plan is to ensure that all facilities are designed, constructed, maintained, and operated to minimize the risk of fire and the possibility of a fire emergency requiring evacuation of occupants. Risk of fire is minimized by:

- Appropriate construction and arrangement of facilities and spaces
- Effective training of staff
- Adherence to operating and maintenance procedures

POLICY

The Fire Safety Management Plan applies to the AHS and all buildings, which serve to treat patients and are under the ownership of control of the governing body. The Fire Safety Management Plan addresses elements necessary to provide a physical environment free of hazards related to fire or Fire safety deficiencies. AHS's Fire Safety Management Plan provides for continuous protection of all patients, staff and visitors from the effect of fire and the products of combustion and provides for the safe use of the buildings and grounds. The Fire Safety Management Plan encompasses all fire safety aspects of building design, all mechanical fire detection and suppressions systems, and the facility fire response policies and procedures.

AHS facilities covered by this management plan are as follow:

- Highland Hospital
- Fairmont Hospital
- John George Hospital
- San Leandro Hospital
- Alameda Hospital
- Eastmont Wellness Center
- Hayward Wellness Center
- Newark Wellness Center
- Park Bridge Rehabilitation and Wellness
- South Shore Rehabilitation and Wellness
- Creedon Wound Center
- Marina Wellness and Surgical Associates

The Director of the Engineering Department /or Designee is responsible to assess compliance (this is accomplished with the collaboration of the 3rd parties' vendors with applicable knowledge and experience and the engineering department) with the Fire Safety Code. Documentation related the Fire Safety Management Plan, inspections, testing and maintenance will be maintained in theengineering department.

OBJECTIVES

The objectives of The Fire Safety Management Plan include:

- Comply with all relevant fire safety codes, standards, and regulations.
- Enforce current fire safety practices for patients, staff, and visitors.
- Provide fire safety education and training as appropriate.
- Monitor the effectiveness of the fire safety program.
- Identify opportunities to improve fire safety performance and develop and implement improvements.

AUTHORITY

The Director of the Engineering Department/ or Designee and the Chair of the Environment of Care Committee (EOC) are responsible for the program's strategic design and overall plan development, implementation, monitoring, and performance improvement. The managers of the engineering department report the performance of the program for their respective facilities to the EOC.

RISK ASSESSMENT

Abnormal hazardous conditions, potentially hazardous situations, unsafe behaviors, and relative risks are identified and assessed through ongoing facility-wide risk assessment processes. These processes are designed to proactively evaluate the impact of building, grounds, equipment, materials, operations and internal physical systems on patient, staff, and visitor safety. The Environment of Care Committee and Risk Management Department to identify, analyze, and control environmental risks to patient, staff, and visitor safety that may contribute to undesirable outcomes. These assessment processes include:

- Annual Risk Assessment
- Environmental Safety Tours
- Statement of Conditions surveys
- Failure / User error / Service interruption reporting and analysis of fire alarm, suppression, and detection systems

PERFORMANCE ELEMENTS

The Fire Safety Management Plan includes provisions for, but not limited to, the inspection, maintenance, repair, and implementation of interim safety measures as needed for the following Fire safety systems according to applicable NFPA codes:

1. Fire detection and fire alarm systems
2. Smoke and fire dampers

3. Smoke and fire doors
4. Automatic fire suppression systems
    4.1. Kitchen Hood Systems
    4.2. Halon Systems
    4.3. Clean Agent Systems
    4.4. Water Based Fire Sprinkler Systems
5. Fire pumps
6. Fire extinguishers
7. Standpipe systems
8. Sliding and rolling fire doors
9. Exit signs and other signage

The hospital manages fire risks.

The hospital minimizes the potential for harm from fire smoke, and other products of combustion.

AHS will protect its patients, staff, visitors, and property by providing appropriate fire protection systems and equipment, employee training and Interim Fire Safety Measures. The hospital buildings are equipped with fire detection and suppression systems that are inspected in accordance with the appropriate NFPA standards.

All buildings in which patients are seen or treated, and buildings under the ownership or control of AHS will maintain compliance with the appropriate provisions of the Fire Safety Code of NFPA. The Director of the Engineering Department/ or Designee and the Chair of the environment of care committee are responsible to ensure and manage all structural elements of Fire safety at AHS.

If patients are permitted to smoke, the hospital takes measures to minimize fire risk.

AHS is a non-smoking facility and does not permit smoking within any building.

The hospital maintains free and unobstructed access to all exits.

AHS will maintain free and unobstructed access to all exits. The hospital will conduct safety rounds on a regular basis to ensure compliance.

The hospital has a written fire response plan.

AHS maintains a written fire response plan. Emergency procedures will be coordinated between the department leaders.
The written fire response plan describes the specific roles of staff and licensed independent practitioners at and away from a fire's point of origin, including when and how to sound fire alarms, how to contain smoke and fire, how to use a fire extinguisher, and how to evacuate to areas of refuge.

The AHS's Fire Procedure Plan describes the Roles & Responsibilities of staff, including how

to:

- Respond at and away from fire point of origin
- Activate and sound fire alarms
- Defend in place
- Contain smoke and fire
- Use a fire extinguisher
- Prepare for building evacuation

Periodic evaluations, as determined by the hospital, are made of potential fire hazards that could be encountered during surgical procedures. Written fire prevention and response procedures, including safety precautions related to the use of flammable germicides or antiseptics, are established.

- Reference Policy: FIRE PREVENTION ASSOCIATED WITH THE PERFORMANCE OF SURGICAL PROCEDURES: https://ahs.policytech.com/dotNet/documents/?docid=30612

When flammable germicides or antiseptics are used during surgeries utilizing electrosurgery, cautery, or l asers, the following are required:
- Nonflammable packaging
- Unit-dose applicators
- Preoperative "time-out" prior to the initiation of any surgical procedure to verify the following:
- Application site is dry prior to draping and use of surgical equipment
- Pooling of solution has not occurred or has been corrected
- Solution-soaked materials have been removed from the operating room prior to draping and use of surgical devices
(For full text, refer to NFPA 99-2012: 15.13)

- Reference Policy: FIRE PREVENTION ASSOCIATED WITH THE PERFORMANCE OF SURGICAL PROCEDURES: https://ahs.policytech.com/dotNet/documents/?docid=30612

The hospital meets all other Health Care Facilities Code fire protection requirements, as related to NFPA 99-2012: Chapter 15.

The hospital conducts fire drills.

The hospital conducts fire drills once per shift per quarter in each building defined as a health care occupancy by the Fire Safety Code. The hospital conducts quarterly fire drills in each building defined as an ambulatory health care occupancy by the Fire Safety Code.

Fire drills are conducted quarterly on all shifts in healthcare occupancies. All drills are documented, and documentation is maintained in the engineering department.

The hospital conducts fire drills every 12 months from the date of the last drill in all freestanding buildings classified as business occupancies and in which patients are seen or treated.

Fire drills in freestanding buildings classified as business occupancies will be conducted every 12 months. All drills are documented and maintained in the engineering department.

When quarterly fire drills are required, they are unannounced and held at unexpected times and

under varying conditions. Fire drills include transmission of fire alarm signal and simulation of emergency fire conditions.
Note 1: When drills are conducted between 9:00 P.M. and 6:00 A.M., the hospital may use coded announcement to notify staff instead of activating audible alarms.

Fire drills are conducted on each shift quarterly. Fire drills are unannounced. Documentation is maintained on file in the engineering department.

Staff who work in buildings where patients are housed or treated participate in drills according to the hospital's fire response plan

Fire drills are conducted in all areas and staff from all areas respond to the alarm as required in the fire response plan. Staff participation is noted on fire drill forms.

The hospital critiques fire drills to evaluate fire safety equipment, fire safety building features, and staff response to fire. The evaluation is documented.

Fire drills are critiqued after each drill. Any necessary education is provided at the time of the fire drill. Fire drill summary reports are prepared and maintained by The Director of the Engineering Department/ or Designee and the engineering managers. The effectiveness of the fire drill response training is reviewed and modified as necessary.

The hospital maintains fire safety equipment and fire safetybuilding features.

The engineering department has oversight for the maintenance and compliance with the Fire Code and Fire Safety Code standards regarding structural requirements for fire protection through routine inspections and the testing and maintenance of fire equipment.

The Engineering Department is responsible for ensuring the following activities are perform in accordance with the Fire Code and Fire Safety Code:

A. Fire Alarm Testing:
   The testing of the fire alarm system and components complies with NFPA 72 standards and on a routine schedule. Testing of the various components will adhere to the following schedule:
   - Quarterly: Supervisory signal devices, and Fire Department notification
   - Semi-Annual: Tamper switches, waterflow device and kitchen suppression system
   - Annually: Duct, heat, smoke detectors, manual fire alarm pull stations, electromechanical releasing devices, emergency service notification and occupant alarm devices (audible and visual).

B. Water-based Automatic Fire Extinguishing Systems (sprinklers, standpipes, fire pumps, fire department connections):
   The testing and maintenance of the water-based automatic fire extinguishing systems complies with NFPA 25 standards and testing is maintained on a routine schedule.
   - **Monthly :** Fire pumps (no water flow required)
   - **Quarterly:** Fire department connections, water flow devices, sprinkler valve Inspection
   - **Annually:** Fire pumps (water flow required) and drain tests at all system

risers

Fire pump inspection records are maintained by the engineering department.

C. Kitchen automatic fire extinguishing systems:
The testing and maintenance of kitchen automatic fire extinguishing systems complies with NFPA 17A and NFPA 96 standards and is the responsibility of the engineering department. Inspections of the kitchen suppression systems are completed semiannually.

D. Gaseous automatic fire suppression systems:
The testing of gaseous automatic fire suppression systems complies with NFPA 2001 and NFPA 12 standards and is the responsibility of the engineering department to ensure the inspection, testing, and maintenance of all gaseous automatic fire suppression systems to include Halon and FM-200 Suppression Systems. Documentation is maintained in the engineering department.

Inspections of those systems are completed semiannually.

E. Portable Fire Extinguishers:
The engineering department is responsible for the installation, maintenance, and testing of fire extinguishers in accordance with NFPA 10.

The engineering department is responsible for ensuring proper fire extinguishers are correctly mounted and clearly identified at installation or after renovation, construction or major changes in occupancy. Extinguishers in cabinets where the location is not clearly visible, or extinguishers located in areas not clearly seen from the path of travel will be marked with signs.

The engineering department is responsible to ensure that all fire extinguishers function properly, are inspected monthly and annually and receive regular preventive maintenance in accordance with NFPA 10 and manufacture specifications.

F. Standpipe Systems:
Testing and maintenance of standpipe systems, both wet and dry, comply with NFPA 14 and NFPA 25 standards, Engineering department is responsible for the testing and maintenance of standpipe systems. Testing of standpipe systems is in accordance with NFPA standards and tested on a routine basis as outline in the NFPA standard. Documentation of inspections and maintenance is maintained in the engineering department.

G. Fire and Smoke Dampers:
Inspection and maintenance of fire/smoke dampers complies with NFPA 90A. Engineering is responsible for the identification and maintenance of all fire/smoke dampers to ensure proper operation. Operate fire smoke dampers one year after installation and then at least every six years to verify that they fully close.

Deficiencies noted during inspections are corrected in-house or through contract services.

Documentation of inspections is maintained in the engineering department.

H. Automatic smoke detection shutdown devices for air handling units:
Testing and maintenance of automatic smoke detection shutdown devices for air-handling units comply with NFPA 90A. The engineering department is responsible for the inspection, testing and maintenance of all air handling shutdown devices. All shut down devices are tested at least annually.

Deficiencies noted during inspections are corrected in-house or through contract services. Documentation of inspections is maintained in the engineering department.

I. Horizontal and vertical sliding and rolling fire doors and shutters:
Testing and maintenance of horizontal and vertical sliding and rolling fire doors and shutters complies with NFPA 80. The engineering department is responsible for the inspection, testing and maintenance of all sliding and rolling fire doors. All rolling and sliding fire doors are tested annually to ensure proper operation and full closure. Deficiencies noted during inspections are corrected in-house or through contract services. Documentation of inspections and corrections is maintained in the engineering department.

J. Smoke Control Systems:
Testing and maintenance of smoke control systems complies with NFPA 92 A&B. The engineering department is responsible for testing and maintenance of smoke control systems.

K. Fire hoses hydro testing is completed by the engineering department, 5 years after the install and everyone 3 years thereafter. All deficiencies are noted during the inspection and corrected in house or through a contract vendor.

L. Inspection of all fire doors is completed by a qualified contracted vendor. Inspection is completed on an annual basis and all deficiencies are noted during the inspection and corrected by the qualified contracted vendor.

M. Elevators with Firefighter emergency operations is completed by a qualified contracted vendor monthly. All deficiencies are noted during the inspection and corrected by the qualified contracted vendor.

N. For automatic sprinkler systems: Every six months, the hospital tests water-storage tank high- and low-water level alarms.

O. For automatic sprinkler systems: Every month during cold weather, the hospital tests water-storage tank temperature alarms.

P. Engineering department maintains and update all the maintenance testing and inspection activities that follow under the EPs.

<u>The hospital manages its environment during demolition, renovation, or new construction to reduce risk to those in the organization.</u>

- Reference Policy: **INTERIM LIFE SAFETY MEASURES (ILSM)**: https://ahs.policytech.com/dotNet/documents/?docid=33377

ANNUAL EVALUATION

The annual evaluation of the Fire Safety Management Plan will include a review of the scope according to the current Joint Commission standards to evaluate the degree in which the program meets accreditation standards and the current risk assessment of the hospital. A comparison of the expectations and actual results of the program will be evaluated to determine if the goals and objectives of the program were met. The overall performance of the program will be reviewed by evaluating the results of performance improvement outcomes. The overall effectiveness of the program will be evaluated by determining the degree that expectations were met. The performance and effectiveness of the Fire Safety Management Plan will be reviewed by the Environment of Care Committee every 12 month.

APPROVALS

		System	Alameda	AHS/Highland/John George/San Leandro/ Fairmont Hospital
Department	**Date:**	N/A	12/2021	12/2021
Pharmacy and Therapeutics (P&T)	**Date:**	N/A	N/A	N/A
Clinical Practice Council (CPC)	**Date:**	N/A	N/A	N/A
Medical Executive Committee	**Date:**	N/A	N/A	N/A
Board of Trustees	**Date:**	N/A	N/A	N/A

ALAMEDA HEALTH SYSTEM	Policy	
	Conducting Monthly Tests of Emergency Diesel Generators	**26463 2**
	LEVEL x System ☐ Site	EFFECTIVE DATE: 1/2026 NEXT REVIEW DATE: 01/2029

POLICY:

- This policy is to ensure operations reliability developed to promulgate the procedures which will be carried out in conducting tests of the emergency generators.

- The following procedures are established for conducting the tests. The personnel responsible to conducting these tests in accordance with the Monthly Test and Inspection Sheet shall be familiar with the procedures outlined below:

  Note: Must be in accordance with the TJC.

  - The emergency diesel generators will be tested under load conditions of the hospital for 30 minutes each month.

  - The emergency diesel generators will be annually load bank tested for four (4) hours.

  - The proper log entries will be made.

  - In the event a holiday or extenuating circumstances preclude the conducting of the test as outlined above, the responsible party will coordinate with Nursing Supervisor or the revised time and date the test will be conducted. The offices concerned will also be notified.

  - Prior to conducting load tests of the units, the following offices and/or personnel associated with the offices, will be notified that the test is to be conducted. This notification shall be 15 minutes prior to the start of the test.

    - Surgery
    - Special Care Units (including ICU, CCU, SNF, etc.)
    - Emergency Department
    - PBX Operator
    - X-Ray

  - Should there be a requirement to delay the test by an individual office, the office concerned will be called again immediately after their requested time delay.

PROCEDURE FOR TESTING OR STARTING EMERGENCY GENERATORS:

- Check the oil level before starting the engine, add oil, if necessary, to bring it to the proper level of the dipstick.
- Check the coolant level and maintain it near the top of the heat exchanger tank or the radiator upper tank.
- Check the battery, the top should be clean and dry, the terminals tight and the electrolyte must be at the proper level. No corrosion should be visible.
- Check all electrical connections; make certain they are correct and tight.
- Make sure the power generator unit has been cleared of all tools or other objects which might interfere with its operation.
- Make sure the selector switch is on auto position.

PROCEDURE FOR CHECKING FUEL LEVELS OF DIESEL TANKS:

- Fuel levels will be checked weekly.
- By using the graduated stick, you can determine how many gallons of diesel fuel oil is inside the tanks.
- Record number of inches of diesel fuel indicated on the dip stick.

  Record number of gallons.
- Notify fueling vendor and the Chief Engineer/Supervisor when reading approaches 75% capacity.

ALAMEDA HEALTH SYSTEM	Policy	
	EMERGENCY GENERATOR FAILURE	26479 2
	LEVEL ☐ System ☐ Site	EFFECTIVE DATE: 1/2026 NEXT REVIEW DATE: 1/2029

POLICY:

In the event of failure of the emergency generators during an electrical power outage, the following procedure will be followed.

PROCEDURE:

- Notify the Director of Engineering or designee, Administrator On-Call and Nurse Supervisor immediately that there has been a total power outage. Check and secure all equipment.
- The Director of Engineering or designee will call the Generator contractor for immediate service on the generators and/or portable backup generator delivery.
- Initiate Emergency Call Plan to call in additional personnel for support as necessary.
- Engineer on duty upon securing critical systems, will ensure battery operated lights are functioning at each nurses station. Spare batteries and flashlights are in the Engineering Department.
- Engineer will assist in distributing spare flashlights to nursing personnel.
- Attempt to determine reason for failure.
    - Generator engine failure:
        - Follow manufacturer's instructions to manually start generator.
            - Check the starter system.
            - Check fuel tank to ensure there is adequate fuel. If not, refuel tank from the main supply. Call fuel supplier for STAT delivery of fuel, if necessary. Fuel co.# located at Generator & in the Engineering Office.
            - If applicable: If additional fuel must be delivered or starter system is not functioning, call the power company to determine length of time for the power outage. Notify the Nursing Supervisor as to when the external or emergency power will be restored, whichever is first.
    - Control panel malfunction or transfer switch malfunction:
        - If generator can be started, check transfer switch to see if it has been tripped.

- ♦ Transfer switch not tripped - check for fault indicators on control panel.
- ♦ No fault indicators - throw transfer switch manually. DO NOT ATTEMPT TO THROW TRANSFER SWITCH MANUALLY IF THERE IS A FAULT LIGHT INDICATOR.
- ♦ Must wear appropriate PPE (i.e. Arch Flash Suite)

- Contaminated fuel source:
  - ■ Check the fuel for contamination if there is no malfunction of the generator or the transfer switch.
    - ♦ Contact 3rd party fuel analysis company. Number is listed on generator and in the engineering office.
    - ♦ If fuel is contaminated, notify the Director of Engineering or designee. The director will direct personnel to call the generator supplier for a portable generator, as necessary.
    - ♦ Notify the Nursing Supervisor that power will be restored.

ALAMEDA HEALTH SYSTEM

MALIGNANT HYPERTHERMIA (MH)

Department	Anesthetizing departments, ED	***Date Revised***	7/2019
Campus	All	***Effective Date***	09/2018
Category	Clinical	***Next Scheduled Review***	11/2028
Document Owner	Chief Administrative Officer/Chief Nurse Executive	***Executive Responsible***	Chief Administrative Officer/Chief Nurse Executive, Chief Medical Officer

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

PURPOSE

To increase potential for a positive patient outcome by providing guidance to personnel in departments that provide General Anesthesia, or utilize Succinylcholine (routinely or emergently only); which are known triggers for inducing a Malignant Hyperthermia episode. **(See appendix A for known unsafe agents, and known safe agents)**

POLICY

- At the onset of a Malignant Hyperthermia (MH) episode, the MH Crisis Hotline will be called for consultation:

MH Crisis Hotline

1-800-644-9737

Be prepared to give your name, number, facility and email, in the event the call is dropped

Departments that provide General Anesthesia or Succinylcholine for patient care will:

- Have access to a MH emergency cart and /or Dantrolene that allows for administration of Dantrolene within 10 minutes of recognition of an MH crisis. The cart will:
  - Be stocked according to MHAUS recommendations **(Appendix B)**
  - Have the MHAUS crisis number clearly visible on the exterior.
  - Be monitored and maintained as an emergency cart
  - Have the cart supply list attached, with identification of each drawer's contents easily discernible

- Provide staff education related to MH, with documented verified staff competencies, which:
    - Are based on the Malignant Hyperthermia Association of the United States (MHAUS) guidelines.
    - Are performed during initial department orientation and annually thereafter.
    - Includes location and contents of nearest MH cart, and how to procure when needed
    - Includes information for identifying patients with increased risk of MH, and how best to care for these patients
    - Includes the method to procure, mix, and administer Dantrolene
    - Includes department procedure for verification of MH cart integrity and supply replacement if needed.
    - Includes location of cooled solutions that will be needed during MH crisis.
    - Includes information on obtaining ice rapidly
    - Includes information on acquiring additional staff if needed during all hours of operations (I.E.: Call a house-wide code if required)

REFERENCES

MHAUS Guidelines, downloaded 02/19/2018 from http://www.mhaus.org/healthcare-professionals/mhaus-recommendations/

ALAMEDA HEALTH SYSTEM

Appendix A (From MHAUS)

Not safe for use in MH-susceptible patients:

The following anesthetic agents are known triggers of MH:

- **Inhaled General Anesthetics**
- **Desflurane**
- **Enflurane**
- **Ether**
- **Halothane**
- **Isoflurane**
- **Methoxyflurane**
- **Sevoflurane**
- **Succinylcholine**

All other anesthetic agents outside of these two categories of Volatile anesthetic agents and depolarizing muscle relaxants are considered safe.

Safe Anesthetic Agents for MH Patients:

Barbiturates / Intravenous Anesthetics

- Diazepam
- Etomidate (Amidate)
- Hexobarbital
- Ketamine (Ketalar)
- Methohexital (Brevital)
- Midazolam
- Pentobarbital
- Propofol (Diprivan)
- Thiopental (Pentothal)

Inhaled Non-Volatile General Anesthetic

- Nitrous Oxide

Local Anesthetics

- Amethocaine
- Articaine
- Bupivicaine
- Dibucaine
- Etidocaine
- Eucaine
- Lidocaine (Xylocaine)
- Levobupivacaine
  Mepivicaine (Carbocaine)
  Procaine (Novocain)
- Prilocaine (Citanest)
- Ropivacaine
- Stovaine
- Proparacaine Hydrochloride ALCAINE®
  (proparacaine hydrochloride ophthalmic solution)

Narcotics (Opioids)

- Alfentanil (Alfenta)
- Anileridine
- Codeine (Methyl Morphine)
- Diamorphine
- Fentanyl (Sublimaze)
- Hydromorphone (Dilaudid)
- Meperidine (Demerol)
- Methadone
- Morphine
- Naloxone
- Oxycodone
- Phenoperidine
- Remifentanil
- Sufentanil (Sufenta)

Safe Muscle Relaxants

- Arduan (Pipecuronium)
- Curare (The active ingredient is Tubocurraine)
- Gallamine
- Methocarbamol (Robaxin, Robaxin-750, Carbacot, Skelex)
- Metocurine
- Mivacron (Mivacurium)
- Neuromax (Doxacurium)
- Nimbex (Cisatracurium)
- Norcuron (Vecuronium)
- Pavulon (Pancuronium)
- Tracrium (Atracurium)
- Zemuron (Rocuronium)

Anxiety Relieving Medications

- Ativan (Lorazepam)
- Centrax
- Dalmane (Flurazepam)
- Halcion (Triazolam)
- Klonopin
- Librax
- Librium (Chlordiazepoxide)
- Midazolam (Versed)
- Paxil (paroxetine)
- Paxipam (Halazepam)
- Restoril (Temazepam)
- Serax (Oxazepam)
- Tranxene (Clorazepate)
- Valium (Diazepam)

ALAMEDA HEALTH SYSTEM

Appendix B (from MHAUS)

MHAUS recommendations for contents of MH cart

(AHS only stocks Dantrium/Revonto, thus all references to Ryanodex have been removed)

Drugs

Therapy should be aimed at prompt administration of dantrolene, treatment of hyperkalemia, hyperventilation, and cooling to a target core temperature of no more than 38°C.

1. **Dantrolene** – To treat an MH episode, an initial dose of dantrolene at 2.5 mg/kg is recommended.
    1. DANTRIUM®/REVONTO® – 36 vials should be available in each institution where MH can occur, each vial to be diluted at the time of use with 60 ml sterile water, USP (without a bacteriostatic agent). There are 3 grams of mannitol in each vial of 20 mg of dantrolene (0.15 g mannitol/ 1 mg dantrolene).
2. **Sterile water for injection USP** (without a bacteriostatic agent) – It is mandatory to get dantrolene sodium to its effective site, the skeletal muscle.
    1. DANTRIUM®/REVONTO® – Each 20 mg vial should be reconstituted by adding 60 ml of sterile water for injection, USP (without a bacteriostatic agent) and the vial shaken until the solution is clear. If the MH episode is proceeding rapidly, simply mix and inject. We advise that the sterile water be stored in 100 ml vials, not bags, to avoid accidental IV administration of this hypotonic solution.
3. **Sodium bicarbonate** (8.4%) – 50 ml x 5
4. **Dextrose** 50% – 50 ml vials x 2
5. **Calcium chloride** (10%) – 10 ml vial x 2
6. **Regular insulin** – 100 units/ml x 1 (refrigerated)
7. **Lidocaine* for injection** (2%) – 100 mg/5 ml or 100 mg/10 ml in preloaded syringes (3). Amiodarone is also acceptable. ACLS protocols, as prescribed by the AHA, would be followed when treating all cardiac derangements caused by MH.
8. **Refrigerated cold saline solution** – A minimum of 3,000 ml for IV cooling

** Lidocaine or procainamide should not be given if a wide-QRS complex arrhythmia is likely due to hyperkalemia; this may result in asystole.*

General Equipment

1. **Charcoal Filters -** Two pairs of activated charcoal filters (Vapor-Clean™, Dynasthetics, Salt Lake City, UT). Attach activated charcoal filters to inspiratory and expiratory ports of the anesthesia machine to quickly reduce the concentration of gas (<5ppm) from the anesthesia machine. In this situation, even though the anesthetic gas has been discontinued when MH was first suspected, the Vapor-Clean™ filter may become saturated after one hour; therefore, a replacement set of filters should be substituted after each hour of use.
2. **Syringes** – (60 ml x 5) to dilute Dantrium®/Revonto®
3. **Intravenous catheters** – 16G, 18G, 20G, 2-inch; 22G, 1-inch; 24G, 3/4-inch (4 each) (for IV access and arterial line)
4. **NG tubes** – (sizes appropriate for your patient population)
5. **Toomey irrigation syringes** – (60 ml x 2) with adapter for NG irrigation

Monitoring Equipment

1. Esophageal or other core (e.g., nasopharyngeal, tympanic membrane, rectal, bladder, pulmonary artery catheter) temperature probes
2. CVP kits (sizes appropriate to your patient population). We recommend these are used in patients who are critically ill.
3. Transducer kits for arterial and central venous cannulation

Nursing Supplies

1. Large sterile Steri-Drape (for rapid drape of wound)
2. Urine meter x 1
3. Irrigation tray with piston (60cc irrigation) syringe
4. Large clear plastic bags for ice x 4
5. Small plastic bags for ice x 4
6. Bucket for ice
7. Test strips for urine hemoglobin

Laboratory Testing Supplies

1. Syringes (3 ml) for blood gas analysis or ABG kits x 6 or point of care monitors; ISTAT with TB syringes (the point of care ISTAT device has replaced lab blood gene and electrolyte measurement).
2. Blood specimen tubes for CK, myoglobin, SMA 19 (LDH, electrolytes, thyroid studies), PT/PTT, fibrinogen, fibrin split products; and lactate, CBC, platelets. If no immediate laboratory analysis is available, samples should be kept on ice for later analysis. This may well prove useful on retrospective review and diagnosis. Blood cultures are very useful and should be included to rule out bacteremia.
3. Urine collection container for myoglobin level. Pigrnenturia (e.g , brown or red urine and heme positive dipstick) indicates that renal protection is mandated, when the urine is centrifuged or allowed to settled, and the sample shows clear supernatant, i.e., the coloration is due to red cells in the sample.

APPROVALS:

		System	Alameda Hospital
Departmental	**Date:**	6/2018	
Clinical Practice Council	**Date:**	7/2019	
Medical Executive Committee	**Date:**	8/2019	8/2019
Board of Trustees	**Date:**	9/2019	

ALAMEDA HEALTH SYSTEM

CONTINUOUS PERIPHERAL NERVE BLOCK USING THE ON-Q INFUSION PUMPS

Effective Date	4/1/2024	***Date Revised***	10/2025
Document Owner	PRIYA PATEL (MGR SYS MED SAFETY-CLIN PHARM)	***Next Scheduled Review***	2/2027
Executive Responsible	CHAIR OF ANESTHESIOLOGY		

Purpose

To define responsibilities of the health care team members involved in the management of the patient receiving a Continuous Peripheral Nerve Block (CPNB) in order to assure safety and effective patient outcomes**.**

Policy

Continuous Peripheral Nerve Blocks (CPNB'S) provides a continuous infusion of local anesthetic near a nerve for regional anesthesia and post-operative pain management. The medication will be delivered by use of and elastomeric disposable infusion pump (On-Q Infusion Pump) filled with local anesthetic with a controlled flow rate. The pump is connected to a catheter that has been placed by the anesthesiologist near a nerve innervating the surgical site. The CPNB will decrease but not eliminate the need for supplemental systemic pain medication.

Guidelines

1. The Anesthesiologist will initiate and medically manage CPNB's.
2. Physician's order must include date/time, drug name, drug concentrations, route of administration, flow rate, and site of catheter.
3. Supplemental analgesia for breakthrough pain will be ordered.
4. Only Physicians or RN with verified competency may manipulate the equipment or the rate of the infusion device.
5. All patients will have a patent IV or saline lock while the catheter remains in place.
6. Only preservative free saline and local anesthetics will be used for CPNB therapy.
7. Pumps and designated tubing without injection ports will be clearly labeled for "Nerve Block." Any tubing with injection ports will not be used.

Procedure

1. **Physician Responsibilities**
    a. Explain the risk, benefits, and indication for the CPNB to the patient and document on the procedure note that informed consent was obtained.
    b. The Anesthesiologist writes orders to initiate the CPNB, including catheter location, **drug** concentration, and infusion flow rate
    c. Verify patient allergies
    d. During placement of the CPNB catheter, patients will be monitored continuously with EKG, blood pressure, and pulse oximetry for at least 30 minutes with vitals being monitored every 5 minutes. If the patient receives sedation, administer supplemental oxygen as needed
    e. The Anesthesiologist and RN assistant will perform a TIMEOUT prior to the procedure.
    f. The Anesthesiologist inserts the CPNB catheter with RN assistance as needed
    g. The Anesthesiologist and/or RN will attach the CPNB catheter to the infusion pump tubing using two-provider Independent verification, as follows:
        i. Use aseptic technique
        ii. Check and verify catheter is not intravascular by negative aspiration for blood with a syringe
        iii. Check and verify patency of infusion pump tubing (clamps open, flow rate set, medication flowing).
        iv. Check and verify patient name, date of birth, drug, dose, infusion flow rate, route, and time.
    h. An Anesthesiologist and/or RN will document dual independent verification in the MAR.
    i. CPNB catheters will be removed by an Anesthesiologist or specially trained RN if removed in the hospital. Catheter integrity will be documented on the CPNB Assessment / Monitoring Form.
    j. For outpatients, catheter removal will be done by the patient after appropriate training. Patients will be called by an anesthesiologist daily until catheter removal and will be given the on-call anesthesiologist contact number for any issues.
    k. An Anesthesiologist and RN will be accessible 24 hours a day for assistance with CPNB pain management problems.
    l. An Anesthesiologist will visit and examine the patient daily and place a progress note in the medical record until the CPNB is discontinued.

2. **Pharmacy Responsibilities**
    a. Patient's drug therapy will be assessed for appropriateness
    b. The medication will be prepared by pharmacy per physician order and labeled appropriately
    c. Medication for ON-Q Infusion Pump will be supplied with pump specific tubing
    d. For CPNB's inserted in the perioperative setting, the Pharmacy will deliver the ON-Q Infusion Pump to the surgery department or the OR transporter will pick up from the Pharmacy
    e. The Pharmacy will be responsible for maintaining appropriate supply

levels and checking expiration dates.

3. **Nursing Responsibilities**

a. After catheter placement and delivery of a loading dose of anesthetic, vital signs will be documented immediately post insertion and every 5 minutes for 30 min. A a cardiac rhythm strip will be monitored and signs and symptoms of local anesthetic systemic toxicity (LAST) will be assessed for a period of at least 30 minutes. Symptoms of LAST include"

i. Metallic taste in mouth, perioral numbness or tingling, ringing in the ears
ii. Lightheadedness or dizziness
iii. Excitation, restlessness, excessive drowsiness, or seizure
iv. Cardiac arrhythmias (e.g. tachycardia, ventricular arrhythmias) or cardiac depression (bradycardia, conduction block, asystole)

***** If Patient experiences any of the above side effects, clamp tubing and contact the Anesthesiologist. In the event or cardiac disturbances, especially cardiac arrest, start BLS/ACLS and retrieve the intralipids from the Pyxis**

b. Independent verification and documentation in the medical records must minimally occur:

i. At the time of initiation therapy
ii. With any change in settings, dose, or concentration
iii. During change of shift/patient handoff

c. Assess and document vitals, signs and symptoms of LAST, effectiveness of the block, motor function/strength, and sensory block distribution at least every 4 hours while the patient is on CPNB therapy. Notify the anesthesiologist of an increasing motor weakness, or inability to move blocked extremity.

d. Administer supplemental analgesics per physician order. If patient pain score is greater than 7/10 despite regional block and supplemental analgesics, notify the Anesthesiologist.

e. Evaluate the catheter site and dressing on admission and at least every 4 hours

i. Make sure the tubing clamp is open for adequate infusion
ii. Monitor patency of tubing
iii. Check for leaks at the site. The site should be clear without excess drainage. A small amount of fluid collection under the dressing is to be expected.
iv. Do not attempt to remove the occlusive dressing as this may dislodge the catheter. Notify physician if dressing no longer intact; reinforce with transparent occlusive dressing until changed by the Anesthesiologist.
v. Do not disconnect catheter from the pump.

f. Trained RN's with a specific order may initiate a CPNB infusion and change the infusion rate per the orders.

g. RNs may HOLD infusion if warranted and must notify the Anesthesiologist immediately if there are signs and symptoms of LAST.

i. Metallic taste in mouth, perioral numbness of tingling, ringing in the ears
ii. lightheadedness or dizziness
iii. excitation, restlessness, excessive drowsiness or seizures

iv. cardiac arrhythmias (e.g. tachycardia, ventricular arrhythmias) or cardiac depression (bradycardia, conduction block, asystole)

h. PACU nurses will serve as a resource for this device.

i. When CPNBs are being used on admitted patients, the bedside RN will change the medication bags and tubing for the reusable infusion pump systems based on the physicians orders and when the infusion bags are empty. The new bags must be verified with a second RN. Both RNs will sign for verification in the EHR

4. **ON- Q c-BLOC Infusion Status**

a. Due to slow flow rate, a change in appearance and size of the pump may not be evident for more than 24 hours after surgery.

b. A fluid level line will not be visible in the pump and fluid cannot be observed moving through the pump tubing

c. Over time, the pump reservoir will become loose and crease

d. As medication is delivered, pump reservoir will gradually become smaller

e. Depending on the size and volume of pump, infusion typically lasts 2-5 days. Infusion is complete when they delivery time has passed and pump is not longer inflated. A hard tube will still be present in the middle of the pump

f. Pump is single use only and cannot be refilled.

5. **Treatment for Local Anesthetic Systemic Toxicity (LAST)**

a. Local anesthetic (LA) induced cardiac arrest differs from ischemic cardiac arrest and requires emphasis on different aspects of the resuscitation process. Whereas defibrillation is a front line therapy for non-LA induced V-tach/V-fib, these disturbances induced by LAST require treatment directed toward the removal of the LA from the sodium channels on cardiac muscle and its displacement from metabolic intracellular mechanisms. Lipid therapy and prolonged CPR need to be remembered / emphasized. Traditional ACLS can be used, but until the LA is displaced from the myocardium, conventional therapies will fail to restore cardiac function.

b. In the event of local anesthetic-induced cardiac arrest, perform standard BLS/ACLS and initiate Lipid Emulsion Therapy as follows per Epic Adult Lipid Emulsion for Local Anesthetic System Toxicity orders:

i. Bolus Intralipid 20 % 1.5 ml/kg over 1 minute (* 120 ml for an 80 kg patient)

ii. Start continuous infusion of 0.25 ml/kg/min (* 20 ml/min for an 80 kg patient)

iii. Repeat bolus every 3-5 minutes up to 3 ml/kg total dose until circulation is restored

iv. Continue infusion until hemodynamic stability is restored, increase the rate to 0.5 ml/kg min if BP remains low

v. A maximum total dose of 8 ml/kg is recommended

vi. If Intralipids are used to treat local anesthetic systemic toxicity, pharmacist shall report it at www.lipidrescue.org.

6. **Discontinue catheter**
   a. The Anesthesiologist or the trained RN will remove the catheter by the following procedure:
      i. Wash hands and don gloves
      ii. Remove catheter site dressing and loosen adhesive skin closure strips at catheter site. Grasp catheter close to the skin and gently pull catheter to remove. Catheter should be easy to remove and not painful Do not use excessive force or jerk the catheter quickly during removal.
      iii. Cover puncture site with adhesive bandage or other appropriate dressing
      iv. **CAUTION**
         - If resistance is encountered or catheter stretches, STOP. Continued pulling could break the catheter. It is advisable to re-apply a fresh dressing, wait 30- 60 minutes and then try again. The patient's body movements may relieve the catheter to allow easier removal
         - If a catheter is still difficult to remove, contact the Anesthesiologist.
         - Do not cut or forcefully remove catheter.
         - Do not apply additional tension if catheter begins to stretch
      v. After removal, check the distal end of the catheter for the black marking to ensure the entire catheter was removed.
         - If the catheter is not intact, contact Anesthesiologist**.**
      vi. Disconnect ON-Q Infusion Pump from tubing and dispose of pump in pharmaceutical waste container

7. Documentation in the medical records will include
   a. Presence of pain pump
   b. Medication and rate of infusion independent verification by each of the 2 participating care providers, initiating the treatment, with any rate changes and at discontinuation when discarding unused high alert medication
   c. Amount infused every 8 hours
   d. Catheter insertion site assessment
   e. Patient education
   f. Discontinuation of the pump/catheter.

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Ingredient? *Anesthesiology and Perioperative Care Service, Veterans Affairs Palo Alto Health Care System, Palo Alto, California; Department of Anesthesiology, Perioperative and Pain Medicine, Stanford University School of Medicine, Stanford, California (E.R.M.); Department of Anesthesia and Pain Management, University Health Network, Toronto, Ontario, Canada; and Department of Anesthesia, University of Toronto, Toronto, Ontario, Canada (A.P.).*

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Reviewed by:

System Pain and Addiction Committee
Dr. Eric Kim – Anesthesia
Dr. Prakash - Anesthesia
Dr. Michael Wu - Anesthesiology

Approvals

	System	AHS Core	Alameda Hospital
System Pain and Addiction	11/2025		
System P&T Committee	11/2025		
Clinical Practice Committee	12/2025		
Medical Executive Committee	12/2025		
Board of Trustees	01/2026		

Attachment A

Continuous Peripheral Nerve Block Assessment and Monitoring Form

Assessment /Monitoring done at the time of initiation, then q 15 minutes x2 hours if no sedation or q 15 minutes x 4 hours if sedation, then every 4 hours while the patient is on the CPNB

Date:	Time:	Time:	0700 1500 2300		
Independent Verification Catheter site:_____ Concentration:_____ Dose:_____	At the time of initiation therapy	With any change in settings, dose, or concentration Concentration/ Dose	During change of shift/patient handoff Concentration/ Dose		
Presence of Pump: Yes /No Patency of tubing: Yes / No	Yes /No Yes /No	Yes /No Yes /No	Yes /No Yes /No	Yes /No Yes /No	Yes /No Yes /No
Rate of infusion:	Rate:	Rate	Rate	Rate	Rate
2 Independent Verifiers Initials	1. 2.	1 2.	0700	1500	2300

Vital Signs – q 15 minutes X 2 hours if no sedation **OR q 15 minutes X 4** hours **if sedation** **B/P P R O2 sat**	Baseline: 15- 30 – 45- 60-	2nd Hr 15- 30 – 45- 60-	3rd Hr 15- 30 – 45- 60-	4th Hr 15- 30 – 45- 60-
Vital Signs : Time / Initials	/	/	/	/
Vital Signs –and pain level **q 4 hours**	B/P P R O2 sat Pain	B/P P R O2 sat Pain	B/P P R O2 sat Pain	B/P P R O2 sat Pain

Pain / LAST Assessment: Time/ Initials																		
Pain Level																		
***M**etallic taste in mouth	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
***P**erioral numbness or tingling	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
***R**inging in the ears	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
***L**ightheadedness or dizziness	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
***E**xcitation, restlessness, excessive drowsiness, or seizure	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
***C**ardiac arrhythmias (e.g. tachycardia, ventricular arrhythmias) or cardiac depression (bradycardia, conduction block, asystole)	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Block Effective	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Motor function/strength																		
Sensory block distribution	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Evaluate the catheter site	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Amount infused every 8 hours																		
Catheter insertion site assessment – C/D/I	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Patient education																		

Discontinuation of the pump/catheter.	Date: Time: By:	Catheter Tip Intact with Black mark visible	Y/N	Any difficulty with removal of catheter?	Y/N	Patient tolerated procedure well	Y/N

*****If Patient experiences any of the above side effects, clamp tubing and contact the Anesthesiologist**

Patient Label

Continuous Peripheral Nerve Block Nursing Assessment and Monitoring Form

ALAMEDA HEALTH SYSTEM

PREPARATION AND ADMINISTRATION OF IV CONTRAST MEDIA IN CT & MRI

Department	Diagnostic Imaging	***Effective Date***	5/03
Campus	All	***Date Revised***	2/16,6/23, 5/25
Unit	All	***Next Scheduled Review***	11/2027
Manual	Radiology	***Author***	Director of Imaging Services
Replaces the following Policies:		***Responsible Person***	Director of Imaging Services

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

I. PURPOSE

To establish standardized renal function screening and intravenous (IV) contrast administration protocols for all patients undergoing CT and MRI examinations, in alignment with the American College of Radiology (ACR) guidelines, The Joint Commission (TJC) standards, and Alameda Health System institutional policies. This policy is intended to ensure patient safety, consistency in clinical practice, and timely access to emergent imaging, while minimizing the risk of contrast-related adverse or allergic reactions through appropriate screening, supervision, and intervention.

II. POLICY STATEMENT

It is the policy of Alameda Health System Diagnostic Imaging Departments to ensure the safe, consistent, and evidence-based administration of intravenous (IV) contrast media for all CT and MRI procedures in accordance with current American College of Radiology (ACR) practice parameters, The Joint Commission (TJC) standards, applicable state and federal regulations, and Alameda Health System institutional protocols.

This policy establishes standardized procedures for renal function screening, contrast dosing, documentation, and clinical escalation to optimize diagnostic quality and minimize patient risk. Radiologists, radiologic technologists, and supervising physician share responsibility for ensuring patient safety through appropriate screening, supervision, adherence to approved protocols, and timely management of any adverse or allergic reactions.

In emergent or clinically urgent situations where renal function data are unavailable, contrast-enhanced imaging may proceed at the discretion of the supervising physician or supervising physician, with documentation clearly indicating that the diagnostic benefit outweighs the potential risk in accordance with ACR and institutional guidelines.

III. SCOPE

This policy applies to all Alameda Health System Diagnostic Imaging Departments, including hospital-based and outpatient imaging sites where intravenous (IV) contrast

media are prepared, administered, or supervised for CT and MRI procedures. It governs all staff involved in contrast use, including radiologists and other supervising physician, radiologic technologists, nursing personnel, and supervising physician, across inpatient, outpatient, and emergency settings for both adult and pediatric patients. The policy ensures compliance with applicable American College of Radiology (ACR) guidelines, Centers for Medicare & Medicaid Services (CMS) supervision standards, The Joint Commission (TJC) requirements, and California Department of Public Health (CDPH) regulations to promote uniform, safe, and evidence-based contrast administration practices throughout the health system.

IV. DEFINITIONS OF SUPERVISION LEVELS

Direct Supervision
As defined by the American College of Radiology (ACR) and the Centers for Medicare & Medicaid Services (CMS), *direct supervision* means the supervising physician is immediately available to furnish assistance and direction throughout the performance of the procedure. The LIP does not need to be physically present in the same room, but must be present in the facility—or, under California Health & Safety Code §106985 (as amended by AB 460, effective 2026), available via real-time audio and video communication with the ability to intervene without delay.

Indirect Supervision
The supervising physician is immediately available through electronic means (e.g., telephone or telehealth platform) and can provide direction but is not physically present within the facility. Indirect supervision may only be used where expressly permitted by state law, CDPH regulations, and institutional policy.

General Supervision
The procedure is performed under the overall direction and control of the supervising physician; however, the LIP's presence is not required during the procedure. The LIP is responsible for establishing protocols, ensuring staff competency, and reviewing the quality and safety of performed procedures.

V. CONTRAST AGENTS USED

- CT Imaging:
  - Routine CT: Omnipaque 300
  - CT Angiography (CTA): Omnipaque 350

- MRI Imaging:
  - Contrast Agents: ProHance (gadoteridol) and Eovist

VI. RENAL FUNCTION (GFR) REQUIREMENTS

CT (Omnipaque)
A GFR check is required if any of the following patient conditions, diagnoses, or procedures apply:

- Age greater than 60 years
- Chronic kidney disease (CKD)
- History of acute kidney injury (AKI)
- Dialysis
- Kidney surgery or ablation
- Albuminuria

Outpatient: Previous GFR value within 90 days may be used
Inpatient: Previous GFR value during the same admission may be used

EXCEPTION: Emergent CT orders do not require a GFR check, in accordance with the radiologist's protocol. The technologist will place a note in the patient's chart to document that the potential benefits of the exam outweigh the risk of potential contrast-induced acute kidney injury (CI-AKI).

GFR must be greater than **30** to administer Omnipaque

- If patient has end stage renal disease and is anuric, contrast may be administered if the patient has an upcoming dialysis appointment scheduled
- If GFR is less than 30, the technologist will contact the radiologist or supervising physician for guidance
- If IV contrast is still desired, prophylaxis with 500 cc of IV normal saline may be considered

MRI (ProHance and Eovist)
Since ProHance and Eovist are group II contrast agents, GFR check is NOT necessary

VII. OMNIPAQUE DOSAGE INFORMATION (CT & CTA)

Contrast Types: Omnipaque 300 and Omnipaque 350
Adult Dose: 100 mL IV for all routine and CTA exams unless otherwise indicated by the radiologist.
Injection Rate:
Routine CT: 2.5 – 3.0 mL/sec
CTA: 4.0 mL/sec
Pediatric Dose: 1.0 mL/kg of Omnipaque 300
Maximum Pediatric Dose: Should not exceed 35 grams of iodine (35 gI)
Administration: Administer via power injector; follow with normal saline flush per departmental protocol.

VIII. PROHANCE & Eovist DOSAGE INFORMATION (MRI)

Prohance:

Standard Dose: 0.1 mmol/kg
Concentration: 0.5 mmol/mL

Dosage Formula: Dose (mL) = 0.2 × Patient weight (kg)
Example: Patient weight: 55 kg → Dose: 0.2 × 55 = 11 mL
Administration: Inject undiluted as an IV bolus at approximately 2 mL/second, followed by a normal saline flush.
Imaging Timing: Begin MRI scanning immediately after injection.

Eovist:

Standard Dose: 0.025 mmol/kg
Concentration: 0.25 mmol/mL
Dosage Formula: Dose (mL) = 0.1 × Patient weight (kg)
Example: Patient weight: 55 kg → Dose: 0.1 × 55 = 5.5 mL
Administration: Inject undiluted as an IV bolus at approximately 1–2 mL/second, followed by a normal saline flush.
Imaging Timing: Dynamic imaging begins immediately after injection; hepatobiliary phase imaging at approximately 20 minutes post-injection.

IX. ROLE OF THE Supervising Physician

The Radiologist serves as the Supervising Physician responsible for the direct supervision of intravenous (IV) contrast media preparation and administration.
Per The Joint Commission (TJC) Standard MM.05.01.01 EP 1, the Radiologist retains oversight and authority for the ordering, preparation, and administration of all contrast agents used in diagnostic imaging.

The supervising physician must be immediately available—either in person or, as authorized under California AB 460, by real-time audio/video communication—to furnish assistance and direction during contrast administration. The LIP shall:

- Supervise and approve contrast protocols during standard operating hours.
- Provide timely clinical intervention in the event of contrast-related reactions.
- Approve and document justification for iodinated contrast administration in patients with GFR < 30 mL/min/1.73 m², when clinically appropriate.
- Ensure compliance with ACR, CMS, CDPH, and California state law supervision standards.
- Verify that all personnel performing venipuncture or contrast administration are appropriately credentialed and trained per **California Health & Safety Code §106985**.

X. RESPONSIBILITIES

Radiologists / Supervising Physician

- Supervise and approve contrast protocols and patient eligibility.
- Maintain immediate availability for assistance and emergency oversight.
- Document supervision and any clinical interventions in the EHR.

- Ensure all operations conform to ACR, CMS, and CDPH requirements.

Radiologic Technologists

- Verify the presence of a valid order and assess for contraindications.
- Confirm renal function only for **iodinated contrast studies**; GFR is **not required** for **MRI studies using Group II gadolinium-based agents (ProHance or Eovist)**.
- Administer contrast under **direct or indirect supervision** as applicable.
- Document contrast type, dose, lot number, rate, and patient tolerance in the EHR.
- Escalate contraindications or adverse events to the supervising physician immediately.

Supervising Physician

- Ensure contrast use is clinically justified and documented.
- Justify emergent contrast studies when renal function data are unavailable.

Emergency Department (ED) Physicians

- Serve as supervising LIP **after standard hours (5:00 PM – 8:00 AM)**, weekends, and holidays.
- Maintain immediate availability for emergency consultation and oversight.

XI. PROCEDURE FOR CONTRAST ADMINISTRATION

All intravenous (IV) contrast administration must occur under the **direct supervision** of a supervising physician. During regular business hours (8:00 AM – 5:00 PM), the **Radiologist** is the supervising physician. During after-hours, weekends, and holidays, the **Emergency Department (ED) physician** assumes supervisory responsibility. Radiologic Technologists must perform appropriate screening and follow all clinical and safety protocols.

1. Confirm Contrast Order and Review Protocol

- Verify that a valid IV contrast order exists and is approved.
- Confirm the correct imaging protocol and contrast type per radiologist instruction.
- Ensure contrast dose and injection parameters match department standards.

2. Verify GFR and Clinical Eligibility

- For **iodinated contrast (CT/CTA studies):**
    - Confirm a current GFR is available and acceptable.
    - Timeframes:
        - **CT outpatients:** within 90 days
        - **Inpatients:** current admission

    - If **GFR < 30 mL/min/1.73 m²** or unavailable, escalate to the supervising Radiologist prior to proceeding.
- For **MRI contrast using Group II agents (ProHance and Eovist):**
    - **GFR verification is not required**.
    - A general renal screening should still be performed to identify patients with known renal failure or dialysis.

3. Pre-Scan Patient Communication and Screening

- Notify inpatient units before transport and confirm patient arrival.
- Verify patient identity using two identifiers.
- Review the **Contrast Screening Form** for allergies, prior contrast reactions, or relevant comorbidities.
- Obtain and verify informed consent when required.

4. Escalate Contraindications

- If contraindications (e.g., allergy, severe renal impairment) are identified, pause the process and notify the supervising physician.
- If unavailable, contact the supervising Radiologist or ED physician.
- Document all communication and decisions in the EHR.

5. Prepare for Contrast Administration

- Verify a patent IV line and flush with saline.
- Confirm contrast type, dose, expiration date, and injector parameters.
- Re-verify patient identity and consent immediately before injection.
- Document all preparation details in the EHR.

6. Administer IV Contrast

- Administer per protocol using a power injector:
    - **Routine CT:** 2.5–3.0 mL/sec
    - **CTA:** 4.0 mL/sec
    - **MRI (ProHance):** 0.2 mL/kg
    - **MRI (Eovist):** 0.1 mL/kg
- Monitor the patient visually and verbally throughout the injection and exam.
- Maintain immediate access to an emergency contrast reaction kit.

7. Respond to Adverse Reactions

If a patient exhibits symptoms of a contrast reaction (e.g., nausea, rash, shortness of breath, dizziness):

- **Stop** the injection immediately.
- Notify the supervising physician (Radiologist or ED physician).

- Activate the emergency response or **Code Blue** if warranted.
- Follow institutional contrast reaction management protocols.
- Document all interventions and outcomes in the EHR.

8. Post-Procedure Documentation and Follow-Up

- Record in the EHR: contrast type, lot number, dose, injection rate, supervising physician, and patient tolerance.
- Report any adverse or near-miss events in the **Midas Occurrence Reporting System**.
- Provide post-procedure hydration and discharge instructions as applicable.

XII. REFERENCES

1. 2024 ACR Manual on Contrast Media (Contrast_Media.pdf (acr.org))
2. 2024 ACR Manual on MR Safety (ACR Manual on MR Safety)
3. 2023 ACR-SPR Practice Parameter for Imaging Pregnant or Potentially Pregnant Patients with Ionizing Radiation (https://www.acr.org/-/media/ACR/Files/Practice-Parameters/Pregnant-Pts.pdf)
4. 2020 ACR-NKF Consensus Statements on CT contrast (Use of Intravenous Iodinated Contrast Media in Patients with Kidney Disease: Consensus Statements from the American College of Radiology and the National Kidney Foundation | Radiology (rsna.org))
5. 2020 ACR-NKF Consensus Statements on MRI contrast (Use of Intravenous Gadolinium-based Contrast Media in Patients with Kidney Disease: Consensus Statements from the American College of Radiology and the National Kidney Foundation | Radiology (rsna.org))
6. TJC MM.05.01.01 EP 1

Approvals

Director Imaging Services	**Date: 11/6/2025**
Chair, Radiology	**Date: 11/6/2025**
P&T Committee	**Date: 11/2025**
CPC	**Date: 12/2025**

ALAMEDA HEALTH SYSTEM

Preparation and Administration of Oral Contrast in CT and MRI

Department	Diagnostic Imaging	***Effective Date***	11/2025
Campus	All AHS Locations	***Date Revised***	n/a
Unit	Diagnostic Imaging	***Next Scheduled Review***	11/2027
Manual	Diagnostic Imaging	***Author***	System Director Imaging Services
Supersedes all prior Policies or SOPs:		***Responsible Person***	System Director Imaging Services

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

I. PURPOSE

To establish standardized procedures for the preparation, administration, and documentation of oral contrast agents used in CT and MRI imaging, including enterography studies, across all Alameda Health System facilities. This policy promotes consistency in clinical practice, ensures radiologist oversight, supports patient safety, and maintains compliance with the American College of Radiology (ACR) Manual on Contrast Media, The Joint Commission (TJC) imaging standards, and applicable California state and federal regulations, while facilitating efficient workflow and quality imaging outcomes.

II. SCOPE

This policy applies to all inpatient, outpatient, and emergency department CT and MRI examinations performed at Alameda Health System facilities, including Highland Hospital, Alameda Hospital, and San Leandro Hospital, where oral contrast is required to enhance bowel opacification or bowel lumen visualization. It applies to all personnel involved in imaging procedures, including technologists, nurses, radiologists, and ordering physician responsible for preparation, administration, and oversight of oral contrast use.

III. APPROVED ORAL CONTRAST AGENTS

Primary CT Contrast Agent:

- Omnipaque (Iohexol) 9 mg/mL or 12 mg/mL, ready-to-drink, 500 mL bottle

Alternative CT Agent:

- Gastrografin (Diatrizoate Meglumine and Diatrizoate Sodium) — used at the radiologist's discretion for suspected perforation, small bowel evaluation, or postoperative leak or when primary CT contrast agent is not available.

CT Enterography Agent:

- VoLumen Oral Contrast (barium sulfate suspension)
- Alternative: Gastrografin mixture if VoLumen is unavailable or contraindicated.

MRI Enterography Agent:

- Breeza Oral Contrast

IV. INDICATIONS FOR ORAL CONTRAST

Oral contrast is administered to opacify and differentiate bowel loops from adjacent structures, aiding diagnostic evaluation of the abdomen and pelvis.

Indications include:

- Suspected bowel obstruction, mass, abscess, or inflammatory process
- Evaluation of bowel leak, fistula, or perforation (use water-soluble contrast)
- Preoperative or postoperative bowel assessment
- CT or MRI enterography

Not routinely indicated for:

- Renal stone protocols
- CT angiography (CTA)
- Trauma abdomen/pelvis studies (unless radiologist specifies)

V. CONTRAINDICATIONS

- Known hypersensitivity to iodinated or oral contrast components
- High aspiration risk or swallowing difficulty (consider G-tube administration)
- Severe nausea, vomiting, or intolerance
- Radiologist discretion to omit for emergent or time-sensitive cases

VI. STANDARD DOSAGE AND ADMINISTRATION

A. Routine CT Abdomen/Pelvis

- **Agent:** Omnipaque 9–12 mg/mL, ready to drink
- **Adult Dose:** 500 mL orally, 45–60 minutes before scan
- **Pediatric Dose:** 1.0 mL/kg of diluted Omnipaque 300 (max 35 g iodine)
- **Alternate Mix:** 25–50 mL Omnipaque 300 in 1000 mL water
- **Alternative Agent:** Gastrografin 30 mL in 1000 mL water for leak or obstruction evaluation

B. CT Enterography

Preparation:

- NPO for at least 6 hours
- Only for patients who can tolerate oral contrast

Primary Agent – VoLumen Oral Contrast:
Total volume: 4 bottles; prep time ~75 minutes

1. 450 mL — 75 minutes before scan
2. 450 mL — 45 minutes before scan
3. 450 mL — 30 minutes before scan
4. 225 mL — 15 minutes before scan
5. 225 mL — 2 minutes before scan

Alternative Agent – Gastrografin Mixture:

1. Mix one 30 mL bottle of 3% Gastrografin with 1000 mL water or juice.
2. Have patient drink 500 mL (or as tolerated).
3. Wait 30 minutes, then administer the remaining 500 mL (or as tolerated).

C. MRI Enterography

Preparation:

- NPO for at least 6 hours
- Only for patients who can tolerate oral contrast

Agent: Breeza Oral Contrast
Administration: Three (3) servings of 500 mL Breeza, given **15 minutes apart** prior to imaging.

- The final serving should be completed immediately before the exam.

VII. PROCEDURE

1. Verify radiologist's protocol and confirm oral contrast requirement in the EHR.
2. Confirm patient identity, allergy status, and NPO compliance.
3. Prepare or retrieve the prescribed contrast (Pyxis or mixed per instructions).
4. Instruct patient to drink steadily within the recommended timeframe.
5. For G-tube administration, confirm tube placement and document route.
6. Monitor for intolerance, nausea, or adverse symptoms.
7. Notify radiologist or ED physician for any concerning reactions.
8. Document all details in EHR, including lot number and expiration date.
9. Report adverse reactions in the **Midas Occurrence Reporting System**.

VIII. ROLES AND RESPONSIBILITIES

- **Radiologists:** Determine necessity of oral contrast; approve protocols.
- **Technologists:** Prepare/administer contrast; document dose, timing, and tolerance; escalate issues.
- **Nursing Staff:** Dispense contrast from Pyxis and assist with patient preparation.

- **Ordering Physician:** Request CT with/without contrast; defer to radiologist for type and use.
- **Pharmacy:** Maintain formulary inventory and monitor expiration dates.
- **Imaging Leadership:** Ensure training, compliance, and protocol standardization.

IX. SAFETY AND EMERGENCY MANAGEMENT

- Observe all patients post-ingestion for intolerance or allergic symptoms.
- If vomiting, distress, or allergic signs occur, notify the radiologist or ED physician immediately.
- Initiate emergency response (Code Blue) for any severe reactions.
- Report adverse reactions in the **Midas Occurrence Reporting System**.

X. DOCUMENTATION REQUIREMENTS

Technologists must document the following in the **Electronic Health Record (EHR):**

- Contrast agent name and concentration
- Total volume/dose administered
- Administration route and timing
- Lot number and expiration date
- Patient weight (for pediatric cases)
- Radiologist protocol reference
- Any adverse events or deviations from standard procedure

XI. REFERENCES

- American College of Radiology (ACR) Manual on Contrast Media
- The Joint Commission (TJC) Imaging Standards
- California Department of Public Health (CDPH-RHB) Regulations
- Omnipaque, Gastrografin, VoLumen, and Breeza Prescribing Information
- AHS Occurrence Reporting and Patient Safety Policies

Approvals

Chair, Radiology	**Date: 11/2025**
Director, Radiology	**Date:11/2025**
P&T Committee	**Date: 11/2025**
CPC	**Date: 12/2025**
Medical Executive Committee	**Date: 1/2025**

ALAMEDA HEALTH SYSTEM	Policy	
	Guideline; Subanesthetic Ketamine Use for Pain or Withdrawal Clinical Practice Guidelines	**29941 2**
	LEVEL ☐ System ☐ Site	EFFECTIVE DATE: 7/2025 NEXT REVIEW DATE: 7/2028

Background:
In general, pain is best managed using a multi-modal analgesic approach including regional anesthetic and analgesic techniques (e.g. nerve blocks, local wound infiltrations, epidural catheters) along with systemically administered analgesics such as acetaminophen, non-steroidal anti-inflammatory drugs (NSAIDs), opioids, and other adjuncts. This multi-modal approach often provides more effective pain relief than opioid treatment alone with a more favorable side effect profile and often has opioid-sparing effects. Ketamine provides analgesic effects by N-methyl-D-aspartate (NMDA) receptor antagonism to modulate pain and central sensitization. Additionally, subanesthetic dosing of ketamine can be helpful when used as an adjunct in the management of withdrawal states (i.e., alcohol, opioid, benzodiazepine, etc.).

Clinical Application:
The following guidelines offer recommended management of patients on subanesthetic doses of ketamine. The intent of these guidelines is to direct physicians and hospital staff on the safe use and benefit of ketamine, and more specifically, ketamine boluses and infusions.

Definitions
ABW – Actual Body Weight
IBW – Ideal Body Weight

Guidelines

Indications include, but are not limited to:

1. Analgesia for:
    a. Moderate to severe pain acute pain
    b. Acute on chronic pain (e.g. sickle cell)
    c. In the opioid tolerant patient
    d. Refractory pain
2. Peri- and post- operative adjuvant analgesia
3. Withdrawal states (e.g. opioid, alcohol, etc)

Absolute Contraindications:

- Hypersensitivity to ketamine or any component of the formulation (e.g. benzethonium)
- Conditions for which a significant elevation in blood pressure would be hazardous (e.g. uncontrolled/poorly controlled hypertension, acute heart failure, unstable tachyarrhythmias, ACS/MI, acute stroke, unstable angina, severe aortic stenosis, or eclampsia)
- Pregnancy

Relative contraindications:

- Cardiac decompensation
- CNS depression
- Tachyarrhythmia
- Increased intraocular pressure
- Aneurysms
- Thyrotoxicosis

General considerations:

1. All patients must be educated on ketamine-induced hallucinations and other associated reactions prior to bolus and infusion initiation
2. Ketamine infusions are compatible and can be used with opioids
3. All ketamine (IV push, IVPB, and continuous infusion) can be given via peripheral IV or central IV lines
4. Weight
    a. Use Ideal Body Weight (IBW) in kg unless the pts Actual Body Weight is less than IBW
5. Ketamine must be administered in a clinical area where the following is available:
    a. Non-invasive BP, HR, RR
    b. Pulse oximetry
    c. Oxygen saturation
    d. Resuscitative equipment/cardiac arrest cart is available

Dosing Recommendations:

	ED/ICU:	**non-ED/ICU:**
Bolus	0.1-0.5 mg/kg (IV or IVPB) IVP over 2-3 min IVPB over 15-30 min Maximum dose 30mg but can be up to 50mg if deemed appropriate by Pain and Addiction provider or Attending MD	0.1-0.3 mg/kg (IV or IVPB) IVP over 2-3 min IVPB over 15-30 min Maximum dose 30mg but can be up to 50mg if deemed appropriate by Pain and Addiction provider or Attending MD
Continuous infusion	Initial (titratable) rate: 0.1-1 mg/kg/hr Max rate: 1 mg/kg/hr	Initial (fixed) rate: 0.1-1 mg/kg/hr Max rate: 1 mg/kg/hr
Titration	TITRATE BY RN Titrate by 0.1 mg/kg/hour q15–20 min to decrease in pain score by ___ to a goal	TITRATE BY MD If pain score not decreased by at least 2 in 30 minutes contact provider for new dose
Duration	Duration dependent on benefit	

a. Dose adjustments are based on suspected toxicity
    i. Ketamine toxicity signs and symptoms include: respiratory depression, hypertension, pulmonary edema , hypertensive encephalopathy, cerebral hemorrhage, delirium
b. If toxicity is suspected:
    i. stop infusion and alert primary/covering team and/or ordering team
    ii. Ketamine infusion should be stopped until toxicity symptoms resolve
    iii. Once toxic symptoms resolve, may resume ketamine infusion at a lower rate if ordered by medical provider. (e.g.; decrease the rate of the continuous infusion by 0.5mg/kg/h from the previous rate)

2. Discontinuation of ketamine
    a. Ketamine can be discontinued without weaning, however weaning can be considered if infusion is > 0.5 mg/kg/hr for > 48 hours) to avoid potential withdrawal symptoms
        i. If weaning, decrease rate by 50% for 4 hours before discontinuing the infusion
3. Medications to manage ketamine side effects:
    a. Excessive lacrimation or salivation
        i. Glycopyrrolate 0.2 mg IV Q6H PRN excessive lacrimation or salivation
    b. Delirium
        i. Midazolam 1 mg IV Q2H PRN delirium (Max total 24-hour dose 5mg)
            - Notify MD if delirium persists after 5 mg
            - Midazolam IV is limited to the use of patients on mechanical ventilation
        ii. Lorazepam 1 mg IV Q2H PRN delirium
            - Notify MD if delirium persists after 4 mg

Monitoring

1. Setting:
    a. Outside OR and ED units, does not need to be administered in a telemetry monitored bed
    b. If provider concerned for cardiac history or hemodynamic instability, can be administered in a telemetry monitored bed
2. Initial Baseline:
    a. Blood pressure (BP), Heart rate (HR), Respiratory rate (RR), transcutaneous O_2 saturation, history and discussion of emergence reactions, pain score, location of pain
3. During infusion:
    a. BP, HR, RR, SpO2, pain score/location of pain, assessment of ketamine toxicity
        i. Every 15 minutes x 1 hr, 30 minutes x 1 hr, then every 4 hours until treatment completed
        ii. With every dose change, restart intensive monitoring (i.e. Every 15 minutes x 1 hr, 30 minutes x 1 hr, then every 4 hours until treatment completed)
    b. Once ketamine infusion discontinued, then monitor the BP, HR, RR, SpO2, and pain score for 1-hour post ketamine infusion

Bolus and Infusion Preparation:

- Preparation:
    1. To prepare ketamine for bolus administration, dilute ketamine (concentration of 50 mg/mL, 100 mg/mL) 50 mL of D5W or NS and mix well.
    2. To prepare ketamine for infusion, dilute to a 1 mg/mL concentration by combining 10 mL (50 mg/mL) or 5 mL (100 mg/mL) of product with 500 mL of D5W or NS.
    3. If fluid restriction is required, may dilute to a 2 mg/mL concentration by combining in 250 mL diluent

Nursing Responsibilities

1. Provide patient education on ketamine-induced dysphoria prior to starting infusion
2. IV Ketamine should be administered only through the Alaris Pump using Guardrails Safety System
3. Ketamine IV Infusions can be given via peripheral IV or central IV lines
4. Notify ordering physician (but continue infusion) if:
    a. SBP > 160 mmHg
    b. HR > 120 bpm
5. Stop the infusion and call the ordering physician IF:
    a. Systemic blood pressure > 180 mmHg
    b. Blood pressure increases > 30 mmHg diastolic or systolic
    c. Heart rate > 140 bpm
    d. Respiratory rate < 8 bpm
    e. spO2% < 93 %
    f. Respiratory distress or respiratory depression
    g. Agitation unresponsive to midazolam
6. Monitor for signs and symptoms of ketamine toxicity:
    a. Respiratory depression
    b. Hypertension
    c. Pulmonary edema
    d. Hypertensive encephalopathy
    e. Cerebral hemorrhage
    f. Delirium

References:

Radvansky BM, Shah K, Parikh A, Sifonios AN, Le V, Eloy JD. Role of ketamine in acute postoperative pain management: A narrative review. *BioMed Research International,* 2015; 1-10.

Schwenk ES, et al. Consensus Guidelines on the Use of Intravenous Ketamine Infusions for Acute Pain Management from the American Society of Regional Anesthesia and Pain Medicine, the American Academy of Pain Medicine, and the American Society of Anesthesiologists. *Reg Anesth Pain Med 2018;43: 456–466*

Klugh JM, Puzio TJ, Wandling MW, et al. Ketamine for acute pain after trauma: A pragmatic, randomized clinical trial.

APPROVALS:

Approvals

		System
Pain and Addiction Committee	**Date:**	**10/2025**
Pharmacy and Therapeutics Committee	**Date:**	**10/2025**
Clinical Practice Committee	**Date:**	**11/2025**
Medical Executive Committee	**Date:**	**01/2026**

ALAMEDA HEALTH SYSTEM	Policy	
	PATIENT IDENTIFICATION	**Reference # tbd**
	Level x System ☐ Site	**Effective Date:** 1/2026 **Last Review Date**: 8/2016, 8/2019, 8/2022, 10/2025
	Document Owner:	Clinical Practice, Nursing

1.0 POLICY STATEMENT

1.1 In addition to verifying patient identification at registration or admission, patient identification is verified by clinicians using two patient identifiers prior to administering medication, blood/blood products collecting specimens for clinical testing, or prior to performing treatments or procedures. The patient's room number or physical location is not used as an identifier.

2.0 PURPOSE

2.1 To protect our patients by providing guidelines ensuring correct patient identification by using two patient identifiers before blood administration, medication administration, and diagnostic and interventional testing, procedures, treatments, and/or surgery.

3.0 SCOPE

3.1 This policy applies to clinical staff working at AHS hospital departments, outpatient departments, procedural sedation sites, and oncology/ infusion suites.

4.0 DEFINITIONS

4.1 **PATIENT IDENTIFIERS:**

4.1.1 Patient Last Name, First Name

4.1.2 Patient Date of Birth

4.1.3 Medical Record Number

5.0 RESPONSIBILITIES

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

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

5.3 This policy applies to all employees who are employed by AHS hospital departments, outpatient departments, procedural sedation sites, and oncology/infusion suites.

6.0 POLICY TEXT

6.1 Patients are identified at registration or admission in accordance with the policy/procedure, patient identification by front office registration and admitting office staff.

6.2 Staff are required to verify two sources of patient identification in both the inpatient and outpatient setting which include: (1) the patient's stated name, and (2) Date of birth. **NOTE:** Medical Record Number may be used as an alternative second identifier.

6.2.1 For **outpatient laboratory** testing, patients will be identified by patient name and medical record number as verified by laboratory order. Date of birth may be used as an alternate second identifier.

6.2.2 All patients treated or seen in the emergency department; oncology/infusion suite, procedural sedation site, and hospital radiology area will wear a patient identification bracelet.

6.2.3 All inpatients are required to wear a patient identification bracelet from admission to discharge.

6.3 Staff are required to place identification bracelets on patients identified in section 6.2. Identification bracelets will be placed as follows:

6.3.1 Identify the patient's name and date of birth verbally with armband.

6.3.2 When verifying the name with the patient, staff must ask the patient to state his/her name (if able); refer to section **6.4.2** if the patient cannot identify self.

6.3.3 Attach the armband to the patient's wrist; in the event it cannot be placed on the wrist, the ankle should be used.

6.3.4 Confirm the correct patient by comparing MRN, name and date of birth on the patient's ID band against the medical record document i.e. electronic Medication Administration Record (MAR), copy of the physician order, or consent, etc.

6.4 VERIFICATION PROCESS

6.4.1 Awake and oriented adult patient

6.4.1.1 The patient or guardian states the name and is verified against the patient's armband.

6.4.1.2 Name, date of birth, MRN listed on patient's armband is compared against a medical document (i.e. electronic medication administration record (MAR) or copy of physician order.

6.4.2 All unresponsive or diminished mental capacity patients without identification will undergo an alternative verification process.

6.4.2.1 Preferred method- Ask family members, legal guardians, care providers, police officers, EMS personnel, or other patient escort personnel to identify the patient upon arrival. Once identified, a photograph may be used as one of the identifiers. Consent for photography must be completed.

6.4.2.2 Preferred method- Assign the unresponsive patient a temporary name and temporary medical record number.

6.4.2.3 Use a photograph to identify unresponsive patients.

6.5 Each department will be responsible for replacing illegible or damaged armbands.

6.5.1 The Emergency Department is responsible for placing identification bracelets on all Emergency Department patients

6.5.2 The Oncology/Infusion, Outpatient, Procedural Sedation site, Radiology Department are responsible for placing identification bracelets on patients who were not processed through the admitting office.

6.5.3 The Admitting Department is responsible for providing all other patients with an identification bracelet at the time of admission.

6.6 In the event that the identification bracelet cannot be placed on either wrist, the ankle should be used.

6.7 Before an ID band is removed from a patient, a second band must be placed in an alternate site by the staff.

6.7.1 Identify the patient's name, MRN and/or date of birth verbally with the armband.

6.7.2 When verifying the name of the patient or caregiver, staff must ask the patient or caregiver to state his or her name.

6.7.3 Attach the armband to the patient's wrist.

6.7.4 For unresponsive patients, refer to section 6.4.2

REFERENCES

Joint Commission Comprehensive Accreditation Manual for Hospitals-NPSG.01.01.01

ALAMEDA HEALTH SYSTEM	Policy	
	MASTER CLOCK POLICY	**28327 3**
	LEVEL ☐ System ☐ Site	EFFECTIVE DATE: 1/2026 NEXT REVIEW DATE: 1/2029

Purpose

1. To identify Alameda Health System's (AHS) master clock as the intranet satellite clock.

2. To ensure all time related devices that are used for services or to provide medical care and treatment are synchronized with the master clock.

Policy

AHS supports and practices safe medical care. This policy was developed to ensure all clocks, devices, and equipment with time functions are synchronized to the master clock (internet satellite clock) at the medical center(s)

Procedure

1. The master clock will be prominently displayed on the tool bar of all computers and on the intranet home page at AHS. The executive responsible for the Information Systems and Technology department will ensure that the master clock is displayed in these two locations.

2. Wall clocks, devices, and equipment used in the medical center will be synchronized with the master clock. The Director of Engineering will ensure that Preventive Maintenance (PM) schedules are generated for the synchronization of clocks. The synchronization of time will occur at a minimum of twice a year in coordination with Day Light Savings beginning and ending times.

3. Medical Equipment and devices used at the medical center will be synchronized with the master clock. The Director of the Biomed Department will be responsible for synchronizing all medical devices with the master clock at a minimum of twice a year in coordination with Day Light Savings beginning and ending times. In addition, the synchronization will occur when medical equipment and devices are placed in service and at the time maintenance occurs.

4. Service contracts will bear language indicating the need to use and synchronize clocks, devices and equipment with AHS's master clock. The identified master clock, which is the intranet satellite clock, will be used by contractors to ensure clocks, devices and equipment are synchronized when services are provided and repairs are performed for AHS. The

Directors of Materials Management, Information Systems, Contracts and Engineering will ensure the necessary language is added to the appropriate contracts.

5. All clocks, equipment, and devices assigned to departments will be synchronized with AHS's master clock (intranet satellite clock). Department Managers will be responsible for ensuring all clocks, equipment and devices are synchronized with the master clock at a minimum of twice a year in coordination with Day Light Savings beginning and ending times. In addition, all managers will ensure that when medical equipment is placed in service for use by BioMed, Engineering or Vendors in their departments; the clocks, devices and equipment are synchronized to the master clock.

ALAMEDA HEALTH SYSTEM	Policy	
	Red Flag Identity Theft Policy	**Reference # tbd**
	LEVEL X☐ System ☐ Site	EFFECTIVE DATE : 1/2026 NEXT REVIEW DATE: 1/2028

PURPOSE 12/5/2025

The AHS Identity Theft Prevention and Response Program is designed to reduce the risk of identity theft through detection, prevention and mitigation of patterns, practices or activities ("Red Flags") that could be indicative of potential identity theft.

SCOPE

To ensure compliance with federal laws pertaining to Identity Theft and to set forth guidelines for establishing the AHS Identity Theft Prevention and Response Program pursuant to the Federal Trade Commission's "Red Flags Rule" which implements Sections 114 and 315 of the Fair and Accurate Credit Transactions Act of 2003 (FACTA).

DEFINITIONS

AHS Workforce Members: Includes employees, contractors, medical staff, trainees, students, volunteers, and other individuals with appropriate AHS affiliations.

Identity Theft: Fraud involves stealing money or getting other benefits by using the identifying information of another person.

Personal Information: Information capable of being associated with a particular individual through one or more identifiers, including, but not limited to Social Security number, driver's license or state identification card number, credit or debit card number, insurance card number. Personal information does not include information that is publicly available, or information made available to the general public from federal, state, or local government records.

Red Flag: A pattern, practice or specific activity that signal possible identity theft. They include, but are not limited to:

1. Suspicious documents such as:
    a. Identification cards or documents that appear to have been altered or forged.
    b. Identification cards that contain information that is not consistent with existing records in the absence or reasonable proof or explanation.
    c. The photograph or physical description on documents or identification provided to Alameda Health System is inconsistent with the appearance of (or information known about) the individual
2. Suspicious identifying information such as invalid phone numbers or address.
3. Alerts from others (e.g. customer, law enforcement)

RESPONSIBILITIES

This policy applies to all AHS Workforce Members.

POLICY

It is the policy of the AHS Identity Theft Prevention Program ("Program") to protect new and existing patient's accounts by reducing the risk from identity fraud and minimizing potential damage of identity theft.

AHS Workforce Members shall follow the Program which includes:

1. Identifying potentially fraudulent activity with new or existing covered accounts.
2. Detecting the presence of identity theft when they occur in covered accounts.
3. Following the Red Flag rules for covered accounts which may indicate potential identity theft.
4. Responding promptly to determine if fraudulent activity has been attempted or committed and take corrective action to mitigate identity theft.

AHS shall follow all federal and state laws and meet reporting requirements regarding identity theft.

AHS shall take all reasonable steps to protect identity information, including medical identity information, for students, medical staff, patients and others for whom AHS maintains identity information.

In particular, for patients receiving care from AHS, all workforce members are responsible for taking the appropriate steps to detect and prevent identity theft for those individuals involved.

PROCEDURES

Identification of Red Flags

In the course of caring for patients, AHS Workforce Members may encounter inconsistent or suspicious documents, information or activity that may signal identity theft. AHS identifies the following as potential red flags:

1. A complaint or question from a patient based on the patient's receipt of:
    a. A bill for another individual;
    b. A bill for a product or service that the patient denies receiving;
    c. A bill from a health care provider that the patient never went to; or
    d. A notice of insurance benefits (or explanation of benefits) for health care services never received.
2. Records showing medical treatment that is inconsistent with a physical examination or with a medical history as reported by the patient.
3. A complaint or question from a patient about the receipt of a collection notice from a bill collector.

4. A patient or health insurer report that coverage for legitimate hospital stays is denied because insurance benefits have been depleted or a lifetime cap has been reached.
5. A complaint or question from a patient about information added to a credit report by a health care provider or health insurer.
6. A dispute of a bill by a patient who claims to be the victim of any type of identity theft.
7. A patient who has an insurance number but never produces an insurance card or other physical documentation of insurance.
8. A notice or inquiry from an insurance fraud investigator or a law enforcement agency, including but not limited to a Medicare or Medicaid fraud agency.

Detecting Red Flags

AHS Workforce Members shall be alert for discrepancies in documents and patient information that suggest risks of identity theft or fraud. Staff will verify patient identity, address and insurance coverage at the time of patient registration.

1. AHS Emergency Departments* and all other registration/intake areas must be reviewed and include in each patient's file a photo ID issued by a local, state, or federal government agency (e.g., a driver's license; passport; military ID, etc.).
    a. In the event the patient does not have photo ID, ask for two forms of non-photo ID, one of which has been issued by a state or federal agency (e.g., Social Security card and a utility bill or company or school identification).
    b. When the patient is under 18 or if the patient is unable due to their condition to produce identification, the party responsible for patient identification shall be requested.
2. Each time a patient visits, check whether the identification provided is valid, copy the identification provided, and match any photo to the patient/responsible party.

For additional information, see Appendix A of this policy.

Responding to Questions.

If asked the reason for the identifying procedures, explain that the procedures are "for patient protection to prevent identity theft and theft of services." Politely remind questioners this is the same process used to cash a check, make a large credit card purchase, or board a plane.

Refusal to Provide or Lack of Identification.

1. No one should be refused care because they do not have acceptable identification with them. Patients should be asked to bring appropriate documents to their next visit.

    *Providing identification is not a condition for obtaining emergency care. The process of confirming a patient's identity must never delay the provision of an appropriate medical screening examination or necessary stabilizing treatment for emergency medical conditions.

Responding to Red Flags

1. If an employee detects fraudulent activity or if a patient claims to be a victim of identity theft, the red flag must be entered in Epic and select Identity Theft from the drop-down menu. Refer to "FYI Flag HIM Tip Sheet" on how to do a red flag for identity theft.
2. The Compliance Office must be notified to respond and investigate the situation. If the fraudulent activity involves protected health information (PHI) covered under the HIPAA security standards, the Compliance Office will also apply its existing HIPAA security policies and procedures to the response.

If potentially fraudulent activity (a red flag) is detected by a AHS Workforce Member:

1. The staff member shall gather all documentation and report the incident to their immediate supervisor.
2. The supervisor shall assess the situation to determine if potential identity theft exists.
    a. The assessment may determine that no risk of identity theft is present (i.e. a mistake has occurred, or the occurrence is readily explainable).
3. If, after preliminary investigation, the supervisor suspects identity theft may have occurred, the person shall notify a Chief Revenue Cycle Officer (CRCO) or their designee shall place a collection hold on the account and enter a Red Flag in Epic. The Compliance Office must also be notified of all suspected incidents of identity theft.

If a patient claims to be a victim of identity theft:

1. AHS Workforce Member must report all patient claims of identity theft to the Compliance Office.
2. The patient should be encouraged to file a police report for identity theft if it has not been done so already and provide a copy of their photo ID to prevent another individual claiming to be that patient.
3. The Compliance Office or AHS Workforce Member may also provide the patient with additional resource information available on https://www.usa.gov/identity-theft. The resource information provides three important steps to report identity theft.
    a. The Federal Trade Commission (FTC) online at IdentityTheft.gov or call 1-877-438-4338
    b. The three major credit reporting agencies. Ask them to place fraud alerts and a credit freeze on your accounts.
    c. The fraud department at your credit card issuers, bank, and other places where you have accounts
4. The Chief Revenue Cycle Officer (CRCO) will direct the Patient Financial Services Team to put all patient accounts potentially affected by the alleged identity theft by:

a. Ensuring the red flag for identity theft is placed in Epic,

b. The account is on hold pending the outcome of the investigation, and

c. Any physician billing and other ancillary department (e.g., radiology, laboratory, pathology, etc.) accounts are reviewed and placed on hold.

If, following investigation, it is determined that a patient has been a victim of identity theft:

1. The Compliance Office Team will promptly consider what further remedial act/notifications may be needed under the circumstances.
2. The physician will review the affected patient's medical record to confirm whether documentation was made in the patient's medical record that resulted in inaccurate information in the record. If inaccuracies exist that are due to identity theft, a notation should be made in the record to indicate identity theft.
3. The HIM/Medical Records staff will determine whether any other records and/or ancillary service providers are linked to inaccurate information. Any additional files containing information relevant to identity theft will be removed and appropriate action taken.
4. The billing department will make appropriate corrections to the patient's billing information, provide documentation to any third-party payer affected by the adjustments, and make any necessary repayments to ensure that the patient and the payer pay only for services actually provided to the patient.

Record Retention.

1. Records related to the incident are to be retained in order to review possible identity theft until the matter is resolved. These records include, but are not limited to the following:
   a. Demographic information collected from a patient or responsible party
   b. Any transactions related to payment for services and/or deferred payment plans
   c. Any documentation related to charity care application
   d. Documents related to insurance coverage or eligibility for third party reimbursement

Accounting for Disclosures.

1. The Compliance Office team shall determine whether, as result of patient misidentification, protected health information was inappropriately disclosed. If PHI was inappropriately disclosed, the Compliance Privacy Team will account for such disclosure in accordance with federal and state law and AHS policy.
2. External notification and reporting will occur only as directed by the Compliance Office.
3. When there is actual knowledge of fraud (e.g., a patient uses another person's Medicare and/or Medi-Cal information to obtain medical care). The Compliance and Revenue Cycle teams will coordinate the necessary reporting.

a. Reporting Medicare Fraud. Call 1-800-MEDICARE (1-800-633-4227) or submit a complaint online at OIG website. https://oig.hhs.gov/fraud/report-fraud/

b. Reporting Medi-Cal Fraud. Call the Department of Health Care Services (DHCS) Medi-Cal Fraud Hotline at (800) 822-6222 or submit a complaint online at DHCS website. https://www.dhcs.ca.gov/individuals/Pages/StopMedi-CalFraud.aspx

If following investigation, it does not appear that the patient has been a victim of identity theft: AHS will take whatever action it deems appropriate, including, but not limited to, removal of the Red Flag in Epic.

REFERENCES

Federal Trade Commission's "Red Flags Rule" which implements Sections 114 and 315 of the Fair and Accurate Credit Transactions Act of 2003 (FACTA)

RED FLAG POLICY APPENDIX A

Key point: In emergent situations screening and stabilization must take place prior to investigation

NON-EMERGENT SERVICE SITUATION GUIDE

IDENTITY THEFT OF RED FLAG	PREVENTION/MITIGATION PROCEDURE	RESOLUTION OF RED FLAG (SUGGESTIONS)
Documents provided for identification appear to have been altered or forged.	Interrupt the admissions or billing process to request additional information or documents to be able to verify identity.	Additional documentation must be provided to resolve discrepancy and continue admissions/billing process.
Personal identifying information provided by the customer is not consistent with other personal identifying information provided by the patient.	Interrupt the admission or billing process to request additional information or documents to be able to verify identity.	Additional documentation must be provided to resolve discrepancy and continue admissions/billing process.
The SSN provided is the same as that submitted by other person opening an account or other customers on file.	Interrupt the admission or billing process to request additional information or documents to be able to verify identity.	Additional documentation must be provided to resolve discrepancy and continue admissions/billing process.
The patient has an insurance number but never produces an insurance card or other physical documentation of insurance.	Interrupt the admission or billing process to request additional information or documents to be able to verify identity.	Additional documentation must be provided to resolve discrepancy and continue admissions/billing process. If the results of the investigation do not indicate fraud, all contact and identifying information is to be re-verified with the patient.
Records showing medical treatment that is inconsistent with a physical examination or with a medical history as reported by the patient (e.g., inconsistent blood type, height).	Investigate the complaint by: • Interviewing individuals as appropriate, and • Reviewing previous files for potential inaccurate records.	Depending on the inconsistency and review of previous file, either delay/do not open a new covered account, or reevaluate services. If the results of the investigation do not indicate fraud, all contact and identifying information is to be re-verified with patient.

	Items to consider include: blood type, age, race, and other physical descriptions may be evidence of medical identity theft.	
Complaint/inquiry from an individual based on receipt of: • A bill for another individual. • A bill for a product or service that the patient denies receiving. • A bill from a health care provider that the patient never patronized. • A notice of insurance benefits (or Explanation of Benefits) for health services never received. • Information added to a credit report by a health care provider or insurer. • A receipt of a collection notice from a bill collector.	Investigate the complaint and interview individuals based on the situation to determine the facts of the case.	• Reevaluate patient treatment and credit granting until identity has been accurately resolved. • Delay attempt to collect the account until identity issues have been resolved. • Notify law enforcement when identity theft has been established. • If the results of the investigation do not indicate fraud, all contact and identifying information is to be re-verified with patient.
A patient or insurance company report that coverage for legitimate hospital stays is denied because insurance benefits have been depleted or a lifetime cap has been reached.	Investigate the complaint and interview individuals based on the situation to determine the facts of the case.	• Obtain additional documentation to resolve the discrepancy and continue admissions/billing process. • Contact insurance company as required. • Notify law enforcement when identity theft has been identified. • If the results of the investigation do not indicate fraud, all contact and identifying information is re-verified with patient.
Mail sent to the patient is returned repeatedly as undeliverable although transactions that continue to be conducted	Skip-tracing procedures are used to find the patient's current mailing address.	Update the contact information appropriately.

in connection with the patient's covered account.		
In situations where: • The hospital or ambulatory site has been notified by a customer. • A victim of identity theft has been reported. • A law enforcement authority reports a potential identity theft. • Any other person who has opened a fraudulent account for a person engaged in identity theft.	Investigate the situation to determine if billing was made fraudulently.	• Obtain additional documentation to resolve the discrepancy and continue admissions/billing process. • Contact insurance company as required. • Notify law enforcement when identity theft has been identified. • If the results of the investigation do not indicate fraud, all contact and identifying information is re-verified with patient.
Personal identifying information provided by the patient is associated with a known fraudulent activity as indicated by internal or third-party sources. For example: 1. The address on an application is the same as the address provided on a fraudulent application; or 2. The phone number on an application is the same as the number provided on a fraudulent application.	Investigate the complaint and interview individuals based on the situation to determine the facts of the case.	• Reevaluate patient treatment and credit granting until identity has been accurately resolved. • Delay attempt to collect the account until identity issues have been resolved. • Notify law enforcement when identity theft has been established. • If the results of the investigation do not indicate fraud, all contact and identifying information is to be re-verified with patient.

ALAMEDA HEALTH SYSTEM	Policy	
	Food and Nutrition Services: Registered Dietitian Nutritionist (RDN) Competency	**Reference # tbd**
	LEVEL x System	**Effective Date: 1/2026** **Next Review Date: 1/2029**

POLICY STATEMENT

The purpose of this policy is to develop a procedure to ensure all AHS Registered Dietitian Nutritionists meet competency standards to provide medical nutrition therapy to patients/residents.

POLICY TEXT

All Registered Dietitian Nutritionists (RDNs) who provide patient/resident nutritional care shall be registered with the Commission on Dietetic Registration and will be assessed for competency.

Verification of RDN Credentials

1. Annually the System Clinical Nutrition Director or designee verifies RDN credentials by using the web-based Commission on Dietetic Registration verification system.
2. A copy of the verification certification is maintained in the Food and Nutrition Services employee file.

Verification of RDN Competency

1. Quarterly
    a. The System Clinical Nutrition Director or designee will complete a minimum of 5 chart reviews per quarter (or 10 biannually) for each full time RDN performing patient care. Part time and per diem RDNs will require a minimum of 5 chart reviews annually.
    b. There will be a documented corrective action plan to improve performance when the quarterly average score of a chart review is less than 90%. Any deficiencies noted are reviewed every thirty days until appropriate skill level is achieved.

2. Annually
    a. All RDNs will complete at least 2 continuing education credits (1.0 CEU or greater) and submit the certificates to the System Clinical Nutrition Director or designee

    b. The System Clinical Nutrition Director or designee will complete a competency validation checklist and competency overview form for each RDN.

	Policy	
	Swallowing Screen, Nursing Bedside	**Reference # Version** 26728
	LEVEL ☐ System ☐ Division ☐ Department X Sites: WGHGH, ALH, SLH	EFFECTIVE DATE: 01/2026 NEXT REVIEW DATE: **1/2029**
	Document Owner: Stroke Core Team	

POLICY STATEMENT

Bedside Swallow Screen (or Dysphagia Screening) ensures all patients who are at risk of swallowing difficulties are assessed early to prevent complications like aspiration pneumonia

PURPOSE

The purpose of the procedure is to enable nurses to assess and screen new patients who may be at risk for aspiration and quickly determine if they are safe for oral intake or if they need a swallowing evaluation performed by the Speech Language Pathologist

SCOPE

This policy applies to all inpatients in clinical areas including, but not limited to: Emergency room, post operative recovery, inpatient, and rehabilitation units.

> **Supportive Data:** Dysphagia (difficulty swallowing) can be caused by many pathologies but is a frequent and potentially serious complication of stroke. Swallowing impairments are associated with a high risk of pneumonia and an increased risk of death (AHA/ASA Guidelines, 2018).
>
> Hospitals that are credentialed as stroke centers must have a screening tool for dysphagia in place and the screen for dysphagia should be administered to patients with a stroke before they are given any "food, fluids and medications by mouth." In compliance with these requirements, this bedside swallowing screen protocol is designed specifically for nurses.

DEFINITIONS

Dysphagia: Difficulty or inability to swallow

Aspiration Pneumonia: A type of lung infection that occurs when food, saliva, or other substance enters the lungs. The cause can be inhaling food or liquid during eating or drinking, vomiting, general anesthesia and neurological disorders that affect swallowing or coughing

Speech and Language Pathologist: A health professional who assesses, diagnoses, and treats communication and swallowing disorders of people of all ages.

RESPONSIBILITIES

The Registered Nurse caring for the patient is responsible for following the steps of this policy.

POLICY TEXT

Equipment:

- Medicine cup
- 3 ounces (90ml) of water in a cup
- Spoon

Steps:

1. The patient tolerates upright position and is alert, can understand and follow commands such as open your mouth, stick out tongue, say "ahhh".

2. Readiness to Participate- Assess the patient for warning signs of aspiration risk or signs and symptoms of swallowing problems or dysphagia such as:

- Slurred speech, weak voice
- "Wet" cough, congestion
- Drooling / difficulty managing secretions.
- Pocketing food in the cheek
- Food remains on the tongue or palate.
- Food sticking in the throat.
- Taking too long to swallow

3. If patient has any of the above warning signs, document "not ready to participate"

4. Have patient drink water from the spoon (or a small sip). If the patient coughs, chokes, or otherwise has swallowing difficulty with the teaspoon of water, STOP/FAIL; keep patient NPO, notify physician, order Speech Therapy swallow evaluation.

(NPO not applicable to John George PES setting*)

4. If the patient tolerates teaspoon (or small sip) of water without difficulty, continue.

5. Measure 3 ounces (90 mls) of water into a cup.
   a. Hand the cup to the patient and ask them to drink the water (NO Straw). Patients may sip gradually or drink all at once. Patients should drink enough for the RN to be able to adequately assess swallowing.
   b. Assess that patient:
      i) Swallows without coughing, choking or throat clearing.
      ii) Voice remains clear, not wet or gurgly – ask patient to count to 5.

6. Patient Passes screening if swallowing and speech remains clear through process
   a. Nurse Action: Request physician order for P.O. diet, monitor for swallowing difficulty especially with first meal.

7. Patient Fails screening if they have any symptoms of: Coughing, choking, throat clearing, or if they are wet and gurgly when they try to speak
   a. Nurse Action: Keep patient NPO including medications and contact physician for Speech Therapy swallowing evaluation.
   (NPO not applicable to John George PES setting*)

8. If a patient fails the screening, and subsequently improves symptoms, the nurse will contact the physician for assessment and swallowing screen may be repeated with the provider order.

*Patients that do not pass the swallow screen at John George PES will be given dysphagia diet and directly observed by staff while eating/drinking

Documentation:

Electronic Health Record Interventions:

Nursing Bedside Swallowing Screen

REFERENCES

Daniels, S. K.; Anderson, J. A. & Wilson, P. C. (2012) Valid Items for Screening Dysphagia Risk in Patients With Stroke: A Systematic Review Stroke Volume 43, Number 3 https://doi.org/10.1161/STROKEAHA.111.6409

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	Policy	
	Hemodialysis Patient Management	**Reference # tbd**
	Level ☐ System X☐ Site	**Effective Date:** 1/2026 **Last Review Date**: **1/2029**
	Document Owner: Director of System Admission & Transfer Center (SATC) – System Administrative Services	

POLICY STATEMENT

This policy establishes the framework for the provision of hemodialysis treatments at AHS Highland facility, ensuring that all procedures are conducted by qualified personnel and that patient care is coordinated effectively between dialysis nurses, primary nurses, and hemodialysis technicians. It is essential that each role is clearly defined to maintain high standards of safety and quality in patient care.

PURPOSE

The purpose of this policy is to delineate the roles and responsibilities of nursing and support staff involved in the care of patients undergoing hemodialysis. This ensures that all staff are aware of their obligations, promotes teamwork, and enhances the overall quality of care provided to patients, while also addressing patient specific medical and educational needs throughout the treatment process.

SCOPE

This policy applies to all healthcare personnel involved in hemodialysis treatment, including dialysis nurses, primary registered nurses (RNs), hemodialysis technicians (PCTs), and any other staff engaged in the care of patients undergoing hemodialysis. It encompasses all treatment facilities, departments, and processes related to hemodialysis care.

DEFINITIONS

Hemodialysis: A medical procedure that uses a machine to filter waste and excess fluids from the blood when the kidneys are no longer able to perform this function.

AV Graft/Fistula: A surgically created connection between an artery and a vein, used for accessing the bloodstream during hemodialysis

SBAR Handoff: A standardized communication framework used to convey critical patient information effectively (Situation, Background, Assessment, Recommendation).

RESPONSIBILITIES

Dialysis Nurse Responsibilities:

1. The dialysis nurse is responsible for hemodialysis treatment and dialysis-related patient care activities, including but not limited to, assessing, accessing and de-accessing of AV graft, fistula, and shunt, as well as blood transfusion/blood product administration during hemodialysis treatment.
2. The dialysis nurse is responsible for carrying out the dialysis orders/ prescription.
3. The dialysis nurse is responsible for all routine dressing changes for the dialysis access site, during dialysis treatment.
    - 3.1 Dressing changes must be performed and labeled appropriately with Date/Time/RN initials post-dialysis treatment.
    - 3.2 All CVC (central venous catheters) with CHG-impregnated disks, capped ports, and occlusive dressings must be changed routinely every 7 days (or as needed per nurse assessment), provided the dressing remains clean, dry, and intact.

4. **Patient Education**

4.1 Explain the procedure and address any questions.
4.2 Explain the need for careful monitoring of patient during treatment for fluid and electrolyte imbalance.
4.3 Review the hemodialysis schedule with patient/ family/ significant other.
4.4 Review the nutritional requirements, fluid restrictions, and special diet.
4.5 Stress the importance of maintaining the vascular access site (temporary or permanent), and to notify the nurse of any new pain, swelling, and bleeding or sensation changes at the vascular access site.

5. A review of the patient's status with the primary RN or designee must occur prior to and upon completion of the dialysis treatment.
6. Notify the primary RN and physician of any changes in the patient's condition during dialysis treatment, and document the notification in the patient medical record.

Primary RN Responsibilities:

1. The primary RN assigned to the patient is responsible for all non-dialysis patient related activities.
2. A review of the patient's clinical status between the primary RN & the dialysis nurse must occur prior to, and at completion of the dialysis treatment
3. The primary RN provides a handoff report to the hemodialysis nurse using SBAR (see reference) to convey pertinent patient clinical information, including the immediate telephone number of the primary RN or Charge Nurse, or break nurse.
4. The primary RN is responsible for all PRN (as needed) changes of the dialysis access site i.e., dressing is damp, loosened, or soiled, post dialysis treatment.
5. The primary RN is responsible for obtaining daily weights in the morning, and post-dialysis weights of the patient. The primary nurse must document this information in the patient's electronic medical record.

Hemodialysis Technician (PCT) Responsibilities:

1. Receives patient into treatment area; weighs patient if ordered by physician, takes temperature and blood pressure pre- and post-dialysis; documents on all dialysis flow sheets.
2. Performs and records vital signs and all other parameters of End-Stage Renal Disease (ESRD) patients as per hospital policy and/or state regulations; obtains blood samples and culture specimens and prepares them for submission to the lab.
3. Collects patient data: monitors and documents status of vascular accesses, documents patient observations and seeks guidance when levels are out of normal range for ESRD patients.
4. Reviews dialysis prescription notes general physical and mental condition of patient through observation and interview, obtains information and/or data to determine compliance to dietary or medication regimen; documents observations in patient electronic medical record.

RESPONSIBILITIES OF MONITORING AND CARE FOR BOTH PRIMARY RN & DIALYSIS NURSE PER STANDARD OF CARE

Perform thorough baseline and ongoing head-to-toe assessments, every shift, which includes:
1. Check the patency of fistula/graft by auscultating the bruit (swishing sound) and feeling for the thrill (vibration). Notify physician if there is a decrease in access function or patency, or absence of bruit or thrill.
2. Neurovascular status of extremity with fistula or graft i.e., capillary refill, pulses distal to access, color & temperature of extremity, or alteration in sensation such as numbness or tingling.
3. Follow diet & fluid restrictions as ordered.
4. Monitor and document intake and output every shift per standard of practice.
5. Monitor electrolytes, glucose, and other pertinent labs, prior to treatment, per institution policy.
6. Notify Physician for K + (Potassium level) greater than 5.5 and less than 3.5
7. Place a sign above the patient's bed indicating which limb has the vascular access (AV fistula or graft). DO NOT use AV fistula/graft extremity for blood pressures; blood draws or IV access. Do not give intramuscular or subcutaneous medications on the extremity where the dialysis access is located. Do not place ID bands, restraints, constrictive clothing, jewelry, or watches on the extremity where the dialysis access is located.
8. Do NOT hold medication pre-dialysis, unless ordered by the physician.
9. All nursing assessments and interventions must be documented in the appropriate patient medical record.
10. An individualized nursing care plan shall be developed for each patient undergoing hemodialysis treatment.
11. Notify the medical provider of any of the following:
    - 11.1 Acute onset of pain in AV graft or fistula
    - 11.2 Coolness of AV graft/fistula to touch, or loss of bruit and/or thrill
    - 11.3 Abnormal neurovascular (color, sensation, mobility) changes in extremity with AV graft or fistula

POLICY TEXT

1. Patient-Centered Care: All actions taken by healthcare personnel must prioritize the safety, dignity, and well-being of patients undergoing hemodialysis. Care should be individualized, considering each patient's unique medical history, preferences, and psychosocial needs.

2. Collaboration and Communication: Effective communication among the healthcare team members—including dialysis nurses, primary RNs, PCTs, and physicians—is essential for coordinated patient care. Staff are expected to engage in open dialogue, share pertinent information, and collaborate to optimize treatment outcomes.

3. Competence and Professional Development: All personnel involved in hemodialysis must maintain the highest standards of professional competence. Continuous education and training are encouraged to ensure that staff are knowledgeable about the latest best practices, technologies, and guidelines pertaining to nephrology nursing and patient care.

4. Compliance with Standards and Regulations: Adherence to established healthcare standards, institutional policies, and regulatory requirements is mandatory. This includes compliance with infection control protocols, safety guidelines, and ethical considerations in patient care.

5. Respect for Diversity: Recognizing and respecting the diverse backgrounds, beliefs, and values of patients and their families is crucial. Care should be culturally sensitive and inclusive, ensuring that all patients receive equitable treatment and support.

6. Accountability and Responsibility: Each member of the healthcare team is accountable for their actions and decisions related to patient care. Staff must take responsibility for their professional conduct, adhere to established guidelines, and report any concerns or deviations from policy promptly.

8. Patient Education and Empowerment: Providing patients and their families with comprehensive education regarding hemodialysis, treatment plans, and self-care is essential. Empowering patients through knowledge enhances their engagement in their own care and promotes adherence to prescribed regimens.

REFERENCES

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Centers for Disease Control and Prevention. (2024, January 21). Guidelines, recommendations and resources. https://www.cdc.gov/dialysis-safety/hcp/recommendations-resources/index.html?utm_source=openai

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ALAMEDA HEALTH SYSTEM	Policy	
	Hemodialysis Patient Management	**Reference # tbd**
	Level ☐ System X☐ Site	**Effective Date:** 1/2026 **Last Review Date: 1/2029**
	Document Owner: Director of System Admission & Transfer Center (SATC) – System Administrative Services	

ATTACHMENT

DAVITA RN HAND OFF

S	**DATE:**	**PATIENT NAME:**			
	PRIMARY RN NUMBER:	**MD:** **CONSULTING NEPHRO:**	**FROM:**	**ISOLATION:**	**CODE STATUS:**
	DIALYSIS ACCESS: CVC AVG AVF	**WEIGHT:**	**FLUID RESTRICTION:**		
	FALL RISK: **Yes** ☐ **No** ☐ **RESTRAINT/TYPE:**		**SCHEDULED DIALYSIS:** S M T W TH F Sat	**LIST OF ON HOLD MEDICATION:**	
	CURRENT DIAGNOSIS:				
	CURRENT VITAL SIGNS:	**BLOOD PRESSURE PARAMETER:**			
	BP: HR: RR: TEMP: O2 Sat: PAIN:				
B	**MEDICAL HISTORY RELATED TO ADMISSION:**			**LATEST BLOOD GLUCOSE:** **Did Patient receive insulin?** **Y** ☐ **N** ☐ CRITICAL LAB RESULT:	
A	**NEURO: (Alert Oriented/Confused)**				
	RESPIRATORY:				
	Telemetry Order: Y ☐ **N** ☐ **Monitor Tech Notified: Y** ☐ **N** ☐ **Current Cardiac Rhythm:**				
	G/U:	**Foley/Drains:** **Output:**			
	SKIN: WOUND/LOCATION:		**MODE OF TRANSPORT:** **WHEELCHAIR: Y** ☐ **N** ☐ **GURNEY/BED: Y** ☐ **N** ☐		
	LINES/IVF:				
	HEPARIN:				
	LAB TEST/PROCEDURE:				
R	**POST PROCEDURE HAND OFF TO FLOOR RN**		**RN HANDOFF TO TRANSPORTER**		
	Dialysis Complete Date/Time:		Patient Name/Age		
	Current Vital Signs:		Room number being transported to		
	How much fluid was removed?		Primary RN name and Tel number		
	How did patient tolerate the procedure?		Fall risk		
	Any concerns?		Safety Concerns		
	DAVITA RN NAME:				

SATC- Hemodialysis 7/2/2024

ALAMEDA HEALTH SYSTEM

January 28, 2026

TO: Quality Professional Services Committee

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

SUBJECT: **Agenda Item:** B3

Meeting Date: January 28, 2026

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 Medical Staff policies and procedures.

Revised Polices for AHS & AH Medical Staff:

- Medical Staff Temporary Privileges

Alameda Health System

MEDICAL STAFF TEMPORARY PRIVILEGES

Department	Medical Staff	***Effective Date***	4/2003
Campus	AHS, AH	***Date Revised***	3/2011, 6/2014, 6/2017, 6/2019, 1/2022; 11/2022; 6/2023; 10/2023; 2/2024; 1/2026
Unit	Medical Staff	***Next Scheduled Review***	1/2029
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 a mechanism for granting temporary privileges to licensed independent practitioners and Advanced Practice Providers who will provide patient care services at Alameda Health System (AHS) and Alameda Hospital.

Policy

1. Temporary clinical privileges may be granted by the Chief Executive Officer (or designee), for a limited period of time, on the recommendation of the Chief of Staff (or designee)

2. Temporary privileges may be granted **ONLY** in the following circumstances:
    a. To fulfill an important patient care treatment and/or service need,
    OR
    b. When an applicant with a completed application that raises no concerns is awaiting review and approval of the Medical Executive Committee and the Board of Trustees.

3. Requests for temporary privileges will be assessed by the Chief Medical Officer, as designated by the Chief Executive Officer, (or designee) and Chief of Staff (or designee).

4. When granting temporary privileges **to fulfill an important patient care treatment and/or service need**, the following must be met:
    a. The applicant for temporary privileges must meet the criteria for temporary privileges described in the Medical Staff Bylaws;
    b. There must be verification of the practitioner's current licensure and current competence; and
    c. There are no Level II Flags as outlined in the "Application Level" policy and procedure. Exceptions may be made at the discretion of the Chief of Staff (or designee).

5. When granting temporary privileges **to a new applicant pending Medical Executive Committee and Board of Trustees approval**, the following must be met:
    a. The practitioner's application must be complete, and the applicant must have received a favorable recommendation from the Division Chief, Department Chair, and Credentials Committee; and
    b. There are no Level II Flags as outlined in the "Application Level" policy and procedure. Exceptions may be made at the discretion of the Chief of Staff (or designee).

6. Temporary privileges must be time-limited and may not exceed one hundred and twenty (120) days.

7. Routine FPPE/proctoring begins at the time temporary privileges are granted.

8. Practitioners requesting temporary privileges must be on Active Staff at a Joint Commission accredited hospital unless exceptions are made in accordance with the Bylaws.

9. Examples of when temporary privileges are **NOT** to be used include, but are not limited to:
    a. The routine granting to new applicants in pendency.
    b. Failure to process, or submit, a practitioner's reappointment application in a timely manner.
        i. Unless justification and documentation that requiring the practitioner to stop practicing would result in an important patient care need situation.

10. Applicants requesting temporary privileges only are required to submit a temporary privilege application fee in the amount of $100.00 payable to the Alameda Health Medical Staff and/or the Alameda Hospital Medical Staff.

Immunization and vaccines are required in accordance with Medical Staff policy. In the event of an important patient care need, evidence of immunizations can be waived, temporarily, upon proof of current vaccinations, including a negative TB test. Any outstanding items will be collected and added to the credential file. For the purposes of communicable disease prevention pending the screening clearance, the practitioner will wear a N95 mask at all times in our facilities.

Procedure

1. Temporary privileges granted to fulfill an important patient care need will require the following:

a. The applicant completes and submits a pre-application, temporary privilege application (if not pursuing membership appointment) including clinical privilege delineation sheet and application fee.
b. The Medical Staff Services Department queries or verifies:
    i. CA Medical or Professional License(s)
    ii. Federation of State Medical Boards (if applicable)
    iii. National Practitioner Data Bank (NPDB)
    iv. LVS 805 Report
    v. CA Secretary of State
    vi. OIG/GSA
    vii. SAM
    viii. Medical Sanctions and CMS Opt Out
    ix. Peer References
    x. Relevant training and experience
    xi. Current competence/clinical activity (for the past 24 months from the most active facility where privileges are held)
    xii. Professional liability insurance for privileges requested
    xiii. Current DEA certificate (if applicable)
    xiv. AMA/ECFMG (if applicable)
    xv. Radiology/fluoroscopy certificate (if applicable)
    xvi. Other Criteria required by the organized Medical Staff Bylaws
    xvii. No current or previously successful challenge to licensure or registration
    xviii. No subjection to involuntary termination of medical staff membership at another organization
    xix. No subjection to involuntary limitation, reduction, denial, or loss of clinical privileges
c. The Division Chief, Department Chair, or Chief of staff or designee may verify current competence relevant to the privileges requested.

2. Temporary privileges are granted in **pendency awaiting review and approval of the Medical Executive Committee and Board of Trustees**:
    a. The Medical Staff Services Department verifies all application information and has received all necessary supporting documentation.
    b. The application is complete with no Level II Flags as outlined in the "Application Level" policy and procedure.
    c. The application is reviewed by the Division Chief, Department Chair, and Credentials Committee and a favorable appointment recommendation has been made.
    d. The application is ready for immediate action by the Medical Executive Committee.
    e. The applicant has requested temporary privileges.
    f. The applicant has no current or previously successful challenges to licensure or registration.
    g. The applicant has not been subject to involuntary termination of Medical Staff membership at another organization.

h. The applicant has not been subject to involuntary limitation, reduction, denial, or loss of clinical privileges.

Notification

1. The practitioner that has been granted temporary privileges will be notified in writing prior to the start date of the temporary privileges.

2. The Authorization for Temporary Privileges and the approved delineation of privileges is disseminated to health system services.

Denial or Rejection of Temporary Privileges

1. There is no right to temporary privileges.

2. A practitioner shall not be entitled to the due process or procedural rights afforded by the Bylaws because a request for temporary privileges is refused or because all or any portion of temporary privileges are terminated or suspended unless the action is taken for medical disciplinary cause or reason.

References:

The Joint Commission standard MS.06.01.13; MS.01.01.01 EP 14

Approvals

		AHS	AH
Credentials Committee	**Date:**	**1/8/2026**	
Medical Executive Committee	**Date:**	**1/21/2026**	**1/16/2026**
QPSC/Board of Trustees	**Date:**	**1/28/2026 / 2/11/2026**	

ALAMEDA HEALTH SYSTEM

January 28, 2026

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:** B4

Meeting Date: January 28, 2026

Item Description: Medical Staff Specialty Privilege Forms

COMMITTEE ACTION: Approval of revised Medical Staff 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.

Analysis:
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 revised privilege forms, that offer a system-wide approach for credentialing and privileging providers that support patient care at AHS.

Privilege Form for AHS:
- Neurological Surgery

Revised Privilege Form for AHS & AH:
- Radiology

(DRAFT) Neurological Surgery - AHS

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 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 in Neurological Surgery.
Certification	Current certification or board eligibility in the examination process leading to certification in Neurological Surgery by the American Board of Neurological Surgery or by the American Osteopathic Board of Surgery with Primary Certification in Neurological Surgery. **AND** Applicant must be active in the maintenance of certification (MOC)/continuous certification program in Neurological Surgery (waived for providers currently Board Eligible).
Clinical Experience (Initial & Reappointment)	Applicant must provide documentation of provision of Neurological Surgery services (30 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).

Primary Privileges in Neurological Surgery

Description: Neurological Surgery is a medical discipline and surgical specialty that provides care for patients in the treatment of pain or pathological processes that modify the function or activity of the central nervous system (brain, hypophysis, and spinal cord), the peripheral nervous system, (cranial, spinal, and peripheral nerves), the autonomic nervous system, and the supporting structures of these systems (meninges, skull and skull base, and vertebral column) and their vascular supply (intracranial, extracranial, and spinal vasculature). Treatment encompasses non-operative management (including prevention, diagnosis, image interpretation, and neurocritical intensive care and rehabilitation) and operative management (including image interpretation, endovascular surgery, functional and restorative surgery, stereotactic radiosurgery, and spinal fusion and instrumentation).

Request	***Request all privileges listed below.*** *Uncheck any privileges that you do not want to request.*	Div Chief Rec	Dept Chair Rec
	Evaluation and Management		
	Admitting/Attending Privileges (including Adolescents 14-21 years of age)		
	Inpatient and Outpatient Consultation and Management		
	Perform history and physical examination		
	Evaluate, diagnose, provide consultation, medically and/or surgically manage and provide surgical and/or non-surgical treatment to patients presenting with injuries, diseases, disorders, or conditions of the central nervous system, peripheral nervous system, autonomic nervous system and the supporting structures of these systems and their vascular supply		
	Lumbar Puncture, including lumbar drain placement (without fluoroscopy)		
	Vascular access including arterial lines and central lines (without fluoroscopy)		
	Neurosurgical intensive care monitoring devices: bedside burr hole for CSF drainage, subdural drainage, intracranial monitor placement		

Focused Professional Practice Evaluation (FPPE)/Routine Initial Proctoring

Two (2) case reviews or H&P's that are representative of the scope and complexity of privileges requested.

Cerebrovascular and Cranial Neurological Surgery

Description: Evaluate, diagnose, provide consultation, treat, and medically and surgically manage patients with cerebrovascular diseases, including ischemic and hemorrhagic stroke, and other diseases and malformations of intracranial, extracranial, and spinal vasculature.

Request	***Request all privileges listed below.*** *Uncheck any privileges that you do not want to request.*	Div Chief Rec	Dept Chair Rec
	Adjunctive use of stereotactic computer-assisted (navigational) device in a cranial procedure		
	Anastomosis, arterial, extracranial-intracranial (eg, middle cerebral/cortical) arteries		
	Carotid endarterectomy		
	Creation and management of ventricular shunt, all types, for cerebrospinal fluid diversion		
	Craniectomy or craniotomy for microvascular decompression		
	Craniotomy for arteriovenous malformation (AVM) or aneurysm repair		

	Craniectomy or craniotomy for hematoma evacuation, intracranial abscess/cyst excision or drainage, skull tumor excision, foreign body removal, and repair of dural/cerebrospinal fluid leak or encephalocele		
	Craniotomy or craniectomy for intra-axial tumor for resection, or involving region of brainstem, sella, suprasellar region or third or fourth ventricle; and for extra-axial tumors involving CP angle (including vestibular schwannomas and meningiomas), skull base, sella or suprasellar, or clival region		
	Cranioplasty for skull defect		
	Cervicocerebral or spinal angiography associated with a neurovascular therapeutic procedure		
	Elevation of depressed skull fracture		
	Excision of carotid body tumor, with or without excision of carotid artery		
	Implantation of brain intracavitary chemotherapy agent		
	Neuroendoscopy, intracranial, with dissection of adhesions, fenestration, placement of catheters, retrieval of foreign body or excision of tumor including transseptal/transsphenoidal resection of pituitary lesion		
	Stereotactic biopsy, aspiration, or excision, including burr hole(s), for intracranial lesion with or without image guidance		
	Twist drill or burr hole(s) for ventricular puncture or pressure monitoring device placement as well as twist drill, burr hole(s) or trephine for drainage of hematoma, brain abscess or cyst		
	Ventriculocisternostomy		

Focused Professional Practice Evaluation (FPPE)/Routine Initial Proctoring

Three (3) case reviews that are representative of the scope and complexity of privileges requested.

Spine Surgery Privileges

Description: Evaluate, diagnose, provide consultation, treat, and medically and surgically manage patients with disorders of the spine, its connecting ligaments, the spinal cord, the cauda equina, and the spinal roots.

Qualifications

Fluoroscopy Qualifications 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 technologist cannot be used in lieu of individual licensed provider.

Request	***Request all privileges listed below.*** *Uncheck any privileges that you do not want to request.*	Div Chief Rec	Dept Chair Rec
	SPINAL PROCEDURES (Fluoroscopy performance requires current California Fluoroscopy certificate/permit)		
	Cisternal Puncture		
	Discography		
	Lumbar Puncture		
	Myelography		
	Pneumoencephalography		
	Posterior lumbar or thoracic laminectomy or laminotomy for decompression of neural elements or excision of disc		
	Posterior cervical decompression		
	Placement of thoracolumbar fixation, segmental or nonsegmental, including pedicle screws, lateral mass screws, transverse process hooks, or sublaminar wires		

	Placement of paddle leads for spinal cord stimulator		
	Thoracolumbar posterior, transforaminal, lateral, or anterior discectomy with or without placement of an interbody fusion device		
	Corpectomy of the thoracolumbar spine including anterior, lateral, transpedicular, or costotransversectomy approach		
	Adjunctive use of navigational tool or device in conjunction with other spinal privileged procedure		
	Instrumentation of the ilium for thoracolumbar or lumbosacral fixation and/or fusion		
	Anterior cervical discectomy with or without interbody fusion device placement or artificial disc implant		
	Posterior cervical fixation with lateral mass screws, pedicle screws, sublaminar wires, or laminar plating		
	Anterior cervical segmental or nonsegmental fixation		
	Cervical corpectomy with or without spinal canal decompression and/or fusion		
	Occipito-cervical fixation or fusion		
	Intrathecal or epidural drug infusion pump implantation and management		
	Kyphoplasty/ Vertebroplasty		
	Epidural Injections		
	Resection of intra-axial spinal cord lesion		
	Resection or biopsy of extradural or intradural, intra-axial or extra-axial spinal cord lesion or arteriovenous malformation		
	Release of tethered cord		
	Repair of syringomyelia or syringohydromyelia		
	Chordotomy		
	Sympathectomy		
	Tractotomies		

Focused Professional Practice Evaluation (FPPE)/Routine Initial Proctoring

Three (3) case reviews that are representative of the scope and complexity of privileges requested.

Peripheral Nerve and Functional/Pain Procedures

Request	***Request all privileges listed below.*** *Uncheck any privileges that you do not want to request.*	Div Chief Rec	Dept Chair Rec
	Peripheral Nerve Graft		
	Peripheral Nerve Repair		
	Peripheral Nerve Resection		
	Peripheral Nerve Transplantation		
	Cranial Nerve Block		
	Frontal Lobotomy		
	Neurectomy		
	Rhizotomy		
	Thalamotomy		
	Implantation of Nerve Stimulators and Pacing Devices		
	Direct Nerve Stimulation		
	Percutaneous Nerve Stimulation		
	Vagal Nerve Stimulator Implantation		

	Deep Brain Stimulation		

Focused Professional Practice Evaluation (FPPE)/Routine Initial Proctoring

One (1) case review reflective of the scope and complexity of privileges requested.

Neuroendovascular Intervention Privileges

Description: Neuroendovascular Intervention is the subspecialty that utilizes minimally invasive catheter-based technology, radiologic imaging, and clinical expertise to diagnose and treat diseases of the central nervous system, head, neck, and spine. The unique clinical and invasive nature of this subspecialty requires special training and skills.

Qualifications

Education/Training	Successful completion of an accredited Committee on Advanced Subspecialty Training (CAST) Neuroendovascular fellowship.
Clinical Experience (Initial/Reappointment)	Applicant must provide documentation of provision of clinical 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).
Fluoroscopy Qualifications	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 technologist cannot be used in lieu of individual licensed provider.

Request	***Request all privileges listed below.*** *Uncheck any privileges that you do not want to request.*	Div Chief Rec	Dept Chair Rec
	INTERVENTIONAL PRIVILEGES (Fluoroscopy performance requires current California Fluoroscopy certificate/permit)		
	Neuroendovascular angiography and intervention		
	Intracranial therapies including embolization and vessel infusion therapy		
	Percutaneous vertebroplasty (with cement) or vertebral augmentation (kyphoplasty)		
	Head and neck endovascular embolization or sclerotherapy		

Focused Professional Practice Evaluation (FPPE)/Routine Initial Proctoring

Three (3) case reviews that are representative of the scope and complexity of privileges requested.

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.

AND

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

Request	***Request all privileges listed below.*** *Uncheck any privileges that you do not want to request.*	Div Chief Rec	Dept Chair Rec
	Moderate Sedation		
	Deep Sedation		

Focused Professional Practice Evaluation (FPPE)/Routine Initial Proctoring

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.*** *Uncheck any privileges that you do not want to request.*	Div Chief Rec	Dept Chair Rec
	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 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

Division Chief Recommendation - FPPE Requirements

Signature of Division Chief/Designee Date

Signature of Department Chair/Designee Date

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.

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

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 Core Radiology 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 the Breast Imaging and Invasive 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)
		Percutaneous vertebroplasty (with cement) or vertebral augmentation (kyphoplasty)
		Neuroendovascular angiography and intervention
		Intracranial therapies including embolization and vessel infusion therapy
		Head and neck endovascular embolization or sclerotherapy

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 the Interventional Radiology 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.*
		Click **shaded blue check box** to Request all privileges. Uncheck any privileges you do not want to request.

AHS Core	AH	
		- Currently granted privileges
		Moderate Sedation

Focused Professional Practice Evaluation (FPPE)/Routine Proctoring Requirements		
AHS Core	**AH**	
		Three (3) Moderate 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

REPORT/DISCUSSION: Medical Staff Reports

No Written Materials

Agenda Item C Medical Staff Reports

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

REPORT/DISCUSSION: Quality Reports

BOT Executive Summary: Quality Report
Ana Torres, Vice President of Quality
January 28, 2025

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

	Performance		
Key Result	**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			✓
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 December for all metrics except HRSN.

HARMS

There were no hospitals-acquired infections or pressure injuries in December.
Harms was reported in the following categories: Falls with Injury (5) and Behavioral Events with Injury (6).

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 causes 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 and Primary

The ambulatory team is working on action plans to improve this metric.

ED BOARDING

The ED Boarding times are being addressed by the systemwide Throughput Steering Committee. The committee has expanded to include five taskforces to address processes that impact patient throughput. The taskforces address: Access, Readmissions, Surge Red, System Bed Capacity, and Length of Stay reduction.

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.

There was one CMS Survey at Alameda Hospital from 12/1/2025 – 12/5/2025. The final report is pending.

asdf

Key Point 2: Below is a summary of the performance by acute care hospital for 7/2025 – 12/2025.

Following is a summary of the QPSC OKR performance by hospital for the first 6 months of the fiscal year.

	Alameda Hospital	Highland Hospital	San Leandro Hospital
Harms			
Sepsis Bundle			
Sepsis Mortality			
Readmissions			
ED Boarding			
HRSN Assessment			
Likelihood to Recommend			

Legend:
- Met goal
- Performed better than baseline, but did not meet goal
- Did not meet goal

Key Point 3: Below are the key regulatory activities that occurred during November and December.

There was one CMS Survey at Alameda Hospital from 12/1/2025 – 12/5/2025. The final report is pending.

Two action plans were submitted to The Joint Commission (TJC).

- A sentinel event occurred in October 2025. The resulting action plan was submitted to and review with TJC.
- The Alameda Hospital Laboratory submitted an action plan for proficiency testing result.

Key Point 4: Highland Hospital, San Leandro Hospital, AHS will be surveyed by 4/22/2026.

The Regulatory Affairs Department continues to offer survey readiness activities. These activities include but are not limited to:

- Weekly rounding
- Weekly communications / bulletins
- Lunch ‘n Learn Education
- Weekly check-ins to support mock survey work
- Offering practice sessions and system-specific tracers
- Validation rounding

January
2026

Regulatory Affairs QPSC Report

- OPEN Session

Nilda Perez – System Director of Regulatory Affairs
ALAMEDA HEALTH SYSTEM

I. Regulatory Events Summary – OPEN Session

A. Site Visits and Complaints

1. CMS Complaint Validation Survey occurred at Alameda Hospital 12/1/2025- 12/5/2025.

B. AHS Licensing Projects

1. Fairmont Hospital – Outpatient Rehabilitation Services Space Program Flex application submitted to CDPH for approval. If granted, this will increase patient treatment space and expand access to services.
2. Alameda Hospital – Outpatient Occupational Therapy Services Program Flex application submitted to CDPH for approval. If granted, this will increase patient treatment space and expand access to services.
3. Highland Hospital – EKG Patient Care Space Program Flex application submitted to CDPH for approval. The request, if granted, will increase patient treatment space within the Emergency Department to help with patient throughput and help reduce patient offloading time.
4. Marina Wellness Outpatient Clinic – Licensing application submitted to CDPH for approval of outpatient services addition to the Alameda Hospital license.

C. Joint Commission Activity

1. The Joint Commission Office of Quality and Patient Safety reviewed and approved the RCA Framework submitted for two self-reported adverse events. (12/19/2025). Action plan with monitoring is in progress.
2. A Proficiency Testing Corrective Action Plan was submitted to the Joint Commission by Alameda Hospital Laboratory (12/18/2025). The plan was accepted and Laboratory Accreditation continues.

D. CONTINUOUS SURVEY READINESS ACTIVITIES

1. The Regulatory Affairs Team is collaborating with operational leaders and administrators to assure compliance with patient safety and quality standards set by the Joint Commission. The next accreditation survey at AHS is expected before this April.
2. Ongoing activities include the following:
    - Weekly rounding with department leaders throughout AHS facilities by Regulatory Affairs
    - Education to department and physician leaders vis Weekly communications, bulletins
    - Monthly “Lunch ‘n Learn” educational webinars on priority topics for all AHS leaders
    - Facilitated weekly check-ins on previous survey findings and follow-up on action plans
    - Survey system-tracer practice sessions
    - Validation rounding with revised readiness tools

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	Dec 2025	FY26 YTD	FY25 Actual	Improvement	Benchmark
Provide safe care	Eliminate Patient Harms	Total Patient Harms	3	12	27	24	14
		CLABSI # Events/SIR	0/NA	0/0	0/0	0/0.317	0/0
		CAUTI # Events/SIR	0/NA	0/0	1/0.56	0/.55	0/.264
		MRSA # Events/SIR	0/NA	0/0	0/0	0/0.658	0/0.335
		C. Difficile # Events/SIR	0/NA	0/0	5/0.75	3/.58	2/.346
		SSI # Events/SIR	0/NA	0/0	1/1.23	1/1.324	0/.849
		Falls with Injury/% Per 1000 Days	0/0	2/0.33	10/0.53	9/0.477	3/0.24
		Reportable HAPI #/% per 1000 Discharges	0/0	2/1.47	0/0	0/0	0/0
		Behavior Events with Physical Injury	3/2.47	8/1.33	10/0.76	9/0.684	8/0.608
		HAPI all Stages #/% per 1000 Discharges	3/12.5	24/17.61	50/18.22	45/16.398	40/14.576
		Serious Safety Events (F or Greater)	1	2	0		
	Reduce Mortality from Sepsis	Sepsis Mortality Observed:Expected & Total Deaths	NA	0.80	1.04	1	0.93
		Bundle Compliance Sepsis Early Management	80.00%	86.28%	77.00%	75%	88%
	Embed Critical Behaviors	Hand Hygiene Compliance	87.21%	83.37%	82.62%		95%

Fiscal Year Starts in July 1 and Ends June 30

FY26 YTD is results from July 2025 to Dec 2025

Timely, Effective, and Efficient Care			Performance			FY26 Goals	
OBJECTIVES	KEY RESULTS	Detailed KPIs	Dec 2025	FY26 YTD	FY25 Actual	Improvement	Benchmark
Promote wellbeing	Provide the right care at the right time	All Cause 30-Day Readmission Rate	10.27%	14.10%	14.82%	11.69%	11.12%
Provide accessible care	Minimize Time Spent Waiting for our Patients	ED Boarding Time for Admitted Patients	2:55	2:27	2:24	2:12	1:30
Equitable Care			**Performance**			**FY26 Goals**	
OBJECTIVES	KEY RESULTS	Detailed KPIs	Dec 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	82.00%	75.00%	49.50%	82%	89%
		% of patients that screened positive for at least 1 Health-related social needs	26.00%	25.00%	NA		
Patient-Centered Care			**Performance**			**FY26 Goals**	
OBJECTIVES	KEY RESULTS	Detailed KPIs	Dec 2025	FY26 YTD	FY25 Actual	Improvement	Benchmark
Be the most welcoming system to receive care	Optimize performance regarding patient experience	Likelihood to recommend Acute	79.30%	71.64%	62.99%	63.89%	71.10%
		Likelihood to recommend ED	64.29%	66.91%	64.40%	65.40%	71.60%
		Communication with Nurses	76.42%	73.90%	69.60%	70.60%	79.90%
		Communication with Providers	83.36%	77.80%	75.91%	76.91%	79.20%

Fiscal Year Starts in July 1 and Ends June 30

FY26 YTD is results from July 2025 to Dec 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	Dec 2025	FY26 YTD	FY25 Actual	Improvement	Benchmark
Provide safe care	Eliminate Patient Harms	Total Patient Harms	0	0	1	1	0
		Behavior Events with Physical Injury	0	0	1	1	0
		Serious Safety Events (F or Greater)	0	0	0	1	0
	Embed Critical Behaviors	Hand Hygiene Compliance	94.00%	93.11%	82.84%		95%
Timely, Effective, and Efficient Care			**Performance**			**FY26 Goals**	
OBJECTIVES	KEY RESULTS	Detailed KPIs	Dec 2025	FY26 YTD	FY25 Actual	Improvement	Benchmark
Promote wellbeing	Provide the right care at the right time	All Cause 30-Day Readmission Rate	11.21%	12.47%	12.26%	11.56%	11.12%
		MyChart Activation Rate	38.00%	38.00%	27.00%		
	Find and treat conditions early	Breast Cancer Screening	59.48%		59.48%	60.27%	63.48%
		Cervical Cancer Screening	50.17%		46.44%	49.64%	67.46%
		Colorectal Cancer Screening	62.78%		61.68%	57.98%	57.98%
	Achieve the best health outcomes	Glycemic status assessment of patients with diabetes	29.56%		31.16%	29.94%	27.01%
		Controlling High Blood Pressure	63.91%		63.82%	63.86%	72.75%
		Child and Adolescent Well-Care Visits	53.22%		49.99%	49.85%	64.74%

Fiscal Year Starts in July 1 and Ends June 30

FY26 YTD is results from July 2025 to Dec 2025

Timely, Effective, and Efficient Care (continued)			Performance			FY26 Goals	
OBJECTIVES	KEY RESULTS	Detailed KPIs	Dec 2025	FY26 YTD	FY25 Actual	Improvement	Benchmark
	Minimize Time Spent Waiting for our Patients	TNAA Primary Care - Return	18	18	10	10	2
		TNAA Specialty Care -Return	5	5	7	15	2
		% of Specialty Clinics with an average of less than or equal to 15 days for New Patients Appointments*	19.00%		11.76%		80%
		% of Adult Primary Care Clinics with an average of less than or equal to 10 days for New Patients Appointments *	0.00%		0.00%		100%
Patient-Centered Care			Performance			FY26 Goals	
OBJECTIVES	KEY RESULTS	Detailed KPIs	Dec 2025	FY26 YTD	FY25 Actual	Improvement	Benchmark
Be the most welcoming system to receive care	Optimize performance regarding patient experience	Likelihood to recommend (Dental)	66.32%	65.03%	62.51%	63.51%	79.10%
		Likelihood to recommend (Primary/Specialty)	75.50%	77.56%	73.18%	74.18%	80.00%
		Communication with Care Provider (Primary/Specialty)	75.92%	76.31%	76.48%	77.48%	83.20%

Fiscal Year Starts in July 1 and Ends June 30

*Preliminary Data

FY26 YTD is results from July 2025 to Dec 2025

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: , Behavior Events that result in Injury	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	10% reduction compared to FY25 overall	20% reduction compared to FY25 overall
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 Readmission Rate	Percentage of inpatient acute med-surg encounters, regardless of payer type, with an unplanned readmission to any AHS facility within 30 days for any cause 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.	11.56% 50% gap reduction to the 50th Percentile CMS Hospital Compare	11.12% 50th Percentile CMS Hospital Compare
MyChart Activation Rate	% of patients who have activated MyChart		
Breast Cancer Screening	The percentage of individuals 50–74 years of age who were recommended for routine breast cancer screening and had a mammogram to screen for breast cancer	60.27%	63.48% 90th %tile
Cervical Cancer Screening	The percentage of individuals 21–64 years of age who were recommended for routine cervical cancer screening who were screened for cervical cancer using any of the following criteria: • Individuals 21–64 years of age who were recommended for routine cervical cancer screening and had cervical cytology performed within the last 3 years. • Individuals 30–64 years of age who were recommended for routine cervical cancer screening and had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years. • Individuals 30–64 years of age who were recommended for routine cervical cancer screening and had cervical QIP PY8 Reporting Manual: Primary Care Access and Preventive Care Measures Page 90 of 581 CPT only copyright 2024 American Medical Association. All rights reserved. cytology/high-risk human papillomavirus (hrHPV) co-testing within the last 5 years.	49.64%	67.46% 90th %tile
Colorectal Cancer Screening	Percentage of adults 45-75 years of age who had appropriate screening for colorectal cancer.	57.98%	57.98% 90th %tile
Glycemic status assessment of patients with diabetes	The percentage of individuals 18–75 years of age with diabetes (types 1 and 2) whose most recent glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) was >9.0% during the measurement year	29.94%	27.01% 90th %tile
Controlling High Blood Pressure	percentage of individuals 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90 mm Hg) during the measurement year.	63.86%	72.75% 90th %tile
Child and Adolescent Well-Care Visits	The percentage of individuals who had the following number of well-child visits with a PCP during the last 15 months. The following rates are reported: 1. Well-Child Visits in the First 15 Months. Children who turned 15 months old during the measurement year: Six or more well-child visits. 2. Well-Child Visits for Age 15 Months–30 Months. Children who turned 30 months old during the measurement year: Two or more well-child visits.	49.85%	64.74% 90th %tile
TNAA Primary Care - Return	Median of all third next available appointment for Return patient visit for Primary Care	10	2
TNAA Specialty Care -Return	Median of all third next available appointment for Return patient visit for specialty Care	15	2
% 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 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%
Likelihood to recommend (Dental)	Percentage of patients who indicated that they would definitely recommend the clinic Percent of surveyed discharges where patient response was highest of the scale (Top Box Score)	63.51%	79.10%
Likelihood to recommend (Primary/Specialty)	Percentage of patients who indicated that they would definitely recommend the clinic Percent of surveyed discharges where patient response was highest of the scale (Top Box Score)	74.18%	80.00%
Communication with Care Provider (Primary/Specialty)	Percentage of patients who indicated that they would definitely recommend the clinic Percent of surveyed discharges where patient response was highest of the scale (Top Box Score)	77.48%	83.20%

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	Dec 2025	FY26 YTD	FY25 Actual	Improvement	Benchmark
Provide safe care	Eliminate Patient Harms	Total Patient Harms	7	49	136	108	66
		CLABSI # Events/SIR	0/NA	0/0	0/0	2/.317	0/0
		CAUTI # Events/SIR	0/NA	1/0.42	8/0.94	4/.55	2/.264
		MRSA # Events/SIR	0/NA	0/0	2/0.97	1/.658	0/0.335
		C. Difficile # Events/SIR	0/NA	5/0.43	18/0.67	15/.579	9/.346
		SSI # Events/SIR	0/0	5/1.35	36/2.35	20/1.32	12/.849
		Falls with Injury/% Per 1000 Days	5/0.42	17/0.4	36/0.44	32/0.396	13/0.24
		Reportable HAPI #/% per 1000 Discharges	0/0	5/0.86	0/0	0/0	0/0
		Behavior Events with Physical Injury	2/0.42	16/0.58	36/0.63	32/0.567	28/0.504
		HAPI all Stages #/% per 1000 Discharges	4/4.296	32/5.52	78/7.01	70/6.309	62/5.608
		Serious Safety Events (F or Greater)	2	9	11		
	Reduce Mortality from Sepsis	Sepsis Mortality Observed:Expected & Total Deaths	NA	1.18	1.10	1	0.93
		Bundle Compliance Sepsis Early Management	71.43%	69.23%	57.94%	75%	88%
	Embed Critical Behaviors	Hand Hygiene Compliance	94.50%	94.44%	89.36%		95%

Fiscal Year Starts in July 1 and Ends June 30

FY25 YTD is results from July 2024 to Dec 2025

Highland FY 2026 Detailed Quality OKR and KPI Dashboard

Timely, Effective, and Efficient Care			Performance			FY26 Goals	
OBJECTIVES	KEY RESULTS	Detailed KPIs	Dec 2025	FY26 YTD	FY25 Actual	Improvement	Benchmark
Promote wellbeing	Provide the right care at the right time	All Cause 30-Day Readmission Rate	8.84%	11.25%	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	10:52	8:18	12:57	8:28	4:00
Equitable Care			Performance			FY26 Goals	
OBJECTIVES	KEY RESULTS	Detailed KPIs	Dec 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	85.00%	85.00%	76.00%	82%	89%
		% of patients that screened positive for at least 1 Health-related social needs	33.00%	30.00%	NA		
Patient-Centered Care			Performance			FY26 Goals	
OBJECTIVES	KEY RESULTS	Detailed KPIs	Dec 2025	FY26 YTD	FY25 Actual	Improvement	Benchmark
Be the most welcoming system to receive care	Optimize performance regarding patient experience	Likelihood to recommend Acute	81.97%	82.26%	76.10%	77.35%	78.30%
		Likelihood to recommend ED	54.67%	59.82%	58.28%	59.36%	71.60%
		Likelihood to recommend Amb Surg	84.38%	80.65%	77.82%	81.43%	86.70%
		Communication with Nurses	79.93%	78.31%	73.68%	74.68%	79.90%
		Communication with Providers	86.95%	85.00%	82.93%	83.93%	93.60%
Fiscal Year Starts in July 1 and Ends June 30			FY26 YTD is results from July 2025 to Dec 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	Dec 2025	FY26 YTD	FY25 Actual	Improvement	Benchmark
Provide safe care	Eliminate Patient Harms	Total Patient Harms	6	34	69	62	55
		Falls with Injury/% Per 1000 Days	3/1.64	12/0.89	16/0.59	14	12
		Behavior Events with Physical Injury	3/1.64	22/1.63	53/1.96	48	42
		Serious Safety Events (F or Greater)	0	0	1	0	0
Patient-Centered Care			Performance			FY26 Goals	
OBJECTIVES	KEY RESULTS	Detailed KPIs	Dec 2025	FY26 YTD	FY25 Actual	Improvement	Benchmark
Be the most welcoming system to receive care	Optimize performance regarding patient experience	Overall Rating of Care	54.70%	55.40%	57.67%	58.67%	67.50%

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, 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	Dec 2025	FY26 YTD	FY25 Actual	Improvement	Benchmark
Provide safe care	Eliminate Patient Harms	Total Patient Harms	1	25	45	32	21
		CLABSI # Events/SIR	0/NA	0/0	0/0	0/0.317	0/0
		CAUTI # Events/SIR	0/NA	1/2.61	0/0	0/0.55	0/0.264
		MRSA # Events/SIR	0/NA	0/0	2/4.12	0/0.658	0/0.335
		C. Difficile # Events/SIR	0/NA	1/0.49	13/2.07	3/0.58	2/0.346
		SSI # Events/SIR	0/NA	0/0	2/1.19	2/1.324	1/0.849
		Falls with Injury/% Per 1000 Days	0/0	4/0.49	11/0.56	9/0.504	3/0.24
		Reportable HAPI #/% per 1000 Discharges	0/0	8/5.44	6/0	7/2.295	6/2.04
		Behavior Events with Physical Injury	1/0.79	11/1.81	11/0.78	9/0.603	8/0.536
		HAPI all Stages #/% per 1000 Discharges	4/13.42	39/26.51	64/20.4	57/18.36	51/16.32
		Serious Safety Events (F or Greater)	0	1	1		
	Reduce Mortality from Sepsis	Sepsis Mortality Observed: Expected	NA	1.51	1.08	1	0.93
		Bundle Compliance Sepsis Early Management	0.00%	63.33%	59.24%	75%	88%
	Embed Critical Behaviors	Hand Hygiene Compliance	95.04%	93.34%	94.46%		95%

Fiscal Year Starts in July 1 and Ends June 30

FY26 YTD is results from July 2025 to Dec 2025

Timely, Effective, and Efficient Care			Performance			FY26 Goals	
OBJECTIVES	KEY RESULTS	Detailed KPIs	Dec 2025	FY26 YTD	FY25 Actual	Improvement	Benchmark
Promote wellbeing	Provide the right care at the right time	All Cause 30-Day Readmission Rate	10.77%	12.95%	12.73%	11.69%	11.12%
Provide accessible care	Minimize Time Spent Waiting for our Patients	ED Boarding Time for Admitted Patients	2:53	2:32	2:20	2:12	1:30
Equitable Care			**Performance**			**FY26 Goals**	
OBJECTIVES	KEY RESULTS	Detailed KPIs	Dec 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	94.00%	93.00%	92.30%	82%	89%
		% of patients that screened positive for at least 1 Health-related social needs	33.00%	27.00%	NA		
Patient-Centered Care			**Performance**			**FY26 Goals**	
OBJECTIVES	KEY RESULTS	Detailed KPIs	Dec 2025	FY26 YTD	FY25 Actual	Improvement	Benchmark
	Optimize performance regarding patient experience	Likelihood to recommend Acute	79.95%	75.55%	67.39%	68.39%	71.10%
		Likelihood to recommend ED	65.12%	68.99%	58.67%	59.67%	71.60%
		Likelihood to recommend Amb Surg	100.00%	85.00%	76.92%	77.92%	86.70%
		Communication with Nurses	77.67%	75.52%	72.60%	73.60%	79.90%
		Communication with Providers	80.75%	79.31%	77.85%	78.85%	79.20%

Fiscal Year Starts in July 1 and Ends June 30

FY26 YTD is results from July 2025 to Dec 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

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	Nov 2025	FY26 YTD	FY2025 Actual	Improvement	Benchmark	Accountable Leaders
Provide safe care	Total Patient Harms*	22	153	410	204	164	R. Lofton, L. Laurent
	Bundle Compliance Sepsis Early Management	69.23%	74%	55%	75%	88%	R. Lofton, L. Laurent
	Sepsis Mortality O/E Ratio	1.11	1.14	1.05	1.00	0.93	R. Lofton, L. Laurent
Timely, Effective, and Efficient Care							
OBJECTIVES	KEY RESULTS	Nov 2025	FY26 YTD	FY2025 Actual	Improvement	Benchmark	Accountable Leaders
Promote wellbeing	All Cause 30-day readmission rate	11.19%	12.23%	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*	16%		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	2:31	2:30	3:10	2:12	1:30	R. Lofton, A.Wu
	ED Boarding Time for Admitted Patients Highland	8:10	8:18	12:57	8:28	4:00	R. Lofton, A. Wu
Equitable Care							
OBJECTIVES	KEY RESULTS	Nov 2025	FY26 YTD	FY2025 Actual	Improvement	Benchmark	Accountable Leaders
Serving all: Deliver equitable care	Health-related Social Needs Assessment Completed on Inpatients	85.00%	86.00%	64.58%	81.95%	89.40%	R. Lofton
	% of Inpatients positive for at least 1 Health-related Social Need	34.00%	32.00%	NA			
Patient-Centered Care							
OBJECTIVES	KEY RESULTS	Nov 2025	FY26 YTD	FY2025 Actual	Improvement	Benchmark	Accountable Leaders
Be the most welcoming system to receive care	Likelihood to recommend care composite	74.60%	75.69%	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
1/28/26

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

7 visits – 3 for Park Bridge – 2 no findings, 1 finding for a self-report, 1 for Fairmont, no findings, and 3 for South shore, no findings

Key Point 3: **ARU quality dashboard:**

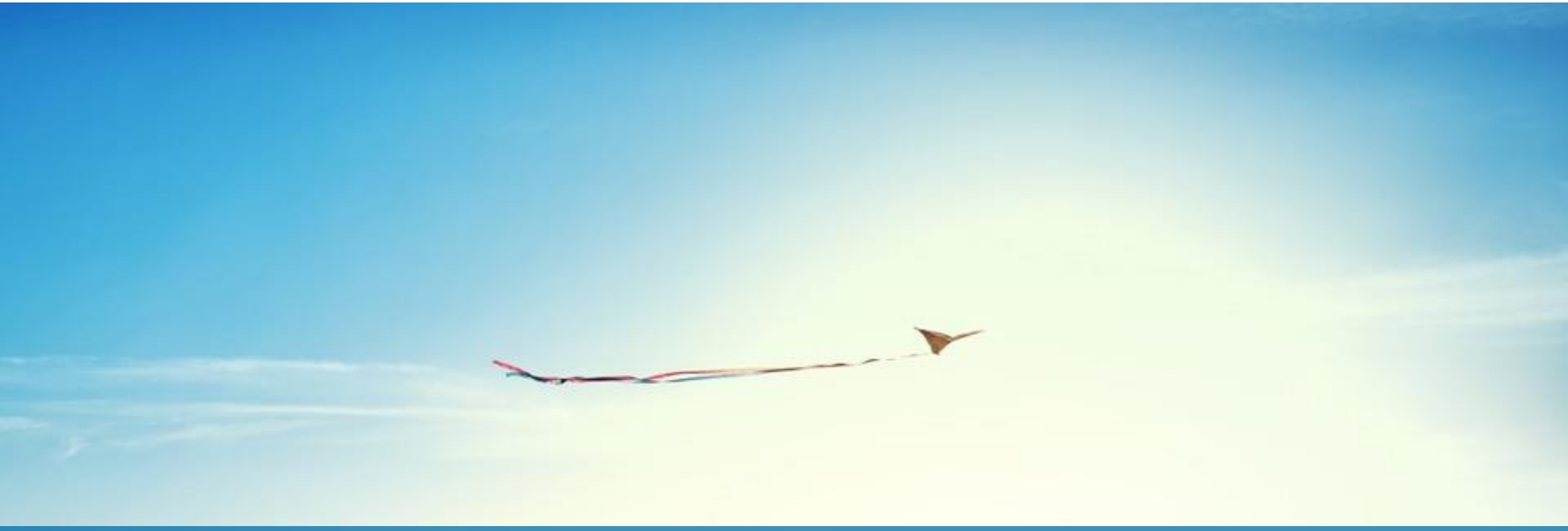
3 falls, lower than goal, and zero for all other categories:
0 CAUTI (Cather Associated Urinary Tract Infections)
0 C-Diff
0 Medication Errors
0 HAPI (Hospital Acquired Pressure Injuries)

Key Point 4: **Alameda Post-Acute Financials:**

The 2 SNF's are contributing a positive $8,160,129 to the hospitals bottom line
22.7% collection rate
The Sub-Acute is ($816,352) behind budget – the unit continues to work on census and OT reduction
17.2% collection rate

Key Point 5: **San Leandro Post-Acute Financials:**

The Acute Rehab Unit (ARU) has a $6,948,466 positive contribution to the hospitals bottom line.
38.7% collection rate



ALAMEDA HEALTH SYSTEM

Post-Acute Quality Report 1/28/26

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 December off-cycle 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 December off-cycle 2025

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

CDPH/CMS Visits

- CDPH visits: 7 visits

- Park Bridge: 2 no findings – 1 self report finding
- Fairmont: 1 no findings
- South shore: 3 no findings

ARU Monthly Quality Metrics

December 2025 Metrics ARU	Actual	Goal
Falls	3	0
Falls per 1000 patient days	4.5	less than 5 stretch to 0
CAUTI	0	0
C-DIFF	0	0
Med Error	0	0
HAPI	0	0
Workplace Violence	0	0

- 3 falls for the month – 4.5%
- 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

Second Quarter
Alameda SNF's/SA

Alameda Hospital District- Dec 2025
by Service Line

	ACUTE*	SNF	SUBACUTE	CLINIC	Grand Total	YTD Budget	YTD Variance
Operating Revenue							
Net Patient Revenue	40,216,095	16,945,203	4,396,878	2,019,470	63,577,645	62,893,725	683,921
Capitation Revenue	965,874	2,836	197,361	-	1,166,071	1,166,071	-
Other Government Programs	10,946,791	5,936,069	1,347,996	306,339	18,537,196	18,762,572	(225,376)
Other Revenues	373,269	91,494	41,663	20,490	526,915	368,397	158,519
Total Revenue - All Sources	**52,502,029**	**22,975,602**	**5,983,898**	**2,346,299**	**83,807,828**	**83,190,765**	**617,063**
Collection %	***14.4%***	***22.7%***	***17.2%***	***18.3%***	***16.3%***	***16.5%***	***-0.2%***
Operating Expenses							
Salaries & Benefits	38,518,242	12,128,895	5,924,449	1,353,116	57,924,702	57,198,489	(726,213)
Purchased Services	2,566,485	578,853	173,514	288,922	3,607,774	4,259,929	652,155
Contracted and Allocated Prov	4,045,074	594,942	207,366	647,321	5,494,703	7,871,345	2,376,642
Materials and Supplies	3,682,487	953,769	485,548	423,092	5,544,896	6,048,994	504,098
Facilities	3,102,849	24,025	7,570	84,014	3,218,458	2,490,843	(727,615)
Depreciation	1,691,358	516,408	168	202,403	2,410,338	2,531,581	121,244
General & Administration	193,585	17,980	1,635	6,342	219,541	191,631	(27,910)
Total Operating Expenses	**53,800,079**	**14,814,873**	**6,800,249**	**3,005,210**	**78,420,411**	**80,592,812**	**2,172,401**
Contribution Margin	**($1,298,050)**	**$8,160,729**	**($816,352)**	**($658,911)**	**$5,387,417**	**$2,597,953**	**$2,789,464**

ALAMEDA HEALTH SYSTEM

Second Quarter
San Leandro

San Leandro Hospital- Dec 2025
By Service Line

	ACUTE	REHAB	Grand Total	YTD Budget	YTD VARIANCE
Operating Revenue ----------					
Net Patient Revenue	47,694,252	16,362,529	64,056,781	65,236,167	(1,179,386)
Capitation Revenue	2,861,214	76,980	2,938,194	2,938,194	-
Other Government Programs	13,842,681	1,377,207	15,219,888	15,789,452	(569,564)
Other Revenues	464,105	64,063	528,168	289,075	239,093
Total Revenue - All Sources	**64,862,253**	**17,880,778**	**82,743,031**	**84,252,889**	**(1,509,857)**
Collection %	***13.5%***	***38.7%***	***16.2%***	***16.4%***	
Operating Expenses ----------					
Salaries & Benefits	45,749,369	9,253,395	55,002,765	51,927,683	(3,075,082)
Purchased Services	2,362,143	606,564	2,968,708	3,103,566	134,858
Contracted and Allocated Provider	11,652,800	873,291	12,526,090	13,050,753	524,663
Materials and Supplies	7,742,829	148,283	7,891,113	8,615,695	724,582
Facilities	1,905,285	-	1,905,285	2,020,176	114,891
Depreciation	1,568,472	50,240	1,618,712	1,906,589	287,877
General & Administration	158,922	538	159,461	160,933	1,472
Total Operating Expenses	**71,139,821**	**10,932,312**	**82,072,133**	**80,785,395**	**(1,286,738)**
Contribution Margin	**($6,277,568)**	**$6,948,466**	**$670,898**	**$3,467,494**	**($2,796,595)**

Thank you

Questions?