BOARD OF TRUSTEES MEETING

WEDNESDAY, FEBRUARY 11, 2026
5:00pm to 9:00pm

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

LOCATION:

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

ZOOM Meeting Link:[1]
https://alamedahealthsystem.zoom.us/j/9361457125?pwd=4JnAmhDnBaLqY4GWf4PQBwp3w0Puy2.1&omn=83249965358
Meeting ID: 936 145 7125
Meeting Password: 20200513

One tap mobile
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+13462487799,,9361457125#

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

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

MEMBERS

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

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

BOARD OF TRUSTEES MEETING AGENDA

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

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

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. CEO REPORT
James E.T. Jackson, Chief Executive Officer

B. MEDICAL STAFF REPORTS

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

C. COMMITTEE AND TRUSTEE REPORTS

C1. Human Resources Committee: January 21, 2026
Donna Linton, Chair

C2. Quality Professional Services Committee: January 28, 2026
Lilavati Indulkar, MD, Trustee

D. CONSENT AGENDA: ACTION

D1. Approval of the Minutes of the November 19, 2025 Board of Trustees Special Meeting.

D2. Recommendation from the Quality Professional Services Committee to approve the policies listed below:

- 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
- HR Section 4.00 - Policy 4.21 Annual Competencies
- HR Section 2.00 - Policy 2.51 Personal Leave of Absence
- HR Section 1.00 – Policy 1.26 Rehire or Reinstatement to Employment

D3. Recommendation from the Quality Professional Services Committee to approve the AHS and AH Medical Staff Policies and Procedures listed below:

- Medical Staff Temporary Privileges

E. ACTION/DISCUSSION: CONTRACTS

E1. Renewal agreement with Roelz Enterprises, LLC dba ELZ Prestige Home Care for provision of sitter services. The term of this agreement is effective October 15, 2025 through October 14, 2027. The estimated impact of this agreement is $2,200,000.
Mark Fratzke, Chief Operating Officer

F. ACTION/DISCUSSION

F1. ACTION: Staff Requests Board Authorization for the allocation of a not-to-exceed amount of $9, 507,500 million to support an Intergovernmental Transfer for the benefit of St. Rose Hospital
Kim Miranda, Chief Financial Officer

G. DISCUSSION: Board Calendar and Tracking

CLOSED SESSION

1. **CONFERENCE WITH LABOR NEGOTIATORS**
   [Government Code Section 54957.6]
   AHS Designated Representatives: Jet Chapman, CHRO
   Employee Organization: SEIU 1021, SEIU-UHW, BTC, ACMEA, SEIU-CIR

2. **CONFERENCE WITH LEGAL COUNSEL - EXISTING LITIGATION**
   (Paragraph (1) of subdivision (d) of Gov. Code § 54956.9)

Case name unspecified: Disclosure would jeopardize settlement negotiations
Ahmad Azizi, General Counsel

3. **CONFERENCE WITH LEGAL COUNSEL - EXISTING LITIGATION**
(Paragraph (1) of subdivision (d) of Gov. Code § 54956.9)
Case name: **Service Employees International Union, Local 1021 v. County of Alameda and Alameda Health System, Superior Court of California, County of Alameda, Case No. 26CV168243**

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

(Reconvene to Open Session)

General Counsel Report on Action Taken in Closed Session

TRUSTEE COMMENTS

ADJOURNMENT

Our Mission
Caring, Healing, Teaching, Serving All

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

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

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

The Board of Trustees is the Policy Body of the Alameda Health System. The Board has several standing Committees where Board matters are the subject of discussion at which members of the public are urged to testify. Board procedures do not permit: 1) persons in the audience at a Committee meeting to vocally express support or opposition to statements by Board Members or by other persons testifying; 2) ringing and use of cell phones, pagers, and similar sound-producing electronic devices; 3) signs to be brought into the meeting or displayed in the room; 4) standing in the meeting room. Citizens are encouraged to testify at Committee meetings and to write letters to the Clerk of the Board or to its members, 1411 East 31st Street Oakland, CA 94602.

Members of the public are advised that all Board and Committee proceedings are recorded (audio), including comments and statements by the public in the course of the meetings. Copies of the audio recordings will be made available to the public. Copies of the agendas and supporting documents can be found here: http://www.alamedahealthsystem.org/meeting-agendas-and-minutes/**. By attending and participating in Board/Committee meetings,**

members of the public consent to audio recording of any statements they may make during the proceedings.

Disability Access

To request accommodation or assistance to participate in the meeting please contact the Clerk of the Board. Requests made at least 48 hours in advance of the meeting will help to ensure availability.

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

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

CEO REPORT

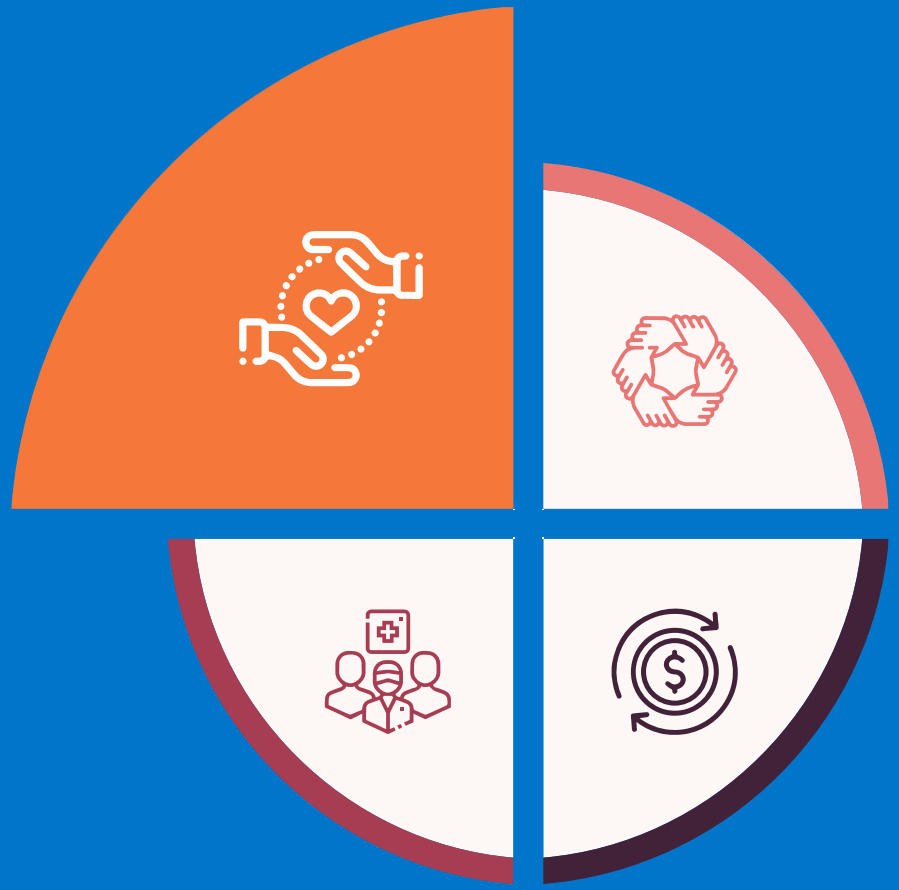
AHS CEO Board Report

James Jackson
2/11/2026
Board of Trustee Meeting

AHS Pillars

Quality Care

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



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
★★★★★	★★★★★	★★★★★	★★★★★

Care Compare Five-Star Ratings of Nursing Homes

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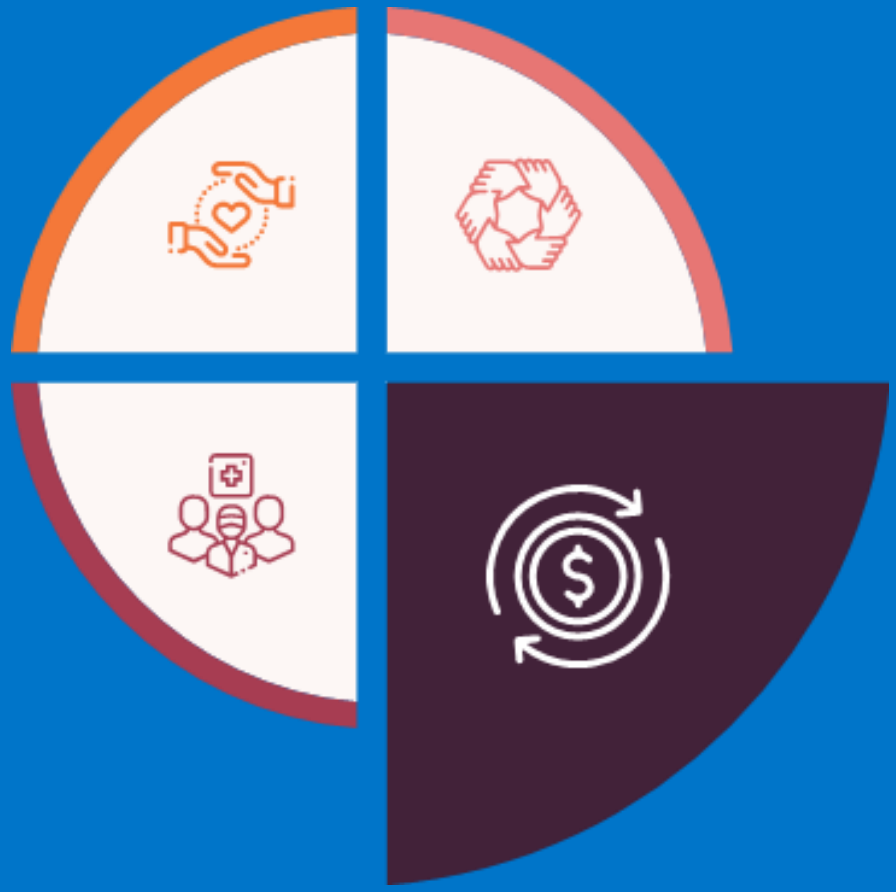
Overall Quality	Health Inspection	Quality Measures	Staffing
★★★★★	★★★★★	★★★★★	★★★

AHS Pillars

Sustainability



AHS will pursue innovative approaches to invest in new programs while managing targeted investments in infrastructure to support the delivery of high-quality care.

Stanford at St. Rose Hospital

St. Rose and Stanford Healthcare have entered into a Bed Reserve Agreement with respect to St. Rose's recently opened 29-bed skilled nursing unit on the 3rd floor of the hospital. The key terms are:

- The agreement is for 5-years.
- Stanford has reserved 20 skilled nursing beds for patients that require skilled nursing after discharge from a Stanford facility.

AHS Pillars

Staff & Physician Experience

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

TO: AHS Staff and Physicians

FROM: James Jackson, MPH – Chief Executive Officer
Lisa Laurent, MD MBA MSc – Chief Medical Officer

DATE: February 2, 2026

SUBJECT: **2026 PULSE Survey – Your Voice Matters**

Your voice plays a vital role in strengthening Alameda Health System's culture of safety and quality. In 2026, we will transition from the SCORE Survey to a modified Pulse Survey, a shorter version of the Culture of Safety survey.

The Pulse Survey will be administered from Monday, February 23rd through March 16th, 2026.

While more concise, the survey remains an important opportunity to share your perspectives. As in prior years, we will conduct debrief sessions to review results and identify opportunities for improvement based on your feedback.

We recognize the demands on your time and have streamlined the survey to minimize burden while ensuring your input continues to inform meaningful changes.

Thank you for your continued commitment to safety, quality, and our shared mission. Additional details and instructions on how to participate will be forthcoming.

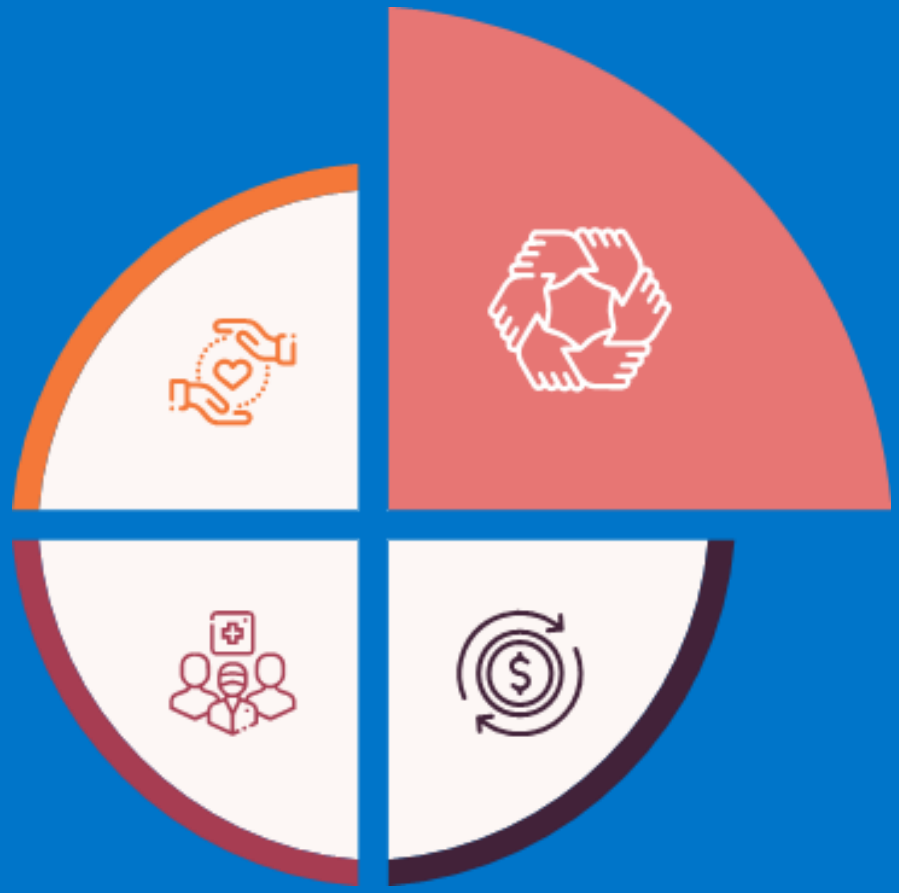
Your perspective matters, and we appreciate you sharing it with us.

SCORE SURVEY VERSUS PULSE SURVEY

Why	SCORE Survey	PULSE Survey
Purpose	Comprehensive Culture and Engagement Survey	Rapid, yet validated survey to assess the Patient Safety Culture
Scope	15 individual domains	4 Core safety culture domains
Survey Length	119 questions across 9 safety and 6 engagement domains—takes 15–20 minutes, which can contribute to survey fatigue.	A brief 5-minute survey with 16 targeted questions assessing Safety Climate, Teamwork, Burnout, and Leadership while minimizing survey fatigue.
Meets	• TJC, CMS, and Leapfrog Requirements • BETA HEART Domain Validation • CMS Patient Safety Structural Measures	• TJC, CMS, and Leapfrog Requirements • BETA HEART Domain Validation • CMS Patient Safety Structural Measures
Follow-Up	Survey results are shared; unit level debriefings are held, and targeted action plans with monitoring are implemented.	Survey results are shared; unit-level debriefings are conducted, and systemwide action plans (i.e., TEAMStepps) are implemented.

Community Connection

AHS is an anchor in its community and aligns its services to deliver a comprehensive continuum of care by providing needed services and being a trusted partner in its community at large.



Donation to Samuel Merritt University
End-of-Life Equipment for Training Purposes


ALAMEDA
HEALTH SYSTEM FOUNDATION
CELEBRATE
5 YEARS OF SOUL
APRIL 25TH, 2026
HENRY J. KAISER CENTER FOR THE ARTS
OAKLAND, CA
SOUL of SPRING

Smithsonian Institution

Lonnie G. Bunch III
Secretary

January 21, 2026

Mr. James Jackson
CEO
Alameda Health System
1411 E 31st Street
Oakland, CA 94602

Dear James,

As the nation's museum, the Smithsonian continually expands the stories it tells about the American experience, so that everyone can recognize themselves in our collections, exhibitions, and programs. Like Alameda Health System, we work to empower individuals through education, ultimately creating stronger communities—and a stronger nation—for all. I especially admire your commitment to health equity, inclusive leadership, and service.

It would be my honor if you joined me as a guest in my conversation series *Understanding America*. Soledad O'Brien will moderate this evening on "Leadership," which would feature you and Calm CEO David Ko, and one additional innovative leader in conversation with me. The event will take place at the Conservatory at One Sansome on Tuesday, February 10, 2026, from 6 to 8 p.m. We will also host a pre-event reception for key Smithsonian donors and members.

I launched *Understanding America* to help the country prepare to commemorate the 250th anniversary of the United States in 2026. Through these discussions about life across our nation, we will spark conversations about our broad cultural fabric and bring communities together.

To foster dialogue on a national level, these intimate gatherings will be recorded and promoted through Smithsonian media channels. This recording from September 2024 with former WNBA player and Olympic Gold medalist Lisa Leslie and sports journalist Hannah Storm provides further context.

Should you have any questions, please contact my colleague Shiba Haley, associate director of advancement for strategic initiatives. She may be reached at haleyv@si.edu or 202.633.5053. We would be grateful for confirmation of your participation by Monday, January 26.

Thank you for your consideration. I would be delighted to see you in San Francisco.

Sincerely,

Lonnie Bunch

Smithsonian Institution
600 Maryland Avenue SW
Washington DC 20024
202.633.1846 Telephone

Questions

James Jackson
2/11/2026
Board of Trustee Meeting

MEDICAL STAFF REPORTS

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

February 11, 2026

Cathy Pyun, DO, AH Chief of Staff

Berenice Perez, MD, AHS Chief of Staff

Guiding Principles

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

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

Alameda Hospital
Medical Executive Committee Report

- **Regulatory & Accreditation**
  - Contract Oversight and Performance
    - Agiliti equipment management affecting systemic operations

- **Quality of Care & Patient Safety**

  AH & AHS Combined Medical Staff Committees
  - Credentials Committee
  - Clinical Practice Council

AHS & AH Combined Medical Staff Committees

Credentials Committee (January 2026)

- Routine credentialing and privileging
- Telemedicine Credentialing by Proxy
- Ongoing Professional Practice Evaluation (OPPE) is factored into reappointment decisions.
- REVISED Medical Staff Temporary Privileges Policy
- REVISED Privileges that align neurologic intervention procedures for radiology and neurosurgery

Clinical Practice Council (January 2026)

- Reviews and approves all protocols, policies and plans that affect the delivery of patient care across the system (HGH, SL, AH)
- APPROVED 24 systemwide policies/protocols and medication order sets
- Ensures system wide clinical alignment to support safe, consistent patient care

Patient Safety Committee: Root Cause Analysis, Operational opportunities to improve patient care

Quality Steering Committee: QAPI Plan, OKR dashboards and CMS 5-star rating

Shared Committee Governance

- Ensures systemwide oversight of quality and clinical standards
- Aligns policies and practice expectations across both medical staffs
- Supports a unified medical staff leadership

AHS Medical Executive Committee Overview

- Medical Staff Governance: Quality and Safe Patient Care
- Regulatory & Accreditation: Joint Commission 360
- Department Reports
  - Summary Appendix A
  - Detailed Reports Appendix B
    - Pathology and Laboratory Medicine
    - Pediatrics

AHS Medical Staff Report

Organized Medical Staff: Responsible for quality and safety of patient care across the organization

Current Governance Goals

- Establish a reliable process for Medical Staff engagement when operational decision impact patient care
- Ensure Medical Staff governance is supported and aligned with the Board and organizational priorities

Clinical Impact Taskforce

- Focus on patient care, quality, safety and organizational success
- Recent meetings with Executive Leadership (1/27/26, 2/5/26)
- Department Chair Clinical Impact Statements presented to Board on 2/4/26

Joint Conference Committee (*mtg date pending scheduling challenges)*

The Joint Commission Survey

Unannounced survey by April 22, 2026

AHS Core Facilities

- Highland Hospital
- San Leandro Hospital
- John George Psychiatric Hospital
- Fairmont Hospital (Outpatient Services)

Focus: Continuous readiness, consistent performance at all sites

Current Readiness Status

- Regulatory affairs is coordinating standardized readiness work across all AHS Core sites
- Updated rounding tool and weekly audits completed between 1/8/26-1/30/26, 40+ departments
- Mock session with consultants 02/11/26, focus on EOC & EM
- Key gaps identified

Key Gaps

- Physical Environment (PE)
- Infection Prevention (IC)
- Emergency Management (EM)
- Equipment Management.

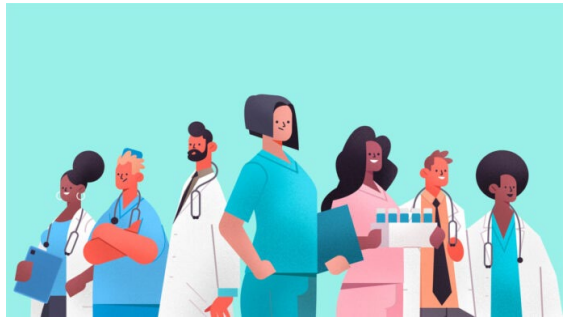
While several items were corrected during rounding, non-compliant, systemic gaps remain in areas of risk.

RECOMMENDED ACTIONS FOR DEPARTMENT LEADERS

- Remove unsafe equipment and environmental risks
- Verify crash cart/defibrillator checks
- Standardize logs and daily readiness practices
- Leader rounding and follow-up/accountability

Medical Staff and House Staff Roles

- ✓ Participate in readiness rounding
- ✓ Lead team huddles on do's & don'ts, suicide risk, and survey expectations
- ✓ **Reinforce Survey Preparedness Tip Sheet items**



ALAMEDA

SURVEY PREPAREDNESS TIP SHEET

Medical & House Staff

February 2026 Edition

OBSERVATIONS:
Surveyors may not readily call out concerns but first make observations to gather data and/or prevent interruption of care.

- Perform hand hygiene: Before/after patient contact and as needed
- Follow appropriate transmission-based precautions
- Wear and have visible your AHS identification badge at all times: Below collar, above waist
- Maintain confidentiality of protected health information (PHI):
  - Cover/flip-over/secure documents containing PHI
  - Sign-out/lock-out workstations displaying PHI
- Time-Out and Universal Protocol: VERBALIZE (at least) two (2) patient identifiers. Timeouts require full attention of the team
- Do not carry medications (syringes and vials) for non-emergent, non-immediate use

DOCUMENTS:
Surveyors will review the quality and consistency of documentation per regulations and/or the institution's expectations (e.g. policies & procedures, Medical Staff Rules & Regulations).

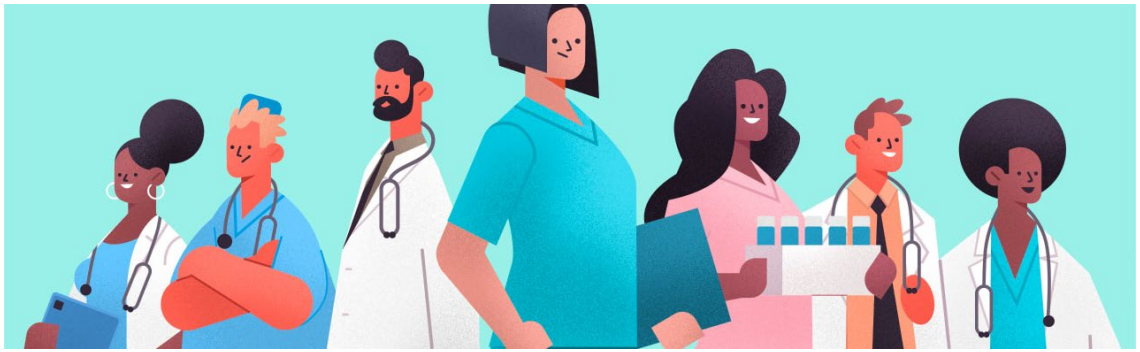
- Medical record entries: DATE, TIME, and AUTHENTICATE
  - **Consents:** Ensure date AND time are completed for both patient AND provider. Do not use abbreviations when writing the name of the procedure on forms.
  - **H&P:** Complete within 24 hours of admission but must be done PRIOR to surgery or procedure requiring anesthesia. H&P UPDATE note must make reference to previously done H&P and must be completed prior to surgery or procedure.
  - **Verbal Orders:** Authenticate within 48 hours of order.
  - **Brief Op Note:** Document immediately upon completion of surgical case or a procedure (inpatient or outpatient) that requires anesthesia, or deep or moderate sedation. MUST be done before the patient is transferred to the next level of care:
    - Include: surgeon and assistant(s), procedures, description of findings, blood loss, specimen removed, complications, and postoperative diagnosis.
- Pended notes are not official until they are **closed.**
- Document use of **interpreters**
- Ensure documentation of **RASS score**, renew **restraint orders** timely, and indicate **ASA class** on pre-anesthesia and pre-sedation assessments.

PRACTICE:
Surveyors may want to

- Describe how unsafe/adverse/near-miss patient safety issues are communicated or escalated in your setting and/or for your service.

Accreditation 360 Overview

- Redesigned 2026 survey model
- Streamlined standards and clearer expectations (burden reduction)



Two Key Changes Under Accreditation 360

NEW Physical Environment (PE) standard (replaces Environment of Care and Life Safety chapters)

NEW National Performance Goals structure (incorporates former NPSG standards and select EC items)

- 48% of Elements of Performance eliminated/merged to clarify expectations

Medical Staff Role in the 2026 Survey

Opening Conference

- Demonstrate MEC Leadership alignment
- Present clear governance related to quality and safety
- Show process improvement framework

Credentialing & Privileging Tracer

- Standardized credentialing and privileging workflows
- Integration of OPPE/FPPE into reappointment decisions
- Compliance with CMS, state law, and Medical Staff bylaws and policies

Reinforce Consistency and Reliability

The Joint Commission

Accreditation 360 SPG:
Medical Staff Participation in Joint Commission Survey

Emergency Management System Tracer

- Demonstrate Medical Staff engagement in emergency preparedness and execution of the Emergency Operations Plan

Quality & Performance Improvement System Tracer

- Show Medical Staff involvement in data-driven performance monitoring and quality improvement initiatives

Leadership Session

- Demonstrate Medical Staff and hospital leadership alignment on safety, quality and organizational priorities

Unified, high-reliability system

The Joint Commission

ALAMEDA HEALTH SYSTEM

ALAMEDA HEALTH SYSTEM

CARING, HEALING, TEACHING, SERVING ALL

Appendix A
Department Summaries

Pathology and Laboratory Medicine: Board Awareness Summary

Overview: System laboratory services supporting all AHS hospitals and clinics; 24/7/365 operations

Current Risks/Constraints

- Red blood cell supply: recent update 1/20/26 highlighted constrained availability requiring close monitoring and utilization controls
- Staffing pressures: vacancies and leaves across laboratory assistants/CLS/management; thin supervisory coverage

Pediatrics: Board Awareness Summary

Overview: Provides inpatient (Well Baby Nursery, Level II NICU) and outpatient pediatric services across 4 sites

Strengths

- Strong clinical team across inpatient and outpatient settings, active community partnerships (DULCE, Read Out & Reach, Diaper Bank)
- High performance in key pediatric quality measures (2025 QI performance contributed materially to QIP revenue)

Challenges

- Limited subspecialty access (Endocrinology, Ophthalmology, Dermatology)
- Space constraints at HGH and Newark clinics impact growth capacity
- Insufficient supportive infrastructure (CHWs, social services, mental health access)

Opportunities

- Urgent Care/Same Day Access: potential $500K-1.2M annual revenue and protection of WCC/QIP
- Level II NICU CCS designation: retain CCS-eligible newborns already cared for at AHS (revenue up to $5M)
- Expansion of Centering Parenting programs to improve equity and outcomes

External Risks: Pediatric workforce shortages, variable physician salary across unions, shifting federal immunization policy

Appendix B
Department Detailed Reports

AHS Pathology and Laboratory Services

Harris S. Goodman, MD
Laboratory Director, AHS Clinical Laboratory

URGENT RED BLOOD CELL SUPPLY UPDATE 1/20/26

American Red Cross

Dear Transfusion Services Partner,

The American Red Cross is currently experiencing a critical blood shortage, especially for types O, A negative and B negative blood, with national inventory levels falling to emergency lows due to the recent holiday season, intense winter weather, and one of the most severe flu seasons in nearly 20 years. In response, **we have issued a public appeal for blood and platelet donors of all blood types to donate now and throughout the winter.**

Historically, donor response to a public appeal accelerates recovery by re-engaging existing donors and attracting new ones. We anticipate that several weeks of strong collections will be needed to stabilize inventory. Thanks to IPS (Inventory Planning Schedule), we maintain stability in our O-negative supply at this time.

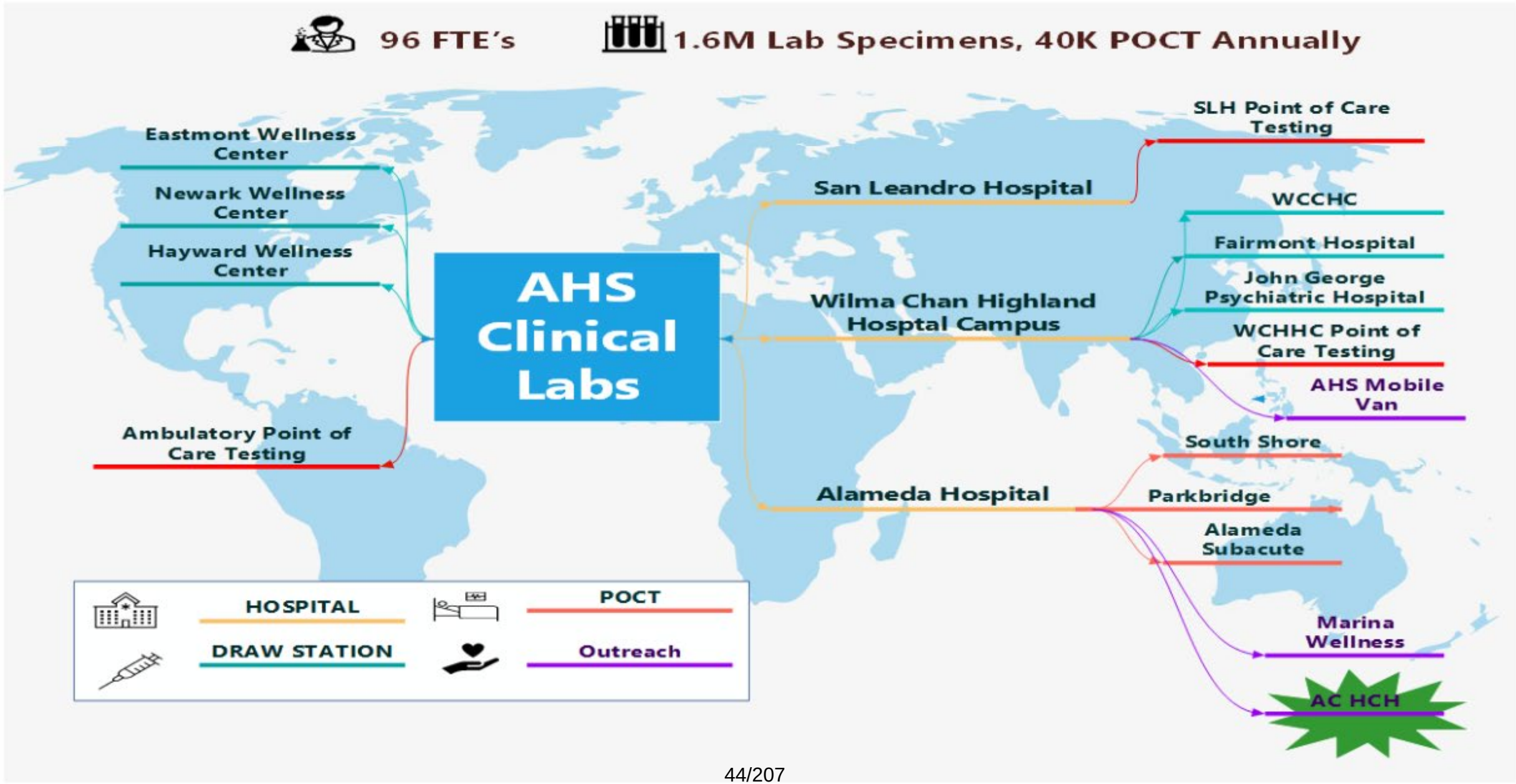
The Red Cross is actively encouraging blood donations nationwide and invites your support in sharing this message with your staff and community, especially during National Blood Donor Month. We are providing a printable flyer for hospital display, a customizable letter for your community partners, and a social media messaging toolkit to encourage blood donation.

Thank you for your partnership and flexibility as we navigate this challenging inventory environment. Your Red Cross Medical Director remains available for consultation on blood utilization during this shortage.

Sincerely,

Pampee P. Young, M.D., Ph.D.
Chief Medical Officer

THE CLINICAL LAB NETWORK WITHIN AHS



AHS Clinical Laboratory Staffing

HGH:

Laboratory Assistants (LA): 27.2

Clinical Laboratory Scientists (CLS): 24

Section Supervisors (CLS): 2

Local Managers: 0

System Managers: 1 (but on extended leave)

System Administrative Directors: 1

Clerks: 1

CLS Trainees: 2

ALH:

Phlebotomists: 7.4

Clinical Laboratory Scientists (CLS): 7.2

Section Supervisors (CLS): ~~3~~ 2

Local Managers: 0

Clerks: 0.6

SLH:

Phlebotomists: 6.3

Clinical Laboratory Scientists (CLS): 7.2

Section Supervisors (CLS): 3

Local Managers: 0

Clerks: 0

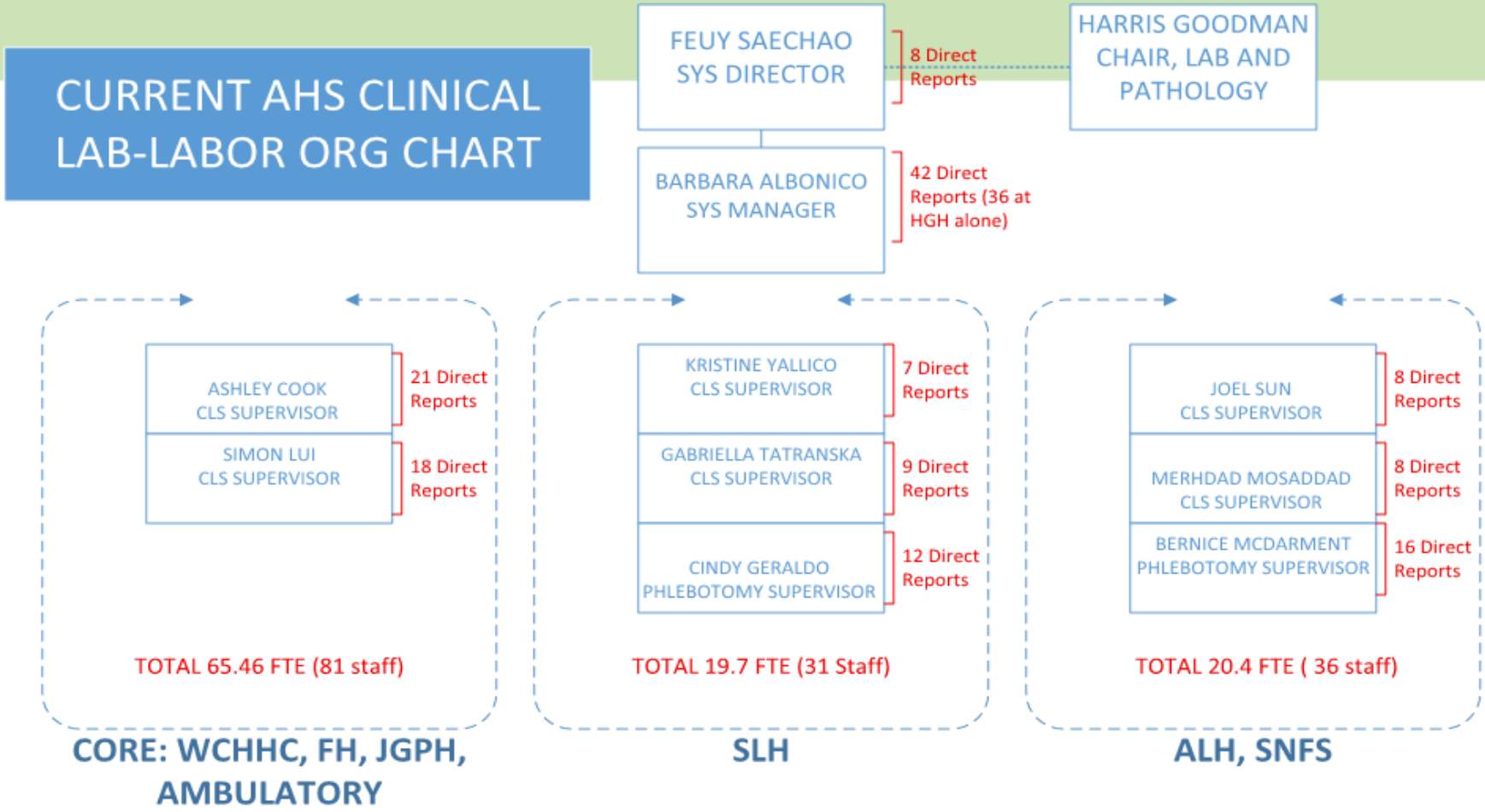
Note that 4 HGH LAs, 2 HGH CLSs, 1 System Manager, and 3 AH Phlebs are on LOA.
Labs are always open; 168 hours per week (24/7/365) .
RIF: 5 people.

System Growth Outpaced Management Structure: Post-acquisition consolidation reduced leadership from 3 Lab Directors + 1 Ops Manager to just 1 Director + 1 Manager, despite significant expansion—now covering three acute clinical labs, psych and rehab, outreach (AC HCH), skilled nursing facilities, 50+ POCT sites, and multiple satellite draw stations. With increasing regulatory audits (CAP, TJC, AABB, CDPH), focused leadership at each service level is critical to maintain compliance and operational readiness.

Regulatory Compliance Risk
CLIA (42 CFR Part 493 – CMS), CAP, TJC, and CA CDPH require defined supervisory oversight to be onsite or readily available. Current limited supervisor coverage (2–3 per site, some union-restricted) forces management backfill and creates compliance gaps, putting licensure and oversight of high/moderate complexity testing at risk.

Unmanageable Scope for One Manager: One manager is responsible for 41 direct reports and oversees 148 staff (105.6 FTE) across three hospitals and multiple outpatient sites, while also overseeing UKG, onboarding/retention, interdepartmental coordination, quality/safety committees, contracts, budgeting, and licensure—creating an unsustainable workload and operational risk.

CURRENT AHS CLINICAL LAB-LABOR ORG CHART



NEW JOB ROLE REQUESTS TO MITIGATE RISK AREAS

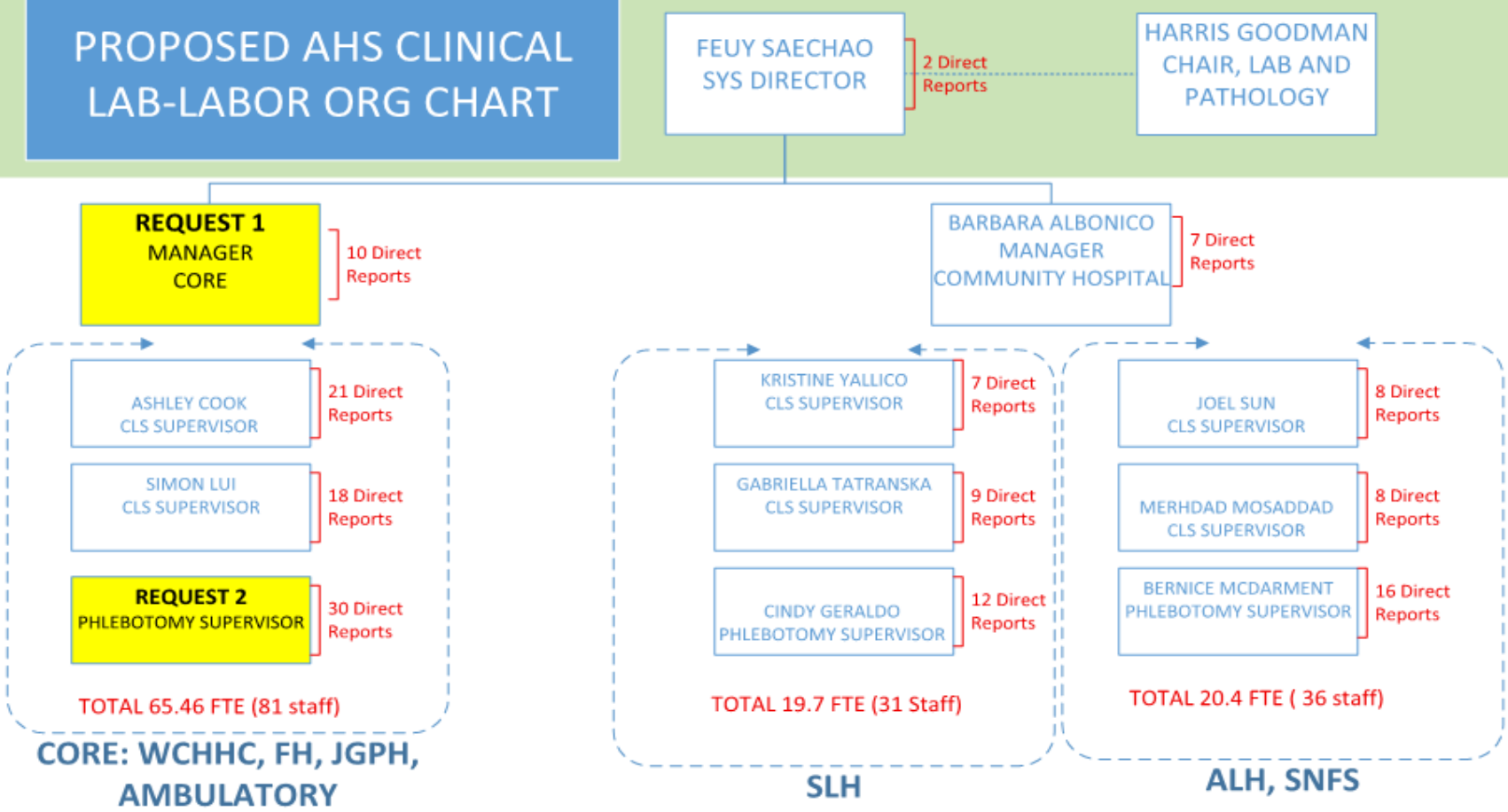
REQUEST 1: MANAGER CORE

Convert System Manager Role: The current span of control is unsustainable—41 direct reports and 148 staff across three hospitals. Splitting the role into a **Manager of Community Hospitals** and a **Manager of the Core** will align leadership capacity with operational demands, reduce compliance risk, and ensure safe, effective oversight

REQUEST 2: PHLEBOTOMY SUPERVISOR (FOR THE CORE)

Add Core Phlebotomy Supervisor: Establishing a **Phlebotomy Supervisor at the Core** brings alignment with the supervisory structure at other AHS acute sites. This role oversees 30 staff supporting acute care, rehab, psych, and satellite labs, ensuring consistent leadership, quality, and service coverage across high-volume areas.

PROPOSED AHS CLINICAL LAB-LABOR ORG CHART



Alameda Health System
Department of Pediatrics
Report to
Medical Executive Committee

Pamela Simms-Mackey, MD, FAAP

February 4, 2026

ALAMEDA HEALTH SYSTEM

Our Mission

To provide exceptional and equitable healthcare to all children, through a commitment of practicing medicine with cultural humility, clinical excellence and addressing social needs to achieve optimal outcomes.

Outpatient Pediatrics-4 sites
Inpatient Pediatrics-Well Baby Nursery
-Level 2 NICU with 24 hour in house Pediatric Hospitalist coverage

Department of Pediatrics Report

Leadership:

Chair-Pam Simms-Mackey, MD

Chief, Inpatient/Medical Director of NICU-Ana Liang, MD

Chief, Outpatient (site lead HGH)-Thresia (Teena) Sebastian, MD

EPIC Superuser-Danielle Nguyen, MD




Site Leads:

Eastmont-Zarah Iqbal, MD (Assistant Medical Director, Eastmont)

Hayward-Mary (Genie) Lim, MD (Interim Medical Director, Hayward)

Newark-Rita Wadhwani, MD



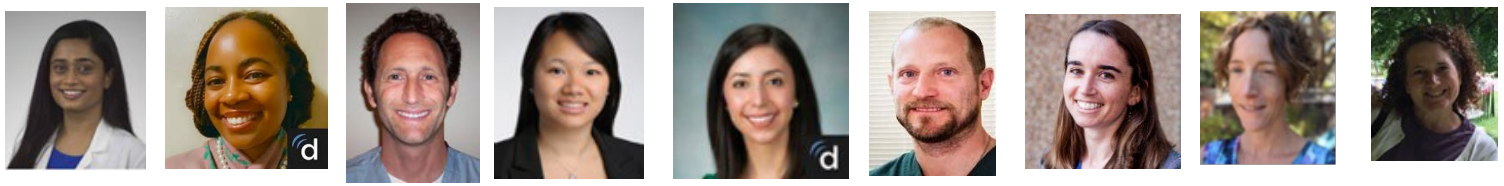
ALAMEDA HEALTH SYSTEM

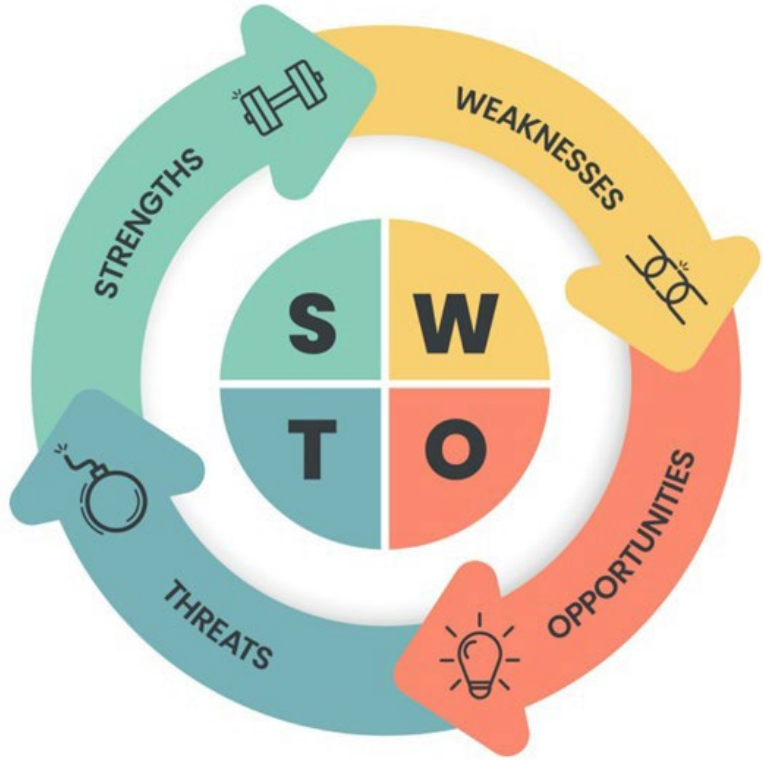
Department of Pediatrics Report

Strength-The People:

Highland Clinic-Drs. Grandis (SAN), Hoffman, Nguyen, Savio, Sebastian, Sengupta (SAN), Shrestha (SAN), Singer, Sood, Tsuchimoto

Highland Pediatric Nursery/NICU Hospitalist- Drs. Amin, Hodge, Hoffman, Howell (SAN)*, Liang, Ponte, Savio, Schwemberger, Singler, Velek



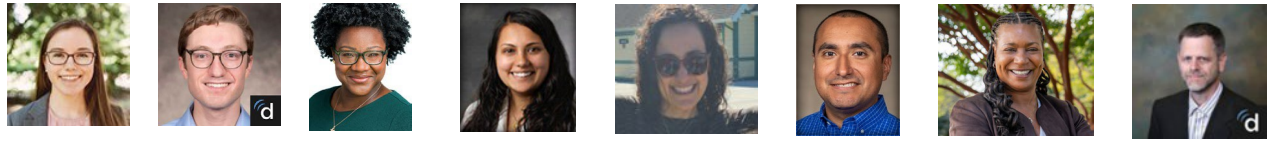


ALAMEDA HEALTH SYSTEM

Department of Pediatrics Report

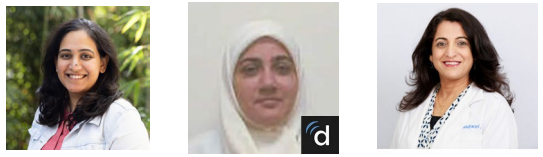
Strength-The People:

Eastmont Clinic-Drs. Crinion (Med/Peds), Drinnan, Griffiths-Randolph (SAN), Iqbal, Leite, Pineros (SAN), Simms-Mackey, Wells



Hayward Clinic-Drs. Hoang, Jimenez, Kamath, Lim, Mack, Miller (SAN), Meshesha (SAN)

Newark Clinic-Drs. Kamath, Mallick (SAN), Wadhwani



Department of Pediatrics Report – Cont.

Strengths

- **Quality Improvement Performance**
- **Maximizing EPIC** to enhance patient care and patient experience (templates, Nabla AI, My Chart self scheduling, Confidential visits/AVS)
- **Community Support and Involvement**

Alameda Post

FRONT PAGE SECTIONS EVENTS TOURS GIVE / JOIN ABOUT

AHS Receives Statewide Award for Excellent Pediatric Care

The Alameda Health System (AHS) Department of Pediatrics has received a Quality Leaders Award for excellence in pediatric primary care, presented by the California Association of Public Hospitals and Health Systems (CAPH), in partnership with the California Health Care Safety Net Institute (SNI).

Still image from Alameda Health System Youtube video.

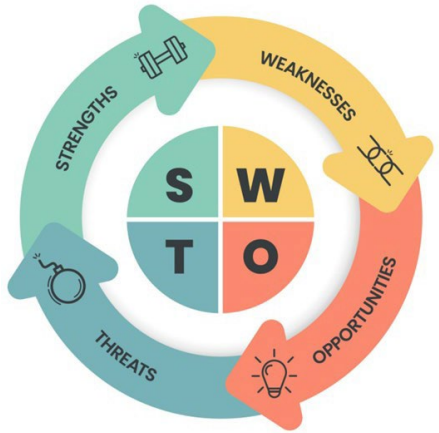
The Quality Leaders Awards are administered by the California Association of Public Hospitals and Health Systems (CAPH), in partnership with the California Health Care Safety Net Institute (SNI), to celebrate public health care systems that demonstrate outstanding efforts in advancing quality, equity, and access to health care for California's underserved

Physician Innovator

Danielle Nguyen, MD

This award is granted to the physician who has developed and implemented a new project, initiative or process that will have a lasting impact on patient care.

ALAMEDA HEALTH SYSTEM



Department of Pediatrics Report – Cont.

Strengths-Quality Improvement

- **Quality Improvement Performance-2025**

	Metric	Target	Dollar Value	25th - 90th Percentile	Number Needed For Target*	2025-09	2025-10	2025-11	*2025-12*
★	Well-Child Visits in the First 15 Months of Life *	69.67%	$750,000.00	54.46 % - 69.67 %		94.87%	95.00%	94.87%	*95.45%*
★	Well-Child Visits in the First 30 Months of Life *	79.94%	$750,000.00	65.53 % - 79.94 %		82.70%	82.70%	82.95%	*83.00%*
	Child and Adolescent Well-Care Visits (WCV) *	49.75%	$1,500,000.00	46.57 % - 64.74 %		52.95%	53.16%	53.07%	*53.22%*
★	Developmental Screening in the First Three Years of Life *	54.39%	$1,500,000.00	34.48 % - 54.39 %		77.91%	79.03%	79.15%	*79.90%*
★	Lead Screening in Children	77.80%	$1,500,000.00	53.12 % - 79.51 %		79.15%	79.32%	79.76%	*80.79%*
★	Childhood Immunization Status (CIS 10) *	42.34%	$1,500,000.00	22.87 % - 42.34 %		55.27%	54.98%	54.85%	*55.22%*
	Childhood Immunization Status (CIS 10) - Black/African American *	29.95%	$1,500,000.00	22.87 % - 42.34 %		33.33%	33.64%	33.65%	*31.73%*
★	Immunizations for Adolescents *	48.66%	$1,500,000.00	29.72 % - 48.66 %		55.42%	56.75%	57.49%	*58.24%*
★	Weight Assessment for Children & Adolescents: BMI	91.24%	$500,000.00	75.00 % - 91.24 %		95.07%	95.27%	95.32%	*95.53%*
★	Weight Assessment for Children & Adolescents: Nutrition Counseling	84.37%	$500,000.00	63.87 % - 84.37 %		96.34%	96.36%	96.36%	*96.26%*
★	Weight Assessment for Children & Adolescents: Physical Activity Counseling	82.16%	$500,000.00	59.85 % - 82.16 %		96.31%	96.31%	96.33%	*96.21%*
★	Chlamydia Screening *	69.07%	$1,500,000.00	49.65 % - 69.07 %		75.11%	74.31%	72.84%	*72.44%*

Year 2025

★ >90%tile (10 metrics)
$13,500,000 (actually **$15,750,000** as dollar value assigned increase to $1,750,000 per John Minot-Schwartz)
plus
additional revenue from overperformance worth 5.5 additional metrics ($1.75M/each) and AAFH P4P (last year 75% of payment due to Pediatrics)

Metric	25th - 50th - 90th Percentile	BaseLine Submitted	Number Needed For Target*	2021-01	2021-02	2021-03	2021-04	2021-05	2021-06	2021-07	2021-08	2021-09	2021-10	2021-11	*2021-12*
Well-Child Visits in the First 15 Months of Life *	44.99% - 54.92% - 68.33%	67.21%	5	67.21%	65.57%	66.15%	66.18%	66.18%	60.87%	61.54%	54.84%	51.92%	45.83%	52.38%	*53.13%*
Well-Child Visits in the First 30 Months of Life *	66.43% - 70.67% - 82.82%	74.13%	83	71.37%	69.86%	68.26%	66.67%	64.99%	63.98%	63.13%	62.39%	61.64%	60.71%	60.67%	*61.19%*
Child and Adolescent Well-Care Visits (WCV) *	39.4% - 45.31% - 61.97%	24.37%		23.31%	23.64%	25.77%	29.22%	31.74%	34.58%	36.60%	38.37%	39.87%	40.87%	41.02%	*41.55%*
Developmental Screening in the First Three Years of Life *	15.10% - 17.40% - 45.00%	16.93%		22.67%	24.64%	25.83%	27.23%	29.32%	32.21%	33.36%	34.92%	36.39%	38.48%	41.65%	*43.63%*
Lead Screening in Children	61.31% - 71.53% - 83.94%	68.50%	57	67.23%	64.94%	62.80%	61.53%	61.15%	60.60%	59.90%	60.32%	59.55%	60.23%	59.54%	*60.44%*
Childhood Immunization Status (CIS 10) *	31.87% - 38.20% - 53.66%	56.68%	53	55.28%	53.61%	51.63%	49.74%	48.84%	47.41%	45.99%	45.48%	43.56%	43.76%	43.95%	*44.78%*
★ Immunizations for Adolescents *	30.90% - 36.74% - 50.61%	58.68%		55.87%	55.73%	54.30%	52.75%	53.47%	52.30%	52.15%	51.13%	50.93%	53.78%	51.80%	*51.23%*
★ Weight Assessment for Children & Adolescents: BMI	69.19% - 76.64% - 87.18%	69.37%		67.71%	66.27%	69.84%	74.86%	78.61%	81.53%	84.77%	86.65%	88.66%	90.14%	90.78%	*91.68%*
Weight Assessment for Children & Adolescents: Nutrition Counseling	61.07% - 70.11% - 82.48%	10.26%		10.37%	10.26%	10.69%	12.96%	18.65%	26.38%	35.25%	46.85%	56.90%	67.34%	73.39%	*77.66%*
Weight Assessment for Children & Adolescents: Physical Activity Counseling	55.79% - 66.18% - 79.32%	7.63%		7.41%	7.65%	8.10%	10.46%	16.08%	23.91%	33.16%	45.40%	55.70%	66.58%	72.89%	*77.27%*

Year 2021
★ >90th percentile (2 metrics)
$6,000,000

Metric	Estimated Target 2023	Dollar Value	25th - 90th Percentile 2022	25th - 90th Percentile 2023	Jan '22	Feb '22	Mar '22	Apr '22	May '22	Jun '22	Jul '22	Aug '22	Sep '22	Oct '22	Nov '22	Dec '22
Well-Child Visits in the First 15 Months of Life *	49.88%		44.99 % - 68.33 %	49.88% - 67.56%	68.75%	65.52%	56.00%	54.55%	52.38%	50.00%	47.62%	50.00%	47.62%	45.00%	38.89%	40.00%
Well-Child Visits in the First 30 Months of Life *	71.06%	$1,500,000.00	66.43 % - 82.82 %	60.53% - 78.07%	62.23%	63.95%	63.77%	63.79%	63.71%	65.30%	65.09%	66.43%	68.15%	69.15%	69.68%	*70.28%*
Child and Adolescent Well-Care Visits (WCV) *	43.50%	$1,500,000.00	39.41 % - 61.97 %	43.50% - 62.70%	43.22%	44.25%	43.84%	43.34%	43.34%	42.11%	41.22%	41.24%	40.68%	41.00%	41.14%	*41.52%*
★ Developmental Screening in the First Three Years of Life *	36.65%	$1,500,000.00	17.65% - 36.65%	Not available	46.01%	47.81%	50.00%	52.61%	54.71%	56.24%	58.65%	61.36%	63.41%	64.99%	65.09%	*66.04%*
Lead Screening in Children	71.62%	$1,500,000.00	61.31 % - 83.94 %	53.28% - 79.57%	60.00%	61.07%	63.70%	65.16%	65.79%	66.37%	66.37%	67.26%	69.86%	70.23%	70.93%	*70.96%*
★ Childhood Immunization Status (CIS 10) *	49.76%	$1,500,000.00	31.87 % - 53.66 %	28.95% - 49.76%	44.70%	44.00%	45.88%	47.21%	48.86%	50.26%	50.80%	51.54%	54.13%	53.74%	54.09%	*54.59%*
Immunizations for Adolescents *	48.15%	$1,500,000.00	30.90 % - 50.61 %	30.4% - 48.42%	37.84%	38.26%	39.31%	40.94%	41.34%	42.03%	44.38%	45.67%	46.92%	46.26%	47.29%	*48.12%*
★ Weight Assessment for Children & Adolescents: BMI	88.31%	$500,000.00	69.19 % - 87.18 %	72.51% - 88.31%	91.60%	91.63%	92.00%	91.73%	91.94%	91.57%	90.96%	91.22%	91.33%	91.09%	91.49%	*91.86%*
★ Weight Assessment for Children & Adolescents: Nutrition Counseling	83.70%	$500,000.00	61.07 % - 82.48 %	63.02% - 83.70%	80.94%	84.18%	88.70%	91.27%	92.47%	93.11%	93.40%	93.40%	93.47%	93.27%	93.54%	*93.93%*
★ Weight Assessment for Children & Adolescents: Physical Activity Counseling	81.27%	$500,000.00	55.79 % - 79.32 %	58.15% - 81.27%	80.66%	84.06%	88.67%	91.37%	92.59%	93.23%	93.53%	93.55%	93.64%	93.51%	93.86%	*94.26%*

Year 2022
>90th percentile (5 metrics)
$9,000,000

Metric	Target	Dollar Value	25th - 90th Percentile	BaseLine Submitt	2023-01	2023-02	2023-03	2023-04	2023-05	2023-06	2023-07	2023-08	2023-09	2023-10	2023-11	2023-12
Well-Child Visits in the First 15 Months of Life *	51.76 %		49.88 % - 67.56 %	50.00 %	52.63 %	52.63 %	63.64 %	60.87 %	62.96 %	66.67 %	65.22 %	60.87 %	62.50 %	64.00 %	62.96 %	63.33 %
★ Well-Child Visits in the First 30 Months of Life *	71.31 %	$1,500,000.00	60.53 % - 78.07 %	70.56 %	72.97 %	74.00 %	76.64 %	77.32 %	77.96 %	77.07 %	77.47 %	77.47 %	77.39 %	78.78 %	78.64 %	79.14 %
Child and Adolescent Well-Care Visits (WCV) *	43.89 %	$1,500,000.00	43.50 % - 62.70 %	41.80 %	42.50 %	42.60 %	41.85 %	42.21 %	43.36 %	43.69 %	44.22 %	44.25 %	44.03 %	44.65 %	44.37 %	44.09 %
★ Developmental Screening in the First Three Years of Life *	44.37 %	$1,500,000.00	23.76 % - 44.37 %	66.20 %	66.81 %	66.75 %	67.98 %	68.13 %	68.50 %	69.49 %	69.65 %	70.62 %	71.44 %	71.91 %	72.97 %	73.30 %
Lead Screening in Children	71.97 %	$1,500,000.00	53.28 % - 79.57 %	71.13%	73.11 %	73.63 %	73.50 %	74.13 %	73.77 %	73.14 %	73.61 %	74.34 %	73.76 %	72.96 %	72.67 %	74.60 %
★ Childhood Immunization Status (CIS 10) *	49.76 %	$1,500,000.00	28.95 % - 49.76 %	56.63 %	56.36 %	57.52 %	57.30 %	58.19 %	58.35 %	56.85 %	57.14 %	58.47 %	57.07 %	58.22 %	58.42 %	60.00 %
Childhood Immunization Status (CIS 10) - Black/African American	29.59 %	$1,500,000.00	28.95 % - 49.76 %	38.46 %	37.65 %	34.94 %	34.57 %	32.10 %	31.65 %	31.03 %	31.52 %	31.58 %	32.35 %	32.46 %	32.46 %	32.46 %
★ Immunizations for Adolescents *	48.15 %	$1,500,000.00	30.41 % - 48.42 %	48.12 %	50.51 %	52.23 %	53.15 %	51.55 %	52.25 %	52.32 %	52.28 %	52.01 %	52.75 %	54.51 %	55.83 %	54.20 %
★ Weight Assessment for Children & Adolescents: BMI	88.31 %	$500,000.00	72.51 % - 88.31 %	90.48 %	93.08 %	92.97 %	92.65 %	92.86 %	93.00 %	93.27 %	93.60 %	93.51 %	93.56 %	93.35 %	93.19 %	93.16 %
★ Weight Assessment for Children & Adolescents: Nutrition Counseling	83.70 %	$500,000.00	63.02 % - 83.70 %	92.49 %	94.56 %	94.75 %	94.81 %	94.99 %	95.25 %	95.40 %	95.73 %	96.05 %	96.07 %	95.94 %	95.97 %	96.27 %
★ Weight Assessment for Children & Adolescents: Physical Activity Counseling	81.27 %	$500,000.00	58.15 % - 81.27 %	92.87 %	95.06 %	95.27 %	95.20 %	95.30 %	95.57 %	95.68 %	95.95 %	96.34 %	96.29 %	96.13 %	96.21 %	96.33 %

Year 2023
>90th percentile (7 metrics)
$10,500,000

Metric	Target	Dollar Value	25th - 90th Percentile	BaseLine Submitted	Number Needed For Target*	2024-09	2024-10	2024-11	*2024-12*
★ Well-Child Visits in the First 15 Months of Life *	63.81%	$750,000.00	52.84 % - 68.09 %	63.33%		73.81%	75.00%	76.92%	*77.78%*
★ Well-Child Visits in the First 30 Months of Life *	77.78%	$750,000.00	62.07 % - 77.78 %	79.14%		82.16%	81.73%	82.28%	*81.94%*
Child and Adolescent Well-Care Visits (WCV) *	45.80%	$1,500,000.00	42.99 % - 61.15 %	44.09%		44.64%	45.48%	46.28%	*48.12%*
★ Developmental Screening in the First Three Years of Life *	47.13%	$1,500,000.00	27.34 % - 47.13 %	73.30%		74.39%	74.39%	74.30%	*75.31%*
Lead Screening in Children	75.07%	$1,500,000.00	49.61 % - 79.26 %	74.60%		76.58%	78.06%	78.22%	*77.50%*
★ Childhood Immunization Status (CIS 10) *	45.26%	$1,500,000.00	24.57 % - 45.26 %	60.00%		56.74%	56.20%	55.81%	*53.54%*
Childhood Immunization Status (CIS 10) - Black/African American *	33.74%	$1,500,000.00	24.57 % - 45.26 %	32.46%	7	27.12%	27.36%	28.18%	*28.32%*
★ Immunizations for Adolescents *	48.80%	$1,500,000.00	29.44 % - 48.80 %	54.20%		52.57%	52.02%	51.09%	*52.64%*
★ Weight Assessment for Children & Adolescents: BMI	89.72%	$500,000.00	71.68 % - 89.72 %	93.16%		93.28%	93.71%	94.37%	*94.84%*
★ Weight Assessment for Children & Adolescents: Nutrition Counseling	83.46%	$500,000.00	61.60 % - 83.46 %	96.27%		97.08%	97.15%	97.22%	*97.33%*
★ Weight Assessment for Children & Adolescents: Physical Activity Counseling	81.54%	$500,000.00	58.35 % - 81.54 %	96.33%		97.21%	97.20%	97.34%	*97.44%*
★ Chlamydia Screening in Women *	67.39%	$1,500,000.00	49.65 % - 67.39 %	70.17%		74.79%	75.41%	75.63%	*76.05%*

Year 2024
★ >90%tile (9 metrics)
$12,000,000

ALAMEDA HEALTH SYSTEM

Department of Pediatrics Report – Cont.

Strengths-Maximizing EPIC

- **Maximizing EPIC** to enhance patient care and patient experience (templates, smart sets, care gaps, Nabla AI, My Chart self scheduling, Confidential visits/AVS)

MyChart Active Patients Scheduling Overview

% Appointments Scheduled Online for MyChart Active Pts

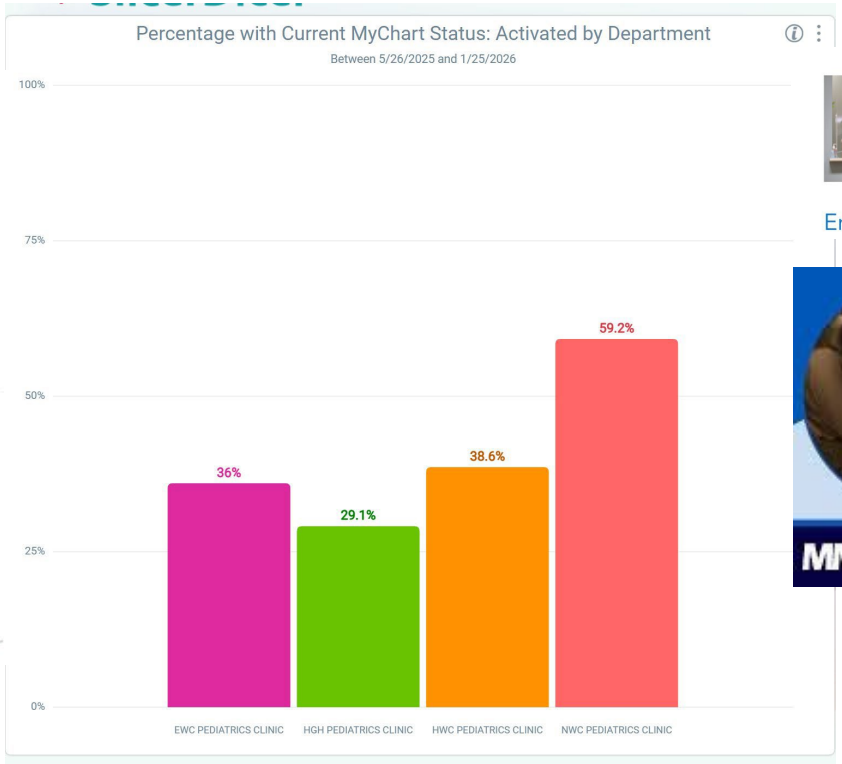
EWC PEDIATRICS CLINIC + HGH PEDIATRICS CLINIC + HWC PEDIATRICS CLINIC + 2 more

	Oct 25	Nov 25	Dec 25
EWC PEDIATRICS CLINIC	2.0%	2.2%	2.8%
HGH PEDIATRICS CLINIC	5.7%	7.8%	7.7%
HWC FAMILY MEDICINE CLINIC	0.2%	0.0%	0.2%
HWC PEDIATRICS CLINIC	7.2%	2.4%	3.5%
NWC PEDIATRICS CLINIC	14.8%	22.9%	9.3%

MyChart Scheduling Breakdown

Direct Scheduling | EWC PEDIATRICS CLINIC + HGH PEDIATRICS CLINIC + HWC PEDIATRICS CLINIC + 2 more

	Oct 25	Nov 25	Dec 25
EWC PEDIATRICS CLINIC	12	11	17
HGH PEDIATRICS CLINIC	20	24	25
HWC FAMILY MEDICINE CLINIC	2	—	2
HWC PEDIATRICS CLINIC	20	6	11
NWC PEDIATRICS CLINIC	33	39	19



MyChart mobile app

Download the MyChart mobile app available at the Apple App Store and Google Play.

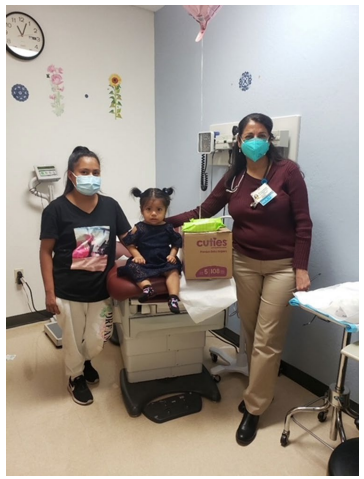
Download on the App Store | GET IT ON Google Play

Engage in your health care

Department of Pediatrics Report – Cont.

Strengths-Community Support and Advocacy

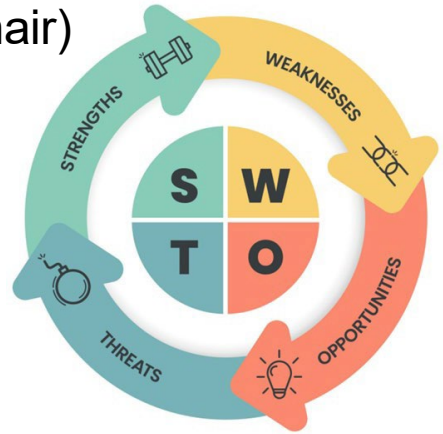
- DULCE (Amalia Jauregui, Aylin Navarette)
- Diaper Bank
- Read Out and Reach
- Food Bank (Fabiola Rodney)
- Parks Rx-Behavioral Health



- California Medical Association Board of Trustees (Dr. Iqbal)
- American Board of Pediatrics Board of Directors (Dr. Simms-Mackey, Immediate Past Chair)

CALIFORNIA MEDICAL ASSOCIATION

The American Board of Pediatrics ABP I AM CERTIFIED Founded 1933

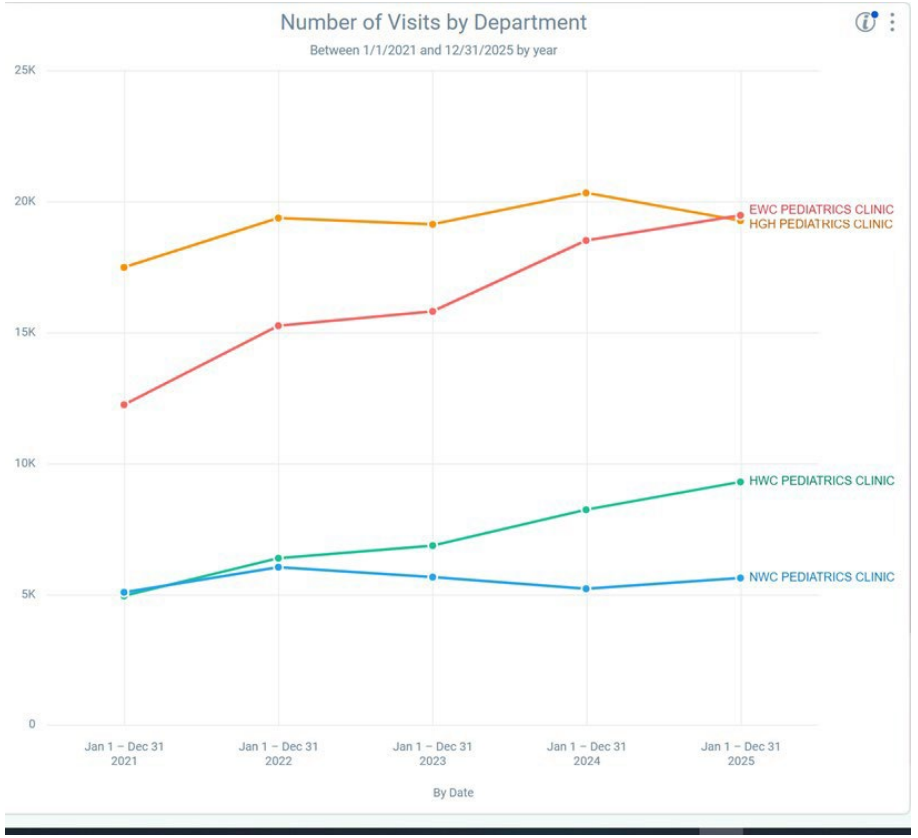


ALAMEDA HEALTH SYSTEM

Department of Pediatrics Report – Cont.

Weaknesses

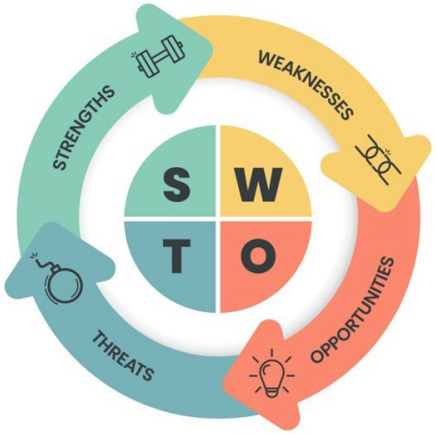
- Lack of internal infrastructure to support pediatrics
  - Social services, CHWs
  - Long term mental health/counseling services
- Poor subspecialty access (Endo, Ophthalmology, Derm)
- Space-Highland and Newark (impeding growth of clinic volumes)



Department of Pediatrics Report – Cont.

Opportunities

- Urgent Care/Same Day Clinic
  - $500K-$1.2 Million in revenue (10-20 patients a day in FQHC or ED)
  - Protects WCC access and QIP revenue
  - Trained staff already working in our pediatric clinics
- Level II Intermediate NICU CCS Designation
  - Retain babies that have CCS diagnosis that we already take care off (such as Congenital Syphilis) up to $5 million in revenue
- Nursing Protocol for normal deliveries
  - Hospitalist well being



ALAMEDA HEALTH SYSTEM

Department of Pediatrics Report – Cont.

Opportunities

- Beloved Black Babies Centering Parenting
  - Reduction in disparities
  - AAFH QI Grant
- Criando Corazones Felices Centering Parenting en Espanol (raising happy hearts)-coming soon

Metric	Race	NC	DC	Rate	Overall DC
Childhood Immunization Status	American Indian/Alaskan Native	0	0		662
Childhood Immunization Status	**Black/African American**	**32**	**112**	**28.57%**	662
Childhood Immunization Status	Hispanic	264	418	63.16%	662
Childhood Immunization Status	White	28	58	48.28%	662
Childhood Immunization Status	Native Hawaiian/Pacific Islander	1	6	16.67%	662
Beloved Babies Participants	**Black /African American**	**23**	**26**	**88.56%**	

Metric	Race	NC	DC	Rate	Overall DC
Well- Child Visits in the First 30 Months	American Indian/Alaskan Native	0	0		658
Well- Child Visits in the First 30 Months	**Black/African American**	**94**	**127**	**74.02%**	658
Well- Child Visits in the First 30 Months	Hispanic	360	409	88.02%	658
Well- Child Visits in the First 30 Months	White	31	42	73.81%	658
Well- Child Visits in the First 30 Months	Native Hawaiian/Pacific Islander	3	4	75.00%	658
Beloved Babies Participants	**Black/African American**	**18**	**23**	**91.31%**	

ALAMEDA HEALTH SYSTEM

Department of Pediatrics Report – Cont.

Threats

- Salary: 2 different unions, 2 different salaries for same work
  - **Pediatrician is a Primary Care Physician**
    - training years the same, same debts incurred
    - patients 0-21 (newborn, toddler, school aged, adolescent, young adult)
    - Essential to work through parents
    - A lot of care coordination with community resources (developmental-RCEB, Schools, mental health care)
    - National issue→ causing workforce shortages
    - Advocacy for Medicaid and Medicare parity
    - FQHC reimbursement is the same for adults and kids
    - Several states pay pediatricians same as primary care physician. AHS does in one union and not the other


AAP News

Latest News

SHARE

Pediatricians remain lowest paid in primary care, report says

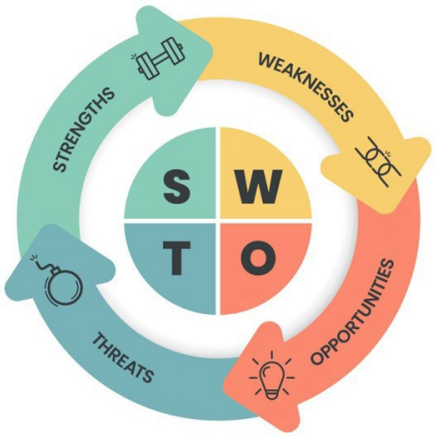
December 1, 2025

Evi Arthur, Digital Content Editor

Download PDF

Article type: Focus on Career

Topics: Workforce



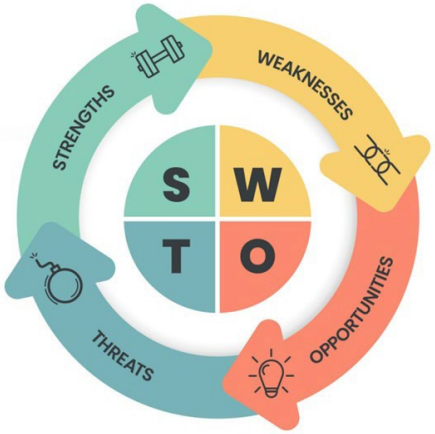
Department of Pediatrics Report – Cont.

Threats

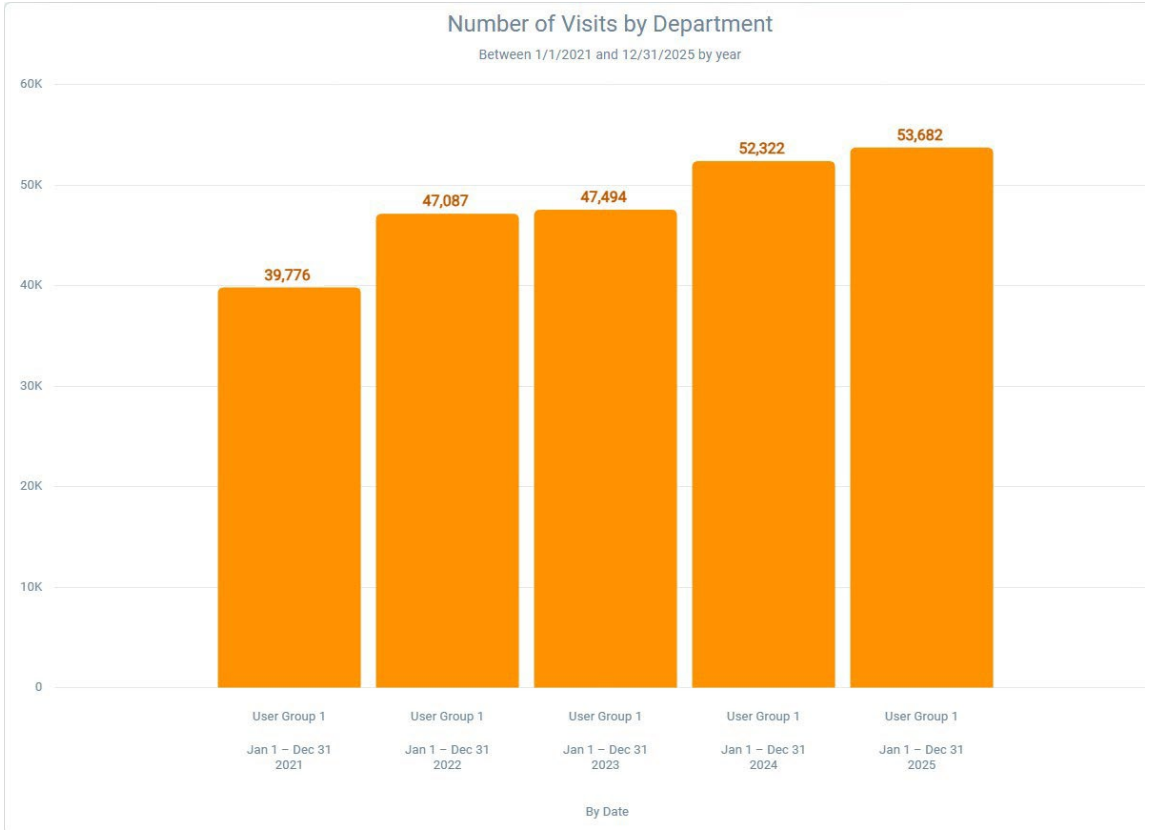
- Federal Policies and Actions
  - CDC and ACIP fired staff and replaced with all new members
  - Modification to Immunization schedule without any new scientific evidence
    - Measles outbreaks (S. Carolina)
    - Routine Hep B vaccine resulted in reduction in disease by 99% with introduction in 1991, now no longer routinely recommended
    - VFC no longer providing vaccines based on Federal recommendations, CA, OR, WA following AAP (increased costs, like MMRV)
  - More vaccine hesitancy and refusal
  - Delivering evidence based quality care is/may become illegal
  - AAP in litigation with Federal Government over these policies and changes.

12 ways RFK Jr. has undercut vaccine confidence as health secretary

Health Sep 26, 2025 1:45 PM EST

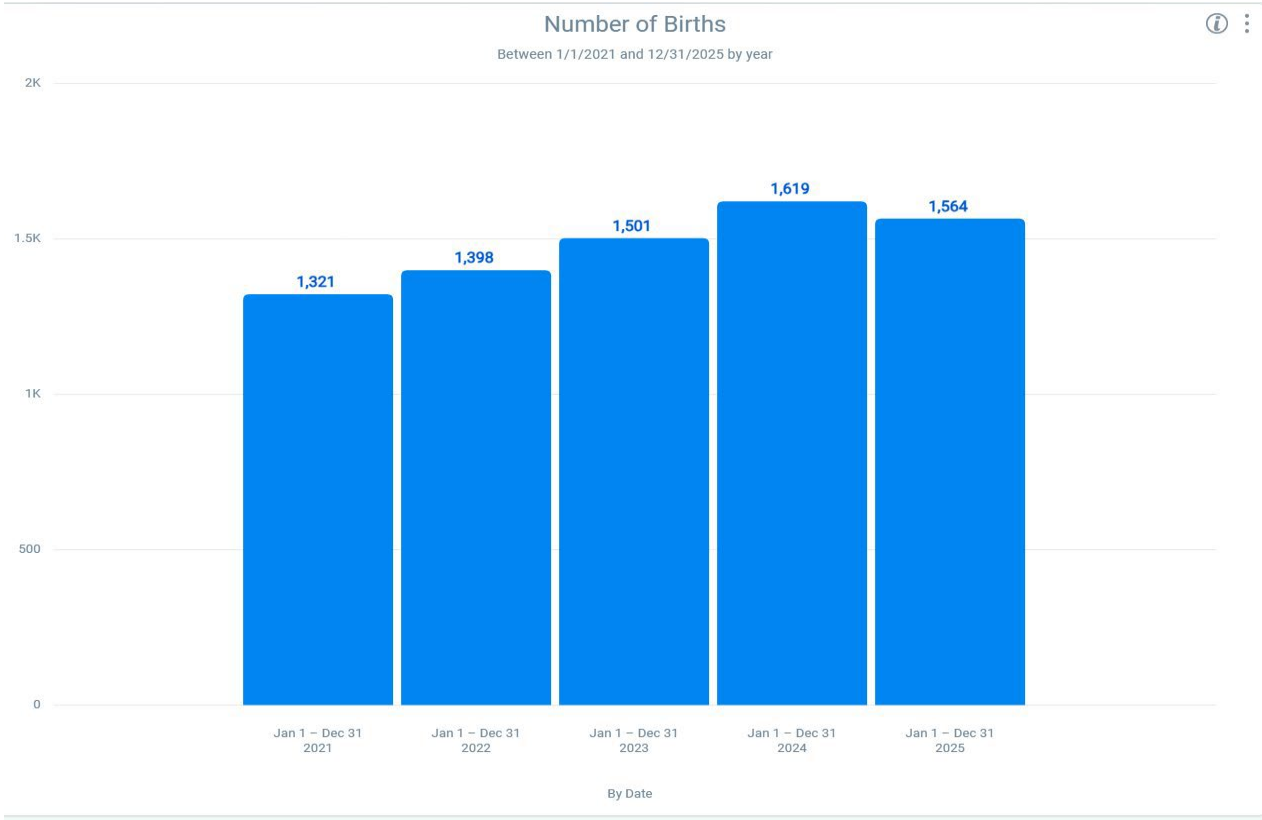


Department of Pediatrics



Outpatient

Inpatient



COMMITTEE AND TRUSTEE REPORTS

No Written Materials

Agenda Item C Committee Reports

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

CONSENT AGENDA: ACTION

BOARD OF TRUSTEES SPECIAL MEETING

WEDNESDAY, NOVEMBER 19, 2025

6:00pm or immediately following the Quality Professional Services Committee Meeting

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

LOCATION:

Open Session, In Person: HCP Conference Center, see above address
Teleconference Location: 4501 Pleasanton Avenue, Pleasanton, CA 94566

MEMBERS

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

BOARD OF TRUSTEES SPECIAL MEETING MINUTES

THE MEETING WAS CALLED TO ORDER AT 6:13 pm

ROLL CALL WAS TAKEN AND THE FOLLOWING TRUSTEES WERE PRESENT: Alan Fox, Greg Garrett, Donna Linton, Nicholas Moss, MD, Rachel Richman, David Sayen and Sblend Sblendorio

ABSENT: Lilavati Indulkar, MD, Nely Obligacion, excused

PUBLIC COMMENT: None

ACTION/DISCUSSION

E1. ACTION/DISCUSSION: Labor Efficiencies to Address Budget Shortfalls
Kim Miranda, Chief Financial Officer

Trustee Linton asked if the individuals in the grant funded programs were permanent employees and if they had bumping rights. Mr. Fratzke said they were mostly AHS employes and, if they were in a union, would have the same bumping rights that other members had.

Trustee Richman asked if optimizing staff levels meant harmonizing the contracts across all the different hospitals. Ms. Miranda said they had labor standards based on volumes for each department. Benchmarking demonstrated that in many instances AHS's labor standards were

higher than a lot of other hospitals. If they knew there was an department that had a lot more staff then they would focus on that department.

Trustee Linton asked if, embedded in the commitment to assist patients once their treatment at AHS was complete, there was the notion that regardless of payor source everyone would receive the same type of care. Mr. Fratzke said they have never differentiated care by those who have insurance or those who do not have insurance. They never have and never would. Ms. Miranda said that if there was no one else to provide whatever service was needed, then AHS needed to ensure that when they made changes, they did not disrupt that service.

Trustee Linton asked if this might end up with AHS having more uncompensated care because other patients with a payor source might have access to another provider. Ms. Miranda said that considering a source like Sutter, they might not take that patient. But other community services may provide the needed service. For example, UCSF often took their patients for services that AHS couldn't manage.

Trustee Linton asked if it was understood that mission integration was a guiding principle. Mr. Jackson said that was the expectation. Dr. Swift would be intimately involved in the process to ensure that we will, to the extent possible, factor mission integration into all of the decisions they made. Trustee Linton asked if they should add that to the guidance. Mr. Jackson said that was something they could do. Dr. Laurent said in other organizations they call it discernment. When an organization looked at expanding or shuttering a service line, it was anchored by the mission. They would consider what the impact to the community would be.

Trustee Sayen said the State was cutting a lot of services. Dental services for adults was an example. AHS was a big provider in that arena and there was no one else who would take on uninsured dental patients. So that service would be less performing from a financial standpoint, but the patients had nowhere else to go. Mr. Jackson said he had a conversation with Dr. Chandra from Alameda Health and they were doing a very similar exercise. They discussed having their teams get together to ensure these decisions were not being made in isolation. It was important for AHS to not make a decision, assuming Alameda Health would provide a service that Alameda Health was deciding to not have in the future.

Trustee Moss asked how they worked together to preserve the essential community health programs subject to consolidating leadership and optimizing staff. Mr. Fratzke said they had been looking at the layers of leadership and the scope of the leaders. They looked at maybe combining leadership roles and restructuring some of the layers of leadership before it got to the C-suite.

Trustee Fox asked if they implemented a hiring freeze. Mr. Fratzke said they had not officially announced a hiring freeze. It's difficult to freeze clinical positions when you had to take care of patients. What they have done is a slow walk to the approval of FTEs. Trustee Fox said a hiring freeze provided a tight grip on the FTE count. It also sent a message to the employees and the community saying that this was serious. If they lost a certain position, they might have to replace it to keep that department going, but they were basically not hiring. Mr. Fratzke said they were keeping a good line of sight on the FTEs. They were essentially doing what Trustee Fox was saying, they were just not calling it a freeze. Mr. Jackson agreed. He said that was basically what they had been doing by only hiring the exceptional positions. Additionally, if they

did move forward with the RIFs, they wanted to keep some space for those who were released to move laterally into the vacant positions.

Trustee Linton asked for clarification on the total financial savings of $78M with a financial savings of $37M for FY26. She asked if the cost for the voluntary retirements and reduction in force would reduce the $78M down to $37M. Mr. Fratzke said the $37M was a prorated amount for the remainder of the fiscal year. Ms. Miranda said they had to offset the severance and other costs. Trustee Linton asked if they estimated what those costs would be. Ms. Miranda said the 372 FTE reduction would be about $60M if it was a full year with no severance or legal costs. Mr. Fratzke said all of that was added to the costs.

Trustee Fox asked if the expected 12 months savings of $78M starting March 1st, would also be the expected impact on the 2027 budget. Mr. Gallo said it would be the $78M total minus the $37M for 2026.

Trustee Moss asked if that meant the $78M encompassed the rest of the current fiscal year and all of the subsequent fiscal year. Mr. Fratzke said it was for part of FY26 and FY27.

Trustee Garrett said he recalled from the COT report they were working on many initiatives including right sizing and the goal was $95M by the end of the fiscal year. He asked if that $37M represented the $97M that was discussed. Trustee Fox said this was only labor. Ms. Miranda said there was a long way to go still.

Trustee Sblendorio said they had to meet this target. They needed to emphasize that message. The rules of the game were changed on them, so they needed to adapt.

Trustee Fox asked if they knew what the normal attrition rate was. If the normal turn over was 5-8%, they may get close to that 372 reduction anyway. Mr. Jackson confirmed from staff that they have an attrition rate of 10.9% annualized.

Trustee Linton said she understood they were looking at savings other than just reduction in workforce and asked if the savings achieved with those initiatives were included in the $95M. Mr. Fratzke said they were. Ms. Miranda said it was important to remember that labor was 75% of all of their costs.

Trustee Linton asked if the voluntary separation programs were structured so that the benefit depended on the years of service. Ms. Chapman said they had two different programs: The IRP (Incentivized Retirement Program and the VRSP (Voluntary Resignation Service Program). The IRP was 17 weeks of pay and two months of COBRA. The VSRP was based on length of service with a maximum of 17 weeks.

Trustee Sayen asked if the Trustees were comfortable authorizing leadership to effectuate this.

Trustee Linton asked if the motion would be that broad or if they would be asked to approve all the various program cuts. Trustee Sayen said this was to approve the 372 FTE reductions. Staff would come back to the Board for specific programs.

Trustee Garrett asked if it was possible they would come back with additional work force reductions by the end of the fiscal year. Mr. Jackson said it was not their intention, but it was possible. They laid out a plan to get to the $95M, but if things did not work out they way they are planning, then yes, they could come back and ask for the latitude to do more. Trustee Garrett said he supported this decision because they had to.

Trustee Moss said he didn't see anything that told him if they didn't do this now they wouldn't have to come back later, under potentially worse conditions.

Trustee Fox asked how this would be socialized in the organization. Mr. Jackson said they had a department leader meeting the following day and would discuss it with them as the leaders would have to then communicate to their teams. They heard about this every week on the chat. This will be topic one of conversations starting tomorrow.

Trustee Linton said any delay will make it worse. Mr. Jackson agreed. It was a terrible message to send during holidays. They had conversations about delaying until after the holidays. But that would mean instead of March they were talking about April or May and that would exacerbate the problem.

Trustee Garrett asked if that was because there were 90-day union reporting requirements. Mr. Azizi said there were a number of required notices that contributed to the timeline.

Trustee Sblendorio said he supported this. They may have further discussion about this and the next fiscal year. But there would be more discussions going forward. The impact of HR1 was not going to end in August. It would continue for years. They were making assumptions, but they were not baseless. They knew people would lose insurance and still need to come in. The message should be that while this needs to be done, the situation will continue to be monitored for impactful changes.

Trustee Sayen moved and Trustee Moss seconded to authorize the CEO to implement a plan, including layoffs as necessary not to exceed the 372 identified to address the funding gap, provided that any program closures will be brought back to the Board for final approval.

Trustee Linton requested an amendment to include that the action would use the guiding principles as set forth in the presentation.

Trustee Sayen and Trustee Moss accepted the amendment.

ACTION: A motion was made and seconded to authorize the CEO to implement a plan, including layoffs as necessary not to exceed the 372 identified to address the funding gap, provided that any program closures will be brought back to the Board for final approval. These actions will be taken using the guiding principles as set forth in the presentation. A roll call was taken, and the motion passed.
AYES: Trustees Fox, Garrett, Linton, Moss, Richman, Sayen, Sblendorio
NAYS: None
ABSTENTION: None

CLOSED SESSION

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

TRUSTEE COMMENTS

ADJOURNMENT: 8:00pm

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		

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

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.**

WM
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) - Faslodex - 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

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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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.

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.

	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.

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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			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			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	Policy	
	HR Section 4.00 - Policy 4.21 Annual Competencies	**Reference # tbd**
	LEVEL ☐ System ☐ Site	EFFECTIVE DATE: 1/2026 NEXT REVIEW DATE: 1/2029

REGULATORY REQUIREMENT & POLICY STATEMENT

Regulatory bodies require healthcare institutions and their employees, contractors, and providers to be continuously survey ready, competent to perform their duties as well as deal with emergencies and other matters that come up as a result of their being AHS employees. AHS is required to administer and ensure all staff, contractors, and providers are educated and knowledgeable of all applicable regulatory training requirements mandated by state and federal regulations. All employees, contractors, and providers to take and successfully pass annual competencies administered by our Learning Management System. Training consists of lessons on topics which are universal and some of which are tailored to their job's functions and duties.

PURPOSE

To establish that the AHS workforce, in this context includes employees, contractors, providers, travelers, students, residents, interns, and volunteers, are compliant with regulatory training requirements established by federal and state laws.

SCOPE

This policy applies to the Alameda Health System (AHS) workforce.

DEFINITIONS

Learning Management System (LMS) - a software application or web-based technology designed to manage and deliver educational courses, training programs, and learning materials, streamlining the process for both instructors and learners.

PROCEDURES

1. Human Resources each year will announce who are to take which competencies, when they are available, and when they are due. This announcement is done electronically.

2. Employees will be required to log into the Learning Management System to complete the required competencies.

3. Annual competencies will be tracked by Human Resources with official records being maintained by Human Resources.

4. Managers and unions will receive notification of employees' non-compliance if the annual competencies are not completed by the due date. An employee's failure to become complaint within 30 days of such notification will result in termination. Employees terminated for non-compliance will receive a letter of non-compliance which includes information regarding the termination.

5. If an employee is on leave of absence approved by Leave Management when required training is due, the employee will be given 30 days from the date of return to work to complete the required training.

6. Employees may take the regulatory competencies during scheduled work time. However, if the employee's duties are such that they cannot be released during working hours, with prior approval from their supervisor, they may complete these competencies at home. Employees will be paid straight time that are preapproved to complete their competencies; therefore, work hours must be adjusted so that overtime is not incurred.

7. **Temporary/Registry Employees**
   - Temporary/Registry staff may take the regulatory competencies during regular work hours.
   - Non-Compliance: Temporary/registry staff who do not complete annual competencies by the day after the due date will be removed from the schedule until the required competencies are completed. Non-compliance notice will be sent to the registry/staff agency.

REFERENCES

- The Joint Commission Accreditation Manual – HR.01.04.01
- Centers for Medicare and Medicaid Services - Conditions for Coverage (CfCs) & Conditions of Participation (CoPs)
- Occupational Safety and Health Administration – Training Requirements in OSHA Standards

ALAMEDA HEALTH SYSTEM	Policy	
	HR SECTION 2.00 - POLICY 2.51 **Personal Leave of Absence**	**Reference # tbd**
	LEVEL ☐ System ☐ Site	EFFECTIVE DATE: 1/2026 NEXT REVIEW DATE: 1/2029

PURPOSE

The purpose of granting a Personal Leave of Absence is to retain for future employment a valuable employee whose circumstances would be improved by an absence from work in excess of available leave (the type of leave depends on MOU language) or compensatory time off. It is the Department Manager's responsibility, however, to ensure that staffing will be sufficient to meet operating requirement when approving a Personal Leave of Absence.

SCOPE

This policy will not be interpreted to conflict with any applicable federal or state laws governing leaves or reinstatement.

MOU: This policy does not apply for employees covered by a Memorandum of Understanding that provides for a personal leave of absence.

DEFINITIONS

Personal Leave of Absence: An authorized absence from work for more than three (3) consecutive work days for reasons not covered by other AHS leave policies. Examples of reasons for Personal Leave might include the following:

1. Personal convenience for an extended vacation.
2. Absence for educational purposes or volunteer work on behalf of the community, political organizations or charitable organizations.
3. Personal crisis such as death of a family member.

ELIGIBILITY

All AHS employees eligible regardless of date of hire and hours worked.

PROCEDURES

Employees must request Personal Leave with their manager before applying for the leave with AHS' third-party leave vendor.

Duration. Personal Leaves can be granted for a maximum of six (6) months. Initial requests for this leave are to be made in 30-day increments by the requesting employee, with approval given by the employee's manager for each 30-day increment. Approval for each 30-day increment is at the Manager's discretion. This six month maximum includes the usage of all vacation leave and compensatory time-off. AHS reserves the right to require FMLA qualifying leave to run concurrent with Personal Leave.

No Work Elsewhere. A Leave of Absence will not be granted for the purpose of allowing an employee to take another paid position temporarily, try out new work, or venture into business.

Personal Leave is a Privilege. Department Managers are encouraged to consider what accommodations can be made to allow employees to take Personal Leaves. They may also consider the length of the employee's service in determining whether a leave is appropriate. The Department Manager must

ALAMEDA HEALTH SYSTEM	**Policy**	
	HR SECTION 2.00 - POLICY 2.51 **Personal Leave of Absence**	**Reference # tbd**
	LEVEL ☐ System ☐ Site	EFFECTIVE DATE: 1/2026 NEXT REVIEW DATE: 1/2029

balance the individual's desires against the organization's staffing requirement to perform its mission. AHS reserves the right to require FMLA qualifying leave to run concurrent with Personal Leave.

During an unpaid leave, the employee ceases accruing paid leave benefits.

Return to Work / Reinstatement

Return to Work. A Personal Leave is to be granted only if there is an understanding that the employee intends to return to work at AHS upon the expiration of the leave.

Reinstatement at AHS. If the approved Personal Leave request is for 30 days or less, the employee will be returned to the former position. If the approved leave request is from 31 to 90 days, AHS will make an effort to return the employee to the former position, or in the same department and classification in which the employee was working prior to the leave of absence. If the approved leave request is for more than 90 days duration, management will attempt, but cannot guarantee, reassignment into an available, comparable position at AHS.

Failure to Return to Work. An employee who fails to return to work after the expiration of a Personal Leave of Absence will be considered to have abandoned their job, and subject to possible termination. This policy will not be interpreted to conflict with any applicable federal or state laws governing leaves or reinstatement.

REFERENCES

HR Section 1.00 – Policy 1.26 Rehire or Reinstatement to Employment
HR Section 2.00 - Policy 2.50 Leave of Absence Overview

	Policy	
ALAMEDA HEALTH SYSTEM	**HR SECTION 1.00 - POLICY 1.26** **Rehire or Reinstatement to Employment**	**Reference # tbd**
	LEVEL ☐ System ☐ Site	EFFECTIVE DATE: 1/2026

POLICY STATEMENT

This policy outlines the guidelines and procedures for rehiring and reinstating former employees. It ensures fair, consistent, and legally compliant practices that support organizational needs while recognizing the value of prior service and experience.

PURPOSE

To define the difference between rehire and reinstatement and outline the process for both.

SCOPE

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

DEFINITIONS

Rehire: When an employee previously worked for Alameda Health System and separated from the organization in good standing, now has applied for a position through the recruiting process.

Reinstatement: When an employee is being reinstated; this could be due to a previous termination being overturned via arbitration/grievance. Their records would show as if they never left the organization.

PROCEDURES

AHS workforce members who have been separated longer than six (6) months for any reason will not be cleared to return to work until they have completed the following employment processes:

Full New Employee Orientation:

- New Employee Orientation eLearning training modules[3]
- Background Check, per HR Policy 1.12[1]
- Drug Screening[2]
- Employee Health Services Clearance in accordance with HR Policy 1.36[2]

REFERENCES

1. HR Section 1.00 – Policy 1.12 Employment Process
2. HR Section 1.00 – Policy 1.36 New Hire & Annual Employee Health Screening, Physical Examination, and Drug Testing Policy
3. HR Section 1.00 – Policy 1.40 Employee Orientation

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**	

ACTION/DISCUSSION: CONTRACTS

Contract Approvals
February 2026

Renewal agreement with Roelz Enterprises, LLC dba ELZ Prestige Home Care for provision of sitter services. The term of this agreement is effective October 15, 2025 through October 14, 2027. The estimated impact of this agreement is $2,200,000.
Mark Fratzke, Chief Operating Officer

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

<table>
<tr><td>Contractor/ Vendor Name:</td><td>Roelz Enterprises, LLC dba ELZ Prestige Home Care (“ELZ”)</td></tr>
<tr><td>Description:</td><td>ELZ Prestige Home Care (“ELZ”) is a local (Fremont, CA) provider of non-medical services for Alameda Health System (“AHS”) skilled nursing facilities (“SNFs”) located at Alameda Hospital, Park Bridge Rehab and South Shore Rehab. The services that ELZ provides include companion sitting services for combative patients, for behavioral monitoring and for patients that display wander behavior. Details below:

ELZ provides the following personnel and services:

1. Provide one-to-one companion sitter to monitor, observe and ensure safety for patients in need of supervision, at risk of falling, or suffering from mental confusion.
2. Provide patient escorts to medical appointments.
3. Sitters will be provided within 2-hours of request. Services will be provided in 12-hour blocks of time.

Additional performance expectations:

1. Sitters will be trained to understand the patient behaviors being monitored.
2. Sitters will share observations and escalate to facility staff and leadership of at-risk behaviors.
3. Sitters shall use the facility’s tools for documentation.

These services are provided as-needed and are patient-specific. The lack of predictability as to when the sitter services are needed, precludes a viable in-house solution, which would require a pool of personnel not continuously engaged.</td></tr>
<tr><td>Contract Type and Term:</td><td>First Amendment of the Standard Agreement
Contract Term: October 15, 2025, through October 14, 2027</td></tr>
<tr><td>Termination Clause:</td><td>AHS may terminate this Agreement without cause and without further liability by providing THIRTY (30) days' notice, in writing, to the other party.</td></tr>
<tr><td>Total Spend with Vendor:</td><td>
<table>
<tr><th>Description</th><th>Board Approval</th><th>Total</th></tr>
<tr><td>10/15/2025 – 10/14/2027</td><td></td><td>$2,200,000</td></tr>
<tr><td>Total Estimated Spend:</td><td>Approval Requested</td><td>$2,200,000</td></tr>
</table>
</td></tr>
<tr><td>Estimated Cost Savings:</td><td>Current rate retained going forward. This allows AHS to avoid $66,000 in additional fees which would typically have been incurred with a standard 3% rate increase.</td></tr>
<tr><td>Fiscal Implications:</td><td>The proposed renewal is in budget for FY26 and will be accounted for in future budget requests.</td></tr>
</table>

Reasons for Recommendation:	Approval will allow for full funding of this key services agreement, ensuring uninterrupted provision of services throughout the term of the agreement. This program provides patients
Coordination with Medical Staff:	Reviewed by Medical Director, Post Acute Services (James Yeh, DO)
Administrative Review:	Primary: Chief Administration Officer, Post-Acute Services Secondary: Chief Operating Officer
Prior BOT Review/Action:	N/A
Executive Sponsor:	Chief Operating Officer

MONTHLY REPORT
LIFETIME VENDOR SPEND - FEBRUARY 2026

Vendor Name	Revised Contract Term	Proposed Contract Spend	Total Lifetime Vendor Spend (including proposed contract)	Proposed Contract Description	Status
HRC Construction	11/25/2025 – 7/31/2026	$9,460.00	$4,115,742.00	This vendor provides construction services. The SOW is for room prep for Audio Room CAPEX: 25CAP037.	Executed
HRC Construction	7/15/2025 – 7/14/2028	$ -	$ 4,106,282.00	Extension to MSA	Executed
JM Keckler	7/15/2025 – 1/30/2026	$85,716.00	$ 1,058,217.05	Amendment to original order for a three light head instead of a two light head.	Executed
Symplr Care Management LLC	11/1/2025 - 3/30/2026	$5,070.00	$ 1,890,252.32	Vendor will download and deliver to AHS 3,425 contract records (current, expired, and archived) and 1,454 vendor evaluation forms, including all associated files, in their original stored formats.	Executed

ALAMEDA HEALTH SYSTEM

BOT Previously Approved Contracts - FY26 (July 1, 2025 - June 30, 2026)

#	Vendor	Amount Requiring BOT Approval	Start Date	Ending Date	BOT approved Date	Agenda Summary	Expectation	Executive Sponsor
1	Alliance HealthCare Services, Inc. dba Alliance HealthCare Radiology	$3,333,044	4/23/2025	4/22/2028	FC - 7-2-25 BOT Approved 7-9-25	Provision of mobile imaging services.		Chief Operating Officer
2	CareFusion Solutions, LLC	$7,206,000	8/19/2025	8/18/1930	FC - 7-2-25 BOT Approved 7-9-25	Provision of infusion pumps and supplies.		Chief Clinical Officer
3	East Oakland Community Project	$1,593,600	8/1/2025	7/31/2028	FC - 7-2-25 BOT Approved 7-9-25	Provision of respite care services.		Chief Clinical Officer
4	The Regents of the University of California on behalf of the University of California, San Francisco, Department of Neurological Surgery	$7,594,371	8/1/2025	7/31/2027	FC - 7-2-25 BOT Approved 7-9-25	Provision of neurological surgery professional services.		Chief Medical Officer
5	Entisys Solutions, Inc. dba E360	$1,499,410	9/29/2025	9/28/2028	FC - 9-3-25 BOT Approved 9-17-25	Citrix virtual access platform		Chief Information Officer
6	GuidePoint Security LLC	$1,457,310	9/30/2025	6/30/2028	FC - 9-3-25 BOT Approved 9-17-25	Arctic Wolf cybersecurity monitoring and recovery services		Chief Information Officer
7	Xerox, Inc.	$3,983,160	11/1/2025	10/31/1930	FC - 9-3-25 BOT Approved 9-17-25	Printer equipment and services.		Chief Information Officer
8	Anthem Blue Cross Life and Health Insurance Company	$5,930,739	1/1/2025	12/31/2027	FC - 9-3-25 BOT Approved 9-17-25	Third-party administrator services for AHS employee health insurance plan.		Chief Human Resources Officer
9	Cardea Health	$6,394,800	10/1/2025	9/30/2028	FC - 9-3-25 BOT Approved 9-17-25	Respite housing services.		Chief Clinical Officer
10	Lifepoint Rehabilitation of California, LLC	$4,211,233	10/1/2025	9/30/2028	FC - 9-3-25 BOT Approved 9-17-25	Inpatient rehabilitation management services.		Chief Operating Officer

11	McKesson Corporation	$447,180,000	4/1/2026	3/31/1931	FC - 9-3-25 BOT Approved 9-17-25	Wholesale pharmaceutical supply services.		Chief Clinical Officer
12	Quest Diagnostics	$13,280,743	3/1/2022	2/28/2026	FC - 9-3-25 BOT Approved 9-17-25	Reference laboratory services.		Chief Clinical Officer
13	Nelson T. Lewis Construction Co., Inc.	$3,197,080	10/15/2025	6/15/2026	FC - 10-1-25 BOT Approved 10-8-25	St. Rose Hospital cath lab upgrade.		St. Rose Chief Administrative Officer
14	ePlus Technology, Inc.	$1,800,000	11/1/2025	10/31/2028	FC - 10-1-25 BOT Approved 10-8-25	Data loss protection services.		Chief Information Officer
15	Switch, Ltd.	$1,509,294	2/16/2026	2/15/1931	FC - 10-1-25 BOT Approved 10-8-25	Data center services.		Chief Information Officer
16	Lescure Company, Inc.	$1,668,200	11/1/2025	3/31/2027	FC - 10-1-25 BOT Approved 10-8-25	Architectural and structural work for Alameda Hospital HVAC replacement project.		Chief Operating Officer
17	Matrix HG, Inc.	$1,214,436	11/1/2025	10/31/2026	FC - 10-1-25 BOT Approved 10-8-25	Installation of COVID prevention HVAC upgrades at JGPH.		Chief Operating Officer
18	Symplr Care Management LLC	$1,112,847	1/1/2026	12/31/2028	FC - 11-5-25 BOT Approved 11-12-25	Patient safety and quality reporting software.		Chief Information Officer
19	LAZ Parking California, LLC	$6,937,194	1/1/2026	12/31/2028	FC - 11-5-25 BOT Approved 11-12-25	Parking services.		Chief Operating Officer
20	Agiliti Health, Inc.	$9,138,690	2/1/2026	1/31/2029	FC - 1-7-26 BOT Approved 1-14-26	Equipment rental services.		Chief Operating Officer
21	Smith-Karn Architecture	$1,492,525	1/15/2026	1/15/2029	FC - 1-7-26 BOT Approved 1-14-26	Architectural services for remodel of SLH medical detoxification clinic.		Chief Operating Officer
22	VTP Holdings, LLC dba VIC the PICC	$1,620,000	2/1/2026	1/31/2029	FC - 1-7-26 BOT Approved 1-14-26	PICC line placement services.		Chief Clinical Officer
	Total Amount for FY 26 year to date	$533,354,676						

F1.ACTION: Staff Requests Board Authorization for the allocation of a not-to-exceed amount of $9, 507,500 million to support an Intergovernmental Transfer for the benefit of St. Rose Hospital

ALAMEDA HEALTH SYSTEM

St. Rose Hospital
IGT Funding Request, 2/11/26

St. Rose Hospital
IGT Funding Request

- FY2026 SRH IGT funding is $36,015,000; expected to be received in June 2026.
- Full IGT was included as part of the approved St. Rose FY2026 budget and is needed to fund operations.
- IGT Local Share is $18,007,500 comprised of:
  - Alameda County Measure A, $7,000,000
  - Eden Health District, $500,000
  - Supervisor Marquez, $1,000,000
  - AHS contribution (pending board approval), $9,507,500

	FY 24-25	FY 25-26	FY 26-27	
Measure A	$ -	$ 7,000,000	$ 7,000,000	
City of Hayward	1,000,000	-	-	
Eden Health District	1,000,000	500,000	500,000	$2M over 3 years
BOS Marquez	1,000,000	1,000,000	-	
AHS	12,166,000	9,507,500	10,991,000	
Local Share	$ 15,166,000	$ 18,007,500	$ 18,491,000	
IGT funding to SRH	**$ 30,332,000**	**$ 36,015,000**	**$ 36,982,000**	
	$ 30,332,000	$ 36,015,000	$ 36,984,000	
	$ 15,166,000	$ 18,007,500	$ 18,491,000	

Consolidated Financial Statement
Fiscal Year 2026 Approved Budget (in thousands)

- FY2026 Net Income is approximately $1.0M loss.

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

**Projected 2025 excludes:*

- Closed departments: Labor & Delivery and Nursery

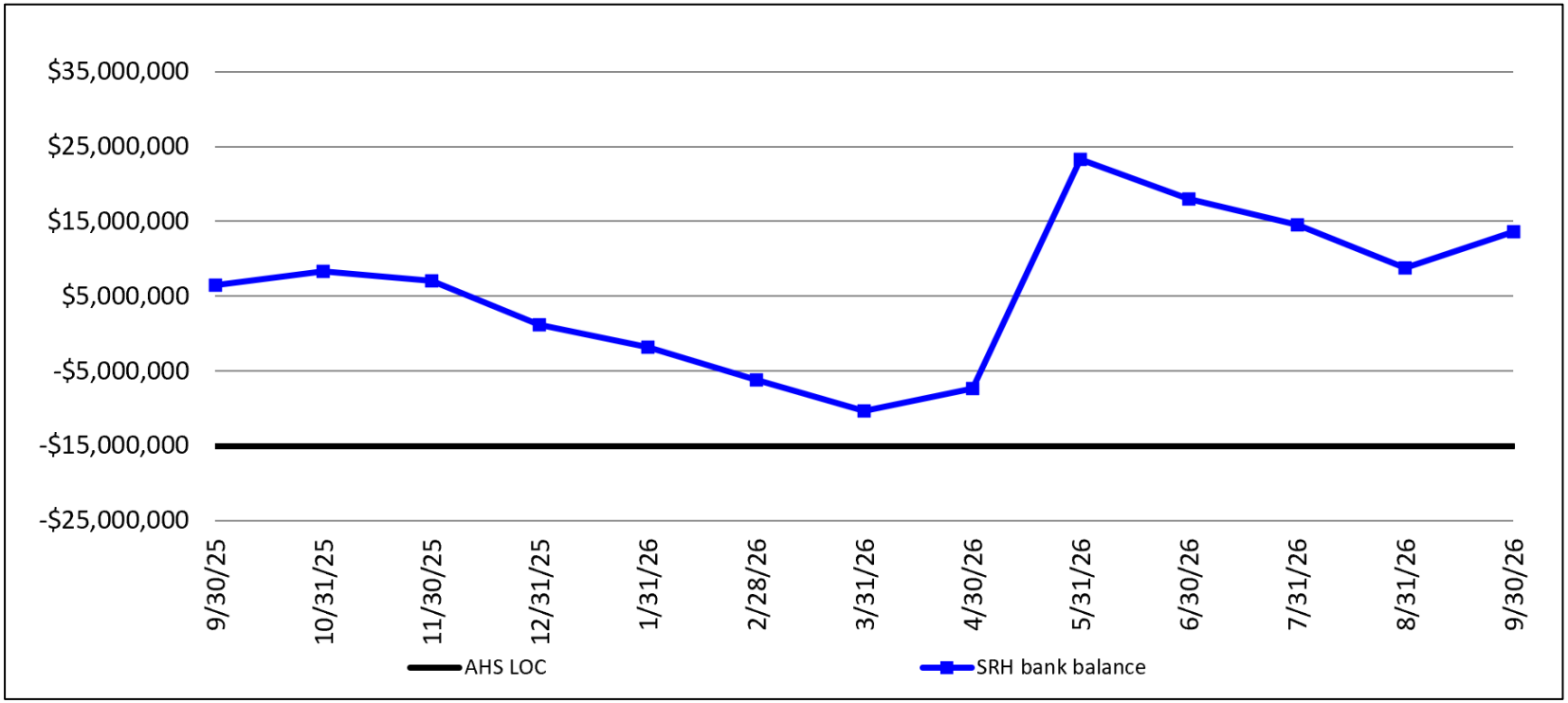
- Severance pay paid to Alecto and Director of Nursing , $3.2M

-Sub Acute: Projected to improve Census, up to maximum of 15 patients

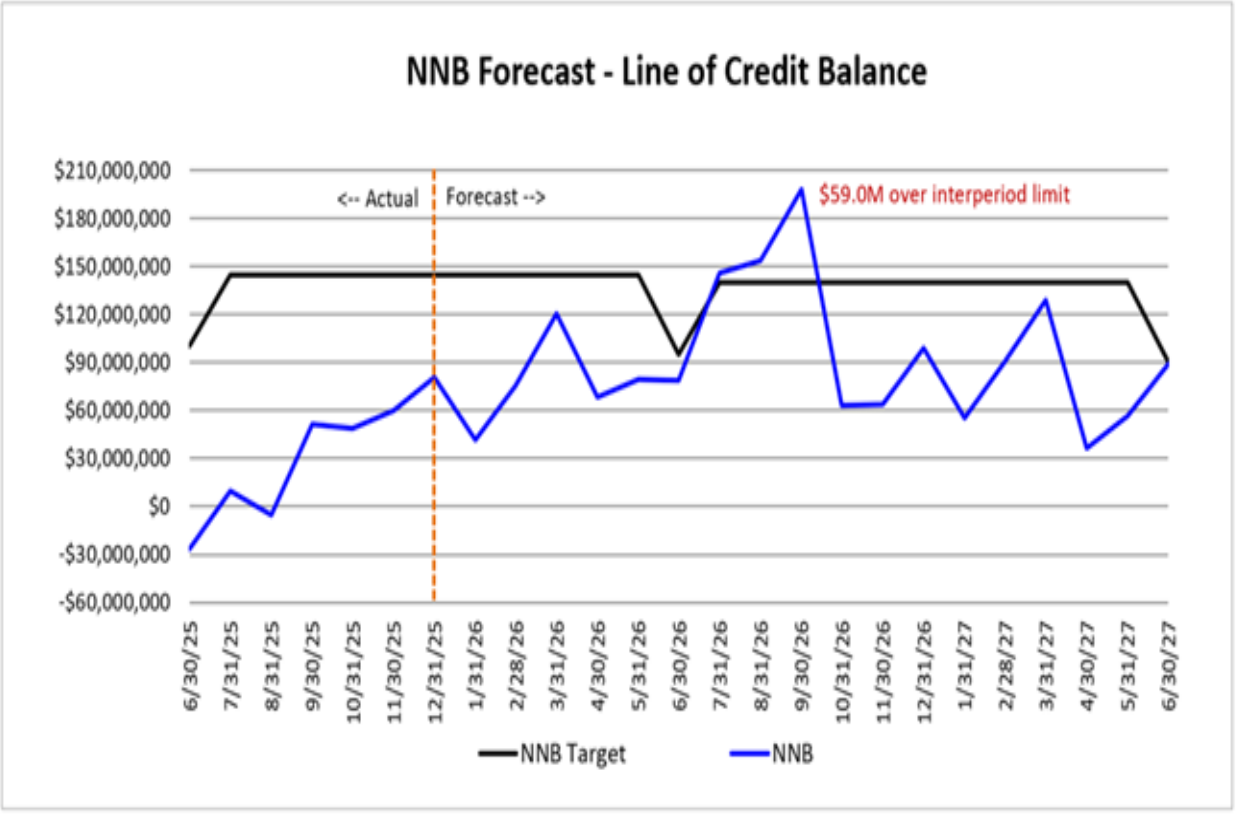
-Other Operating Revenue: Includes IGT/Measure A; MOB Rent Revenue & SRF Donations

November 2025
Cash Flow Projection

- St. Rose has $15.0M line of credit (LOC) with AHS and drew $2.5M in January 2026.
  - LOC is expected to be paid off in May/June 2026.
  - Same timing as last year.
- St. Rose has a management agreement with AHS effective November 2024.
  - Outstanding balance at 1/31/26 is $4.4M, including interest of $23.8k.
  - No payments paid by St. Rose.



December 2025 Financial Report
Line of Credit (NNB) Forecast through 6/30/26



- FY2026 forecast is consistent with prior month and expected to be compliant with the debt agreement with the County.
  - below $95M at 6/30/26
  - below $90M at 6/30/27
- Forecast shows increasing debt for the entire fiscal year with no payoff this fiscal year-end. NNB expected to exceed the inter-period limit by $59.0M.
  - *Insufficient credit available to fund operations in Q1.*
- As a result of the seismic shift in healthcare funding (HR1 and other state impacts) immediate action to overt fiscal crisis is needed. The graph does not take into consideration the impact and timing of HR1.
- Assumptions will be updated during the budget cycle.

December 2025 Financial Report
Material Items Impacting NNB Forecast

Material Items Included in NNB Forecast
(in thousands)

	Jan-26	Feb-26	Mar-26	FY26 Q4	FY27 Q1	FY27 Q2	FY27 Q3	FY27 Q4
GPP (quarterly)	$ 17,725	$ 266	$ 5,600	$ 25,210	$ 23,550	$ 23,550	$ 28,650	$ 19,700
EPP (semi-annual)	-	-	-	31,800	-	75,350	-	39,500
QIP	-	-	-	36,658	-	50,000	-	50,000
Medi-Cal Rate Range	48,228	-	-	-	-	-	51,300	-
BHCS (JGP/Alameda County) - fy26	10,728	6,084	6,084	18,251	12,167	-	-	-
BHCS (JGP/Alameda County) - fy27	-	-	-	-	-	18,900	18,900	25,200
HPAC	-	10,800	-	10,800	-	21,600	10,800	10,800
AB85 Realignment	-	-	-	-	-	4,800	-	-
SNF DP-NF (final pmt Jan-27)	-	-	-	-	-	-	26,000	-
Waiver recoupment (fy11, fy12)	-	3,922	-	29,169	-	-	-	-
St. Rose Hospital LOC	2,500	2,500	2,500	(7,500)	-	-	7,500	(7,500)
Donation to St. Rose Hospital	-	-	10,507	-	-	-	10,507	-
	$ 79,181	$ 23,572	$ 24,691	$ 144,388	$ 35,717	$ 194,200	$ 153,657	$ 137,700

Prior Year Reimbursement Settlements

AB915 (fy14-fy20)	(17,000)	TBD
Medi-Cal FQHC recoupment (fy08 - fy13)	(40,000)	TBD
Physician SPA (fy08 - fy13)	(25,100)	TBD
	$ (82,100)	

- DP-NF Pass-through for $25.8M moved from January 2026 to December 2025 based on receipt of payment.
- Waiver recoupment (fy11, fy12) moved from Prior Year Reimbursement Settlements as the amount and timing has been determined.
- St. Rose drew on the line of credit of $2.5M in January 2026.
- St. Rose donation is TBD, pending approval.

Appendix: SRH Approved Budget

St. Rose Hospital

An ALAMEDA HEALTH SYSTEM Affiliate

Fiscal Year 2026 Budget

Board of Directors

Fiscal Year 2026 Budget – Key Assumptions

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

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

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

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

Fiscal Year 2026 Budget – Key Assumptions

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

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

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

Fiscal Year 2026 Budget – Key Assumptions

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

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

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

- **Long Term Debt**
  - Currently assumes $17.6M Distressed Hospital Loan Program repayment begins July 1, 2026; however, application in progress for 12 months of debt service forgiveness. If awarded, total debt for DHLP would be reduced by $3.5M and repayment period would begin July 1, 2027 on balance estimated at $14.1M.

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

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

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

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

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

**Projected 2025 excludes:*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Fiscal Year 2026 Proposed Budget - Volume

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

**Sub Acute Budgeted Census:*

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

Fiscal Year 2026 Proposed Budget – Capital Expenditures

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

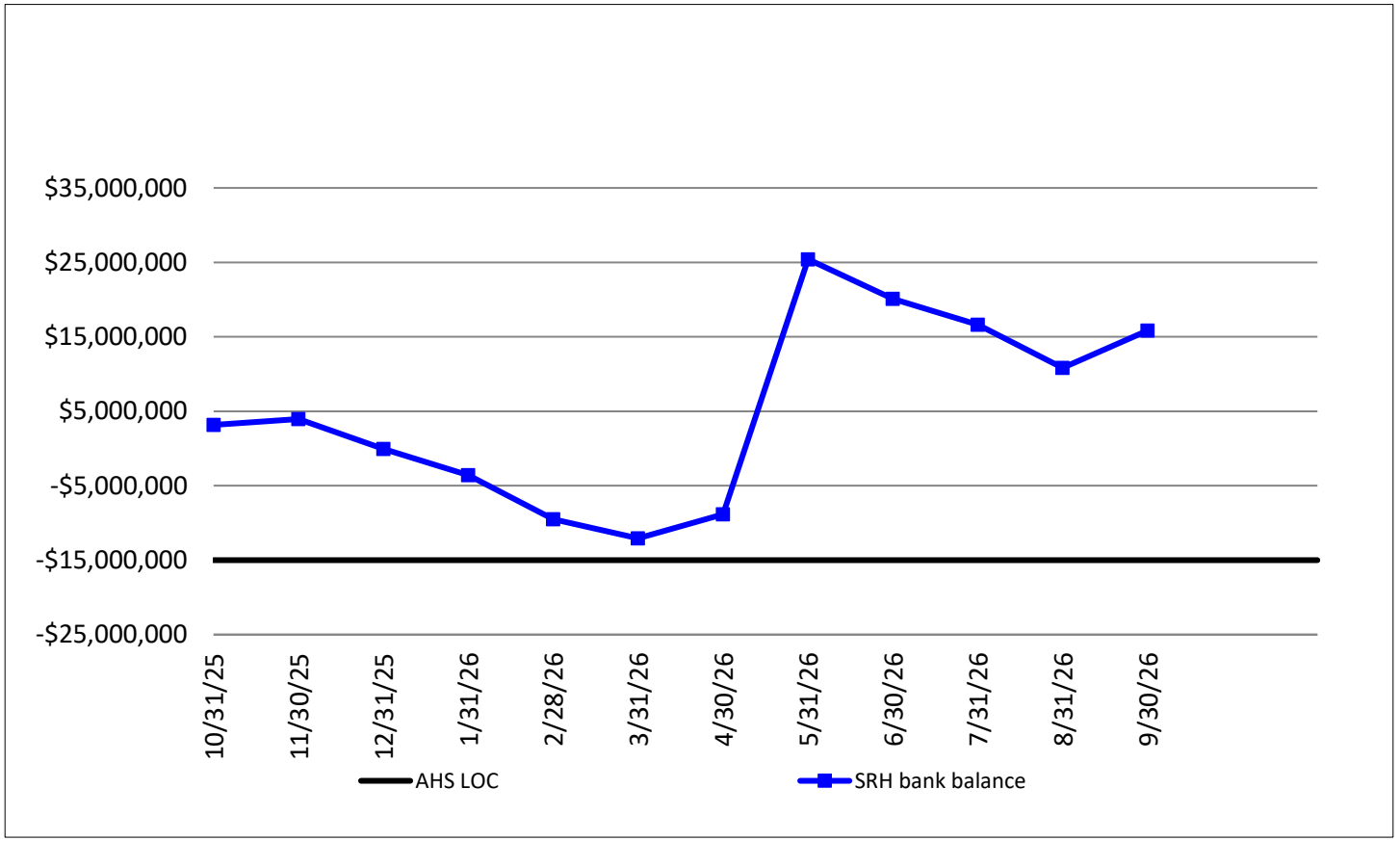
	FY2022	FY2023	FY2024	FY2025
Land Improvements	9,169	80,790	-	-
Building & Building Improvements*	3,563,372	2,080,715	159,528	5,473,357
Capital Leases	182,909	-	718,673	-
Automobiles	33,834	-	-	-
Furniture	-	19,183	-	-
Equipment	625,132	1,218,833	612,100	61,712
Computer Hardware	7,974	98,299	123,946	15,391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

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

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

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

Fiscal Year 2026 Proposed Budget – Projected Cash Flow



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