



BOARD OF TRUSTEES MEETING

WEDNESDAY, MARCH 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
55 S. Market Street, 9th Floor, San Jose, CA 95113

ZOOM Meeting Link:¹

<https://alamedahealthsystem.zoom.us/j/9361457125?pwd=4JnAmhDnBaLqY4GWf4PQBw.p3w0Puy2.1&omn=85083309239>

Meeting ID: 936 145 7125

Meeting Password: 20200513

One tap mobile

+14086380968,,9361457125# or

+13462487799,,9361457125#

Dial by your location

+1 408 638 0968 US (San Jose)

+1 346 248 7799 US (Houston)

+1 646 518 9805 US (New York)

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

MEMBERS

| | |
|-----------------------|-----------------|
| Alan E. Fox | Greg Garrett |
| Lilavati Indulkar, MD | Donna Linton |
| Nicholas Moss, MD | Nely Obligacion |
| Rachel Richman | David Sayen |
| 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 or on Zoom and wish to address the Board or Committee regarding an item on the agenda or in their purview, please communicate your intent with the Clerk of the Board at the beginning of the meeting.

Each speaker will be allotted no more than 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: February 18, 2026

Donna Linton, Chair

C2. Quality Professional Services Committee: February 27, 2026

Lilavati Indulkar, MD, Trustee

C3. Finance Committee: March 4, 2026

Alan Fox, Trustee

D. CONSENT AGENDA: ACTION

D1. Approval of the Minutes of the January 7 Special Meeting, January 14 Regular Meeting, and February 4 Special meetings of the Board of Trustees.

D2. Recommendation from the Medical Executive Committee to approve the policies listed below:

- Surge Policy
- Diabetic Ketoacidosis (DKA) Policy

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

- AHS & AH Medical Staff Credentialing and Privileging of Providers
- AHS & AH Medical Staff Immunization and Vaccination
- AHS & AH Medical Staff Ongoing Monitoring of Expiring Items

END OF CONSENT AGENDA

E. ACTION / DISCUSSION: Contracts

E1. New agreement with Fisher Scientific Company LLC dba Fisher Healthcare for provision of laboratory supplies. The term of this agreement is effective April 1, 2026 through March 31, 2029. The estimated impact of this agreement is \$6,600,000.
Mark Fratzke, Chief Operating Officer

E2. New agreement with Hill-Rom Company, Inc. for provision of a new nurse call system at our skilled nursing facilities. The term of this agreement is effective March 12, 2026 through March 11, 2027. The estimated impact of this agreement is \$1,430,000.
Mark Fratzke, Chief Operating Officer

F. ACTION/DISCUSSION

F1. ACTION/DISCUSSION: Diagnostic Imaging Equipment Replacement Plan
Albert Roh, MD, Chair Radiology

F2. ACTION/DISCUSSION: New Adult Patient Access Assignments from Alameda Alliance
Porshia Mack, MD, Associate Chief Medical Officer, Ambulatory Services

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.

AHS CEO Board Report

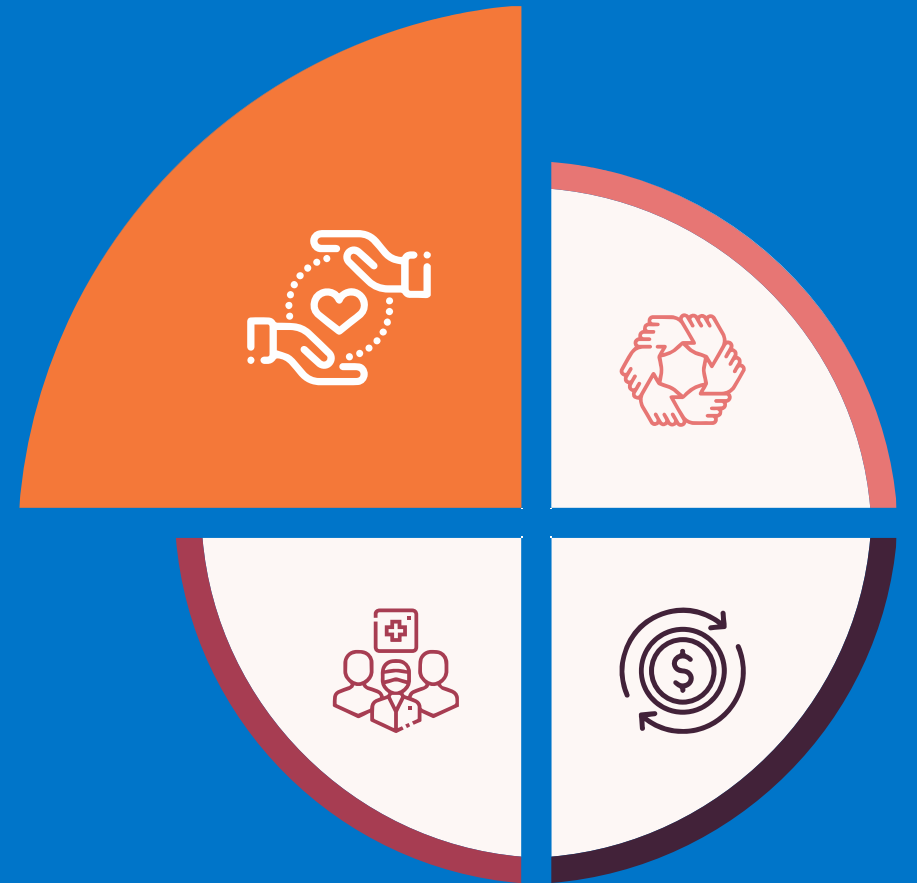
James Jackson
3/11/2026
Board of Trustee Meeting



AHS Pillars

Quality Care

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



SNI Spotlight on Cancer Screening Campaign

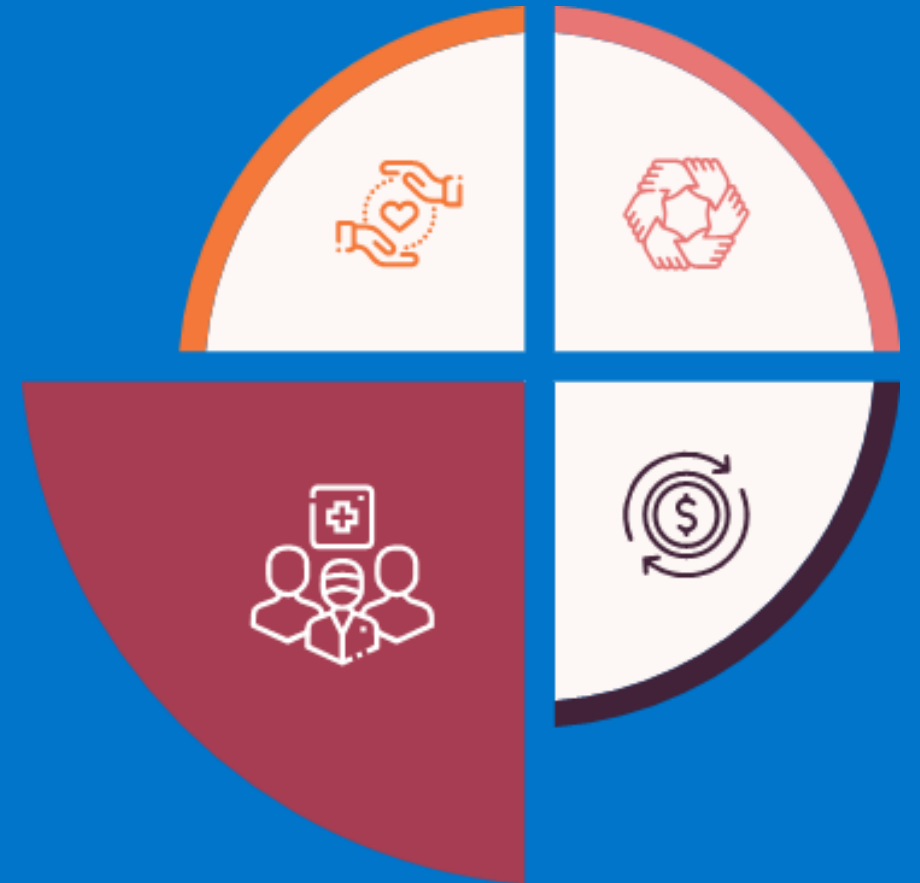
SNI Spotlight: Black Patients Co-Design Cancer Screening Campaign at Alameda Health System

SNI's Equity Community of Practice published a [new story](#) highlighting Alameda Health System's (AHS) cancer screening campaign, which was co-designed with Black patients and community members and rooted in shared decision-making. Learn how AHS embedded equity across its quality improvement work, hear first-hand perspectives, and explore the frameworks that guided these efforts. Short video included.

AHS Pillars

Staff & Physician Experience

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



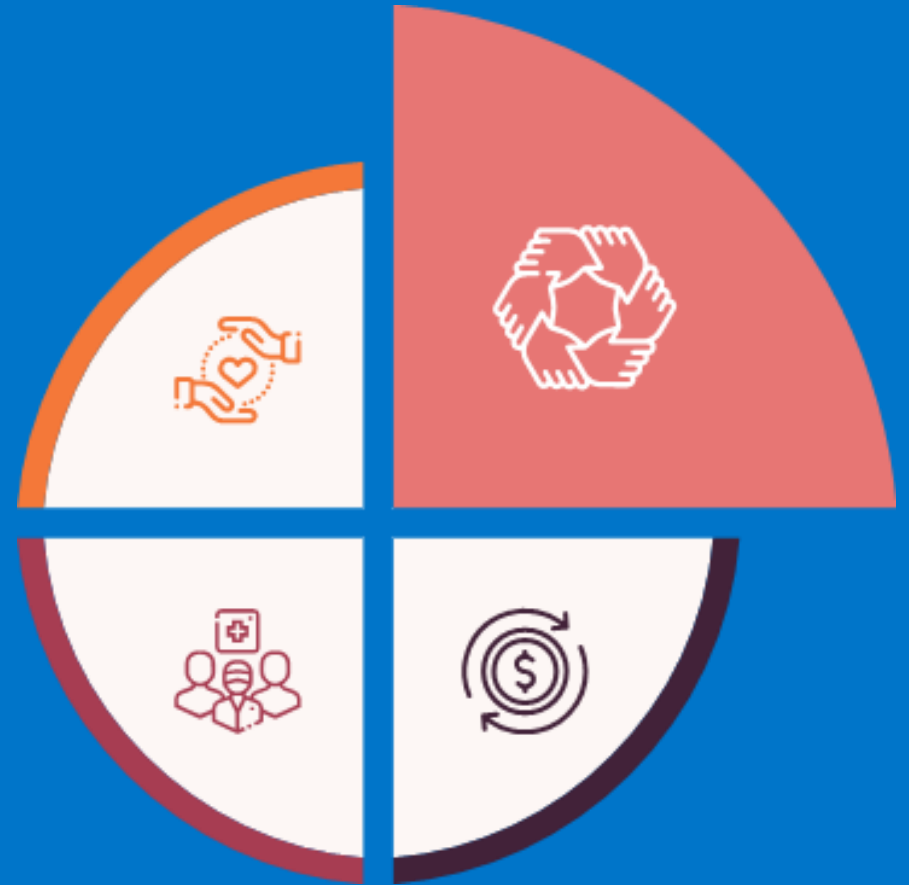
WEEK TWO PERFORMANCE: AHS Pulse Survey

| 2026 SCORE (PULSE) SURVEY LINKS | | | |
|--|--|--|--|
| ALAMEDA HOSPITAL | AMBULATORY CARE | Beh. Health & JGPH | HIGHLAND HOSPITAL |
| <ul style="list-style-type: none"> English Poster Spanish Poster | <ul style="list-style-type: none"> English Poster Spanish Poster | <ul style="list-style-type: none"> English Poster Spanish Poster | <ul style="list-style-type: none"> English Poster Spanish Poster |
| PHYSICIANS & APPs | POST ACUTE CARE | SAN LEANDRO HOSPITAL | SYSTEMWIDE SERVICES |
| <ul style="list-style-type: none"> English Poster Spanish Poster | <ul style="list-style-type: none"> English Poster Spanish Poster | <ul style="list-style-type: none"> English Poster Spanish Poster | <ul style="list-style-type: none"> English Poster Spanish Poster |

| SCORE Alameda Health System 2026 SCORE Surveys | | | |
|--|-------------|----------------------------|---------------|
| FACILITY | # RESPONSES | TOTAL ELIGIBLE RESPONDENTS | RESPONSE RATE |
| AHS Alameda Hospital | 71 | 309 | 23% |
| AHS Ambulatory Care Clinics | 110 | 535 | 21% |
| AHS Behavioral Health and JGPH | 71 | 290 | 24% |
| AHS Highland Hospital | 152 | 1234 | 12% |
| AHS Physicians and APPS | 88 | 650 | 14% |
| AHS Post-Acute Care | 242 | 386 | 63% |
| AHS San Leandro Hospital | 71 | 307 | 23% |
| AHS Systemwide Services | 234 | 1161 | 20% |
| Overall | 1039 | 4872 | 21% |

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.





Let's Volunteer at the Alameda County Community Food Bank

Saturday, March 21, 2026

8:30 a.m. – 11:30 a.m.

Alameda County Community Food Bank (ACCFB)
7900 Edgewater Drive, Oakland

Join CEO James Jackson for another AHS volunteer opportunity at the Alameda County Community Food Bank!

ACCFB is an important community partner as we work towards a stronger, healthier, and more nourished Alameda County, where no one worries where their next meal will come from.

Space is limited | RSVP by March 14, 2026 | PACE@alamedahealthsystem.org

Questions

James Jackson
3/11/2026
Board of Trustee Meeting



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

March 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 Root Cause presentation regarding equipment downtime, response time going forward
- **Quality of Care & Patient Safety**
 - AH & AHS Combined Medical Staff Committees
 - Credentials Committee
 - Clinical Practice Council
- **Medical Staff Officer Changes**
 - Chief of Staff

AHS & AH Combined Medical Staff Committees

Credentials Committee (February 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 (February 2026)

- Reviews and approves all protocols, policies and plans that affect the delivery of patient care across the system (HGH, SL, AH)
- APPROVED 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
- Clinical Shortages and Coverage
 - Anesthesiology, OB/GYN, Trauma - Vascular Surgery
- Patient Care Equipment: Clinical Impacts
 - Trauma, STEMI and Stroke
- Diagnostic Imaging Modernization Plan (FY2027-FY2030)
- Department Reports
 - Radiology/Imaging Equipment Plan
 - Continuing Medical Education

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

Quality Steering Committee

- 2025 Submissions for MIPPs program and performance metrics: harm reduction, Falls
- Contract oversight with patient care impact: process to engage and involve clinicians in the oversight and endorsement of the contracts and performance metrics of the vendor

AHS Medical Staff Report

Clinical Impact Taskforce

- AdHoc Board of Supervisors Committee
- Focus on patient care, quality, safety and organizational success
- Recent meetings with Executive Leadership (2/13/26, 2/20/26, 3/6/26)

Joint Conference Committee

- Transparent and Effective meeting on 2/20/26 to start working collaboratively; next meeting 3/20/2026
- Seeking legal counsel on developing a communication guidelines



CARING, HEALING, TEACHING, SERVING ALL



Approval of the Minutes of the January 7 Special Meeting, January 14 Regular Meeting, and February 4 Special meetings of the Board of Trustees.



BOARD OF TRUSTEES SPECIAL MEETING
WEDNESDAY, JANUARY 7, 2026
6:00pm or immediately following the Finance 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 | Greg Garrett |
| Lilavati Indulkar, MD | Donna Linton |
| Nicholas Moss, MD | Nely Obligacion |
| Rachel Richman | David Sayen |
| Sblend A. Sblendorio | |

THE MEETING WAS CALLED TO ORDER AT 5:10 pm

ROLL CALL WAS TAKEN AND THE FOLLOWING TRUSTEES WERE PRESENT: Alan Fox, Greg Garrett, Lilavati Indulkar, MD, Donna Linton (arrived at 5:23pm), Nicholas Moss, MD (arrived at 5:41pm), Nely Obligacion, Rachel Richman (arrived at 5:43pm), David Sayen and Sblend Sblendorio

ABSENT: None

PUBLIC COMMENT:

Craig Metz spoke regarding the IOP which provides services that were not provided anywhere else in the County. They were currently running at a profit due to some changes they've recently made. There was no financial justification to close the program.

Lydia Apple spoke regarding the IOP. No program had such a deep and meaningful impact on the people they served. The Board must immediately rescind these layoffs and return to the table to find real solutions.

Dan Allen

Hope Schwartz

Veronica Perez spoke regarding her job as a nurse case manager for the most marginalized communities. Finding someone to help them read their texts and write down their appointments was difficult. She was very worried.

Jo Fox spoke regarding rehab team having departments eliminated. She said therapists were told not to come to work today because they were laid off, but then called and told they needed to return to work to care for patients.

Dori Salmon spoke regarding the need to understand the human cost. They were not just employees, but the people who serve the community. The patients deserved better. The process was cruel and destabilizing.

Eric Mc Cown, an Alameda Firefighter came in solidarity with SEIU 1021. They took vulnerable patients to AHS every day. Laying off these employees would jeopardize patient care. They needed to return to the table and negotiate in good faith.

Ashley Mar said these layoffs had not been guided by evidence or a consideration for patient care. Students in training were being laid off partway into their programs making them unable to graduate. This was detrimental to the availability of healthcare professionals.

Hillary Larkin requested they rescind the layoffs and return to the negotiating table for a more collaborative plan. The SART program was critical and provided services to victims of crime that they could not get elsewhere.

Carmen Melendez

Alicia Caldwell

Jamila Walker

Parisa Farrohi said she chose to be a social worker at AHS as she moved from Iran when she was 13. Their program was unique as it provided specialized levels of care to highly acute parents who could not get the care elsewhere.

Gillian Gillette

Marie Hopper demanded the Board rescind the lay offs and that any cost saving measures are done in a collaborative and patient centered manner. She came to work even though she had been laid off. They had an ethical obligation to not abandon patients.

Diana Lawton

Jordan Pelot said they came to the table with ideas to be profitable two years ago and were told that no one expected behavioral health to be profitable, just care for the patients. Now they were being told they did need to be profitable but were out of time to implement plans.

Andrew Scott shared a story about a patient who was helped by the Fairmont IOP. It was the only place she could find access for the care she needed. She felt peace and completeness for the first time. Closing the program won't eliminate the need, it will remove the access.

Bryan Smith Turner said the age number of psychiatric emergency room visits at JGPH, the number of visits per patient, and the length of stay once admitted, all decrease once patients came through and PHP. He requested the lay offs get rescinded.

Greg Denny said these cuts were going to increase suffering and cost lives. He wanted to know who they were willing to take risks for. The implementation of these cuts were not convincing indications of their wisdom.

Michelle said they took an oath to protect their patients and to prevent patient harm. These cuts were going to cause harm. The pharmacists have created over \$2M in savings for the hospital. She requested the cuts get reconsidered.

Jennifer Esteen said they needed to go to the County and request the NNB be forgiven. The Trump cuts were problematic, but these lay offs were premature. The State legislature still had an opportunity to provide statewide extensions.

Anthony Melgar
Cindy Kane

Navjot Tatlah said pelvic floor physical therapy was critical. If the services were cut the community would have none of this therapy at all. This felt like patient abandonment. She has patients who would not be able to complete their treatment.

Shelby McCray

Neil Laibert requested the layoffs be rescinded and they return to the table for real solutions for the pending cuts. Outpatient care was a proactive shield keeping people out of the ER or jail. Closing the doors is not redirecting, it's abandoning the patients.

Nina Villa said the decision to shut down outpatient services directly impacted patients. Many of whom were low income, medically fragile, and from minority communities and already struggled to access care. Now that care would end and that was not healthcare.

Jodi Huang said the PT team provided an average of over 1000 evaluations a month. Fairmont Rehab was the only setting in AHS that provided specialized post traumatic neuro-ortho, vestibular, pelvic, certified hand, dysphagia, and dysphonia treatment

Felix Thomson
Eloise Thomas

Reilly Gardine said if they went through with these lay offs there would not be staff to feed the patients. There would not be any post surgical care. There would not be any dignified deaths if they laid off palliative care providers.

Ming Ting "Dream" Chew said they hired contractors with no relevant experience to make these cuts. Shutting down the Outpatient Rehab and laying off therapists meant patients will have nowhere else to go and will struggle to heal from strokes, illnesses, or accidents.

Jenae graham

Carmen Melendez lugo

Evon Williams said the chaos impacted patient care. Leadership did not realize what they have done.

Eden Foley said she was terrified of these cuts in a deeply understaffed hospital. Corners were already cut. The people getting laid off will be impacted and it was terrifying for both the employees and the community.

Naomi Caldwell said these cuts were being made by people who did not understand how the hospital worked. The kitchen was in chaos this morning not knowing who was going to feed the patients. There was not enough people to feed the evening meals.

Sasha Rockwell supported the workers at the hospital. If they were doing the cuts in California, what precedent were they setting. Her father spent two days on a gurney in the hallway, and that was prior to these cuts. Patients may not be as lucky going forward.

Casey Kettering asked why they waited until people were let go to check seniority. If the positions were budgeted through June, she wanted to know why they were destabilizing the community now.

KC Chung said they were facing shortages at Kaiser as well. Highland was struggling to support their patients. This was not the solution. The cuts should be reconsidered.

Ansel Schmidt said he was expecting a baby in March, some of his co workers were supporting their patients and multiple children on a single salary. These people will suffer because of the choices AHS management was making. The Trustees had a choice to make, they should listen.

Cynthia Harris AHS has failed to follow the MOU. The MOUs were not suggestions they were binding agreements. AHS has sent out incorrect lay off notices. The errors were not harmless. When healthcare workers were distracted by uncertainty, patient care suffered.

Yamasia Ajedo said the MA was cut the day before she was supposed to staff four clinics. They would not be able to clean the cath lab if they fire the EVS team. The reduction in force was misconstrued and they should have collaborated.

Susan Sandoval said her job helped the community stay safe and healthy. Cutting EVS staff was ridiculous. She said the AHS had to rescind these cuts. These cuts would not heal. They were here to serve and they needed to find a real solution.

Erica Peters Blaauw said the community they served was full of love, joy, culture, and strength. They were also burdened with poverty, violence, and tragedy. The workers at AHS saw this firsthand and dedicated their careers to serving these patients.

Saundra Marshall supported the program being kept open. They served the severely mentally ill patients. They served them in order to keep them on their medications. They helped them see their doctors, ensure they had food and shelter. No one else took care of them this way.

Peter Masiak said this was bungled. The cuts from the Trump administration were bad. But instead of collaborating, they've done the opposite. Instead of finding higher ground they were running to the water. They've not yet had Beilenson Hearings.

Nathan Hansford said he was continuously ignored while they bargained in bad faith and cut people without Beilenson Hearings. There was no reason to do this. They currently collected 10% of the collections, the standard was 40-50%. That was millions of dollars missed.

Stephen Miller understood the importance of addressing the challenges and would love to work with the administration. But there was minimal involvement with the MEC or department leadership. Secondary considerations were not factored into these decisions.

Anthony Fuentes said the elimination of key and critical personnel represents a level of irresponsibility that places patient care, operational integrity, and community trust in jeopardy. The layoff of key nurses represents more than labor, it represents experience that is now lost.

Nicholas Pirnia said physician services were hard to turn on and off. Whether or not changes need to be made, the way it was being done was amplifying the negative effects. They needed to facilitate transitions.

Kimberley Sevcik spoke regarding the Fairmont Outpatient Program. She worked there but also had a brother who participated in many programs that were not as effective as Fairmont. It was hard to see the precious need for these services unless you witnessed it first hand.

Jay Sheets advocated for patients and spoke against the cuts. Central Supply has had many cuts over the years. It was imperative for everyone involved in these decisions to recognize they were here for the patients.

Micheal McAdoo said the outpatient program was a unique program. He was devastated to receive a notice. His patient population was devastated as well. These cuts will worsen the symptoms and the crises of the patients.

Jamilla Walker said the specialist clerk positions at JGPH was critical because they sit at the face of the hospital. JGPH was fined because no one was up front. These jobs needed to be saved. They provided important information to the community.

Elizabeth said this was a trauma hospital. They didn't have any fancy patients and they took care of all patients. They took workers who did really good work, people who had experience in labor and delivery, in trauma, the work was important.

Mo Fennel spoke regarding the consultants AHS hired to do this work and how they didn't know anything about how the hospital worked. The OR generated revenue for the hospital. They all worked together to serve the patients.

Carl Calhoun said he was a client of the IOP services. Thanks to the program he has been out of JGPH since 2000.

Wallace Osborne said his supervisor texted him last night saying he had been laid off. His department now had no supervision. The waste of the hospital was tremendous. They spent more money trying to save money when the nurses won't use them.

Patrick said he would be devastated if they closed the IOP.

Stevon Schwartz said when he first came to the IOP he was suffering from savage depression. The therapists there were spectacular. If the program went away he would be lost.

Micheal Kay was a patient in the IOP for three years. He had no hospitalizations during that time. There was no alternative to this program, and they deserved care.

Tim Dreebe spoke regarding the struggles they've had with low staff. It was painful to see the department targeted for closure. It was hard for the patients to hear they were not important enough for this program.

Tanya said it was a shame they were doing this without consideration of the patients. Cutting staff around the holidays was very insensitive. There was no way to draw patients blood when they were cut.

Salam Muri loved her job, her coworkers, and the community they served. They were facing fear due to these layoffs. This was their lives, they weren't numbers. Every badge in the system represents a human who shows up and pours everything they have into their work.

Melissa Gong said she was hired two months ago and that made these lay offs particularly disturbing. AHS served the most vulnerable residents. Safe patient care depended on stable, experienced staff.

Christy Feast believed in the mission statement of healing, teaching, and serving all. The lack transition plans left patients without the skilled training they needed to return to work leaving them with lifelong disabilities as a result of the extended wait times.

Jordan Patterson said leadership saw them as numbers. They spoke of compassion and leadership but all he saw was greed, disappointment, exploitation of workers, deceit, and heartlessness. The workers have had to steer the ship when the moral compass shifts.

Jesse said the outpatient therapy services waitlist is 4,000 and that was going to get worse. Secondary complications, readmissions, and additional surgeries would cost the system more. These cuts were done with no clinical knowledge or care.

Molly said occupational therapists worked on all of the floors. They were the front line workers who supported the people in the community. Management tried to give layoff notices on Christmas Eve, before the union forced them to reschedule.

A speakers said she was also a patient at AHS. She had to wait six months to be a patient. Now they were cutting doctors, PSRs, Mas, and nurses. It was not fair. Wait times at adult clinics were one year and four months.

Henny Darwish said he was informed that these outside clinics now addressed the patient load he was hired to manage. He asked that they share that data. This was the public sector and there were expectations of transparency. These layoffs were handled poorly.

Diana Lawton said their program was on the chopping block. They were a service that kept people out of JGPH, and helped them get stable and stay out of homelessness. It was a beautiful and strong program.

Dan Allen said the elimination of plastic surgery services would jeopardize the level 1 trauma certification. The services were not optional and were core to trauma service. Additionally, it generated substantial revenue.

Hope Schwartz spoke on behalf of the resident union. She said they were negotiating the contract now, nothing has inflamed the membership more than these cuts. She requested they come spend an hour in the ED. The social workers were critical.

ACTION/DISCUSSION

A. ACTION: FY 25 Financial Statements Approval

Kim Miranda, Chief Financial Officer

Ann Metzger, Vice President of Finance

Trustee Fox asked if the control deficiencies were reconciled monthly or at year end. Mr. Feneis said that it needed to be monthly given the significance of accounts receivable.

Trustee Garrett asked if the new accounting standards training was ongoing to ensure the St. Rose reporting was compliant with GASB (Governmental Accounting Standards Board) rather than FASB (Financial Accounting Standards Board). Mr. Feneis said they understood what they needed to do. The proof would be in the September 2025 stand alone audit that St. Rose needed to perform.

Trustee Fox asked if they planned to eventually get St. Rose to a June 30 year end. Ms. Miranda said she thought they were going in that direction. The decision would need to be made soon as a lot of the work would have to be done in January.

Trustee Fox asked if the ACERA contributions seemed high to him. Mr. Feneis said it was pretty consistent within public hospitals that have these types of pensions. Mr. Conner said the contribution rates depended on a lot of factors and could vary significantly year to year. As they reviewed the pension plan disclosure for ACERA there was nothing that stood out as alarming to him. Ms. Miranda said the plan had a rich benefit which made it more expensive. Additionally the returns have been incredible recently, which made the deferred liabilities go down.

Trustee Fox asked what percentage of the ACERA plan was funded. Mr. Conner said that would be in the actuarial report. He would look for that. Ms. Miranda said she'd bring it back at the next meeting.

Trustee Fox asked that they distribute final audit to the Board.

Trustee Fox moved, Trustee Sayen seconded to approve the FY 25 Financial Statements.

ACTION: A motion was made and seconded to approve the consent agenda. A roll call was taken, and the motion passed.

AYES: Trustees Fox, Garrett, Indulkar, Linton, Moss, Richman, Obligacion, Sayen, Sblendorio

NAYS: None

ABSTENTION: None

B. ACTION: Staff Requests Board Authorization for the allocation of a not-to-exceed amount of \$10, 507,500 million to support an Intergovernmental Transfer for the benefit of St. Rose Hospital

Kim Miranda, Chief Financial Officer

Trustee Sayen asked to confirm that if they gather \$15.1M they will get \$30M from the State, but in reality it is only \$15M, because they put up the first \$15M. Ms. Miranda said that was correct.

Trustee Sayen asked if it was true that if they did not have St. Rose, they would be doing better financially. Ms. Miranda said they wouldn't have the donations (\$12M last year, and \$10.5M this year, if approved) impacting the AHS financial statements.

Trustee Fox asked if this was in the FY26 budget. Ms. Miranda said it was not, and that was why there were here asking for approval. They did discuss it during the budget approval process, but it was not approved because they were estimating they would maximize out the NNB during the year. The Board asked staff to come back.

Trustee Linton asked what the impact would be, to both St. Rose and AHS, if they did not approve the \$10M transfer. Ms. Miranda said St. Rose would lose \$20M. It would save AHS \$10, reducing the NNB by \$10M.

Trustee Garrett said they just heard that St. Rose has now consolidated into AHS financials, so if St. Rose loses \$20M, that would impact AHS's financials. Ms. Miranda said AHS was not responsible for St. Rose debt. They could walk away. It was the control of the Board that required them to consolidate, but it did not change the structure.

Trustee Linton clarified that if they did not approve this donation, St. Rose's budget would need to be reduced and because this was not included in AHS's budget, we would still have the same level of layoffs. Ms. Miranda said that was correct. They needed to eliminate \$100M out of our operating budget, which would just get us through until H1 picks up in 2028, 2029, and 2030.

Trustee Linton asked why other possible sources such as Stanford cannot be used as part of the local share. Ms. Miranda said it would not be allowed. Their funds help us in other ways. It was the same with the Alliance who gave us money for the geriatric psychology ward.

Trustee Linton asked if Supervisor Marquez had funds to contribute. Ms. Dong said the \$1M her officer donated last year came from a one time special distribution given to the Supervisors that year. Trustee Linton asked if she had discretionary funds this year. Ms. Dong said the Supervisor informed her that there were limited funds available.

Trustee Moss asked if there was a loan they'd authorized for St. Rose. Ms. Miranda said they had authorized a line of credit for St. Rose to borrow up to \$15M. They have to pay that back when they have funds. These IGT funds can't be used to pay AHS back. It was used for Medi-Cal losses. Mr. Azizi said this was a donation and they could not try to get it back.

Trustee Indulkar said if they didn't give this \$10M the funds would be available for AHS. Ms. Miranda said that was correct.

Trustee Garrett said that if AHS didn't give that \$10M, the full amount of the IGT would not happen, putting St. Rose in a deficit of about \$21M, which would not be consolidated in AHS's financials. He asked what would backfill that loss for St. Rose. Ms. Miranda said they would end up defaulting.

Trustee Garrett said that then \$10M would stay with AHS, but St. Rose would potentially go into bankruptcy, and all those people would be laid off. There was no good answer. Ms. Miranda said that they did talk about this when they approved the St. Rose transaction. At the time we thought we could do this for at least three years. This funding mechanism is one of the main reasons they decided they could do this affiliation. All of that was before the current Federal administration. HR1 was nonexistent. The vote to affiliate with St. Rose was not an easy one. But they recognized the importance of it. Commitments from the community were made to support funding.

Trustee Obligation asked if it was possible to wait until they reached out to their community partners who supported the affiliation initially to see if they could make a contribution to reduce the AHS contribution. Ms. Miranda said the County needed the answer so they could complete their Board letters and submit it to the State.

Trustee Sblendorio asked why they had to make the decision today. Ms. Miranda said the Board of Supervisors collected all the money and sent it to the State. They needed to vote on this and asked AHS to let them know where the local share was coming from. The funds were not due until late March but they needed to know the source of the funds in advance.

Trustee Sblendorio said they were working backwards from March 31st. He understood the City of Hayward was having financial difficulties, but they would have more financial difficulties if St.

Rose closed. He asked why more pressure was not being put on the City of Hayward. Mr. Fratzke said perhaps they could approve up to that amount and let them follow up on other donations. Trustee Sblendorio said AHS shouldn't be the cash of last resort.

Trustee Obligacion asked if the County would have to fund it if AHS did not approve the donation. Ms. Miranda said they have told her there isn't other funding.

Trustee Garrett said there isn't funding here either. They were laying people off to try to cover a \$100M budget deficit.

Trustee Indulkar said AHS was in a budget deficit. They had no update on Stanford, no update on the Alliance, no update on the City of Hayward. It was surprising that Supervisor Marquez wasn't putting money in. She wasn't seeing efforts and wasn't sure if she could support AHS efforts if no one else was putting effort in. Ms. Miranda said there was some support. Stanford put money in, but it can't be used for the donation. The Alliance put money in and raised the rates starting in July, but it can't be used for this.

Trustee Fox asked how much the County understood about what AHS was facing with HR1 over the next several years. They were talking about \$300M. AHS could not solve that themselves. If they couldn't get the State and the County to step up, AHS would be out of business. It was an unfixable problem. Now might be the time to tell the County that they had 70 speakers here whose arguments had merit.

Trustee Linton moved and Trustee Obligacion seconded to table the item and direct staff to go back and call their partners again to see if other funds could be made available and that they communicate to the Board of Supervisors that they do not have the ability to solve their own problems much less make this transfer.

Trustee Fox asked for a recap on the motion.

Trustee Linton said the motion was to table the item and direct staff to review other sources of funding to address the IGT and that they communicate to the BOS that they were struggling to resolve existing budget problems and the IGT transfer exacerbates it. She added that she would be willing to add to the motion that they need an adjustment on the line of credit if they want the hospital (St. Rose) to be able to operate while they resolve the IGT and other issues. Trustee Obligacion seconded the amendment.

Trustee Garrett suggested a stronger signal might be to vote no and revisit the issue when other funds were identified rather than table the item.

Trustee Richman said it was tempting to vote no. They had to remember they were part of the County, and they should communicate the seriousness of the problem.

Trustee Sblendorio explained that tabling means the chair or staff could bring it back at another board meeting. Or they could continue it to a board meeting next week or in February. Was there a benefit in continuing it versus tabling it.

Trustee Obligacion said the County should be able to provide support. The speakers today would escalate to the County, and it would come back to the Trustees to be accountable. If they had to have a special meeting because they found some more money, then at least they found something that could help.

Trustee Sayen said it was their call. He was inclined to support the motion that was presented.

Trustee Garrett asked for clarification between continuing and tabling. Mr. Azizi said to continue would be to a specific time and date, tabling is to bring it back when staff is ready to put it on an agenda.

Trustee Linton said leadership should come back to the Board with a more fully thought out proposal whenever they have it put together. They wanted answers about what the impacts on the rest of the system would be if they made that transfer and exactly where everyone was on this. She didn't have enough information to make a vote to make the transfer. They did not know what the conversations had been with the County. They didn't know what the strategic vision was.

Trustee Richman said it was important that they had a drop dead date. They don't want to miss the deadline to get the match.

Trustee Linton said staff could figure it out and bring it back.

03:20:28

Trustee Indulkar said she wanted to hear what the impact to the AHS and St. Rose patient community was and what the strategic vision of the collaboration was. It was difficult to make decisions on where the money should go because it may change based on where the strategic vision was.

Trustee Sayen said the Board of St. Rose was sitting in the room. When AHS took on St. Rose, they did it the way they did to insulate themselves from certain risks associated with debt. St. Rose was still a part of their program now and if it failed, they will be seen as having failed. Leadership seemed to be saying that they should make this money available to help them succeed. Either they provide the bridge to get there or walk away from something that would be hard to walk away from. Ms. Miranda said she recalled this Board having that discussion and there was a lot of hesitation.

Trustee Garrett said there was no HR1 at that time. They just spent two hours listening to the grief of the employees being laid off. The circumstances have changed and yet they were being asked to add \$10M to the budget that was unbudgeted.

Trustee Obligacion said that if staff came back after trying to get more money from their partners, then at least the Trustees would know that and could make a decision at that time.

Trustee Garrett said there was no intention for St. Rose to close. He was dedicated to ensuring they survive. They also had two hours of public comment from community members supporting the AHS collaboration with St. Rose. He was asking that staff reach out to them.

Trustee Sblendorio said if they contribute the \$10M St. Rose gets \$10 plus another \$10M. So as a whole they get to provide \$20M instead of \$10M in services. He echoed the effort to get the community partners to understand they needed their help. This was going to come up again next year. AHS might be in a worse position next year. AHS understands they need to provide the services and donating that \$10M goes further than keeping it, however this is not the end of the story.

Trustee Fox said if they make this contribution that was how much AHS would be out. The amount they loan them later this year would come back. AHS was with St. Rose, but that was going to pale against what they need with HR1. We will have to work with the County and the State with or without St. Rose. They might as well do it with St. Rose.

ACTION: A motion was made and seconded to approve the IGT A roll call was taken, and the motion passed.

AYES: Trustees Fox, Garrett, Indulkar, Linton, Moss, Richman, Obligacion, Sayen, Sblendorio

NAYS: None

ABSTENTION: None

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

2. Conference with Legal Counsel – Anticipated Litigation

(Paragraph (2) of subdivision (d) of Gov. Code § 54956.9)

1 Case

Ahmad Azizi, General Counsel

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.

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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.



BOARD OF TRUSTEES MEETING

WEDNESDAY, JANUARY 14, 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

MEMBERS

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

THE MEETING WAS CALLED TO ORDER AT 5:07 pm

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

ABSENT:

PUBLIC COMMENT

Iman Khalil spoke regarding Oliver Williams who was killed on November 20, 2019 as a result of the cuts AHS did in 2019. She saw the same tactics being used this time.

Jordon Pelot said they did a study of 111 patients in April 2020. There was a 62% reduction in PES once they started the program, 73% reduction in inpatient admissions, and 83% reduction in inpatient days.

Parisa Farrohi said her job helped the community stay healthy. These patients were vulnerable. The IOP was a lifeline for them. Patients rarely went back to the hospital after they participated in the program.

Christy Thies spoke regarding autistic patients who often did not get to advocate for themselves. She was concerned about how the last minute changes will impact these patients.

Ashley Mar said creative thinking and collaboration was needed. Departments with no equivalent in the county were being shut down. Patients would be unable to access needed services.

Dori Salmon said the cuts were devastated. These patients had no resources elsewhere. Her skill and experience were not being seen as valid. The reduction in workforce has not been handled well.

Dream Chew said rehab was important in the continuum of care. As a level one trauma center, they were supposed to provide comprehensive care. It did not make sense to cut these essential services.

Craig Metz was critical of the process. They should have been collaborating from the beginning. The clinic he worked in would be making a profit in a couple of months. This process was not aligned.

Alicia Caldwell said this wasn't just about predetermined layoffs but it was about protecting patients. The IOP was being shut down without legally required hearings. Patient safety had to be protected.

Teena Sebastiann said the pediatrics department obtained CCS approval for the California Department of Healthcare Services. The critical NICU nurse manager position has been eliminated.

Nathan Hanford said there was \$22M in a queue that has not been collected. The discovery of this has not changed the layoffs. He asked the COT members, leadership, and the Board to come work with labor.

Halley Darrigan said they have already been critically short staffed in her department. Further delays will be caused by these cuts causing increased morbidity and mortality.

Andrew Luu said closing Fairmont Outpatient Rehab will eliminate the services that are not duplicated in the community. They were the sole providers for rehab patients in Alameda County.

Sunny Lai said her team reduced barriers for people living with HIV to get linked, steady care and to thrive. Their sole medical assistant was laid off, and they had no one to perform basic clinic functions.

Carmen D. Meléndez-Lugo said the interpreter services team was being cut again. There was no more to cut. They were essential to providing care. They wondered if their department would be next.

Claire Chalmers said that cuts to services will have a death toll associated with them. Many patients in the ICU were there because of already delayed outpatient care. These cuts will mean more ER visits.

Sasha Rockwell said her students and families were patients at Highland Hospital. They already waited a long time before going to the hospital. These cuts would hurt the highest needs people in the County.

Reilly Gardine said most of the patients were on Medi-Cal. It was hard to get an appointment. Often they just let conditions go untreated then they got worse. These cuts would make this worse.

Marina Stankov said it was absurd they could not find revenue in the richest state in the richest country. On the first day of the cuts there were babies being delivered in encampments that were freezing to death.

Drew Scott said these cuts would be devastating for the Fairmont IOP clients as there was no alternative program. For many this was their chosen place, a place they called home.

Sarah Menahan said it was important to not lay off the only pelvic floor physical therapist. This was essential healthcare to AHS's most vulnerable and traumatized patients.

Kip Waldo said the communities trust was placed with the Board. The money was here. There were many billionaires in the bay. He said they needed to advocate with politicians.

Casey Kettering said these cuts have been cruel and confusing. The RNs minimums are being increased. Each day nurses were calling off because of stress.

Kyle Peerless urged them to stop the layoffs. It was a workplace safety decision. Workplace injuries and violence will increase. There were better options.

John Rockwell said he spent two days on a gurney in the hall because there was no room. Cuts would make that worse.

Dr Arun Nagdev said the ED billed \$40M in point of care ultrasound billing with zero cost. He worked with the CMO to build a plan to generate money like this in other departments.

Dr Youssef Youssef said they had a problem of hiring friends and weaker candidates instead of stronger candidates. Layers of redundant leadership wasted money and diluted accountability.

Dr Tristan Klostermann said he could not do his job without Fairmont. They had therapy that was not available in the community. They would limit access to care across the community.

Dr. Nicholas Nelson said AHS had an obligation to provide care for patients whose care was funded by HPAC. The sole case manager for HPAC was laid off effectively terminating the vital program..

Dr. Marina Trilesskaya said they delivered high quality care despite the challenging resources. She was disappointed to see this dangerous response to the budget cuts. Cardiology services brought revenue.

Dr. Dan Allan said he reconstructed defects all over the body. All plastic surgery at AHS was reconstructive and medically necessary and was core infrastructure.

Dr. Moe Ma said her ability to do standard breast care is inextricably tied to having plastic surgery done. Comprehensive breast care is a national standard. They will be unable to offer this care with the layoffs.

Shannon Hendon said that Fairmont Behavioral Health has been a constant in her life. She said they offered real support for real programs. Her life has been bettered and so have many others.

Dr. Guido DiStefano said the organization was charged with treating extremely complicated pathology in a vulnerable population with limited resources. He was concerned about having comprehensive care.

Dr. Jorge Aceves said the cuts have left the hospital in disarray. Managers were on the brink of quitting. They could not find enough gurneys. All of this and more amounted to incompetence.

Dr. Caitlin Bailey said she's worked many shifts lately with garbage cans overflowing and no one to clean the rooms. They were always at capacity, and these cuts were making the problem worse.

Dr. April Mendoza said Highland was the busiest trauma center in the Bay. They were facing two primary deficiencies. They were risking losing their trauma certification.

Dr. Benny Liu said he took the AHS mission seriously. The manner in which these cuts were being made without input from clinical leadership was a profound failure of process, judgement, and accountability.

Dr. Kristen Bascombe said any risk to the ED would be detrimental to patient care. AB40 mandated that patients were off the EMS gurney within 30 minutes, 90% of the time. They were 55.8 minutes.

Dr. Bhrett Lash said that primary care was a central part of AHS. The waits were long, the patients needed interpreters, public transportation, and other support provided by the AHS team.

Dr. Harris Goodman said cuts were made at the laboratory without regard to the lab functioning. They were told to cut the ED phlebotomist would lead to a significant cost to the organization.

Dr. Shahram Aarabi said the cath lab was already understaffed and now they won't have anesthesia coverage for complex cases and they have not been given a contingency plan.

Dr. Charlotte Wills said she campaigned for Measure A, which passed overwhelmingly to support the hospital. She asked why they were not exploring options like that again.

Jo Fox said the problem was the executive team. To find out they could give \$22M to a private, affiliate hospital was telling. They wanted them to fail. Maybe they needed a new executive team.

Chelsea Demarte said if the Outpatient Behavioral Health closed the clients have nowhere else to go. JGPH is going to be overwhelmed. More 5150s will be at Highland.

Nisha Bhatia, MD, said outpatient services cared for 2100 patients each year, stroke services cared for 770 patients across the system. They needed the therapists as part of their recovery.

Neil Liebert demanded the Board rescind the layoffs. The clinic was a proactive shield for the ER. When he started they had nine or 10 therapists, now they had one full time and two part time.

Leah Bushman was saddened by these cuts. She could not do her job without the support of a multidisciplinary team. About 30% of her clients benefited from these services.

Ingrid Pampalone was broken hearted by the way they were treating these superheroes. They needed therapists. Cutting these programs hurt patients.

Stevon Schwartz said the outpatient program saved his life.

Stephen Miller was concerned with the layoffs. He could not understand why the focus was on decreasing staff as opposed to a commitment to increasing revenue. Patient lives were at risk.

Colette Cooper was scheduled out past the layoff date in March. There were 1000 patients on the waiting list, and it grew every day. These were very real fears about the system, and they needed to change.

Bonna Nix was disheartened by the plans to close the outpatient services. This would create crowding in the ED from people not getting care in the outpatient setting.

Mark Demaria said his live was saved by services provided by AHS. Budget cuts will be disastrous. The staff will find work elsewhere and be unavailable if you try to hire them back.

Rexi Dizon said their contract with Alameda expired in December 2025. The members were deeply concerned about how the bargaining process was being handled.

Tim Dreby was alarmed by what was happening to mental health in this country. These cuts will return to individuals being criminalized. He asked what side of history they wanted to be on.

Kayla Alcollete said today has clearly indicated how devastating these cuts are for the hospital. They already worked with limited resources. Cuts overstretched the baseline.

Samana said that the people in this room provide frontline care 24-7. Impulsive decisions to lay off colleagues without collaboration would lead to damaging consequences.

Tammy Yancey said they had to come together. They were in Sacramento today fighting and AHS leadership was not there. They should have been there.

Deidre Kubak believed in the work being done at AHS by the attending physicians who trained her and the ancillary staff who were amazing. Patients leaving without discharge papers were in danger.

Hope Schwartz said the residents didn't get much sleep. They came to AHS to become excellent physicians. These layoffs show that leadership has no idea what happens in the hospital.

Gabby Weimber said it was offensive to say that them asking for a living wage conflicted with maintaining the jobs of their colleagues. These cuts were going to make it impossible to work.

Donna Mac spoke about the relationship between management and the Board as a whole. They were all doing the work. There was a ballot initiative that the Board should have supported before cutting jobs.

Veronica Perez said she helped patients reduce their costs. She was laid off. She wanted them to go back to the negotiating table and rescind the layoffs.

Jay Hughs implored the Board to undo what has been done and rescind the layoffs. The culture at AHS was adversarial at best. They've seen cuts that led to no support on the graveyard shift now.

Walz Osbourne said there was a lot of waste at the hospital that could be fixed to save jobs. He said there were supplies that people won't use because they were inferior.

Indhu Subramanian said they had to balance operations with financial constraints. Each person was essential. Wrong choices have dyer consequences with direct patient impact.

Ansel asked why there was no transparency or good faith negotiations with the unions. These cuts threatened accreditation. They were doing Trump's work for him.

A. [DISCUSSION: EXECUTIVE OFFICERS REPORT \(Estimated 20 min\)](#)

A1. ACTION/DISCUSSION: Election of 2026 Board Officers

Trustee Indulkar asked for some clarification on this process. Trustee Sayen said it was provided for in the bylaws that officers are elected at the first meeting of the year, but there isn't a lot of guidance on the process. The first step is to have nominations.

Trustee Fox nominated Trustee Sayen as the 2026 Board President.

Trustee Indulkar asked if there were terms associated with the officers, she did not see it in the bylaws. Mr. Azizi said they were one year terms, with no limit on how many one year terms an officer could serve, subject to being reappointed as a Trustee at the end of their three year term by the Board of Supervisors. There was no cap on how many terms an officer can serve, but the Board had to vote on who the officers are at the annual meeting.

Trustee Indulkar asked if there needed to be a statement of interest by potential candidates. Mr. Azizi said the process of how they wanted to conduct this was up to the Board.

Trustee Obligation asked if it was required to have this vote today. She was concerned that they were focusing on this when there were so many issues brought up during public comment. She wanted to hear about where patients were going to go when services were cut. She said that there were questions about process and then nominations, and she thought they needed to focus on the services.

Trustee Sayen said he had the same concerns. They were subject to their Bylaws and to the Brown Act. The Brown Act required them to carry out the published agenda. And the Bylaws require this process to take place at this meeting. If we do not do this, we do not have any officers and we do not have a Board.

Mr. Jackson said the conversations Trustee Obligation was asking for critical. They were doing the work every day. They were working mitigating the impact. The speakers spoke their truth, but leadership was doing the work every day to minimize the impact. This is what the Beilenson Hearings were for. They had an agenda that they needed to follow, and if they could so without appearing to minimize these concerns it would be ideal.

Trustee Obligation asked why when they closed the Alameda Hospital OR last year, they did not have Beilenson Hearings. And now they were saying they were going to have them. She was confused about the process. She wanted to hear from management that they had it covered. She requested a presentation that detailed who was involved in the decisions and what the plan was for transition. Mr. Azizi said Alameda Hospital, along with San Leandro Hospital and the SNF's, were not County facilities and not subject to Beilenson. Trustee Obligation said that is the type of education the Trustees need. Mr. Jackson agreed with Trustee Obligation and clarified that they did not close ED services at Alameda Hospital. They reduced the OR services and went to an on-call model.

Trustee Linton said it would be useful prior to the next BOT meeting, if the Trustees knew when the Beilenson hearings would be heard, how they would be conducted, and what role the Trustees would have in that process. They also needed well as follow up on the larger concerns brought up in public comment. It would be helpful for Trustees to have that information in writing prior to the next meeting. Additionally, the Trustees should have an updated report so the Trustees and the public know the status and whether or not the Medical Staff has been included in a meaningful way in terms of the impact of the cuts.

Trustee Moss suggested a standing agenda item for updates on RIFs. Mr. Jackson said a standing agenda item might be best process.

Trustee Garrett said the CEO report was too limited. This topic would be enriched by having the executive team communicate regarding this.

Trustee Sayen said this was very important and of course it needed to be discussed. Some of the Trustees felt that leadership communicated a number of positions that would be impacted a few months ago but then didn't share more about how the RIFs were being deployed. He agreed that they needed that information, and it could be added to the future agendas.

Trustee Linton said she had asked last week about the process of electing new officers, and it was not clear. She said that for the Supervisors, the president serves for two years then the vice president ascends to president. Any discussion was about who would serve as the new vice president. When she served on the Foundation their bylaws called for a nominating committee who met to determine who was willing to do what and that was presented to the Board for action. But this body didn't seem to have a formal process which left Trustees wondering how to put forth the best structure and individuals for the business at hand. She suggested the formation of an ad hoc committee that could meet and come forth with a slate of officers.

Trustee Indulkar said it was awkward for her to say who she chose. She didn't know if Trustee Sayen even wanted to serve as president or what his plan or strategy as president would be.

Trustee Sayen said this is what the practice had been here. They couldn't have a lot of conversations about who could do what because of the Brown Act. So, people either nominate themselves or someone else. The person nominated could say no, but if they agree, the Trustees have a vote by a show of hands or a formal motion. They could amend the bylaws down the road for a better procedure.

Trustee Linton said she knew they operated under the Brown Act, but there could be an ad hoc committee. Mr. Azizi said they could have an ad hoc committee made up of less than a quorum to report back to the Board.

Trustee Indulkar asked if Trustee Sayen wanted to be President. Trustee Sayen said he would have to agree before they voted.

Trustee Sayen said the president doesn't have any authority really other than working leadership to set the agenda. He would like to open that process up to the Trustees to be more involved in agenda planning. Every agenda included a space for Trustees to weigh in on future topics. He opened the floor for nominations. He was willing to serve as president in 2026.

Trustee Fox said they were talking about a process, if they did not do the process tonight, could they do it for next year. Mr. Azizi said an ad hoc committee could look at it for next year.

Trustee Indulkar said they needed to consider how the election process set them up for succession planning.

Trustee Moss said a nominating committee and looking at the bylaws in terms of the roles of the officers and succession planning. Mr. Azizi said it could be in the Policies and Procedures.

Trustee Sblendorio said it wouldn't take a bylaws change to figure out a structure for how to transition officers. Mr. Azizi said the chair can put together an ad hoc committee that can bring their report back to the Board with no need to change the bylaws or Policies and Procedures.

Moved by Trustee Garrett and seconded by Trustee Moss to vote for David Sayen to be president in 2026.

Trustee Garrett said that in his experience stability was important in times of trouble. Trustee Sayen is a stable force and he appreciated that. He appreciated the conversations recently

about improving the agenda planning process to be more inclusive. Trustee Sayen was an active listener who took input and advice well. His stable influence was important.

Trustee Indulkar appreciated that Trustee Sayen was willing to serve. She agreed that it was important for the Board to have a sense of purpose. Her focus was patient safety and quality which had to be balanced with fiscal responsibility. The CMS Star journey was grounding and improved the bottom line. There was value attached to that. She wanted to see more central items of discussion around patient safety and quality, and she believed under Trustee Sayen's leadership they could get there.

Trustee Obligation appreciated that he wanted to continue as President and that they would focus on having a process that was clearer in the future. Additionally, she wanted to feel more like Trustees were being heard and she wanted to know what the process was so that it was more inclusive for all the Trustees. There needed to be some education around the Brown Act.

Trustee Fox said the responsibility for the agenda belongs to all of them. If one of them wanted to see something on the agenda they needed to make sure it got on. Mr. Azizi said they put an agenda item at the end of every agenda to discuss future agenda items.

Trustee Garrett said they have an executive committee that didn't meet that often. They should be quarterly or some such. Agenda item G is Board calendar and tracking. The Trustees have a responsibility to discuss the future agendas. He suggested they put that item earlier on the agenda.

Trustee Sayen said he met with staff in an agenda planning meeting several weeks prior to each meeting. He took responsibility for not exploring agenda item G on the agenda more often. He recognized that Trustee Obligation has brought up items in the past and they've never really come to light.

Trustee Obligation said moving forward lets make it better and do more coordination and have more conversations about what went on the agenda.

ACTION: A motion was made and seconded to approve Trustee Sayen as the Board of Trustees President for 2026. A roll call was taken, and the motion passed.

AYES: Trustees Fox, Garrett, Indulkar, Linton, Moss, Obligation, Richman, Sayen, Sblendorio

NAYS: None

ABSTENTION: None

Trustee Sayen asked for nominations for Vice Chair and Secretary. He said that the work of the Executive Committee was to be convened if management needed approval from the Board for something and couldn't achieve a quorum.

Trustee Indulkar nominated Trustee Garrett, Trustee Linton seconded the nomination.

Trustee Moss said they had not created a process for succession.

Trustee Obligation asked if Trustee Garrett wanted to continue. Trustee Garrett said yes.

Trustee Sayen nominated Trustee Richman for Secretary.

Trustee Obligation asked if there was an agreement from all of them to vote on a slate. She said there was no agreement to vote as a slate. It was concerning that they were voting on two positions when someone may have a different opinion on another.

The trustees voted unanimously with ayes for Trustee Garrett to serve as Vice President in 2026.

Trustee Sayen asked if there were other nominations other than Trustee Richman for Secretary. Trustee Linton seconded Trustee Richman's nomination.

Trustee Richman said she would be happy to serve, but said if anyone else wants to, they certainly could.

The trustees voted unanimously with ayes for Trustee Richman to serve as Secretary/Treasurer in 2026.

Ms. Jojola Gonsalves said that in years past they had a fourth officer to help achieve quorum.

Trustee Sblendorio nominated Trustee Obligation. Trustee Obligation declined.

Trustee Linton nominated Trustee Moss, Trustee Garrett seconded. Trustee Moss agreed to serve. The trustees voted unanimously with a show of hands.

A2. DISCUSSION: 2026 Committee Membership and Chairs

Trustee Sayen asked Trustee Indulkar to continue to serve as Chair of the QPSC. Trustee Indulkar agreed.

Trustee Sayen asked Trustee Fox to continue to serve as Chair of the Finance Committee. Trustee Fox said he was happy to but also as he has been chair for four years, if someone else was interested he would be happy to step aside.

Trustee Sayen asked Trustee Sblendorio to continue to chair the Audit and Compliance Committee. Trustee Sblendorio agreed.

Trustee Sayen asked Trustee Linton to serve as the chair of the Human Resources Committee. Trustee Linton agreed.

Trustee Sayen said that Trustee Garrett, Indulkar, Linton, and Moss served on the QPSC last year and asked if they wanted to continue or if anyone else wanted to serve. Trustee Indulkar said that patient safety and quality was going to be the central theme and everyone should be on this committee. Trustee Sayen said they had to consider the Brown Act. The President could sit in on any Committee.

Trustee Indulkar said they didn't vote a lot on QPSC, other than credentials. Mr. Azizi said they voted on the TNMs each year.

Trustee Garrett, Indulkar, Linton, and Moss agreed to serve on QPSC in 2026.

Trustee Sblendorio said he'd be happy to serve on QPSC, but his schedule does not allow him to meet on that Wednesday.

Trustee Linton said Human Resources Committee met the following week and would like to work with the CHRO on the agenda. Ms. Jojola Gonsalves said the agenda had to go out on Friday and she would schedule a planning session for the next day.

Trustee Sayen confirmed that he was stepping down from the HR Committee.

Trustee Sayen said the Finance Committee was Trustees Fox, Garret, Sayen, and Sblendorio. He asked if anyone else wanted to serve.

Trustees Fox, Garret, Sayen, and Sblendorio agreed to continue their service on the Human Resources Committee.

Trustee Fox said he was not on that CEO Board Eval ad hoc. Ms. Jojola Gonsalves said she'd remove it from the roster.

Trustee Sayen said the Homeless Health Center Trustee was Trustee Garrett, who agreed to continue.

Trustee Sayen said the Alameda Hospital Committee did not exist. Ms. Jojola Gonsalves said she'd remove it from the roster.

Trustee Sayen said the HEDI Committee also did not exist. Ms. Jojola Gonsalves said she'd remove it from the roster.

Trustee Obligation asked if the HR Committee people wanted to stay on or if anyone else wanted to join.

Trustee Sayen said the Human Resources Committee was currently Trustees Obligation, Richman, Indulkar, and Chair Linton.

Trustees Richman Obligation and Indulkar said they will serve on the Human Resources Committee in 2026.

A3. ACTION/DISCUSSION: 2026 Board Meeting Calendar

Trustee Linton asked if the Human Resources Committee could meet more often given everything happening right now. She proposed that they meet monthly until they got a better handle on what was going on with HR and the RIFs and various things. They could then scale back if necessary. Mr. Azizi said she could put a regular meeting of the Committee on the calendar when needed. Ms. Jojola Gonsalves said they could not meet on the regular

Wednesday in March, June, September, or November. It would have to be on an alternate day in June as all the Wednesdays were taken.

Trustee Linton requested the clerk poll the committee members to see if they could meet prior to 5pm so they could hold a regular meeting if needed. Ms. Jojola Gonsalves confirmed if the poll should be for 4pm when necessary. Trustee Linton suggested they just do 4.

Trustee Obligation said that was her working hours and could occasionally be difficult.

Mr. Azizi said that Trustees Obligation and Indulkar may have conflicts of interest for some of the discussions that they may want to have in closed session. There were a lot of other topics than the RIFs. Trustee Linton said she would appreciate advice as they develop the agendas.

Moved by Trustee Linton and seconded by Trustee Indulkar to approve the 2026 calendar as written including the HR meetings.

ACTION: A motion was made and seconded to approve . A roll call was taken, and the motion passed.

AYES: Trustees Fox, Garrett, Indulkar, Linton, Moss, Obligation, Richman, Sayen, Sblendorio

NAYS: None

ABSTENTION: None

B. CEO REPORT

James E.T. Jackson, Chief Executive Officer

Trustee Linton asked what the anticipated impact on the quality of services that were provided in Post Acute due to COVID. Mr. Jackson said they fully expected they will maintain the same level of excellence they've provided previously.

C. MEDICAL STAFF REPORTS

AHS Medical:

Berenice Perez, MD, Chief of Medical Staff

AH Medical:

Catherine Pyun, DO, Chief of Medical Staff

Trustee Garrett asked for clarification on the joint committee. Dr. Perez said they were proposing to have a joint committee that would work on anything that impacted patient care. The CMO and physicians selected by the CMO would be on the committee. They would find mitigation strategies to ensure patient care would not be impacted.

Trustee Garrett said the perception was that staff was not involved. Was this a remedy to that. Dr. Perez said that was correct. Trustee Garrett asked if Mr. Jackson had a response to that. Mr. Jackson said he did not have a response at this time.

Trustee Garrett said they were drafting a response to the letter that requests this committee.

D. COMMITTEE AND TRUSTEE REPORTS

D1. Audit and Compliance Committee: September 17, 2025

Sblend Sblendorio, Chair

Trustee Obligacion left at 8:37pm

D2. Quality Professional Services Committee: November 19, 2025

Greg Garrett, Trustee

D3. Finance Committee: January 7, 2026

Alan Fox, Committee Chair

E. CONSENT AGENDA: ACTION

E1. Approval of the Minutes of the November 12, 2025 Board of Trustees meeting.

E3. AHS and AH Medical Staff:

New Policy for AHS & AH Medical Staff:

- Medical Staff Credentialing Information Integrity and Data Security

Revised Policies for AHS & AH Medical Staff:

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

Retired Policy for AHS & AH Medical Staff:

- Medical Staff Credentialing Systems Control

Moved by Trustee Linton and seconded by Trustee Indulkar to approve the consent agenda.

ACTION: A motion was made and seconded to approve . A roll call was taken, and the motion passed.

AYES: Trustees Fox, Garrett, Indulkar, Linton, Moss, Richman, Sayen, Sblendorio

NAYS: None

ABSTENTION: None

F. ACTION/DISCUSSION

F1. ACTION Contracts

F1a. Renewal agreement with Agiliti Health, Inc. for provision of equipment management and rental services. The term of this agreement is effective February 1, 2026 through January 31, 2029. The estimated impact of this agreement is \$9,138,690.

Mark Fratzke, Chief Operating Officer

Trustee Fox said the write up said there would be a savings of \$1.2M. But it wasn't clear if that meant the cost would go down by \$1.2M from the last contract. Mr. Johnson said the

savings would result in a significant reduction in the rental of devices. They spend millions of dollars each year on rental devices that stay in the system after the patient is discharged. This contract allows a team from Agility to round frequently to correct the situation. Additionally, they will manage our owned products so we do not end up renting a device that we have in stock.

Trustee Indulkar said she had quality concerns regarding both F1a and F1b. Agility could not fix the CT scanner at Alameda Hospital for nine days. They had broken scopes and broken gurneys that they could not fix. She wanted to know if there were measures in place to correct that and what the penalty or repercussions were for those issues. Mr. Fratzke clarified that they had two separate contracts. They were aware of the issues Trustee Indulkar spoke of and intended to address those when the maintenance contract comes up. Mr. Johnson said it was a separate division of Agility that handled the maintenance.

Trustee Obligation returned at 8:41pm.

Trustee Obligation asked if they could enter into a one year contract instead of a three year contract. Mr. Johnson said they would have to renegotiate the contract and the terms would change. Mr. Holley said after the first 18 months, they were able to terminate with notice.

Trustee Indulkar said these contracts needed to go to the MEC before going to the Board and she did not see these contracts at the MEC. Mr. Holley said the Medical Staff review has traditionally been with the business owner. There was a physician dyad review when it was a clinically impactful contract.

F1b. Renewal agreement with VTP Holdings, LLC for provision of PICC line services. The terms of this agreement is February 1, 2026 through January 31, 2029. The estimated impact of this agreement is \$1,620,000.
Romoanetia Lofton, Chief Clinical Officer

Trustee Indulkar asked why they were not internalizing this service. She had quality concerns around this agency providing these services. Ms. Littlepage said that she had similar concerns. They recently finished bargaining so they would push their own PICC positions forward in an effort to limit the utilization of VTP. There were not any other PICC providers at this time and their services were critical while AHS set up the internal structure.

F1c. New agreement with SMITH-KARNG ARCHITECTURE for provision of architectural and engineering services for the inpatient medical detox unit remodel at San Leandro Hospital. The term of this agreement is January 15, 2026 through January 15, 2029. The estimated impact of this agreement is \$1,492,525.
Mark Fratzke, Chief Operating Officer

Moved by Trustee Linton and seconded by Trustee Garrett to approve the contracts with the proviso that they follow existing policies.

ACTION: A motion was made and seconded to approve . A roll call was taken, and the motion passed.

AYES: Trustees Fox, Garrett, Indulkar, Linton, Moss, Obligacion, Richman, Sayen, Sblendorio

NAYS: None

ABSTENTION: None

F2.DISCUSSION: The Joint Commission Update

Ana Torres, Vice President, Quality

Nilda Perez, System Director of Regulatory Affairs

Trustee Sayen said some education on what the Trustees can expect so they are not caught short would be appreciated. Ms. Perez said she could provide a one page document talking them through what to expect.

Trustee Linton if there were any weaknesses or major concerns that she had as the Commission prepares. Ms. Perez said whenever there was a large change to the organization they were required to notify the account executive within 30 days. She would contact them soon. In terms of weaknesses she said they were still challenged in management. They needed to bring that back to the forefront and simplify the process. Their biggest vulnerability was the low hanging fruit items.

Trustee Indulkar said Joint Commission accreditation was extremely important to our trauma certification.

F3.ACTION: Staff Requests Board Authorization for the allocation of a not-to-exceed amount of \$10, 507,500 million to support an Intergovernmental Transfer for the benefit of St. Rose Hospital

Kim Miranda, Chief Financial Officer

Mr. Azizi said they were deferring this item to a date uncertain.

F3.DISCUSSION: Alameda Health System Governance Structure Update

James E.T. Jackson, Chief Executive Officer

Jeanette Dong, Chief Public Affairs and Community Engagement

Trustee Moss asked if there were legal issues with Supervisors serving on the Board of Trustees. Mr. Aziz said the County Council was reviewing that.

Trustee Obligacion asked if either option would have to pass through legislation. Mr. Azizi said it did. AHS's enabling statute was State legislation that provided us the authority to run as a hospital authority. The legislation would have to be amended.

Trustee Obligacion asked if option B would have the same number of Trustees, or would the Supervisors be in addition to the current Board. Mr. Azizi read the proposed legislation which stated that the governing board may be made up entirely of the Board of Supervisors, or it may include any number of the members of the Board of Supervisors, County officers, or employees appointed to represent the interests of the County.

Trustee Linton asked if they would have to appoint Supervisors to the Board or if it was optional. Mr. Azizi said he believed the intent to be that they have discretion.

Trustee Obligacion asked if option A would place the Board of Trustees in a position of being an advisor to the Supervisors. Mr. Aziz said that was correct. AHS could still have QPSC and Finance Committee for example, but the Supervisors would be the governing body.

Trustee Linton asked if it specified the functions the AHS Board would have. Mr. Azizi said he believed they would be able to make that decision. They would be able to create an advisory board and determine what that would look like.

Trustee Linton asked about decisions like HR, employee negotiations, salary setting, etc. Mr. Azizi said they would likely be an advisory board. So there would be an HR committee possibly reporting to the full board or the County board. Supervisors would make the ultimate decisions.

Trustee Obligacion said the Board of Supervisors did not have the capacity to do the groundwork, though they would make the ultimate decisions. The committees would be in place to do that groundwork.

Trustee Richman asked if it would mean AHS committees would recommend approval of contracts to the Supervisors. Mr. Azizi said that could be the process.

Trustee Moss asked if they would be voting as the Board of Supervisors or the governing body of AHS, as a separate body. Mr. Azizi said they didn't have answers to all of these things yet.

Trustee Garrett said this gave them great discretion to create any structure they wanted. The bottom line was that they would select the CEO, the budget, and the union negotiations. Mr. Azizi said option B would give them the authority to appoint the CEO and approve the budget. It did not go into approving contracts or union negotiations.

Trustee Linton said it made sense from an accountability perspective. It would be a direct line between them and operations. The question would be would the AHS Trustees be involved at all in better identifying the role of the Trustees.

Trustee Linton asked who was pushing the legislation. Ms. Dong said the Personnel and Legislative Committee of the Supervisors. Supervisors Miley and Tam brought the potential legislation forward and it was approved. It was both options A and B to keep it broad and provide a vehicle for it to be introduced in time for the January legislative deadline. Potential supporters were SEIU. AHS offered to be a co-sponsor so they could partner with them on developing the language.

Trustee Linton asked how the co-sponsorship would work. Ms. Dong said they would work together to create agreement. Trustee Linton asked if the Supervisors would act in good faith. Mr. Jackson said he believed they would. They would not have allowed AHS to be co-sponsors otherwise.

Trustee Linton asked how AHS would set policy regarding governance. Mr. Jackson said that was still to be determined.

Trustee Linton asked if the Trustees would be involved in the governance determination of the position that AHS has. Mr. Jackson said he hoped so. The process was not yet determined.

Trustee Linton asked if there would be a monthly report or what the process would be. Mr. Jackson said the process was not yet determined.

Trustee Garrett said there was no cost issue or funding issue, this would sail through.

Trustee Richman said they needed to think about how some of these things would be implemented.

Trustee Moss asked for clarification on what the Supervisors passed Mr. Azizi said it was this legislation.

Trustee Garrett said this needed to get through the process. They wouldn't know what they intended until the legislation passed and then it came back to the County and they determined what to do.

G. DISCUSSION: Board Calendar and Tracking

H. STAFF REPORTS (Written)

H1. Chief Financial Officer Report, September Financial Report
Kimberly Miranda, Chief Financial Officer

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
- 2. Conference with Legal Counsel – Anticipated Litigation**
(Paragraph (2) of subdivision (d) of Gov. Code § 54956.9)
1 Case
Ahmad Azizi, General Counsel
- 3. 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: 10:50pm



BOARD OF TRUSTEES SPECIAL MEETING

WEDNESDAY, FEBRUARY 4, 2026

5:00 pm to 8:00pm

Conference Center at Highland Care Pavilion

1411 East 31st Street Oakland, CA 94602

Ronna Jojola Gonsalves, Clerk of the Board

(510) 535-7515

LOCATION:

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

Teleconference Location: 4501 Pleasanton Avenue, Pleasanton, CA 94566

MEMBERS

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

BOARD OF TRUSTEES SPECIAL MEETING MINUTES

THE MEETING WAS CALLED TO ORDER AT 5:14 pm

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

ABSENT: None

Addressing Budget Shortfalls : Program Closures, Service Reductions, and Reductions in Force – Final Approval on Closures and Service Reductions

Closed Session:

Regulatory Affairs, Risk Management, Patient Safety; Hearing to Consider Testimony/Deliberations Concerning Report of Medical Staff

[Health and Safety Code 1461 and 101850(ai)(1) & (2)]

Conference with Labor Negotiators

[Government Code Section 54957.6]

AHS Designated Representatives: Jet Chapman, Chief Human Resources Officer

Employee Organization: BTC, ACMEA, SEIU 1021, SEIU-UHW

(Reconvene to Open Session)

PUBLIC COMMENT

Stephanie Ung believed there were opportunities for stronger oversight. The focus needed to be on revenue integrity and mitigating risks with low productivity staff.

Kip Waldo said they were acting as if there was no alternative. There had to be an alternative. There was a lot of money in the Bay Area they needed to go after.

Craig Metz said the passage of the 2026 Federal appropriations law provided relief from the projected healthcare cuts. He requested AHS pause the layoffs.

Drew Scott said closing the Fairmont IOP would be devastating to the clients and community. There was no comparable program in Alameda County.

Parisa Farrohi said the Fairmont IOP worked. She loved the patients. She didn't care about the awards; she needed the Board to advocate for the programs and staff.

Nathan Hansford spoke of his son's passing. He wondered how many people in the next year would be mourning the loss of someone if they close the IOP.

Alicia Caldwell said outpatient behavioral health was not a nice-to-have it kept people out of the ED, out of JGPH, off the streets, it kept people alive.

Peter Masiak said some of the RIFs were rescinded, which was great. But it gave more weight to the union's request to postpone the layoffs

Dori Salmon said she just found out her job had been saved, but there were lots of others who still needed solutions. They needed to keep these services in place.

Reilly Gardine asked if they finally realized how important these positions were. Patients needed to be fed. They were not going to stop showing up.

Navjot Tatlal said this entire process has been a roller coaster. Fairmont was the only AHS location with pelvic floor therapy, vestibular therapy, and many others.

Marie Hopper was hoping her job would be saved, but at this point it the clinicians were still being laid off. They've been successfully treating patients for decades.

Claire Chalmers asked that they tirelessly exhaust all other possibilities before considering cuts.

Iman Khalil did not understand why they were going along with these Federal cuts. Horrible things happened last time there were layoffs and it would happen again.

Tanya Yancey said they needed to stop the layoffs. Everyone was suffering. As a lab assistant she was shocked they were laying anyone off from the lab.

Iris Mendoza said because of their laziness the call center for cardiology was closed and transferred. There were 200 patients waiting to be called.

Neil Liebert said the deliberate shrinking and closure of the psychiatric day treatment program was an act of cruelty against an already discriminated against minority.

Stevon Schwartz was told AHS was going to give out \$7M in bonuses to specific leaders while laying off 200 people.

Ansel Schmidt spoke to the high salaries and bonuses given to the leadership team. Meanwhile garbage cans were overflowing and patients had long wait times.

Andrew Luu spoke to the cuts in the therapy departments and the health advocates and complex care management. They could not bow to the administration.

Micheal Martinez said that prevention was worth a pound of care. The Health Advocates Program was the very last net these people had.

Veronica Perez said English was her second language. She connected patients to resources. She requested they stop the layoffs.

Marta Insogurt said she was the only orthopedic provider for AHS. She was told she was getting laid off but has not received a notice. Her patients have been canceled.

- **Budget Presentation**

Trustee Fox asked if the delay in hiring providers was because it was determined that they were not needed because of volume or because of the financial condition. Ms. Miranda said they had a tighter process on hiring physicians and staff. The physician requisitions were being reviewed by the WORC committee to determine which requisitions needed to move forward.

Trustee Sblendorio left at 6:00pm

Trustee Indulkar said there was a specific time frame when a physician can be hired based on how they graduate. They were in this critical time frame now. If they did not hire during this time frame they would have to wait another year.

Trustee Linton asked why the process was slowing down for physician positions that were in the budget and that position remained in place, she wanted to know why it was slowing down. Ms. Miranda said they were going to be \$100M in debt. Additionally, they had done a lot of recruitment that was not in the budget in previous years. Now they had a process where they actually look at the volumes.

Trustee Fox said for several years the hiring process for physicians was out of control. Every year physician compensation expenses were millions of dollars above budget. Finally, in part due to AHMG coming into AHS, a more thoughtful process has been developed.

Trustee Richman said they have heard about some ambitious hiring and even overstaffing. She asked if that was true and if so, where it was. Ms. Miranda said they were looking at productivity, community needs, and that was all that was part of the process.

Trustee Garrett said the next step would be to work with physician leadership who knew their departments to refine the cuts and refinements to their departments. That's what medical leadership has been saying. They were told many times that 75% of their costs were labor. The physician leadership should already have been involved. Ms. Miranda said they had none of this information when they went live with EPIC. They also had a separate company where all the salaries sat and AHS had no data about them. Trustee Garrett hoped that through this crisis they came out stronger through finding ways to collaborate.

Trustee Linton asked if dental services have been eliminated from Medi-Cal reimbursement. Mr. Minot Swartz said he believed it was only for people with unsatisfactory immigration status.

Trustee Sayen asked if a state provided Medicaid services with its own dollars to people who have unsatisfactory immigration status the Medicaid across the board was cut. Mr. Minot Schwartz said that was correct.

Trustee Linton noted that the revenue impacts were listed by calendar year. She asked if they had determined the impact for the fiscal year. Ms. Miranda said they didn't try to figure out the timing. They knew it started in January. Some of the Alliance members had come down. Mr. Jackson confirmed that the Alliance anticipated decreases were coming to fruition.

Trustee Linton asked if they would be tracking that number as they finish the fiscal year. Ms. Miranda confirmed they would.

Trustee Sayen said he understood the appropriations bill that just passed ensured the Federal matching funds would continue flowing to states for Medicaid coverage. Additionally, it delayed cuts to disproportionate hospitals. Mr. Minot Schwartz said that it only affected the DSH cuts. It did not repeal or mitigate any portion of HR1.

Trustee Moss asked what the timeframe the Federal appropriation bill applied to. Mr. Minot Schwartz said most of it was the federal fiscal year. Most of the bills passed ran through September. The DSH was an exception.

Trustee Linton asked how much the projected piercing of the NNB was related to the current year's budget in terms of expenses being higher than expected versus how much of it was related to cash flow. Ms. Miranda said the NNB was cash flow. They had to pay \$42M of the realignment money back from two years ago. That drove the NNB up \$42M. It did not impact the revenue or income statements.

Trustee Linton asked if the over expenditures in the current fiscal year did not show up in the use of the line of credit. Ms. Miranda said they were currently at a deficit. They looked at the payroll, the AP, and the actual revenue that came in. This was her looking at the current draws and what they thought would happen based on what was happening now.

Trustee Fox asked if the fact that they were behind budget was in the NNB graph. Ms. Miranda said it was.

Trustee Moss asked if nothing else changed, what would this mean to the day to day operations. Ms. Miranda said this has only happened one other time, to her knowledge. They couldn't pay their vendors, so they couldn't get supplies. The Board of Supervisors did provide money to pay employee salaries. Trustee Moss asked if that was an extension of the line of credit. Ms. Miranda said it was. They had to create a new permanent agreement where they had to pay it off a little more each year.

Trustee Linton said it really was true they needed to control their budget based on the number of physicians they had on board, the salaries, benefits, and all that stuff. We were not just managing to the NNB. Ms. Miranda said they would love to be in a position where they had reserves. AHS has always been in a negative position since the beginning of the organization. They had to estimate what their revenue would be given the significant fluctuations.

Trustee Linton said the projection was that they could exceed the number of employees on payroll and make it up with fluctuating source of revenue. She asked what the assumption was.

Trustee Sayen said the government can claw back money from previous years because we provided the services, they paid the claims, and we have the money. Ms. Miranda agreed that was a big piece of this.

Trustee Obligation would like to hear more about the process. They should have conversations with the departments about how many employees were needed to run the department. They could then work with HR to have some tracking to make sure they don't exceed what was needed. They never engaged in these conversations with the physicians. She hoped the process would happen going forward. Ms. Miranda said they may change the process this year, but they had a Budget Oversight Committee made up of the senior team, including the CMO. Every single department in the organization has benchmarks and tracked volumes.

Trustee Obligation asked if they communicated with the physicians in that process. Ms. Miranda said they report up to the CMO. The physicians did come to the Committee. They were involved in the conversations. Mr. Jackson said they were not as involved as he would have hoped. The budget process was one thing. The physicians helped them build the budget and they've made progress. He did not think they did a good job involving them in the reduction process. They had the clinical impact task force that Dr. Perez initiated. They have already made changes to the RIF as a result, and they would continue to do so.

Trustee Fox asked if the Supervisors understood the magnitude of the numbers when they were looking at over \$100M a year out to 2029 and 2030. If they were not set up as a separate Hospital Authority with separate books, this would be coming directly to the County. Even if they increased the NNB to \$250M it wouldn't be half of what they were going to need if the projections came to pass. Mr. Jackson said they were actively having those conversations with the Supervisors. They continued to provide updates. The increase to the NNB was on the table. The reality was that they would need more than just the NNB and those would be ongoing conversations.

Trustee Indulkar said they've done amazing work with the FTEs. There was still close to 4600 FTEs outside of physicians that also needed to be looked at. They needed to consider how to structure themselves around clinical institutes, so everyone had a role and everyone was held accountable.

Trustee Obligacion said they needed to look at the projected cost savings from when people retired, for example. This was just the beginning. The physicians would be involved in the decisions, but maybe they should be involved now.

Trustee Garrett said it was sad that they were there, but he saw some positive movement toward the communications that needed to happen. He said when he looked at total operating revenue year to date was budgeted at \$811M, operating expenses year to date were \$799M. That told him that they were budgeting year to date for a \$12M profit. However, there were factors that led into this deficit. Ms. Miranda agreed that they budgeted to cover capital. Trustee Garrett said that in an ideal world, if they met budget, they would have to go to the NNB for standard operations. They budgeted for a neutral budget. Cashflow, the timing of supplementals required them to drop down, but from an operating standpoint, had they met budget on revenues and expenses they would not be reliant for that purpose on the NNB.

Trustee Linton said they did not fully fund the labor cost in the budget. Ms. Miranda said they instructed them to come back.

Trustee Sayen said these projections could be conservative given that people won't have ACA, won't go to Kaiser and will come to AHS. Mr. Jackson agreed. There were folks falling off insurance. When they did come to AHS they would be in worse shape, without preventative care.

Trustee Obligacion said some education about where they could lobby. She asked if they ask the County to forgive maybe 50%.

- **The \$100M Expense Reduction Update**

Trustee Richman asked what optimizing supply chain to drive cost reductions meant. Mr. Gallo said they did not have all the details. This was a roll up of Doug Johnsons initiative around driving down supply chain costs in general.

Trustee Richman asked if the OR efficiency program meant they were reducing OR hours. Mr. Fratzke said that was an initiative to improve the schedule blocks.

Trustee Fox asked if they had surgeons waiting for OR time that could fill an underutilized block time. Mr. Fratzke said it has become more efficient.

Trustee Obligacion they were areas they could use as examples to help them understand things like bargaining issues.

Trustee Indulkar said they had to consider the quality and equity lens when making these decisions. Maybe there were more revenue generating projects. They needed to consider how to prioritize those projects and determine what needs to rise up to the Board. She wanted to

understand the process that guided these decisions. Mr. Fratzke said all those different realms were part of the intake process. When a person submitted a project it was evaluated through those elements to determine if it would go forward and what the timing would be.

Trustee Linton asked how the forecasted savings were determined. Mr. Gallo said that they made preliminary targets by C-Suite leadership. But then to get to the targets these were bottom up. An operations manager would provide input on what they thought could happen.

Trustee Sayen said it was February and they were projecting a pretty sure \$37M in expected savings for the year. He asked how much of that they had already realized. Mr. Gallo said when they asked for operational reports, they asked them to include within the financials the actual to date numbers. It was still early in the process.

Trustee Moss asked if the Stanford collaboration went into FY27. Mr. Fratzke said what they knew was this year. They had six workstreams that they were working on, but they didn't have the financial details on those yet.

Trustee Fox said that the Board was supposed to concentrate on strategic issues. These plans were operational but were good. It seemed to be the time when the Board should discuss the strategic direction and get a little more out front of management rather than just reacting to plans. HR1 was going to unfold over many years and required strategic planning. Stanford was a great example of a strategic project. They should review what services AHS provided that were really good and how they could make those services available to strategic partners where they could get paid for them and get some commercial volume. Mr. Aminy said that these were just our efficiency initiatives. They had a different set of growth initiatives that were not presented here.

Trustee Linton said they were considering an agenda for the retreat where the Board would discuss these savings, a strategic vision, how all of this rolled out, and what kind of things needed to be prepared for the upcoming year. She suggested they advance the retreat. They also needed a budget planning session.

Trustee Garrett said that last year the administration had committed to bringing forward 2026 capital projects. There were 40 or so operational projects. The Board wanted to have input in those projects. He hoped that at some point those would come up to the Board.

Trustee Obligacion said the retreat needed to be longer so they could have in depth discussions.

Trustee Obligacion recused herself from the Conference with Labor Negotiators.

Trustee Indulkar recused herself from the Conference with Labor Negotiators.

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

Mr. Azizi said the Board met in Closed Session and took no reportable action.

- **Program Closures and Service Reductions**

Trustee Indulkar said the equipment they purchased for the tele-sitter program was expensive. She asked how they could repurpose the equipment. Dr. Littlepage said she was in the process of looking at how they could leverage the technology to create greater efficiencies and offset the burden on nursing.

Trustee Linton asked if there were any plans for alternative food sources, such as a food truck, to compensate for the closure of the Fairmont cafeteria. Ms. Rojas said there were no plans at this time.

Trustee Garrett asked where people were going to eat. Ms. Rojas said they would have to find other sources for food. It was difficult often for staff to get to the cafeteria. They had roughly 50 customers a day and it was mostly staff.

Trustee Linton asked if the Complex Care Management program was reimbursed by the Alliance. Ms. McCrae said it was not.

Trustee Garrett said this program was designed to operate at a loss. Serving 500 people with 27 staff was a lot. Dr. Francis said intensive care programs for people with serious mental illness and people experiencing homelessness usually do have ratios of 1:15 or 1:20 people. Dr. Francis said lower caseloads were required to achieve outcomes for people with serious mental illness and people experiencing homelessness. They were designed for the specific purpose of taking care of a higher needs population.

Trustee Garrett said it was good that the program was being reduced and not closed. It was hard to imagine 500 patients provided enough revenue to fund 27 people.

Trustee Indulkar said the Health Advocates program started with residents who were providing these low-barrier services and care. She asked when it transitioned to a funded program. Ms. McCrae said the staffing model shifted eight or nine years ago, before she inherited the program.

Trustee Indulkar asked what other low barrier resources were available in the system. Ms. McCrae said there would be a gap. They would have to rely on the County and local teams to navigate resources.

Trustee Linton asked if the Complex Care Management program would be operating within the received revenue with the cuts. Mr. Jackson said he did not know.

Trustee Garrett said that with the large number of staff they had they were probably saving tons of emergency room visits and ambulance rides. ECM programs, even at a lower level of intensity, saved money on ED visits and such.

Trustee Indulkar said she struggled with the IOP closures the most. There was an emphasis in the County and State around behavioral health. Any resource for a system was valuable. PHP/IOP programs were a resource for keeping people out of psychiatric hospitals. She asked if it was possible to achieve a financial benefit from this program if it were restructured. Ms. Espeseth said they could restructure some things to get a different outcome, but that would meet the dollar amount needed.

Trustee Sayen said they didn't want to reduce any of these services.

Trustee Sayen moved, Trustee seconded, to approve the proposed service reductions and closures subject to the final approval by the Board of Supervisors following the completion of the required Beilenson Act notice and hearing.

Trustee Indulkar asked if they had to approve all of the presentations given today in one, or did they have to separate them out. Mr. Azizi said if the Trustees felt strongly about specific items, they could vote one-by-one.

Trustee Garrett asked if these were the service reductions that were sent to the County for the Beilenson hearing. Mr. Azizi confirmed. Trustee Garrett asked how many FTEs would be impacted by the closure of the cafeteria. Ms. Rojas said 2.7. Trustee Garrett asked why that triggered Beilenson but not some of the other things they saw earlier. Trustee Sayen said it was because this was the intentional closing of a service.

Trustee Sayen said these were going to the Supervisors for a public hearing.

Trustee Linton asked Mr. Jackson to explain why these programs were selected to require Beilenson.

Trustee Garrett said it was difficult to understand why the 2.7 people in the cafeteria triggered a Beilenson and some of the other larger programs they were talking about did not.

Trustee Indulkar said the reduction of FTE was already approved by this Board. She asked why another approval was required to approve what they already approved that would be approved by the Supervisors. Mr. Azizi said the RIFs generally were approved with a motion that required staff to return to the Board before they closed any specific service lines.

Trustee Garrett said they approved the layoffs and asked if they had to approve the closures. Mr. Azizi said that this was discussed in closed session.

Trustee Fox seconded the motion.

Trustee Sayen read the motion again: Trustee Sayen moved, Trustee Fox seconded, to approve the proposed service reductions and closures subject to the final approval by the Board of Supervisors following the completion of the required Beilenson Act notice and hearing.

ACTION: A motion was made and seconded to approve the proposed service reductions and closures subject to the final approval by the Board of Supervisors following the completion of the required Beilenson Act notice and hearing. A roll call was taken, and the motion passed.

AYES: Trustees Fox, Moss, Sayen

NAYS: Garrett

ABSTENTION: Indulkar, Linton, Richman

Mr. Jackson asked if they had enough to proceed. Mr. Azizi said they did not, the motion failed.

Trustee Garrett asked if they could entertain another motion. He said they wanted the Board of Supervisors to understand the urgency. They were not taking the pressure off. He asked how they communicate that but also allow for the fact that there was some progress made. Administration stated their commitment to come to the table and find a solution.

Trustee Indulkar asked again if they could vote separately on each item. Trustee Sayen said if they don't vote on an item they are voting to keep it with money they did not have.

Trustee Fox said that was counterproductive to what they were trying to do.

Trustee Moss asked if others needed to consider things independently.

Trustee Linton asked if they could send all of the reductions to the Board for the Beilenson Hearing. Mr. Azizi said that's what they did with the original notice.

Trustee Fox said he understood they could take something off the table down the road. This vote just kept the conversation going with the Board of Supervisors.

Trustee Richman moved, Trustee Linton seconded, to reconsider the motion to approve the proposed service reductions and closures subject to the final approval by the Board of Supervisors following the completion of the required Beilenson Act notice and hearing.

ACTION: A motion was made and seconded to reconsider the motion to approve the proposed service reductions and closures subject to the final approval by the Board of Supervisors following the completion of the required Beilenson Act notice and hearing. A roll call was taken, and the motion passed.

AYES: Trustees Fox, Indulkar, Linton, Moss, Richman, Sayen

NAYS:

ABSTENTION: Garrett

Trustee moved, Trustee seconded, to reconsider the motion to approve the proposed service reductions and closures subject to the final approval by the Board of Supervisors following the completion of the required Beilenson Act notice and hearing.

Trustee Indulkar said it seemed that what they were really doing was trying to get the Supervisors to fund the programs. She asked if the Supervisors decided to close the programs then that was the decision made by them.

Trustee Moss said that, from his point of view, even though the Supervisors have the definitive vote, our Board was voting to create a pathway for them to step in. If we do not do this, then the Supervisors cannot act.

Trustee Sayen said they could still keep the programs open if they found money, regardless of the hearing.

Trustee Sayen moved, Trustee Linton seconded to approve the proposed service reductions and closures, including any other reduction or closure that may flow from the reduction in force

generally to final approval by the Board of Supervisors following completion of the required Beilenson Act notice and hearing.

Trustee Garret said he was trying to understand why the motion was to approve proposed service reductions and closures subject to Beilenson. But there have already been reductions for people who were now out of work

ACTION: A motion was made and seconded to approve the proposed service reductions and closures, including any other reduction or closure that may flow from the reduction in force generally to final approval by the Board of Supervisors following completion of the required Beilenson Act notice and hearing.

AYES: Trustees Fox, Indulkar, Linton, Moss, Richman, Sayen

NAYS: Garrett

ABSTENTION:

Adjournment: 11:37pm

Recommendation from the Medical Executive Committee to approve the policies listed below:

| | | | | | | |
|---------------------------------|------------------------|---------------------------|---|--|----------------|------------------------------------|
| Alameda Health System | | | CPC Executive Summary to AHS and AH Medical Executive Committee(s) – February 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 | | | | | | |
| Adult DKA Order Set | Berenice Perez, MD | <ul style="list-style-type: none"> Epic orders to align with paper orders that were previously approved 3/2025 by P&T System P&T Approved 1/2026 Consent Item – Order Set | | 02/2029 | | <ul style="list-style-type: none"> System P&T 1/2026 CPC 2/5/2026 MEC 3/4/2026 |
| Surge Overcapacity Escalation Policy | Salma Adin, VP of Patient Care Services Alison Lowry, Clinical Quality Improvement Manager | <ul style="list-style-type: none"> New This Policy establishes guidance to support decision making and departmental actions during periods of unusually high patient volume or acuity, ensuring the continued delivery of safe and effective care. | | 02/2029 | | <ul style="list-style-type: none"> CPC 2/5/2026 MEC 3/4/2026 |

Adult Diabetic Ketoacidosis Management [304000004]

Only Appears If: AHS SB INPATIENT NAVIGATORS AND DECISION SUPPORT [1073]

- 2024 ADA Guidelines - <https://alamedahealthsystem.sharepoint.com/:b:/s/EDQuality/ETmuusRJ5iNDIA0xQ-HSmpcB8EOsrTl0Enm0ZTxHuRva8A?e=ARDotx>

General [192682]

Diet/Nutrition [3040004329]

- Adult NPO diet: until gap closes [DIET30] Effective now, Starting Today, At: N
- Adult NPO diet [DIET30] Effective now, Starting Today, At: N
NPO except: Ice chips, Sips of clear liquids
- Adult diet: Clear liquid/Reduced concentrated sweet [DIET24] Effective now, Starting Today, At: N
Diet texture: Clear liquid
Diet modifier: Reduced concentrated sweet

Nursing [191526]

Vital Signs [400076]

- Continuous pulse oximetry [NUR586] Starting Today, At: N

Notify Physician [3040004336]

- Notify physician (specify parameters) [NUR983] Starting Today, At: N
Other: K+ less than 3.5 mEq/L and insulin gtt is stopped, Glucose less than 150, If patient is off insulin drip for 2 hours or more

Nursing Assessments [3040004332]

- Intake and output [NUR467] Starting Today
Call MD if urine output less than 50ml/hr 2 hours after initial fluid resuscitation
- Bladder scan [NUR374] If patient does not have an indwelling urinary catheter
- Weigh patient [NUR450] Estimate weight if unable to weigh patient and notify provider

Add: notify physician for stage progression

Insert and Maintain IV [130816]

- Insert and Maintain IV [70929] (Selection Required)

Insert peripheral IV [IVT3]

STAT, Once, For 1 Occurrences
Insert and maintain 2 large bore peripheral IV's

And

Maintain IV access [NUR562] Starting Today, At: N

And

Saline lock IV [IVT11] Routine, Once, For 1 Occurrences

And

sodium chloride flush [408400175]

10 mL, intravenous, q8h, For 31 Days
Line care

And

sodium chloride flush [408400175] 10 mL, intravenous, q1h PRN, line care, line care maintenance after medication administration, For 31 Days

Nursing Interventions [400064]

1/8

12/9/25, 11:48 AM

- Cardiac monitoring [NUR436] Starting Today, At: N
- Use serum glucose for all adjustments if patient with poor perfusion, on inotropic support, significant shock, MAP < 60 [NUR185] Starting Today, At: N
- If blood glucose is less than 70mg/dL start AHS hypoglycemia order set [NUR185] Starting Today, At: N
- Consider PICC/Central line placement [NUR185] Starting Today, At: N

Consider PICC/Central line placement once the DKA protocol is initiated

Lab check requirement for potassium replacement [426230] (Selection Required)

Check serum K+ every 2 hours x3, then every 4 hours [NUR185]

Starting Today, At: N

Use post replacement serum K+ to guide additional replacement per protocol

Check serum K+ (istat or BMP) after each K+ [NUR185]

Starting Today, At: N

Check serum K+ (istat or BMP) after each K+ replacement is complete (wait 15 minutes after IV replacement or 60 minutes if only oral K+ given). This will be in addition to the scheduled BMPs unless the timing is the same
replacement or 60 minutes if only oral K+ given). This will be in addition to the scheduled BMPs unless the timing is the same

Labs [191524] Only Appears If: SB INPATIENT [466]

Initial Labs [304000002]

PLACE INITIAL LABS IF BASELINE LABS HAVE NOT YET BEEN ORDERED

POCT glucose meter docked device [POC117]

Routine, q1h, For 24 Hours
And PRN until insulin infusion is stopped

Glucose, random [LAB82]

Once, For 1 Occurrences
Blood

CBC and Differential [LAB1748A]

STAT, Starting Today, For 1 Occurrences
Blood

Comprehensive metabolic panel [LAB17]

Once, For 1 Occurrences
Blood

Basic metabolic panel [LAB15]

q2h, For 3 Occurrences
every 2 hours starting 2 hours after initial CMP x 3 checks then every 4 hours until insulin infusion is discontinued, Blood

Basic metabolic panel [LAB15]

q4h, Starting 6 Hours after signing
every 2 hours starting 2 hours after initial CMP x 3 checks then every 4 hours until insulin infusion is discontinued, Blood

Osmolality [LAB107]

Once
Blood

Blood gas, venous [LAB79]

STAT, Starting Today, For 1 Occurrences
Blood, Blood, Venous

Urinalysis w/ Reflex Microscopic exam [LAB347]

Once, For 1 Occurrences
Urine
DUUU

Blood gas, venous [LAB79]

STAT, Starting Today, For 1 Occurrences
Blood, Blood, Venous

Urinalysis w/ Reflex Microscopic exam [LAB347]

Once, For 1 Occurrences
Urine

2/8

12/9/25, 11:48 AM

Beta Hydroxybutyrate [LAB2336]

STAT, Starting Today, For 1 Occurrences
Blood

Potassium [LAB114]

STAT, For 1 Occurrences
every 2 hours x3, then every 4 hours.
Use post replacement serum K+ to guide additional replacement per protocol.
Blood

POCT CHEM8 + Panel [POC158]

STAT, Specify frequency
Check after each K+ replacement is complete (wait 15 min after IV replacement or 60 minutes if only oral K+ given). This will be in addition to the scheduled BMPs unless the timing is the same.

Magnesium [LAB103]

STAT, Starting Today, For 1 Occurrences
Blood

Phosphorus [LAB113]

STAT, Starting Today, For 1 Occurrences
Blood

Blood culture (2 sets) [LAB46201]

STAT, For 1 Occurrences
Blood

Urine culture [LAB239]

Once

Hemoglobin A1c [LAB90]

Once, For 1 Occurrences
Blood

Additional labs [376928] (Selection Required) Only Appears If: AHS IP GHG ED PATIENTS ONLY [2964]

POCT CHEM8 + Panel [POC158] STAT, Once

POCT lactic acid (lactate) docked device [POC70] STAT, Once

Pregnancy Tests [425046] (Selection Required) Only Appears If: AHS SB (INPATIENT / AMB) FEMALE CHILD-BEARING AGE [3040000009]

hCG pregnancy, urine [LAB437]

Once, For 1 Occurrences
Urine

hCG, quantitative, pregnancy [LAB143]

Once
Blood

Imaging [191525]

Imaging - Chest [400065]

X-ray chest 1 view [IMG1259]

Routine, Once, For 1 Occurrences
Portable? Yes

Cardiac Studies [3040004330]

Electrocardiogram, 12-lead [ECG1]

Routine, Once, Starting Today, For 1 Occurrences
Reason for Exam/Diagnosis: DKA (diabetic ketoacidosis)
every 2 hours x3, then every 4 hours.
Use next replacement serum K+ to guide additional replacement per protocol

IV Fluids [191527]

3/8

RESTRICTOR: ED PATIENTS ONLY

RESTRICTOR: FEMALE CHILD-BEARING AGE

12/9/25, 11:48 AM

IV Fluid Bolus and Maintenance [408001352]

Initial Fluid Resuscitation [408001353] (Selection Required)

lactated Ringer's bolus [400296]

1,000 mL, intravenous, Administer over: 1 Hours, Once, For 2 Doses
Rate 1000 mL/hr. Caution in patients with corrected serum sodium of less than 136 mmol/L, potassium greater than 5.3 mmol/L, or on dialysis. If potassium greater than 5.3 mmol/L, call physician to change to normal saline.

sodium chloride 0.9 % bolus [400291]

1,000 mL, intravenous, Administer over: 1 Hours, Once, For 2 Doses
Rate 1000 mL/hr.

Maintenance IV Fluids [40800000415] (Selection Required)

Usual rate is 150 to 250 mL/hour.

Maintenance IV Fluids [40800000416] (Selection Required)

The provider will choose either sodium chloride 0.9% or sodium chloride 0.45% when initiating the maintenance IV fluids and is responsible for reevaluating.

Usual rate is 150 to 250 mL/hour.

Corrected sodium greater than 136 mmol/L [4080001358] (Selection Required)

sodium chloride 0.45 % infusion [7318]

150 mL/hr, intravenous, Continuous PRN, See admin instructions, For 1 Days
Maintenance IV fluid when potassium is greater than 5.3 mmol/L. Evaluate and adjust with each BMP or potassium result.

sodium chloride 0.45 % with KCl 20 mEq/L infusion [200005]

150 mL/hr, intravenous, Continuous PRN, see admin instructions, For 3 Days
Maintenance IV fluid when potassium is 5.3 mmol/L or less. Evaluate and adjust with each BMP or potassium result.

Corrected sodium 136 mmol/L or less [408001359] (Selection Required)

sodium chloride 0.9% infusion [27838]

150 mL/hr, intravenous, Continuous PRN, See admin instructions, For 1 Days
Maintenance IV fluid when potassium is greater than 5.3 mmol/L. Evaluate and adjust with each BMP or potassium result.

sodium chloride 0.9 % with KCl 20 mEq/L infusion [11081]

150 mL/hr, intravenous, Continuous PRN, See admin instructions, For 1 Days
Maintenance IV fluid when potassium is 5.3 mmol/L or less. Evaluate and adjust with each BMP or potassium result.

dextrose 5% and sodium chloride 0.9 % infusion [9815]

150 mL/hr, intravenous, Continuous, For 1 Days

Start when glucose is less than 250 mg/dL.

Medications [400077]

Potassium [40800000418]

12/9/25, 11:48 AM

potassium bicarbonate-citric acid (EFFER-K) effervescent tablet [408600042]

60 mEq, oral, PRN, potassium less than 3.5 or 3.5-4.5, For 31 Days

Ensure adequate renal function prior to K+ replacement (urine output more than 50 mL/hr). If urine output is not adequate and patient's potassium is less than 3.5 mmol/L, call physician.

Do not use potassium sliding scale for patients on dialysis or CrCl/GFR below 40; contact MD for potassium replacement.

If K less than 3.5 mmol/L: Give 60 mEq K PO/NG/G-tube x1 if tolerating AND give KCl

IVPB over 1 hour every hour until K is equal to or greater than 3.5; give either 20 mEq IVPB via PICC/central line or 10 mEq via two PIV simultaneously (20 mEq total). Call MD if K less than 3.3.

If K 3.5 to 4.5 mmol/L: Give 60 mEq K PO/NG/G-tube x1 if tolerating OR give KCl IVPB over 1 hour every hour until K is equal to or greater than 4.5; give either 20 mEq IVPB via PICC/central line or 10 mEq via two PIV simultaneously (20 mEq total).

If K 4.6-5.3: Do not replace K.

If K greater than 5.3: Call MD; do not replace K; if patient receiving LR, call MD to change to NS.

10 mEq IVPB via 2 PIV simultaneously [40800000361] (Selection Required)

potassium chloride IVPB [48400253]

10 mEq, intravenous, Administer over: 1 Hours, q1h PRN, potassium less than 3.5 or 3.5-4.5, For 31 Days

Ensure adequate renal function prior to K+ replacement (urine output more than 50 mL/hr). If urine output is not adequate and patient's potassium is less than 3.5 mmol/L, call physician.

Do not use potassium sliding scale for patients on dialysis or CrCl/GFR below 40; instead contact MD for potassium replacement.

If K less than 3.5 mmol/L: Give 60 mEq K PO/NG/G-tube x1 if tolerating AND

give KCl IVPB over 1 hour every hour until K is equal to or greater than 3.5; give either 20 mEq IVPB via PICC/central line or 10 mEq via two PIV simultaneously (20 mEq total). Call MD if K less than 3.3.

If K 3.5 to 4.5 mmol/L: Give 60 mEq K PO/NG/G-tube x1 if tolerating OR give KCl IVPB over 1 hour every hour until K is equal to or greater than 4.5; give either 20 mEq IVPB via PICC/central li

ne or 10 mEq via two PIV simultaneously (20 mEq total).

If K 4.6-5.3: Do not replace K.

If K greater than 5.3: Call MD; do not replace K; if patient receiving LR, call MD to change to NS.

And

potassium chloride IVPB 10 mEq [48400253]

10 mEq, intravenous, Administer over: 1 Hours, q1h PRN, potassium less than 3.5 or 3.5-4.5, For 31 Days

Ensure adequate renal function prior to K+ replacement (urine output more than 50 mL/hr). If urine output is not adequate and patient's potassium is less than 3.5 mmol/L, call physician.

Do not use potassium sliding scale for patients on dialysis or CrCl/GFR below 40; instead contact MD for potassium replacement.

If K less than 3.5 mmol/L: Give 60 mEq K PO/NG/G-tube x1 if tolerating AND

give KCl IVPB over 1 hour every hour until K is equal to or greater than 3.5; give either 20 mEq IVPB via PICC/central line or 10 mEq via two PIV simultaneously (20 mEq total). Call MD if K less than 3.3.

If K 3.5 to 4.5 mmol/L: Give 60 mEq K PO/NG/G-tube x1 if tolerating OR give KCl IVPB over 1 hour every hour until K is equal to or greater than 4.5; give either 20 mEq IVPB via PICC/central li

ne or 10 mEq via two PIV simultaneously (20 mEq total).

If K 4.6-5.3: Do not replace K.

If K greater than 5.3: Call MD; do not replace K; if patient receiving LR, call MD to change to NS.

20 mEq IVPB via central line [40800000367] (Selection Required) Only Appears If: SB CENTRAL LINE AND TELEMTRY (FOR IV POTASSIUM ONLY) [1865]

KCl 20 mEq IVPB via central line [408400253]

20 mEq, intravenous, Administer over: 1 Hours, q1h PRN, potassium less than 3.5 or 3.5-4.5, For 31 Days

Ensure adequate renal function prior to K+ replacement (urine output more than 50 mL/hr). If urine output is not adequate and patient's potassium is less than 3.5 mmol/L, call physician.

Do not use potassium sliding scale for patients on dialysis or CrCl/GFR below 40; instead contact MD for potassium replacement.

If K less than 3.5 mmol/L: Give 60 mEq K PO/NG/G-tube x1 if tolerating AND

give KCl IVPB over 1 hour every hour until K is equal to or greater than 3.5; give either 20 mEq IVPB via PICC/central line or 10 mEq via two PIV simultaneously (20 mEq total). Call MD if K less than 3.3.

If K 3.5 to 4.5 mmol/L: Give 60 mEq K PO/NG/G-tube x1 if tolerating OR give KCl IVPB over 1 hour every hour until K is equal to or greater than 4.5; give either 20 mEq IVPB via PICC/central li

ne or 10 mEq via two PIV simultaneously (20 mEq total).

If K 4.6-5.3: Do not replace K.

If K greater than 5.3: Call MD; do not replace K; if patient receiving LR, call MD to change to NS.

IV Insulin [40800000045]

Discontinue all insulin orders that were present prior to the start of this order set.

insulin regular (HumuLIN R) bolus from bag [6000012]

RESTRICTOR: CENTRAL LINE AND
TELEMTRY

0.1 Units/kg, intravenous, Once, For 1 Doses
If potassium is less than 3.5 mEq/L, replace potassium; do not give insulin; once potassium is at 3.5 mEq/L or greater, can initiate insulin.
Give bolus dose when starting Stage 1 of insulin protocol. Use actual body weight. Maximum dose 10 units. See link to DKA Protocol. Link can be found on the MAR under insulin infusion More Details.

insulin regular infusion [408600086]

0-20 Units/hr, intravenous, Titrated, For 31 Days
If potassium is less than 3.5 mEq/L, replace potassium; do not give insulin; if patient is on insulin drip, stop drip. When potassium is 3.5 or greater, restart insulin at the previous rate.
Initial infusion rate 0.1 units/kg/hour actual body weight. Maximum dose 20 units/hour. Titrate per protocol. See link to DKA Protocol. Link can be found on the MAR under insulin infusion More Details.
Initial Infusion Dose (units/kg/hr): 0.1

Insulin Protocol Stage 1 [NUR185]

Starting Today, At: N
Go to Stage 1 of insulin protocol if: Blood glucose is 200 mg/dL or more AND one of the following is present: 1) anion gap is greater than 14 mEq/L, 2) serum bicarbonate is less than 18 mmol/L, 3) pH is less than 7.3.
Initial insulin infusion rate is 0.1 units/kg/hour. Use actual body weight. Maximum dose 20 units/hour. Call physician if blood sugar does not drop by 50mg/dl/hour on maximum insulin dose. Titrate insulin rate per protocol. See MAR link.

Insulin Protocol Stage 2 [NUR185]

Starting Today, At: N
Go to Stage 2 of insulin protocol when: Blood glucose is less than 200 mg/dL, AND one of the following is present: 1) anion gap is greater than 14 mEq/L, 2) serum bicarbonate is less than 18 mmol/L, 3) pH is less than 7.3. Do not go back to Stage 1 once glucose is less than 200 mg/dL. When moving to Stage 2, decrease current insulin rate by half.

Insulin Protocol Stage 3 [NUR185]

Starting Today, At: N
Go to Stage 3 of insulin protocol when: Blood glucose is less than 200 mg/dL, AND 1) anion gap is less than or equal to 14 mEq/L, AND 2) EITHER serum bicarbonate is equal to or greater than 18 mmol/L OR pH is equal to or greater than 7.3.

CALL PHYSICIAN to consider starting DKA transition orders, prior to initiating.
Once physician writes for transition orders, then continue insulin infusion for 2 more hours after subcutaneous insulin started.
Stop insulin infusion 2 hours after subcutaneous insulin started.
Discontinue DKA order set after insulin infusion stopped.

If potassium is less than 3.5mEq/L: [NUR185]

Starting Today, At: N
Replete K+. Do not give insulin; if patient is on insulin drip, stop drip. Notify physician if insulin drip is stopped. Restart insulin drip when K+ is 3.5 or greater, at the previous rate.
Notify physician if insulin drip is stopped due to potassium less than 3.5 mEq/L

Hypoglycemia Treatment [132984]

Hypoglycemia Treatment Panel [408000925] (Selection Required) Only Appears If: SB PATIENT ADMITTED TO FMT [1847] or SB PATIENT ADMITTED TO JGP [408000009]

Mild hypoglycemia [408000927] (Selection Required)

dextrose (GLUTOSE) oral [40860001110]

15 g of dextrose, oral, q15 min PRN, low blood sugar (specify BG in comments), mild hypoglycemia, For 31 Days
Give for blood glucose 60-70 mg/dL if patient is alert and symptomatic. Repeat as ordered until blood glucose above 70 mg/dL.

Moderate hypoglycemia [408000928] (Selection Required)

dextrose (GLUTOSE) oral [40860001110]

30 g of dextrose, oral, q15 min PRN, low blood sugar (specify BG in comments), moderate hypoglycemia, For 31 Days
Give for blood glucose 45-59 mg/dL if patient is alert. Repeat as ordered until blood glucose above 70 mg/dL.

Severe hypoglycemia [408000929] (Selection Required)

dextrose (GLUTOSE) oral [40860001110]

30 g of dextrose, oral, q15 min PRN, low blood sugar (specify BG in comments), severe hypoglycemia, For 31 Days
Give for blood glucose value less than 45 mg/dL if patient is conscious/alert (may be disoriented). Repeat as ordered until blood glucose above 70 mg/dL.

Severe hypoglycemia if patient unconscious or not alert [408000930] (Selection Required)

glucagon (human recombinant) injection [408400144]

1 mg, intramuscular, q15 min PRN, low blood sugar (specify BG in comments), severe hypoglycemia if patient is unconscious or not alert, For 31 Days

RESTRICTOR: ADMITTED TO FMT
or JGP

Give for blood glucose value less than 45 mg/dL if patient unconscious or not alert.
Caution: glucagon can cause nausea and vomiting. Roll patient on their side when administering to prevent aspiration.

Hypoglycemia Treatment [40800734] (Selection Required) Only Appears If: SB PATIENT ADMITTED TO SLH & SLH REHAB [304000405] or SB PATIENT ADMITTED TO HGH [408000004] or SB PATIENT ADMITTED TO ALH [408000008]

Mild hypoglycemia [71013] (Selection Required)

dextrose (GLUTOSE) oral [40860001110]

15 g of dextrose, oral, q15 min PRN, low blood sugar (specify BG in comments), mild hypoglycemia, For 31 Days

Give for glucose 60-70 mg/dL if patient is alert and symptomatic. Repeat as ordered until glucose above 70 mg/dL.

Or

if patient NPO or unable to swallow: dextrose IV solution [40860001101]

12.5 g, intravenous, Administer over: 5 Minutes, q15 min PRN, low blood sugar (specify BG in comments), mild hypoglycemia, For 31 Days

If patient NPO or unable to swallow, give for glucose 60-70 mg/dL. Repeat as ordered until glucose above 70 mg/dL. Infuse rapidly, including manually squeezing the IV fluid if using D10W bag.

Moderate hypoglycemia [71014] (Selection Required)

dextrose (GLUTOSE) oral [40860001110]

30 g of dextrose, oral, q15 min PRN, low blood sugar (specify BG in comments), moderate hypoglycemia, For 31 Days

Give for glucose 45-59 mg/dL if patient is alert. Repeat as ordered until glucose above 70 mg/dL.

Or

If patient NPO: dextrose IV solution [40860001101]

12.5 g, intravenous, Administer over: 5 Minutes, q15 min PRN, low blood sugar (specify BG in comments), moderate hypoglycemia, For 31 Days

If patient NPO and alert, give for glucose 45-59 mg/dL. Repeat as ordered until glucose above 70 mg/dL. Infuse rapidly, including manually squeezing the IV fluid if using D10W bag.

Severe hypoglycemia [71017] (Selection Required)

dextrose (GLUTOSE) oral [40860001110]

30 g of dextrose, oral, q15 min PRN, low blood sugar (specify BG in comments), severe hypoglycemia, For 31 Days

Give for glucose value less than 45 mg/dL if patient is conscious/alert (may be disoriented). Repeat as ordered until glucose above 70 mg/dL.

Or

If patient NPO: dextrose IV solution [40860001101]

12.5 g, intravenous, Administer over: 5 Minutes, q15 min PRN, low blood sugar (specify BG in comments), severe hypoglycemia, For 31 Days

If NPO, give for glucose value less than 45 mg/dL if patient is conscious/alert (may be disoriented). Repeat as ordered until glucose above 70 mg/dL.

Infuse rapidly, including manually squeezing the IV fluid if using D10W bag.

Severe hypoglycemia if patient unconscious or not alert [71018] (Selection Required)

If IV access: dextrose IV solution [40860001101]

25 g, intravenous, Administer over: 5 Minutes, q15 min PRN, low blood sugar (specify BG in comments), severe hypoglycemia, For 31 Days

Give for glucose value less than 45 mg/dL if patient unconscious or not alert. Repeat as ordered until glucose above 70 mg/dL. Infuse rapidly, including manually squeezing the IV fluid if using D10W bag.

Or

If no IV access: glucagon injection [408400144]

1 mg, intramuscular, q15 min PRN, low blood sugar (specify BG in comments), severe hypoglycemia, For 31 Days

If no IV access, give for glucose value less than 45 mg/dL if patient unconscious or not alert.

Caution: glucagon can cause nausea and vomiting. Roll patient on their side when administering to prevent aspiration.









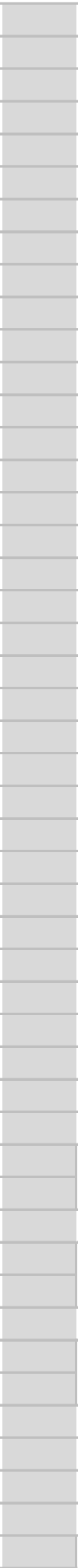






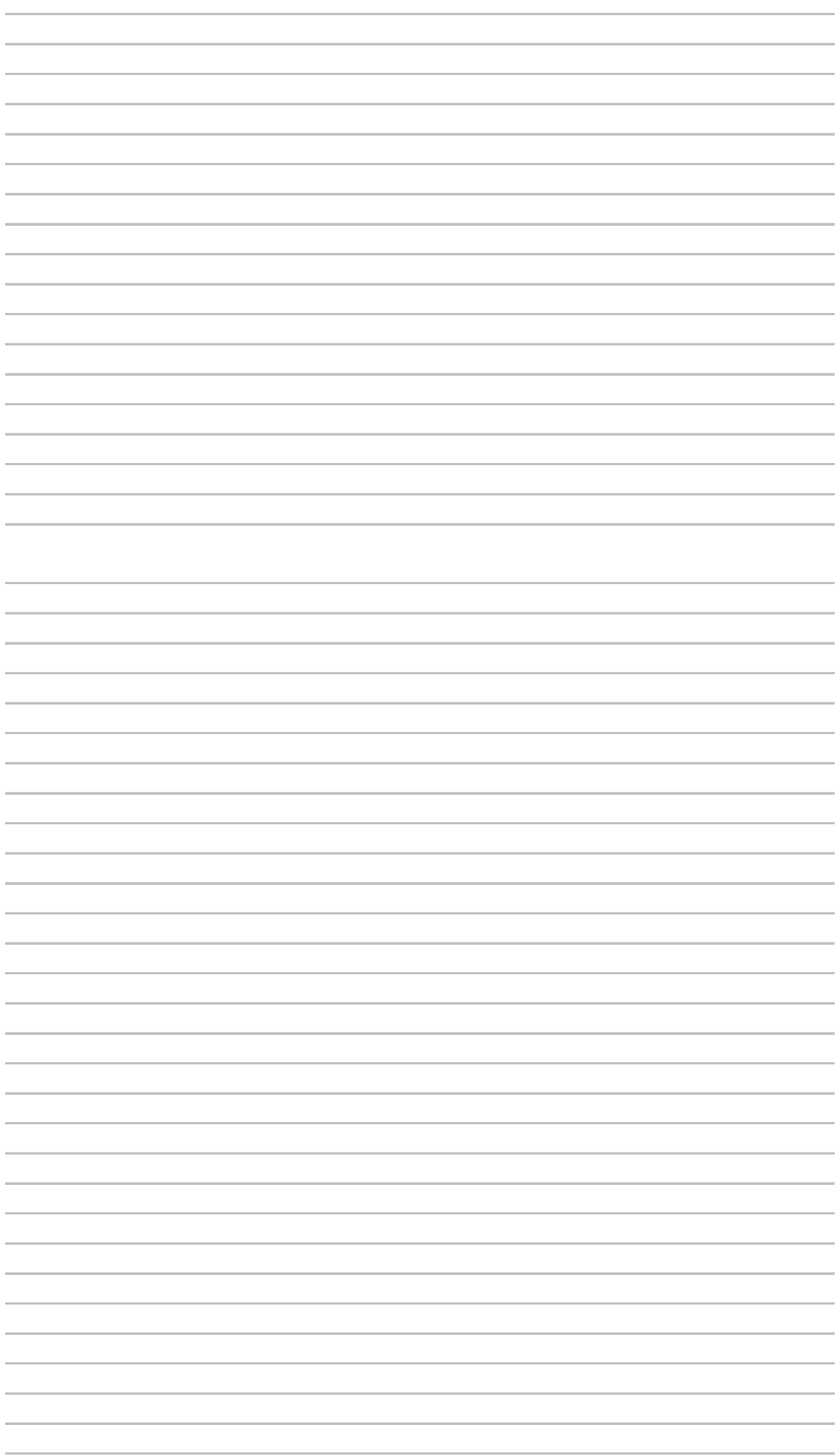









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|  | Policy | |
|---|---|--|
| | Document Title: Surge Overcapacity Escalation Policy | Reference # tbd |
| | Level <input checked="" type="checkbox"/> System <input type="checkbox"/> Site | Effective Date: 3/2026 Last Review Date: 1/28/2026 Next Scheduled Review: 1/27/2027 |
| | Document Owner: VP Patient Care Services & ED Manager | |

POLICY STATEMENT:

Alameda Health System (AHS) is committed to delivering safe, effective, and timely care during periods of increased patient volume or acuity. This policy establishes the organizational framework for managing Emergency Department (ED) surge and hospital overcapacity conditions to reduce hospital congestion, preserve patient safety, support operational continuity, and maintain optimal patient flow across the health system.

PURPOSE:

The purpose of this policy is to ensure a coordinated, consistent, and proactive response to Emergency Department (ED) overcrowding across all Alameda Health System (AHS) facilities.

This policy is intended to:

- Implement a standardized Surge Overcapacity Escalation Action Plan (Attachment A) across AHS facilities
- Utilize National Emergency Department Overcrowding Scale (NEDOCS) as an objective early-warning system to identify operational strain
- Support timely mobilization of resources and operational adjustments to maintain patient flow
- Provide clinical and administrative staff with clearly defined phase-specific response actions

SCOPE:

This policy applies to all Alameda Health System (AHS) employees, contractors, and leadership involved in emergency, inpatient, ancillary, and administrative operations at the following facilities:

- A. Alameda Hospital
- B. San Leandro Hospital
- C. Highland General Hospital

DEFINITIONS

- A. **Ambulance Patient Offload Time (APOT)** -- The time when an ambulance arrives and requests patient handoff to ED staff until the ED assumes care and the patient is moved off the EMS gurney.
- B. **ED Hold** -- Any patient who remains in the Emergency Department (ED) more than 2 hours after the request to admit has been made without inpatient orders.
- C. **ED Boarder** -- Any patient in the ED who has written inpatient admission orders and remains in the ED or alternative care spaces more than 2 hours after the request to admit.
- D. **Code Triage Internal/External – Activate** -- Indicates that a disaster, mass-casualty incident (MCI), patient surge, or other significant event has occurred and is disrupting hospital operations. This notifies staff that the Emergency Operations Plan (EOP) has been activated in response.
- E. **Code Triage Internal/External – Alert** -- Indicates that a disaster, MCI, patient surge, or other event has occurred and may disrupt hospital operations. This alerts staff that the Emergency Operations Plan may need to be activated.
- F. **Diversion** -- The temporary closure of the hospital's ED to incoming ambulance patients, including specialty service transports.
- G. **Healthcare Emergency** -- An unpredictable or unavoidable event related to healthcare delivery that requires immediate medical intervention and care.
- H. **Mass Casualty Incident (MCI)** -- An acute event in which hospital resources, including personnel and equipment, are overwhelmed by the number and/or severity of patients.
- I. **NEDOCS** -- The National Emergency Department Overcrowding Scale, a tool used to quantify ED overcrowding severity. During periods of increased patient volume and/or acuity, AHS utilizes the National Emergency Department Overcrowding Scale (NEDOCS), developed by Weiss et al. (2004), as a standardized operational tool to identify capacity strain, guide escalation decisions, and support timely mobilization of resources.
- J. **Over Capacity** -- A situation in which the demand for hospital or emergency services exceeds available resources.
- K. **Overcrowding** -- A situation in which the demand for hospital or emergency services is approaching resource limitations.
- L. **Surge** -- A significant increase in demand for resources compared to baseline. Components

include:

- a. **Influx:** volume and rate of incoming patients
- b. **Event:** type, scale, and duration
- c. **Resource Demand:** consumption and degradation of resources

M. **Surge Capacity** -- The maximum potential level of resource delivery is achieved through augmentation or modification of resource management. Components include:

- a. **System: operational integrity**
- b. **Space:** availability and suitability of physical areas
- c. **Staff:** number and skill level of personnel
- d. **Supplies:** volume and quality of required materials

N. **Surge Response Capability** -- The ability of the system's Surge Capacity to meet and accommodate the Surge (the demand for resources).

RESPONSIBILITIES

I. ED Charge Nurse

- a. Calculates NEDOCS at required intervals
- b. Communicates capacity status to ED staff
- c. Initiates phase-specific actions in collaboration with Nursing Supervisor

II. Nursing Supervisor

- a. Confirms NEDOCS calculations and validates escalation needs
- b. Implements operational actions according to escalation phase
- c. Notifies the Administrator-on-Call (AOC) as indicated
- d. Ensures appropriate internal notifications are completed in accordance with AHS emergency management procedures.

III. Administrator-on-Call (AOC)

- a. Evaluates the need for Hospital Incident Command System (HICS) activation
- b. Approves ambulance diversion requests in collaboration with county requirements
- c. Supports systemwide coordination during surge and overcapacity events
- d. Ensures required external notifications and coordination occur in alignment with county and regulatory expectations

IV. Hospital Leadership & Department Managers

- a. Ensures appropriate staffing, resource allocation, and operational adjustments
- b. Support implementation of surge response actions within respective departments
- c. Participate in post-event review and performance improvement activities following surge or overcapacity events, as appropriate

V. All Staff

- a. Comply with guidance and operational directive issued during surge phases

PROCEDURE

A. Response Thresholds

The National Emergency Department Overcrowding Scale (NEDOCS) serves as an objective indicator of Emergency Department (ED) and hospital overcrowding. The score is calculated using variables statistically correlated with system congestion, including:

- a. Number of staffed ED beds
- b. Number of hospital beds
- c. Total ED patient count
- d. Number of critical patients in the ED
- e. Longest admit time
- f. Total number of admissions
- g. Longest waiting room time

While NEDOCS provides standardized guidance, it may not capture all contributing operational factors, such as prolonged inpatient boarding, behavioral health holds, or concurrent system events. Additional response plans, including the Emergency Operations Plan (EOP), Mass Casualty Incident Plan, or Highly Infectious Disease Plan, may be activated concurrently when appropriate.

This policy functions as an operational component of the AHS Emergency Management Program and aligns with established Emergency Operations Plan (EOP) and Hospital Incident Command System (HICS) processes.

| Status | NEDOCS score | Description |
|----------|----------------------|---|
| Green | 0 – 60 | Normal Operations |
| Yellow | 61 – 100 | Daily Operations Nearing capacity limitations |
| Orange | 101 – 140 | Overcrowded Resources strained |
| Red | 141 – 180 | Over Capacity Code Triage Internal Alert may be considered |
| Black | 181 – 250 | Critical Over Capacity Code Triage Internal Activation strongly recommended |
| Disaster | No Score Required | Extreme Acute or Extended Disaster Response; HICS activation required |

Response actions must consider the overall operational environment, not solely the score. Any internal or external disaster, including medical, trauma, or Chemical, Biological, Radiological, Nuclear, and Explosive (CBRNE) mass casualty incidents, automatically escalates operational status to Black until the event is resolved and normal operations resume.

B. Response Actions

The NEDOCS score is intended to support, not replace, professional judgment. Response actions may vary based on hospital-specific conditions, inpatient capacity, specialty service availability, and concurrent operational impacts. The Action Plan is not all-inclusive, and additional emergency or disaster response plans may be activated as warranted.

Each phase requires specific institutional actions involving systems, space, staff, and supplies. Response measures intensify as overcrowding escalates and continue into subsequent phases unless otherwise specified. Detailed operational actions are outlines in Attachments A and B.

- ***Phase I – Normal Operations (Green)***
Effective Patient Flow. Occurs when no capacity issues are present.
- ***Phase II – Daily Operations (Yellow)***

Not exceeding current capacity/ resources.

- ***Phase III – Overcrowded (Orange)***

Need for hospital/ emergency services is nearing the limitations of available resources.

- ***Phase IV – Over Capacity (Red)***

Need for hospital/ emergency services exceeds available resources. Code Triage Internal Alert and Hospital Incident Command System (HICS)

- ***Phase V – Critical Over Capacity (Black)***

Code Triage Internal/External Activation, and Hospital Incident Command System (HICS) is activated.

- ***Disaster***

Represents an external disaster requiring extended response. Local, state, and federal agencies may be involved. County Alternate Care Sites and austere care protocols may be initiated as indicated. Refer to Emergency Operations Management Plan in Attachment B.

Staff education and training related to surge and overcapacity response are conducted in accordance with the AHS Emergency Operations Plan and applicable emergency preparedness requirements. Post-event debrief and performance improvement activities may be conducted following surge or overcapacity events to inform operational improvements and readiness planning.

Local, State, and potentially Federal agencies may be involved.

County Alternate Care Sites and Austere Care Protocols may be initiated.

References

Weiss, S. J., Derlet, R., Arndahl, J., Ernst, A. A., Richards, J., Fernández-Frackelton, M., Schwab, R., Stair, T. O., Vicellio, P., Levy, D., Brautigan, M., Johnson, A., & Nick, T. G. (2004). Estimating the degree of emergency department overcrowding in academic medical centers: results of the National ED Overcrowding Study (NEDOCS). *Academic emergency medicine : official journal of the Society for Academic Emergency Medicine*, 11(1), 38–50.

<https://doi.org/10.1197/j.aem.2003.07.017>

Alameda County Emergency Medical Services policies and diversion protocols.

Joint Commission Emergency Management Standards.

California Code of Regulations Title 22 – Hospital Licensing Requirements.

AHS Emergency Operations Plan (EOP).

Hospital Incident Command System (HICS) Guidebook.

ATTACHMENTS

Attachment A: [AHS Surge Protocol - High Census Escalation ACTION PLAN.docx](#)

Attachment B: [Emergency Operations Management Plan](#)

Attachment C: [Highland Hospital Ambulance Patient Offload Time \(APOT\) Mitigation Protocol](#)

Attachment D: [San Leandro and Alameda Hospital Ambulance Patient Offload Time \(APOT\) Mitigation Protocol](#)

Attachment E: [ED Referrals Process for Medicine Subspecialties - HGH.docx](#)

Surge Overcapacity Escalation Action Plan



| Status | Green | Yellow | Orange | Red | Black |
|--------|--|--|--|--|---|
| NEDOCS | 0-60 | 61-100 | 101-140 | 141-180 | 181-250 |
| | <p>Normal Operations</p> <p>APOT ≤ 30 minutes</p> <p>0 ED Boarders In ALL EDs</p> <p>Effective Patient Flow. Occurs when no capacity issues exist.</p> <p>Response: ED Charge Nurse to use the NEDOCS tool to generate a score at least once per shift or more frequently as needed.</p> | <p>Daily Operations</p> <p>APOT ≤ 30 minutes</p> <p>1-10 ED Boarders @HGH OR 1-3 ED Boarders @ALH OR 3 ED Boarders @SLH</p> <p>Not exceeding current capacity/ resources.</p> <p>Response: ED Charge Nurse to ensure notification to ED personnel advising of capacity status and use NEDOCS with increasing frequency, as the situation dictates.</p> | <p>Overcrowded</p> <p>APOT > 30 minutes</p> <p>11-20 ED Boarders @HGH OR 4 ED Boarders @ALH OR 6 ED Boarders @SLH</p> <p>Need for hospital/ emergency services is nearing the limitations of available resources.</p> <p>Response: ED Charge Nurse to validate scoring with Nursing Supervisor and implement the Surge Plan as appropriate. ED Charge Nurse to update NEDOCS tool at least every 4 hours and with increasing frequency as the situation dictates and engage Nursing Supervisor, who may notify Administrator-on-Call (AOC).</p> | <p>Over Capacity</p> <p>APOT > 30 minutes</p> <p>21-24 ED Boarders @HGH OR 5 ED Boarders @ALH OR 8 ED Boarders @SLH</p> <p>Need for hospital/ emergency services exceeds available resources.</p> <p>Code Triage Internal Alert and Hospital Incident Command System (HICS)</p> <p>Response: ED Charge Nurse to validate scoring with Nursing Supervisor and implement the Surge Plan as appropriate. Nursing Supervisor may contact AOC to determine if the Hospital Incident Command System should be activated. ED Charge Nurse or designee shall calculate NEDOCS score at least every 2 hours.</p> | <p>Critical Over Capacity <i>(Internal/External Disaster)</i></p> <p>APOT > 30 minutes</p> <p>25+ ED Boarders @HGH OR 7+ ED Boarders @ALH OR 10 ED Boarders @SLH</p> <p>Code Triage Internal/External Activation, and Hospital Incident Command System (HICS) is activated.</p> <p>Response: ED Charge Nurse to validate scoring with Nursing Supervisor and implement the Surge plan as appropriate. Nursing Supervisor shall contact AOC to determine if the Hospital Incident Command System should be activated.</p> |

| Green Normal Operations | |
|----------------------------|--|
| Department | Response Actions |
| Hospital Administration | <p>Chief Administrative Officer (CAO) / Associate Chief Nursing Officer (ACNO):</p> <ul style="list-style-type: none"> ○ Ensure standard operating procedures are fully implemented and maintained <p>Associate Chief Medical Officer (ACMO), Acute Care Services:</p> <ul style="list-style-type: none"> ○ Ensure standard operating procedures are fully implemented and maintained <p>Inpatient & Emergency Nursing Directors and VP:</p> <ul style="list-style-type: none"> ○ Maintain standard operating procedures across inpatient and ED units <p>Administrator on Call (AOC)-Of Hours and Weekends:</p> <ul style="list-style-type: none"> ○ Maintain standard operating procedures and routine administrative oversight |
| House Supervisors | <p>HGH House Supervisor:</p> <ul style="list-style-type: none"> ○ Standard operating procedures in effect: Take proactive measures to staf beds ahead, ensure open beds, and expeditiously receive admitted patients <p>ALH/SLH House Supervisor:</p> <ul style="list-style-type: none"> ○ Standard operating procedures in effect: Take proactive measures to staf beds ahead, ensure open beds, and expeditiously receive admitted patients ○ SLH House Supervisor Coverage: <ul style="list-style-type: none"> ○ House Supervisor on Duty <ul style="list-style-type: none"> ■ 4p-8am M-F ■ 24/7 Weekends ○ No Coverage (Unit Managers responsible for escalation) <ul style="list-style-type: none"> ■ 8am – 4pm M-F |
| Emergency | <p>HGH ED Charge Nurse:</p> <ul style="list-style-type: none"> ○ Standard operating procedures in effect ○ Run NEDOCS per policy ○ Attend bed huddles and report NEDOCS scores ○ ED Diversion Status: Open ○ ED Charge Nurse will update NEDOCS, ReddiNet, and EMSsystems as needed ○ Fast Track of appropriate triage patients to appointment as indicated. ○ Unit Attending MDs and Nurse Managers continually round to evaluate the workload and productivity of the areas and redistribute patients and staf as indicated |

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| | <ul style="list-style-type: none"> ○ Continual and periodic physician assessment of triage patients with work-up and treatment initiated as necessary. ○ ED Observation Area utilized for appropriate patients to make available acute treatment beds ○ When inpatient bed is ready, send ED bedside RN name and extension to inpatient Charge Nurse ○ Ensure RN to RN report initiated within 15 minutes of bed becoming available, escalating to inpatient Charge Nurse for transport and bedside report. If delay continues, contact House Supervisor for resolution. <p>HGH ED Physicians and PAs:</p> <ul style="list-style-type: none"> ○ Maintain situational awareness of NEDOCS score ○ Review ED census with ED Charge Nurse regularly (before every bed meeting or more often) regarding patients’ anticipated admission (Floor, Tele, ICU) or discharge disposition ○ Maintain communication with ED Charge Nurse regarding trend of NEDOCS score for anticipated needs ○ Identify on EPIC the following facility timely disposition planning by EN and House Supervisor and Case Management: <ul style="list-style-type: none"> ○ Hallway appropriate patients ○ Possible admissions ○ Conditions for conditional discharges ○ ED Provider will coordinate with admitting physicians/services to expedite patient care; hospitalists will place order for appropriate patients including ICU admissions, per normal workflow <p>SLH/ALH Emergency Departments:</p> <ul style="list-style-type: none"> ○ Standard operating procedures in effect ○ Review EPIC Overcrowding & NEDOCS Scores on ED control center ○ Ensure RN handoff or report initiated within 15 minutes of bed becoming available. <ul style="list-style-type: none"> ○ Patient to be up in assigned bed within 30 minutes. If delay continues, contact House Supervisor for resolution. |
| <p>Inpatient Providers:</p> | <p>Physicians/Hospitalists/Intensivists/Surgeons:</p> <ul style="list-style-type: none"> ○ Standard operating procedures in effect |
| <p>Inpatient Nursing: Medical Surgical, Surgical, Telemetry, Oncology, ICU, Pediatrics</p> | <p>HGH Inpatient Units:</p> <ul style="list-style-type: none"> ○ Units will expeditiously process discharges and prepare bed for new occupancy. ○ Reports bed status and attends bed huddles and reports bed status as required. ○ Units will assist ED transport teams when patients are delivered to their respective units. <p>ALH/SLH Inpatient Units:</p> <ul style="list-style-type: none"> ○ Units will expeditiously process discharges and prepare bed for new occupancy. ○ Reports bed status and attends bed huddles and reports bed status as required. |
| <p>Family Birthing Center</p> | <p>All Family Birthing Center (FBC) Staf:</p> <ul style="list-style-type: none"> ○ Standard operating procedures in effect |

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|-------------------------|---|
| Same Day Surgery & PACU | All Surgery Staf: <ul style="list-style-type: none"> ○ Standard operating procedures in efect |
| Care Management | All Care Managers <ul style="list-style-type: none"> ○ Standard operating procedures in efect |
| Bed Control | All Bed Control Staf: <ul style="list-style-type: none"> ○ Standard operating procedures in efect |
| Transfer Center | All Transfer Center Staf: <ul style="list-style-type: none"> ○ Standard operating procedures in efect |
| Transportation Tech | All Transportation Tech Staf: <ul style="list-style-type: none"> ○ Standard operating procedures in efect |
| Laboratory | All Laboratory Staf: <ul style="list-style-type: none"> ○ Standard operating procedures in efect |
| Diagnostic Imaging | All Radiologists: <ul style="list-style-type: none"> ○ Standard operating procedures in efect All Imaging Staf: <ul style="list-style-type: none"> ○ Staf technicians for Ultrasonography 24/7/365 ○ Staf technicians for CT to ensure that, at a minimum, 2 scanners are in operation 24/7/365. |
| Respiratory Therapy | All Respiratory Therapists: <ul style="list-style-type: none"> ○ Standard operating procedures in efect |
| Pharmacy | All Pharmacies and Pharmacy Personnel: <ul style="list-style-type: none"> ○ Standard operating procedures in efect |
| Rehabilitation Services | All Rehabilitation Staf: <ul style="list-style-type: none"> ○ Standard operating procedures in efect |
| Environmental Services | All Environmental Services (EVS) Staf: <ul style="list-style-type: none"> ○ Standard operating procedures in efect |
| Facilities | All Facilities Staf: <ul style="list-style-type: none"> ○ Standard operating procedures in efect |
| Materials Management | All Materials Management Staf |

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| | <ul style="list-style-type: none"> ○ Standard operating procedures in efect |
| Security | <p>All Security</p> <ul style="list-style-type: none"> ○ Standard operating procedures in efect |
| Food & Nutrition Services | <p>All Food & Nutrition Services (FNS) Staf:</p> <ul style="list-style-type: none"> ○ Standard operating procedures in efect |

| <p>Yellow Daily Operations</p> | |
|---|---|
| Department | Response Actions |
| Hospital Administration | <p>Chief Administrative Officer (CAO) and Associate Chief Nursing Officer (ACNO):</p> <ul style="list-style-type: none"> ○ Maintain standard operating procedures and monitor throughput indicators <p>Associate Chief Medical Officer (ACMO), Acute Care Services:</p> <ul style="list-style-type: none"> ○ Ensure standard operating procedures are fully implemented, monitor throughput indicators and remain available for escalation <p>Inpatient & Emergency Nursing Directors and VP:</p> <ul style="list-style-type: none"> ○ Respond to House Supervisors requests for consultation ○ Participate in additional bed meetings and leadership rounding ad directed to support throughput needs <p>Administrator on Call (AOC)-Of Hours and Weekends:</p> <ul style="list-style-type: none"> ○ Maintain standard operating procedures and remain available for escalation |
| House Supervisors | <p>HGH House Supervisor:</p> <ul style="list-style-type: none"> ○ Take proactive measures to staf beds ahead, ensure open beds, and expeditiously receive admitted patients ○ Maintain NEDOCS awareness <p>ALH/SLH House Supervisor:</p> <ul style="list-style-type: none"> ○ Take proactive measures to staf beds ahead, ensure open beds, and expeditiously receive admitted patients ○ Maintain NEDOCS awareness ○ SLH House Supervisor Coverage: <ul style="list-style-type: none"> ○ House Supervisor on Duty <ul style="list-style-type: none"> ■ 4p-8am M-F ■ 24/7 Weekends ○ No Coverage (Unit Managers responsible for escalation) <ul style="list-style-type: none"> ■ 8am – 4pm M-F |
| Emergency | <p>HGH ED Charge Nurse:</p> <ul style="list-style-type: none"> ○ Standard operating procedures in efect ○ Run NEDOCS per policy ○ Attend bed huddles and report NEDOCS scores ○ ED Diversion Status: Open ○ ED Charge Nurse will update NEDOCS, ReddiNet, and EMSsystems as needed |

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| | <ul style="list-style-type: none"> ○ Fast Track of appropriate triage patients to appointment as indicated. ○ Unit Attending MDs and Nurse Managers continually round to evaluate the workload and productivity of the areas and redistribute patients and staff as indicated ○ Continual and periodic physician assessment of triage patients with work-up and treatment initiated as necessary. ○ ED Observation Area utilized for appropriate patients to make available acute treatment beds ○ When inpatient bed is staffed and ready and notified by secure chat, send ED bedside RN name and extension to inpatient Charge Nurse ○ Ensure RN to RN report initiated within 15 minutes of receiving bed assignment for admitted patients ○ If report has not been requested or given within 15 minutes of bed becoming available, escalate to inpatient Charge Nurse for transport and bedside report. If delay continues, contact House Supervisor for resolution. <p>HGH ED Physicians and APPs:</p> <ul style="list-style-type: none"> ○ Maintain situational awareness of NEDOCS score ○ Review ED census with ED Charge Nurse regularly (before every bed meeting or more often) regarding patients' anticipated admission (Floor, Tele, ICU) or discharge disposition ○ Maintain communication with ED Charge Nurse regarding trend of NEDOCS score for anticipated needs ○ Identify on EPIC the following facility timely disposition planning by EN and House Supervisor and Case Management: <ul style="list-style-type: none"> ○ Hallway appropriate patients ○ Possible admissions ○ Conditions for conditional discharges ○ ED Provider will coordinate with admitting physicians/services to expedite patient care; hospitalists will place order for appropriate patients including ICU admissions, per normal workflow <p>ALH/SLH ED Charge Nurse:</p> <ul style="list-style-type: none"> ○ Reference EPIC Overcrowding & NEDOCS Scores once per shift or if conditions change ○ Attend AM Daily Bed Huddle ○ Collaborate with CM / MSW to facilitate discharges and referral to outpatient facilities <p>ALH/SLH ED Physicians and APPs:</p> <ul style="list-style-type: none"> ○ Monitor census, EPIC Overcrowding, & NEDOCS Scores. Direct EMS patients to WR as appropriate. |
| <p>Inpatient Providers:</p> | <p>Physicians/Hospitalists/Intensivists/Surgeons:</p> <ul style="list-style-type: none"> ○ Prioritize discharges before and after rounds ○ Evaluate admitted patients boarded in the ED related to possible downgrades/ discharges/ transfers ○ Facilitate and prioritize intercampus and interfacility transfers to ensure utilization of beds across the health system. |
| <p>Inpatient Nursing: Medical Surgical, Surgical, Telemetry, Oncology, ICU, Pediatrics</p> | <p>HGH Inpatient Units:</p> <ul style="list-style-type: none"> ○ Units will expeditiously process discharges and prepare bed for new occupancy. ○ Reports bed status and attends bed huddles and reports bed status as required ○ Units will assist ED transport teams when patients are delivered to their respective units. |

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| | ALH/SLH Inpatient Units: <ul style="list-style-type: none"> ○ Units will expeditiously process discharges and prepare bed for new occupancy. ○ Reports bed status and attends bed huddles and reports bed status as required |
| Family Birthing Center | All Family Birthing Center (FBC) Staf: <ul style="list-style-type: none"> ○ Standard operating procedures in efect |
| Same Day Surgery & PACU | Surgery Manager: <ul style="list-style-type: none"> ○ Standard operating procedures in efect |
| Care Management | All Care Managers: <ul style="list-style-type: none"> ○ Standard operating procedures in efect |
| Bed Control | All Bed Control Staf: <ul style="list-style-type: none"> ○ Standard operating procedures in efect |
| Transfer Center | All Transfer Center Staf: <ul style="list-style-type: none"> ○ Standard operating procedures in efect |
| Transportation Tech | All Transportation Tech Staf: <ul style="list-style-type: none"> ○ Standard operating procedures in efect |
| Diagnostic Imaging | Radiologists: <ul style="list-style-type: none"> ○ Receives updates regarding surge status ○ Considers prioritizing ER Exam reads Staf: <ul style="list-style-type: none"> ○ Staf technicians for Ultrasonography 24/7/365 ○ Staf technicians for CT to ensure that, at a minimum, 2 scanners are in operation 24/7/365. |
| Laboratory | All Laboratory Staf: <ul style="list-style-type: none"> ○ Expedite pending labs and maintain awareness of NEDOCS score ○ Standard operating procedures in efect |
| Respiratory Therapy | ED Assigned Respiratory Therapist: <ul style="list-style-type: none"> ○ Prioritizes discharge treatments within each ED ○ Prepare patients for interfacility transfers ○ Maintain and monitor respiratory supply availability |

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| <p>Pharmacy</p> | <p>HGH Inpatient Pharmacy:</p> <ul style="list-style-type: none"> ○ Unit based pharmacists will check with charge nurse to expedite possible discharges <p>HGH Outpatient/Discharge Pharmacy:</p> <ul style="list-style-type: none"> ○ Pharmacists will receive pending discharge medications request from nurse, nursing leadership or case manager and will prioritize assessments for IP and ED discharges. <p>SLH Pharmacy:</p> <ul style="list-style-type: none"> ○ Pharmacists will check with charge nurse to expedite possible discharges <p>ALH Pharmacy:</p> <ul style="list-style-type: none"> ○ Pharmacists will check with charge nurse to expedite possible discharges |
| <p>Rehabilitation Services</p> | <p>Rehabilitation Services Manager:</p> <ul style="list-style-type: none"> ○ Reallocate staf as appropriate <p>Inpatient & ED Therapists:</p> <ul style="list-style-type: none"> ○ Therapist in the ED evaluating and assessing for Rehabilitation Needs ○ Monitor, review and treat ○ Triage, assign patient referrals, and provide outcomes and updates ○ Patients will be seen in the following prioritization order: <ul style="list-style-type: none"> ○ Patients who are “discharge ready” or need an evaluation for transfer or discharge |
| <p>Environmental Services</p> | <p>All Environmental Services (EVS) Staf:</p> <ul style="list-style-type: none"> ○ EVS will focus on proactive rounding of common areas, such as waiting rooms and public restrooms, to maintain cleanliness as trafic increases. Staf will ensure all sharps containers are empty, locked, and changed out according to fill lines. |
| <p>Facilities</p> | <p>Infrastructure Check:</p> <ul style="list-style-type: none"> ○ Proactive verification that HVAC, applicable negative pressure rooms, medical vacuum, and medical oxygen systems are fully operational. <p>Emergency Power:</p> <ul style="list-style-type: none"> ○ Confirm emergency generators are ready, full of fuel, and on standby. <p>Utilities:</p> <ul style="list-style-type: none"> ○ Verify stable water pressure and sewer system capacity for normal operation. <p>Communication:</p> <ul style="list-style-type: none"> ○ Local Chief Engineer/Engineering Manager will confirm readiness status to department leaders. |

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| Materials Management | All Materials Management (MM) Staf: <ul style="list-style-type: none"> ○ Standard operating procedures in efect: ensure all departments are stocked to PAR |
| Security | All Security: <ul style="list-style-type: none"> ○ Standard operating procedures in efect |
| Food & Nutrition Services | All Food & Nutrition Services (FNS) Staf: <ul style="list-style-type: none"> ○ Standard operating procedures in efect |

| <p>Orange Overcrowded</p> | |
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| Department | Response Actions |
| Hospital Administration | <p>Chief Administrative Officer (CAO) / Associate Chief Nursing Officer (ACNO):</p> <ul style="list-style-type: none"> ○ Participate in additional bed control meetings upon request by the House Supervisor ○ Conduct leadership rounding, as indicated to address throughput constraints <p>Associate Chief Medical Officer (ACMO), Acute Care Services:</p> <ul style="list-style-type: none"> ○ Communicate with department chairs and division chiefs overcrowded status to proactively improve inpatient capacity ○ Participate in additional bed control meetings upon request by the House Supervisor ○ Conduct leadership rounding, as indicated to address throughput constraints, when available <p>Inpatient Nursing Directors and VP:</p> <ul style="list-style-type: none"> ○ Engage in additional bed control meetings as directed by the House Supervisor ○ Adjust unit-level operations and rounding practice to support patient flow <p>Administrator on Call (AOC)-Of Hours and Weekends:</p> <ul style="list-style-type: none"> ○ Participate in additional bed control meetings and operational decision-making as requested ○ Support escalation planning and situational awareness |
| House Supervisors | <p>HGH House Supervisor:</p> <ul style="list-style-type: none"> ○ Reports to the ED and coordinates with the ED Charge Nurse for a situation report. ○ Coordinate as needed with ED Director and ED Nurse Manager in regards to patient flow. ○ May schedule additional bed control meetings, rounding as necessary, to meet throughput demand. ○ Obtains updated unit readiness information from all patient care areas ○ Consider NEDOCS notification via text/Everbridge/email message. Consideration based on ability to return to yellow less than 1 hour versus impending progression to Red ○ Consider reprioritization of the order in which patients are granted inpatient beds from our current standard of: surgical, patients in beds not licensed for inpatient use, patients in downgrading level of care, then ED. Reprioritize based upon most urgent need. ○ Refocus EVS to priority STAT cleans for urgent needs ○ Deploy Transport with a focus on ED Admissions ○ Consider bedside report from ED to units for admitted patients ○ Communicate with inpatient unit leadership to accept ED admissions and in house transfers during change of shift report. ○ Consider request for inpatient units to accept stable, alert and oriented admit or transfer patient to hallway when staffed bed is "In Progress" (EVS stationed in room actively cleaning. Maximum number of hallway beds allowed is one per wing. This requires notification and approval of Unit Director or Nurse Manager and will occur only when unit leadership present. |

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| | <ul style="list-style-type: none"> ○ Consider fast track transfer of most recently admitted, appropriate patients transferring non-neuro, non-trauma, stable, ICU patients to other AHS facilities ○ Consider opening an overflow inpatient unit on Periop, PACU, or ISSU as able in regards to bed availability and staffing - call in staff as necessary. (Notify Regulatory Affairs to assess and initiate CDPH notification, if applicable) ○ Evaluate impact of elective surgeries that require a post op, inpatient bed ○ Communicate with Case Manager to expedite pending discharges <p>ALH/SLH House Supervisor:</p> <ul style="list-style-type: none"> ○ Reports to the ED and coordinates with the ED Charge Nurse for a situation report. ○ Coordinate as needed with ED Assistant Nurse Manager and ED Nurse Manager in regards to patient flow. ○ Obtains updated unit readiness information from all patient care areas ○ Consider NEDCOS notification via text/Everbridge/email message. Consideration based on ability to return to yellow less than 1 hour versus impending progression to Red ○ Consider reprioritization of the order in which patients are granted inpatient beds from our current standard of: surgical, patients in beds not licensed for inpatient use, patients in downgrading level of care, then ED. Reprioritize based upon most urgent need. ○ Refocus EVS to priority STAT cleans for urgent needs ○ Consider bedside report from ED to units for admitted patients ○ Communicate with inpatient unit leadership to accept ED admissions and in-house transfers during change of shift report. ○ Consider a floating Admit/Discharge Nurse – reassign available RN or call staff in ○ Consider opening an overflow inpatient unit in Periop & PACU, or other designated areas as able regarding bed availability and staffing - call in staff as necessary. (Notify Regulatory Affairs to assess and initiate CDPH notification, if applicable) ○ Evaluate impact of elective surgeries that require a post op, inpatient bed ○ Communicate with Case Manager to expedite pending discharges <ul style="list-style-type: none"> ○ SLH House Supervisor Coverage: <ul style="list-style-type: none"> ○ House Supervisor on Duty <ul style="list-style-type: none"> ■ 4p-8am M-F ■ 24/7 Weekends ○ No Coverage (Unit Managers responsible for escalation) <ul style="list-style-type: none"> ■ 8am – 4pm M-F |
| <p>Emergency</p> | <p>HGH ED Charge Nurse:</p> <ul style="list-style-type: none"> ○ Review the Emergency Department census with the Attending Emergency MD and House Supervisor to look for disposition opportunities <ul style="list-style-type: none"> ○ Tests/Procedures /Medications/Treatments ○ Discharge Issues (Family, Transportation, Prescriptions, Equipment, etc...) ○ Transfer of Appropriate Patients ○ Discuss announcing NEDCOS Orange with House Supervisor and ED MD ○ Discuss opportunities and barriers with ED team leads, radiology, laboratory, security, registration, pharmacy, inpatient Charge Nurse, and other stakeholders ○ Assign additional staff to: <ul style="list-style-type: none"> ○ Optimize space and location of boarding patients in the ED |

- Designate specific treatment areas as needed (i.e. boarding area, ED Treatment area, Discharge area, triage area)
- Allocate resources to each designated area as appropriate
- Update NEDOCs Score and (ReddiNet/EMSystems/HAVBED/NEDOCs) at least every 4 hours or more frequently, as needed.
- Assure rapid transport of admissions to floor (ether by transport, ED, or floor staf)
- When inpatient bed is stafed and ready and notified by text, send ED bedside RN name and extension to inpatient Charge Nurse
- Ensure RN to RN report initiated within 15 minutes of receiving bed assignment for admitted patients
- If report has not been requested or given within 15 minutes of bed becoming available, escalate to inpatient Charge Nurse for transport and bedside report. If delay continues, contact House Supervisor for resolution.

HGH ED Physicians and PAs:

- Discuss if NEDOCs Orange level notification should be executed.
- ED MD may request a current NEDOCs score if concerned for over capacity.
- If no beds, or very limited beds, available in the facility, the Lead ED Physician or the ED Medical Director may work with admitting physicians and the Nursing/Administrative Supervisor to arrange and coordinate transfer of ED patients awaiting admission to other AHS Health facilities if applicable.
- Review the Emergency Department Census with the ED Charge Nurse and House Supervisor to look for disposition opportunities
- Tests/Procedures /Medications/Treatments
- Discharge Issues (Family, Transportation, Prescriptions, Equipment, etc...)
- Transfer of Appropriate Patients
- Contact flex or backup provider, if available and indicated
- Consider additional care sites may be opened.
- Consider mass notification (Everbridge) if elevation of NEDOCs score anticipated.
- Consider Rapid Medical Evaluation with Provider and RN Teams to initiate Medical Screening Exams on waiting patients.
- ED Provider will coordinate with admitting physicians/services to expedite patient care; hospitalists will place order for appropriate patients including ICU admissions, per normal workflow

ALH/SLH ED:

- Review the Emergency Department census with the Attending Emergency MD and House Supervisor to look for disposition opportunities
 - Tests/Procedures /Medications/Treatments
 - Discharge Issues (Family, Transportation, Prescriptions, Equipment, etc...)
 - Transfer of Appropriate Patients
- Collaborate with House supervisor with their response items
 - Notification via Everbridge, Additional staf resources
 - Estimate duration to determine when additional housing areas will need to be deployed.
- Assure rapid transport of admissions to floor (ether by transport, ED, or floor staf)
- Ensure RN to RN report initiated within 15 minutes of receiving bed assignment for admitted patients
- If report has not been requested or given within 15 minutes of bed becoming available, escalate to inpatient Charge Nurse for transport and bedside report. If delay continues, contact House Supervisor for resolution.

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| | <p>ALH/SLH ED Physician and APPs:</p> <ul style="list-style-type: none"> • In addition to standard operating procedures • Monitor census, EPIC Overcrowding, & NEDOCS Scores. <ul style="list-style-type: none"> ○ Direct EMS patients wo WR as appropriate ○ As census allows, shift APP staffing to busier ED |
| <p>Inpatient Providers</p> | <p>Physicians/Hospitalists/Intensivists/Surgeons:</p> <ul style="list-style-type: none"> ○ May consult with House Supervisor on additional bed control meetings, rounding as necessary, to meet throughput demand depending on the incident ○ Prioritize discharges before and after rounds ○ Evaluate admitted patients boarded in the ED related to possible downgrades/ discharges/ transfers <ul style="list-style-type: none"> ○ Assist with the focus on prioritizing discharges and transfers ○ Facilitate and prioritize intercampus and interfacility transfers to ensure utilization of beds across the health system. ○ Communicate during rounds to RN Staf and SM/MSW potential same day and next day discharges ○ Huddle with Case Management / Social Work early afternoon about discharges and barriers to discharges. ○ Extra Hospitalist can be called in based on the hospitalist group census and the NEDOCS score (extra day shift rounding hospitalist for next day). |
| <p>Inpatient Nursing: Medical Surgical, Surgical, Telemetry, Oncology, ICU, Pediatrics</p> | <p>HGH Inpatient Nurse Managers/Directors:</p> <ul style="list-style-type: none"> ○ Implement leadership rounding on departments/units with a focus on service recovery, patient throughput and identify potential discharges. ○ Report available beds to Nursing/Administrative Supervisor. ○ Facilitate timely discharge of patients in collaboration with Case Management/Discharge Planning and physicians. <p>HGH Inpatient Charge Nurses:</p> <ul style="list-style-type: none"> ○ Ensure inpatient beds are maximally occupied. ○ Ensure rooms are operational, clean and ready to accept patients. ○ Ensure the STAT discharges are a priority. ○ Ensure staf can accept report within 15 minutes of notification of room readiness on the EHR system. ○ Encourage discharges; hold staf accountable for STAT discharge once the discharge order has been written. Inform department Nurse Manager or Director of delays and causative factors. ○ If staf awaiting patient transfer from the ED and transfer is delayed, staf may go to the ED to receive and transport their patient if staf available to do so. ○ Facilitate prompt discharge by calling families arranging for transport home, negotiating early Skilled Nursing Facility (SNF) placement if available; contact Case Management/Discharge Planning to assist with this process as needed <p>ALH/SLH Inpatient Nurse Managers:</p> <ul style="list-style-type: none"> ○ Implement leadership rounding on departments/units with a focus on service recovery, patient throughput and identify potential discharges. ○ Report available beds to Nursing/Administrative Supervisor, if on duty ○ Facilitate timely discharge of patients in collaboration with Case Management/Discharge Planning and physicians. <p>ALH/SLH Inpatient Charge Nurses:</p> <ul style="list-style-type: none"> ○ Ensure inpatient beds are maximally occupied. |

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| | <ul style="list-style-type: none"> ○ Ensure rooms are operational, clean and ready to accept patients. ○ Ensure the STAT discharges are a priority. ○ Ensure staf can accept report within 15 minutes of notification of room readiness on EPIC ○ Encourage discharges; hold staf accountable for STAT discharge once the discharge order has been written. Inform department Assistant Nurse Manager or Nurse Manager of delays and causative factors. ○ Facilitate prompt discharge by calling families arranging for transport home, coordinate with Case Management/Discharge Planning to assist with this process as needed |
| Family Birthing Center | <p>Nurse Manager:</p> <ul style="list-style-type: none"> ○ Identify possible discharges earlier in the admission process & communicate with MDR team to expedite ○ Review potential discharges for next day prior evening and daily in MDR ○ Identify patients who can be downgraded from higher level of care twice daily ○ Identify patients who need higher level of care or transfers for procedures or consults twice daily and alert transfer center promptly ○ Accept appropriate transfers from other acute care sites promptly ○ Work with CM team to identify patients who may be able to go back to into the community and that bed is held ○ Identify goals of care and decision maker for patients upon admission. Review this daily if goals are not clear |
| Same Day Surgery & PACU | <p>Surgery Manager:</p> <ul style="list-style-type: none"> ○ Prepare for potential ED overflow patient admissions ○ Monitor equipment and supplies |
| Care Management | <p>Managers of Case Management/Social Work:</p> <ul style="list-style-type: none"> ○ Inform Care Management Staf surge level and direct to standard work for discharge priorities ○ Confirm discharges during MDR with treatment team, ensuring that Charge Nurse/Unit Manager is aware of discharges for the day. <p>Case Managers / Social Workers:</p> <ul style="list-style-type: none"> ○ Continual update to CM leadership of potential and confirmed discharges. <p>RN Case Manager:</p> <ul style="list-style-type: none"> ○ Notify skilled nursing facilities of high census in hospital when discussing discharge transfer times |
| Bed Control | <p>Bed Control Staf:</p> <ul style="list-style-type: none"> ○ Review current bed availability and patient status (Isolation, Tele/MS/OBS/Post Op) ○ Create bed request according to patient level of care and status . ○ Update bed status as patients is admit, discharge, or transfer. ○ Coordinate with nursing staf (HS/CN) to ensure timely patient placement in available beds/Stafed beds based on prioritization. |

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| Transfer Center | <p>Transfer Center:</p> <ul style="list-style-type: none"> ○ Review all Emergency Department boarders with orders for possible transfer ○ Communicate with Medicine Team on call to determine team patient load ○ Transfer Coordinator to contact/chat with the team and assigned providers to determine appropriate transfer candidates for transfer to alternate AHS Acute Care campuses ○ Initiate transfer of all ED boarders that are appropriate transfer candidates. ○ Communicate with House Supervisors at all sites (AH & SLH) to facilitate immediate transfer to designated open beds with approximate transfer time of arrival. |
| Transportation Tech | <p>Nursing Supervisor on Duty:</p> <ul style="list-style-type: none"> ○ May coordinate with Administrative Supervisor to Prioritize patient transport responsibilities if applicable ○ May provide additional personnel to as needed and available to expedite turnaround times (TAT) for patient transportation ○ ALH NST to be utilized to expedite patient transportation |
| Diagnostic Imaging | <p>Radiologists:</p> <ul style="list-style-type: none"> ○ Receives updates regarding surge status ○ Considers prioritizing ED exam reads <p>Director of Imaging, Point Person or Assigned ED DI Tech on Duty:</p> <ul style="list-style-type: none"> ○ Reports to the ED and coordinates with the ED Charge Nurse for a situation report and if they can assist with the surge situation such as modification of daily operations and prioritization of all imaging studies. ○ Attend bed huddles ○ Call in addition staf ○ Consider need for transport resources |
| Laboratory | <p>ED Phlebotomist on Duty:</p> <ul style="list-style-type: none"> ○ Reports to the ED and coordinates with the ED Charge Nurse for a situation report and if they can assist with the surge situation such as modification of daily operations and prioritization of blood draws. ○ Reports to their Supervisor/Manager on duty as needed in regards to the surge capacity situation and requests assistance if needed and applicable. |
| Respiratory Therapy | <p>ED Assigned Respiratory Therapist:</p> <ul style="list-style-type: none"> ○ Reports to the ED and coordinates with the ED Charge Nurse for a situation report and if they can assist with the surge situation such as modification of daily operations and prioritization of all Respiratory Therapy: ○ Prioritizes discharge treatments within each ED ○ Prepare patients for interfacility transfers ○ Maintain and monitor respiratory supply availability <p>Inpatient Respiratory Therapists:</p> <ul style="list-style-type: none"> ○ Coordinates with the unit Charge Nurse for a situation report and if they can assist with the surge situation such as modification of daily operations and prioritization of all Respiratory Therapy: ○ Prioritizes discharge diagnostics, treatments, and teachings |

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| | <ul style="list-style-type: none"> ○ Prepare patients for interfacility transfers ○ Receive Pending Discharge Orders List from IP Case Manager and Prioritize testing for Inpatient Discharges where appropriate as it relates to acuity <p>Imaging Manager:</p> <ul style="list-style-type: none"> ○ Alert Radiology on prioritization of Inpatient and ED patients awaiting discharge <p>Cardiology Manager:</p> <ul style="list-style-type: none"> ○ Prioritize studies on ED and IP patients awaiting possible discharge ○ Alert Cardiologist on prioritization of IP and ED patient studies awaiting discharge <p>ISSU Manager:</p> <ul style="list-style-type: none"> ○ Discuss with Cardiologist on expanding clinical care to ED patients with cardiac-related diagnosis and placing them into ISSU Observation. If decision to expand ISSU, contact VP of Patient Care Services and Risk. |
| <p>Rehabilitation Services</p> | <p>Rehabilitation Services Manager:</p> <ul style="list-style-type: none"> ○ Expedite reviewing charts and accepting patients for transfer to Rehab facilities ○ Reallocate staff as appropriate <p>Inpatient & ED Therapists:</p> <ul style="list-style-type: none"> ○ Therapist in the ED evaluating and assessing for Rehabilitation Needs ○ Monitor, review and treat ○ Prioritize PT / OT / SLP assess / evals pending discharge ○ Prioritize providing DMEs for discharge patients ○ Triage, assign patient referrals, and provide outcomes and updates ○ Patients will be seen in the following prioritization order: <ul style="list-style-type: none"> ○ Patients who are “discharge ready” or need an evaluation for transfer or discharge |
| <p>Pharmacy</p> | <p>All Pharmacy Managers</p> <ul style="list-style-type: none"> ○ Assess the need to call in additional SAN support ○ Assess inventory and shortages; borrow/loan meds between sites as needed ○ If needed, work with buyers to place emergency medication orders from Mckesson as needed <p>HGH Inpatient Pharmacy</p> <ul style="list-style-type: none"> ○ Standard operating procedures in effect for all inpatient holds in ED. ○ Unit based pharmacists will check with charge nurse to expedite possible discharges ○ If House Supervisor activates overflow inpatient units, run pyxis reports for Periop Overflow Pyxis and fill pyxis to max <p>HGH Outpatient/Discharge Pharmacy</p> <ul style="list-style-type: none"> ○ Pharmacists will receive pending discharge medications request from nurse, nursing leadership or case manager and will prioritize assessments for IP and ED discharges. |

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| | <ul style="list-style-type: none"> ○ Pharmacy leadership will reassign staf from supporting ambulatory care patient medication processing, to ED or Discharge patient medications, if multiple discharge medication orders are concurrently requested. <p>SLH Pharmacy</p> <ul style="list-style-type: none"> ○ Pharmacists: <ul style="list-style-type: none"> ○ Pull All Pharmacists to central pharmacy to help with production workflow ○ Call SAN's for availability, Check with Staf for OT availability. ○ Call remote services- Cardinal to be on standby to work on the production workflow if needed. ○ Technicians: <ul style="list-style-type: none"> ○ Run Pyxis report and fill to max <p>ALH Pharmacy</p> <ul style="list-style-type: none"> ○ Pharmacists: <ul style="list-style-type: none"> ○ Pull All Pharmacists to central pharmacy to help with production workflow ○ Call SAN's for availability, Check with Staf for OT availability. ○ Call remote services- Cardinal to be on standby to work on the production workflow if needed. ○ Technicians: <ul style="list-style-type: none"> ○ Run Pyxis report and fill to max |
| <p>Environmental Services</p> | <p>All Environmental Services (EVS) Staf: We will refocus staf on Priority STAT cleans for inpatient beds to expedite throughput. Techs are required to immediately update EHR/Epic status to "Clean" the moment a room turnover is finalized</p> <p>ED EVS Technician:</p> <ul style="list-style-type: none"> ○ Checks in with the ED Charge Nurse for a situation report and expedites bed cleaning to assist with the surge situation as needed. ○ Quickly updates AHS EHR by changing dirty rooms to clean once turnover is completed. ○ Reports to their Director or Supervisor on Duty as needed regarding the surge capacity situation. <p>Director or Supervisor on Duty:</p> <ul style="list-style-type: none"> ○ Attends bed huddles ○ May coordinate with Administrative House Supervisor to Prioritize In-Patient Bed Cleaning responsibilities if applicable. ○ May assign more EVS staf to the ED, if needed ○ Dispatch assigned ED EVS Personnel to next room that needs cleaning in house to expedite turnaround times (TAT) for admission to the floor |
| <p>Facilities</p> | <p>Infrastructure Check:</p> <ul style="list-style-type: none"> ○ Increase checks on critical HVAC, negative pressure areas, medical vacuum, and medical oxygen systems, focusing on potential satellite units if required. <p>Emergency Power:</p> <ul style="list-style-type: none"> ○ Check fuel levels and ensure priority maintenance readiness for generator systems. |

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| | <p>Utilities:</p> <ul style="list-style-type: none"> ○ Proactively monitor water and sewer systems for any capacity strain. <p>Communication:</p> <ul style="list-style-type: none"> ○ Local Chief Engineer/Engineering Manager to provide the first escalation notification to on-call leadership if infrastructure risk is identified. |
| Materials Management | <p>Materials Management (MM) Manager</p> <ul style="list-style-type: none"> ○ Round to ensure supplies are sufficiently stocked in Fast Track and ED Stations. ○ Call-in additional MM staf to support ED Supply Chain. ○ Contact Purchasing with supplies needed for anticipated Surge activity. ○ Continue to report on supply chain and staf status in the ED to the ED Charge Nurse. |
| Security | <p>Site Lead on Duty:</p> <ul style="list-style-type: none"> ○ Reports to the ED and coordinates with the ED Charge Nurse for a situation report and if Security can assist with the surge situation. |
| Food & Nutrition Services | <p>Food & Nutrition Services (FNS) Supervisor:</p> <ul style="list-style-type: none"> ○ Call the Emergency Department (ED) and other impacted units for a list of supplies needed to help expedite discharge (i.e., takeaway meals, snacks, etc.) ○ Reassess unit needs if surge continues into the next meal period <p>Registered Dietitian:</p> <ul style="list-style-type: none"> ○ Prioritize consults and care planning needed for discharge <p>Food Service Staf:</p> <ul style="list-style-type: none"> ○ Prepare and deliver supplies needed |

Red
Over Capacity

| Department | Response Actions |
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| Hospital Administration: | <p>Chief Administrative Officer (CAO) / Associate Chief Nursing Officer (ACNO):</p> <ul style="list-style-type: none"> ○ Upon notification from House Supervisor, assess conditions and determine activation of: <ul style="list-style-type: none"> ○ Code Triage: Internal Alert ○ The Hospital Incident Command System (HICS) ○ Direct communication regarding NEDOCS activation via Everbridge and authorize: <ul style="list-style-type: none"> ○ Code Triage: Internal Alerts ○ Emergency Bed Huddle ○ ED notification to County via Reddinet/EMSystems/HAVBED/NEDOCS ○ Assess operational impact and notify the Administrator on Call (AOC) ○ Report on site or delegate an Incident Commander (IC) to activate the Hospital Incident Command System (HICS) if indicated ○ Notify Department Chairs and Associate CMO as needed to discuss System Throughput ○ Ensure coordination with House Supervisor so that Situational Updates are issued after each Emergency Bed Control Briefing. ○ Cancel non-essential meetings to prioritize surge response <p>Associate Chief Medical Officer (ACMO), Acute Care Services:</p> <ul style="list-style-type: none"> ○ Partner with CAO/ACNO on determination of activating Code Triage and HICS ○ Direct engagement with medical staff department chairs and division chiefs to activate early discharges, downgrades, and interfacility transfers to level load admissions ○ As nursing and inpatient staffing capacity increase to accommodate increasing patient census, work with medical staff department chairs and division chiefs to consider deploying hospitalists and intensivists to support inpatient rounds and discharge decision-making. <p>Inpatient Nursing Directors and VP:</p> <ul style="list-style-type: none"> ○ Evaluate and determine acceptance of all incoming transfers ○ Implement staffing adjustments to support surge operations, including: <ul style="list-style-type: none"> ○ Activation of alternative care area satellite units (i.e. Periop, PACU, ICCU) ○ Staffing for ED Boarders ○ Temporary mandatory overtime, if required ○ Short-term staffing variances (i.e. Charge RN with assignment, out-of-ratio staffing) ○ Notify Regulatory Affairs to assess and initiate CDPH notification, as applicable ○ Review surgical schedule with the Administrative Supervisor and the Surgical Services leadership and direct delays or cancellations of elective and add-on procedures as needed. ○ Deploy PACU or ISSU for ED surgical holds or general ED Boarders when staffing and space allow ○ Coordinate with Quality and Regulatory Affairs to secure approval from regulatory agencies for alternate patient care areas ○ Direct Case Management to accelerate discharges and interfacility transfers |

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| | <ul style="list-style-type: none"> ○ Initiate service recovery planning as appropriate <p>Administrator on Call (AOC)-Of Hours and Weekends:</p> <ul style="list-style-type: none"> ○ Upon notification from House Supervisor, assess conditions and determine activation of a Code Triage: Internal Alert and the Hospital Incident Command System (HICS) ○ Notify Nursing and Physician leadership of operational impacts ○ Report onsite or assume Incident Commander role (or delegate as appropriate) as required ○ Ensure coordination with House Supervisor so that Situational Updates are issued after each Emergency Bed Control Briefing. |
| | <p>HGH House Supervisor:</p> <ul style="list-style-type: none"> ○ Consult immediately with ED Charge Nurse, ED Nurse Manager, ED Director, and ED Medical Director to evaluate Code Triage: Internal Alert activation if: <ul style="list-style-type: none"> ○ Surge Capacity Score remains between 141 – 180 for at least two (2) consecutive hours ○ Full census prevents accommodation of surgeries and ED admissions ○ Work with CAO to decide on activation of the Hospital Incident Command System (HICS) or designated briefing location ○ Collaborate with Nurse Managers, Case Management, and Discharge Planning to <ul style="list-style-type: none"> ○ Identify discharge-ready patients ○ Identify discharges that can be expedited ○ Arrange expedited discharges with attending physicians and care teams. ○ Review non-urgent/elective surgeries with Surgical Services Manager to determine cancelations due overcapacity and lack of inpatient beds ○ Deploy additional staf as needed ○ Redirect EVS to STAT cleans for urgent bed turnover ○ Redirect Transport with a focus on decompressing the ED ○ Alert inpatient units to: <ul style="list-style-type: none"> ○ Prioritize accepting report, and prepare for reports at bedside, as needed ○ Assist with patient transfers out of the ED, if possible ○ Alert specific units to accept bedside report. Floor RNs should come to ED for report and transfer patients to floors ○ Communicate with inpatient unit leadership to accept ED admissions and in house transfers during change of shift report. ○ Consider fast track transfer of most recently admitted, appropriate patients transferring non-neuro, non-trauma, stable, ICU patients to other AHS facilities ○ Call in extra staf with a focus on supporting ED with admitted, holding patients. ○ Consider opening a satellite inpatient unit on Periop, PACU & ISSU, pending bed availability and stafing - call in staf as necessary. (Notify Regulatory Affairs to assess and initiate CDPH notification, if applicable) ○ Consider postponing elective surgeries that require a post op, inpatient bed – Consult with AOC and Surgical providers ○ Consider reassigning any available Nurse Manager to function as a 2nd House Supervisor (one to manage beds, 2nd to manage house) ○ Recommend Case Manager facilitate early discharges and transfers of admitted patients to other facilities <p>ALH/ SLH House Supervisors:</p> <ul style="list-style-type: none"> ○ Consult with ED Charge Nurse, ED Assistant Nurse Manager, ED Nurse Manager, and ED Medical Director for possible declaration of a Code Triage: Internal Alert if the Surge Capacity Score remains between 141 – 180 for at least two (2) consecutive hours or deemed activation needed due to a full census inability to accommodate surgeries and ED admissions. ○ Work with the CAO to complete a high-level assessment of the potential operational impact on the facility and determine the need to activate a Code Triage: Internal Alert and the Hospital Incident Command System (HICS) or other designated location for briefing if applicable. |

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| | <ul style="list-style-type: none"> ○ Reprioritize the order in which patients are granted inpatient beds from our current standard of surgical, patients in beds not licensed for inpatient use, patients in downgrading level of care, then Emergency Dept. Reprioritize based upon most urgent need. ○ Collaborate with Nurse Managers and Case Management and Discharge Planning, to identify patients who can potentially be discharged and make the appropriate discharge arrangements with the attending physician and other applicable patient care service providers. ○ Review surgical schedule with the Administrator on Call, Surgical Services Nurse Manager, Chief of Surgery, and Chief of Anesthesiology to and consider delaying, altering or cancelling elective and add-on surgeries if OR availability is an issue ○ Refocus EVS to priority STAT cleans for urgent needs ○ Communicate with inpatient unit leadership to accept ED admissions and in-house transfers during change of shift report. ○ Consider accepting fast track transfers of most recently admitted, appropriate patients transferring non-neuro, non-trauma, stable, ICU patients from other AHS facilities ○ Consider opening a satellite inpatient unit in Periop & PACU as able regarding bed availability and staffing - call in staf as necessary. (Notify Regulatory Affairs to assess and initiate CDPH notification, if applicable) ○ Recommend Case Manager facilitate early discharges and transfers of admitted patients to other facilities ○ SLH House Supervisor Coverage: <ul style="list-style-type: none"> ○ House Supervisor on Duty <ul style="list-style-type: none"> ■ 4p-8am M-F ■ 24/7 Weekends ○ No Coverage (Unit Managers responsible for escalation) <ul style="list-style-type: none"> ■ 8am – 4pm M-F |
| <p>Emergency</p> | <p>HGH ED Charge Nurse:</p> <ul style="list-style-type: none"> ○ Discuss announcing NEDOCS with House Supervisor and ED MD ○ Review the Emergency Department Census with the Attending Emergency MD and House Supervisor to look for disposition opportunities <ul style="list-style-type: none"> ○ Tests/Procedures /Medications/Treatments ○ Discharge Issues (Family, Transportation, Prescriptions, Equipment, etc...) ○ Transfer of Appropriate Patients ○ Update NEDOCS Score and (ReddiNet/EMSystems/HAVBED/NEDOCS) at least every 2 hours or more frequently, as needed ○ Discuss opportunities and barriers with ED team leads, radiology, laboratory, security, registration, pharmacy, inpatient Charge Nurses, and other stakeholders ○ Assign additional staf to: <ul style="list-style-type: none"> ○ Optimize space and location of boarding patients in the ED ○ Designate specific treatment areas as needed (i.e., boarding area, ED Treatment area, Discharge area, triage area) ○ Allocate resources to each designated area as appropriate ○ Attend bed huddles and provide ED updates ○ Consider expanding the Triage Staffing to include additional provider, RN and ED Technician and requesting EVS and Transport staf ○ Determine and request additional supplies a needed ○ Assure rapid transport of admissions to floor (ether by transport, ED, or floor staf) ○ When inpatient bed is staffed and ready and notified by text, send ED bedside RN name and extension to inpatient Charge Nurse ○ Ensure RN to RN report initiated within 5 minutes of receiving bed assignment for admitted patients |

- If report has not been requested or given within 5 minutes of bed becoming available, escalate to inpatient Charge Nurse for transport and bedside report. If delay continues, contact House Supervisor for resolution.

If after two (2) hours of no change, consecutive Surge Capacity scores between 141 – 180, or based on patient census in department, worsening of the surge or deemed increased response needed due to the hospital at full census, or inability to discharge patients, accommodate surgeries and ED admissions:

- Consider contact with area EMS Providers and ALCO County hospitals by phone as needed.
- Maintain notes on situation and time frames of incidents for after action and corrective action reports.
- Consider request to Administrative Supervisor for additional staff to ED assist with patients and monitoring the ED Lobby, such as Nurse's Aides, Float/Hold Nurses.
- May request EVS and Transportation assigned to the ED to bring additional, available supplies, such as inpatient beds for ED holds, gurneys, IV Poles, portable monitors and more etc., the needed item types and locations of items to be delivered.
- Ensure no delay in report and transfer of inpatients and inpatient holds to rooms when they are available on the EHR Screen. Report will be called by the ED RN to the assigned unit, when the EHR
- Open designated PACU or ISSU Area of the Emergency Department if staffing available.
- Consult with ED nurse manager and consider initiation of Ambulance Bay Triage Procedures if applicable for the situation. If this is initiated, provide a radio and assign an ED Technician and ED RN for Triage.

HGH ED Physicians and APPs:

- Run board with House Supervisor and ED Charge Nurse
- Discuss if NEDOCS Red level notification should be executed.
- If no beds, or very limited beds, available in the facility, the Lead ED Physician or the ED Medical Director may work with admitting physicians and the Administrative Supervisor to arrange and coordinate transfer of ED patients awaiting admission to other AHS facilities if applicable.
- Discuss with ED Charge Nurse possible request for EMS diversion if trend is towards NEDOCS BLACK (Note: Follow local county guidelines)
- Review the Emergency Department Census with the ED Charge Nurse and House Supervisor to look for disposition opportunities
- Tests/Procedures /Medications/Treatments
- Discharge Issues (Family, Transportation, Prescriptions, Equipment, etc...)
- Contact flex or backup provider, if available and indicated
- Consider additional care sites may be opened.
- Consider mass notification (Everbridge) notification if elevation of NEDOCS score anticipated.
- Consider Rapid Medical Evaluation with Provider and RN Teams to initiate Medical Screening Exams on waiting patients.
- ED Provider will coordinate with admitting physicians/services to expedite patient care; hospitalists will place order for appropriate patients including ICU admissions, per normal workflow
- Coordinate and work together with ED Charge Nurse, ED Nurse Manager in assisting with patient flow and throughput.
- Lead ED Physician or the ED Medical Director may contact additional ED Physicians and PAs not on duty to respond to the department to assist.

ALH/SLH ED Charge Nurses:

- Review the Emergency Department Census with the Attending Emergency MD and House Supervisor to look for disposition opportunities
 - Tests/Procedures /Medications/Treatments
 - Discharge Issues (Family, Transportation, Prescriptions, Equipment, etc...)
 - Transfer of Appropriate Patients
 - Staffing

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| | <ul style="list-style-type: none"> ○ Update NEDOCS Score and (ReddiNet/EMSystems/HAVBED/NEDOCS) at least every 2 hours or more frequently, as needed ○ Assure rapid transport of admissions to floor (ether by transport, ED, or floor staf) ○ When inpatient bed is stafed and ready and notified by text, send ED bedside RN name and extension to inpatient Charge Nurse ○ Ensure RN to RN report initiated within 5 minutes of receiving bed assignment for admitted patients ○ If report has not been requested or given within 5 minutes of bed becoming available, escalate to inpatient Charge Nurse for transport and bedside report. If delay continues, contact House Supervisor for resolution. <p>If after two (2) hours of no change, consecutive Surge Capacity scores between 141 – 180, or based on patient census in department, worsening of the surge or deemed increased response needed due to the hospital at full census, or inability to discharge patients, accommodate surgeries and ED admissions:</p> <ul style="list-style-type: none"> ○ Consider contact with area EMS Providers and ALCO County hospitals by phone as needed. ○ Maintain notes on situation and time frames of incidents for after action and corrective action reports. ○ Consider request to Administrative Supervisor for additional staf to ED assist with patients and monitoring the ED Lobby, such as Nurse’s Aides, Float/Hold Nurses. ○ May request EVS and Transportation assigned to the ED to bring additional, available supplies, such as inpatient beds for ED holds, gurneys, IV Poles, portable monitors and more etc., the needed item types and locations of items to be delivered. ○ Ensure no delay in report and transfer of inpatients and inpatient holds to rooms when they are available on the EHR Screen. Report will be called by the ED RN to the assigned unit, when the EHR ○ Open designated overflow Area of the Emergency Department if stafing available. <p>ALH/SLH ED Physicians and APPs:</p> <ul style="list-style-type: none"> ○ In addition to standard operating procedures ○ Physician/APP ○ Monitor census, EPIC Overcrowding, & NEDOCS Scores. <ul style="list-style-type: none"> ○ Direct EMS patients wo WR as appropriate ○ As census allows, shift APP stafing to busier ED |
| <p>Inpatient Providers</p> | <p>Physicians/Hospitalists/Intensivists/Surgeons:</p> <ul style="list-style-type: none"> ○ For ICU admits, ED attending will sign out to intensivists/hospitalists for ICU patients to be transferred to ICU as soon as possible. Hospitalists/Intensivists will provide an admit order as soon as possible. ○ Prioritize discharges before and after rounds ○ Evaluate admitted patients boarded in the ED related to possible downgrades/ discharges/ transfers <ul style="list-style-type: none"> ■ Assist with the focus on prioritizing discharges and transfers ○ Facilitate and prioritize intercampus and interfacility transfers to ensure utilization of beds across the health system. ○ Communicate during rounds to RN Staf and CM/MSW potential same day and next day discharges ○ Huddle with CM/MSW early afternoon about discharges and barriers to discharge ○ Continue calling in Extra Hospitalist until census and score no longer reflects overcapacity ○ If Code Triage Internal Alert is activated, Physicians/Hospitalists/ Intensivists/Surgeons may be called in early for rounding as applicable. ○ May make request to Admin on Call to delay or cancel elective surgical cases until situation stabilizes ○ Assist with potential admission to other AHS facilities. |

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| <p>Inpatient Nursing: Medical Surgical, Surgical, Telemetry, Oncology, ICU, Pediatrics</p> | <p>HGH Inpatient Nurse Managers/Directors:</p> <ul style="list-style-type: none"> ○ If a Code Triage Internal Alert is called in this phase, the Department Director, Nurse Manager (if on-site) or Charge Nurse would complete the Departmental Disaster Status Report. ○ Assist with staffing needs and patient care on units, if needed and applicable. ○ Implement leadership rounding on departments and units with a focus on service recovery and identify unresolved problems. ○ May provide/assign departmental staff to the ED as requested and if applicable. ○ Report to emergency bed control meetings/Hospital Incident Command System (HICS) meetings as requested. ○ Consider calling in additional staff to facilitate admits and discharges. ○ Enforce “no delay” reporting and patient transfer to receiving unit with bed identification and readiness ○ Encourage discharge or transfer ASAP; assist with discharge and hold staff accountable for prompt discharge once the discharge order has been written (ASAP). Eliminate bed occupancy due to waiting discharge transportation. <p>HGH Inpatient Charge Nurses:</p> <ul style="list-style-type: none"> ○ If a Code Triage Internal Alert is called in this phase, the Department Director, Nurse Manager (if on-site) or Charge Nurse would complete the Departmental Disaster Status Report when requested. ○ Ensure no delay in report and transfer of inpatients and inpatient holds to rooms when available. Report to be called from ED when room is listed as ready on EHR for patient. If receiving nurse unable to take initial report from ED and has not called ED back for report within 15 minutes, the patient to be transported to room and receiving RN may call the ED with any questions. <p>SLH/ALH Inpatient Nurse Managers:</p> <ul style="list-style-type: none"> ○ If a Code Triage Internal Alert is called in this phase, the Department Nurse Manager, Assistant Nurse Manager, or Charge Nurse would complete the Departmental Disaster Status Report and report out to the Incident Command Center ○ Assist with staffing needs and patient care on units, if needed and applicable. ○ Implement leadership rounding on departments and units with a focus on service recovery and identify unresolved problems. ○ Report to emergency bed control meetings/Hospital Incident Command System (HICS) meetings as requested. ○ Call in additional staff to facilitate admits and discharges. ○ Enforce “no delay” reporting and patient transfer to receiving unit with bed identification and readiness ○ Encourage discharge or transfer ASAP; assist with discharge and hold staff accountable for prompt discharge once the discharge order has been written (ASAP). Eliminate bed occupancy due to waiting discharge transportation, approve Lyft/Uber for all appropriate patients <p>SLH/ALH Inpatient Charge Nurses:</p> <ul style="list-style-type: none"> ○ If a Code Triage Internal Alert is called in this phase, the Department Nurse Manager, Assistant Nurse Manager, or Charge Nurse would complete the Departmental Disaster Status Report and report out to the Incident Command Center ○ Ensure no delay in report and transfer of inpatients and inpatient holds to rooms when available. Report to be called from ED when room is listed as ready on EHR for patient. If receiving nurse unable to take initial report from ED and has not called ED back for report within 15 minutes, the patient to be transported to room and receiving RN may call the ED with any questions. |
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| Family Birthing Center | <p>Physicians:</p> <ul style="list-style-type: none"> ○ Coordinate with House Supervisor and/or Incident Commander (IC) on: <ul style="list-style-type: none"> ○ which overflow patients to expect and staffing needs ○ providing additional interdisciplinary staffing and supplies ○ Refer to Internal Escalation Policy for additional physician staffing ○ Prioritize and facilitating transfers and discharges <p>Nurse Manager:</p> <ul style="list-style-type: none"> ○ Work with nurse staffing and supervisors to identify any increased capacity for accepting transfers from other acute care sites ○ Palliative care and subspecialty consultants to prioritize seeing patients for earlier disposition |
| Same Day Surgery & PACU | <p>Surgery Manager:</p> <ul style="list-style-type: none"> ○ Coordinate with House Supervisor and/or Incident Commander (IC) on: <ul style="list-style-type: none"> ○ which overflow patients to expect and staffing needs ○ providing additional interdisciplinary staffing and supplies ○ Prepare for potential ED overflow patient admissions ○ Monitor equipment and supplies |
| Care Management | <p>Managers of Case Management/Social Work:</p> <ul style="list-style-type: none"> ○ Assign Managers on each floor to round to focus on expediting discharges with staf. ○ Provide Updates on discharges during the 1pm and 4pm bed huddle call with nursing leadership ○ Escalate to Director for special discharge needs that exceed Managers scope of approval then VP Care Management ○ Continual update to nursing supervisor of SLH/ALH of potential and confirmed discharges. <p>RN Case Managers:</p> <ul style="list-style-type: none"> ○ Notify skilled nursing facilities of high census in hospital when discussing discharge transfer times <p>Director:</p> <ul style="list-style-type: none"> ○ Director to huddle with managers to assess progress and any barriers |
| Bed Control | <p>Reprioritize patients bed assignment based on their Level of Care (LOC) and urgency:</p> <ol style="list-style-type: none"> 1. Prioritize inpatient code blue or Rapid Response Team (RRT) situations that require high-level of care (HLOC) transfers. 2. Prioritize the sickest/critical patients in the ED. 3. Consider HLOC transfers from AHS/SLH based on urgent needs, evaluated on a case-by-case basis. 4. Follow up with surgical patients from PACU/ISSU, considering any level of care provided there is no surge. 5. Finally, Observation (OBS) patients (elderly, dementia, frail patient). |
| Transfer Center | <p>Transfer Center:</p> <ul style="list-style-type: none"> ○ Transfer Coordinator to contact/chat with the team and assigned providers to determine appropriate transfer candidates for transfer to alternate AHS Acute Care campuses ○ Initiate transfer of all ED boarders that are appropriate transfer candidates. |

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| | <ul style="list-style-type: none"> ○ Communicate with House Supervisors at all sites (AH & SLH) to facilitate immediate transfer to designated open beds with approximate transfer time of arrival. ○ Partner with Dept of Medicine Director to revisit and communicate with patients who have declined transfer to facilitate transfers for patient safety (During office hours) Also need patient centered scripting. |
| Transportation Tech | <p>Director or Nursing Supervisor on Duty:</p> <ul style="list-style-type: none"> ○ Assure adequate staffing to support ED and in-house patient needs ○ Call-in additional Transportation personnel, if requested, to assist with transportation issues such as the transportation of additional needed equipment like gurneys, IV poles, monitors and other items requested at the time to the ED, ED Lobby or other locations utilized for emergency triage and treatment, such as the MCI Triage Surge Tent or other identified surge capacity locations. ○ Coordinate with House Supervisor to prioritize patient transport responsibilities, if applicable. ○ Provide additional personnel as needed and available to expedite turnaround times (TAT) for patient transportation. ○ ALH NST to be utilized to expedite patient transportation |
| Diagnostic Imaging | <p>Radiologist:</p> <ul style="list-style-type: none"> ○ Receives updates regarding surge status ○ Expedites interpretation of emergency exams or inpatient exams that are pending discharge ○ Reach out to Radiologists reading at other facilities through electronic communication to help read overflow exams ○ Place preliminary results on all ER exam reads ○ Consider calling ER physician with read results <p>Director of Imaging or Imaging Admin on Call:</p> <ul style="list-style-type: none"> ○ Huddle with ED Charge Nurse to determine how Imaging could assist in this phase of surge management when Code Triage Internal Alert is announced. ○ As requested, focus on other key locations in the department and vary their daily assignments. ED patients with acute needs take precedence over holding patients in department. Expedite any pending imaging exams for pending discharge patients ○ Consider the need to call in additional Imaging personnel if requested to do so by ED Charge Nurse, House Supervisor and/or Incident Commander (IC) to ensure adequate staffing to support ED and/or in-house increased patient capacity. ○ Consult with House Supervisor, ED Nurse Manager and Incident Commander (if applicable) prior to decisions of releasing staff for unit downsizing. ○ Participates in debriefing |
| Laboratory | <p>Laboratory Director or on-Duty Supervisor:</p> <ul style="list-style-type: none"> ○ Attend bed huddles and Hospital Incident Command System (HICS) meetings to assist with surge management when Code Triage Internal Alert is announced. ○ Expedite lab draws for pending discharge patients ○ Consider the need to call in additional laboratory personnel if requested to do so by ED Charge Nurse, House Supervisor and/or Incident Commander (IC) to ensure adequate staffing to support ED and/or in-house increased patient capacity. ○ Depending upon the incident, utilize Down Time forms. ○ Consult with House Supervisor, ED Nurse Manager and Incident Commander (if applicable) prior to decisions of releasing staff for unit downsizing. ○ Report to emergency bed control meetings/Hospital Incident Command System (HICS) meetings as applicable. ○ Participates in debriefing |

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| | <p>ED Phlebotomist on Duty:</p> <ul style="list-style-type: none"> ○ Focus on other key locations in the department, as requested by ED leadership. Note that, ED patients with acute needs take precedence over holding patients in department. |
| <p>Respiratory Therapy</p> | <p>Respiratory Therapy Practitioner Lead on Duty:</p> <ul style="list-style-type: none"> ○ Contact the ED Charge Nurse to determine how RT could assist in this phase of surge management when Code Triage Internal Alert paged overhead. ○ Focus on other key locations in the department and vary daily assignments to address urgent needs first, as requested by ED leadership. ED patients with acute needs take precedence over holding patients in department. ○ Consider the need to call in additional RT personnel if requested to do so by ED Charge Nurse, House Supervisor and/or Incident Commander (IC) to ensure adequate staffing to support ED and/or in-house increased patient capacity. ○ Consult with House Supervisor, ED Nurse Manager and Incident Commander (if applicable) prior to decisions of releasing staff for unit downsizing. ○ Participates in debriefing <p>ED Assigned Respiratory Therapist</p> <ul style="list-style-type: none"> ○ Reports to the ED and coordinates with the ED Charge Nurse for a situation report and if they can assist with the surge situation such as modification of daily operations and prioritization of all Respiratory Therapy: <ul style="list-style-type: none"> ■ Prioritizes discharge treatments within each ED ■ Prepare patients for interfacility transfers ■ Maintain and monitor respiratory supply availability <p>Inpatient Respiratory Therapists:</p> <ul style="list-style-type: none"> ○ Coordinates with the unit Charge Nurse for a situation report and if they can assist with the surge situation such as modification of daily operations and prioritization of all Respiratory Therapy: <ul style="list-style-type: none"> ■ Prioritizes discharge diagnostics, treatments, and teachings ■ Prepare patients for interfacility transfers |
| <p>Rehabilitation Services</p> | <p>Rehabilitation Services Manager:</p> <ul style="list-style-type: none"> ○ Expedite reviewing charts and accepting patients for transfer to Rehab facilities ○ Reallocate staff as appropriate <p>Inpatient & ED Therapists:</p> <ul style="list-style-type: none"> ○ Therapist in the ED evaluating and assessing for Rehabilitation Needs ○ Monitor, review and treat ○ Prioritize PT / OT / SLP assess / evals pending discharge ○ Prioritize providing DMEs for discharge patients ○ Triage, assign patient referrals, and provide outcomes and updates ○ Patients will be seen in the following prioritization order: <ul style="list-style-type: none"> ○ Patients who are “discharge ready” or need an evaluation for transfer or discharge |

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| Pharmacy | <p>All Pharmacy Managers:</p> <ul style="list-style-type: none"> ○ Assess and identify department needs related to increased staffing, support in the ED and inpatient units, inventory and medications stations. Report to Incident Command Center. ○ Attends bed huddles and Hospital Incident Command System (HICS) meetings to assist with the surge situation management when Code Triage Internal Alert is announced. ○ Assess the need to call in additional SAN support for management of ED patients and boarders, and medication deliveries or compounding ○ Assess inventory and shortages; borrow/loan meds between sites as needed ○ If needed, work with buyers to place emergency medication orders from Mckesson as needed ○ Check in with ED Nurse Manager/Charge Nurse to identify any medication/pharmacy related opportunities and barriers to assist throughput ○ Evaluate supply of emergency kits/transport boxes. Ensure all emergency kits/trays are replenished and sent out to their assigned locations if used. ○ If additional staff used, consult with Administrative Supervisor, ED Nurse Manager and Incident Commander (if applicable) prior to decisions of releasing staff for unit downsizing. <p>HGH Inpatient Pharmacy:</p> <ul style="list-style-type: none"> ○ Standard operating procedures in effect for all inpatient holds in ED. ○ Unit based pharmacists will check with charge nurse to expedite possible discharges ○ If House Supervisor activates overflow inpatient units, run pyxis reports for Periop Overflow Pyxis and fill pyxis to max ○ Ensure all pyxis medications are filled to max and stockouts refilled by the next hourly delivery ○ Expedite any medications that need to be administered prior to patient discharge <p>HGH Outpatient/Discharge Pharmacy:</p> <ul style="list-style-type: none"> ○ Pharmacists will receive pending discharge medications request from nurse, nursing leadership or case manager and will prioritize assessments for IP and ED discharges. ○ Pharmacy leadership will reassign staff from supporting ambulatory care patient medication processing, to ED or Discharge patient medications, if multiple discharge medication orders are concurrently requested. <ul style="list-style-type: none"> ○ Discharge medications, based on order of request from nursing or discharge teams, will be prioritized for processing. ○ Offer medication courier delivery, offer ambulatory care patients (non-ED or IP Discharge) patients to pick up medications from outside pharmacy (if insurance allows) or next day pick up from Highland Outpatient pharmacy. <p>SLH Pharmacy</p> <ul style="list-style-type: none"> ○ Pharmacists: <ul style="list-style-type: none"> ○ Pull All Pharmacists to central pharmacy to help with production workflow ○ Call SAN's for availability, Check with Staff for OT availability. ○ Call remote services- Cardinal to be on standby to work on the production workflow if needed. ○ Technicians: <ul style="list-style-type: none"> ○ Run Pyxis report and fill to max <ul style="list-style-type: none"> ■ Expedite any medications that need to be administered prior to patient discharge. |
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| | <p>ALH Pharmacy</p> <ul style="list-style-type: none"> ○ Pharmacists: <ul style="list-style-type: none"> ○ Pull All Pharmacists to central pharmacy to help with production workflow ○ Call SAN's for availability, Check with Staf for OT availability. ○ Call remote services- Cardinal to be on standby to work on the production workflow if needed. ○ Technicians: <ul style="list-style-type: none"> ○ Run Pyxis report and fill to max <ul style="list-style-type: none"> ■ Expedite any medications that need to be administered prior to patient discharge. |
| <p>Environmental Services</p> | <p>All Environmental Services (EVS) Staf: Additional EVS personnel will be assigned to the ED to assist with room cleaning and the setup of surge equipment, such as gurneys, IV poles, and gurneys for ED holds</p> <p>ED EVS Technician:</p> <ul style="list-style-type: none"> ○ Checks in with the ED Charge Nurse for a situation report and expedites bed cleaning to assist with the surge situation as needed. ○ Quickly updates AHS EPIC by changing dirty rooms to clean once turnover is completed. ○ Reports to their Director or Supervisor on Duty as needed regarding the surge capacity situation. <p>Director or Supervisor on Duty:</p> <ul style="list-style-type: none"> ○ Attends bed huddles and Hospital Incident Command System (HICS) meetings as required ○ Coordinates with House Supervisor to prioritize in-patient bed cleaning responsibilities if applicable. ○ Assigns additional EVS staf to the ED, to assist with room cleaning or other issues in ED such as the transportation of additional needed equipment like gurneys, IV poles, monitors and other items requested at the time to the ED, ED Lobby or other locations utilized for emergency triage and treatment, such as the MCI Triage Surge Tent or other identified surge capacity locations. ○ Dispatches assigned ED EVS Personnel to next room that needs cleaning in house to expedite turnaround times (TAT) for admission to the floor ○ Consults with Administrative Supervisor, ED Nurse Manager and Incident Commander (if applicable) prior to decisions of releasing staf for unit downsizing. |
| <p>Facilities</p> | <p>Infrastructure Check:</p> <ul style="list-style-type: none"> ○ Activate continuous monitoring for all critical HVAC, life-safety, negative pressure, medical vacuum, and medical oxygen systems. <p>Emergency Power:</p> <ul style="list-style-type: none"> ○ Confirm continuous monitoring of generator operation and fuel supply. Pre-stage supplementary fuel if required. <p>Utilities:</p> <ul style="list-style-type: none"> ○ Assign staf to monitor high-volume water and sewer connections for potential failure. <p>Communication:</p> <ul style="list-style-type: none"> ○ Director-level notification (James Helena) to the Hospital Incident Command System (HICS) if an infrastructure failure or imminent threat is detected. |

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| <p>Materials Management</p> | <p>Materials Management (MM) Manager:</p> <ul style="list-style-type: none"> ○ Allocate Central Supply resources to support ED Surge with needed supplies ○ Pull Emergency supplies to replenish fast moving and other ED items as needed. ○ Report staf and supply availability to the House Supervisor. ○ If other facilities are stable, MM Manager will assess feasibility of allocating additional resources to the Highland Campus for immediate support. <p>Central Supply Staf:</p> <ul style="list-style-type: none"> ○ Be available in Central Supply to fill request and act as runners. |
| <p>Security</p> | <p>Site Lead on Duty:</p> <ul style="list-style-type: none"> ○ When Code Triage Internal Alert is paged overhead, reports to the ED and coordinates with the ED Charge Nurse for a situation report and if Security can assist with the surge situation. ○ May consider recall and potential posting of additional Security Personnel on-site in key locations such as the ED Waiting Area and potential posting in ED Surge Triage sites if applicable. ○ Consult with Administrative Supervisor, ED Nurse Manager and Incident Commander (if applicable) prior to decisions of releasing staf for unit downsizing. ○ Reports to emergency bed control meetings/Hospital Incident Command System (HICS) meetings as requested. |
| <p>Food & Nutrition Services</p> | <p>Food & Nutrition Services (FNS) Manager:</p> <ul style="list-style-type: none"> - Assess stafing needs and reallocate stafing and resources as indicated <p>Food & Nutrition Services (FNS) Supervisors:</p> <ul style="list-style-type: none"> - Round unit nourishment rooms to assess supply and restock as indicated |

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Critical Over Capacity
(Internal / External Disaster)

| Department | Response Actions |
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| Hospital Administration | <p>Chief Administrative Officer (CAO) / Associate Chief Nursing Officer (ACNO):</p> <ul style="list-style-type: none"> ○ Upon notification from House Supervisor, activate a Code Triage: Internal/External Alert and Hospital Incident Command System (HICS) ○ Coordinate with Regulatory Affairs regarding State notification requirements ○ If Code Triage is activated, ensure the Chief Nursing Executive or AOC assumes the Incident Commander (IC) role ○ Receive SBAR from House Supervisor and lead operational briefings and HICS meetings ○ Direct acceptance decisions for higher-level-of-care transfers (i.e. Traumas) in coordination with the Trauma Program Director ○ Reassign available Nurse Managers to serve as a second House Supervisor to support bed management and hospital operations. ○ Authorize opening of alternate care sites (e.g. Periop, PACU, ISSU) and activation of additional staffing. (Notify Regulatory Affairs to assess and initiate CDPH notification, if applicable) ○ Direct postponement or cancellation of elective surgeries requiring inpatient beds ○ Direct Case Management to expedite discharges and transfers ○ Deploy PACU as a step-down option for stable ICU patients to decompress ICU capacity ○ Activate the Administrative Recovery Team as indicated ○ Ensure debriefing is scheduled within 7 calendar days of incident resolution <p>Associate Chief Medical Officer (ACMO), Acute Care Services:</p> <ul style="list-style-type: none"> ○ Partner with CAO/ACNO on activating Code Triage and HICS ○ Partner with CAO/ACNO on prioritizing higher-level-of-care transfers (i.e. Surgical specialties, Gastroenterology, Interventional Radiology, etc.) in coordination with specialist on call ○ Direct engagement with medical staff department chairs and division chiefs to expedite discharges, downgrades, and interfacility transfers to level load admissions ○ As nursing and inpatient staffing capacity increases to accommodate increasing patient census, work with medical staff department chairs and division chiefs to deploy hospitalists and intensivists to support inpatient rounds and discharge decision-making ○ Work with perioperative and procedural leaders to consider delaying elective surgeries and procedures ○ Work ED leadership, inform EMS Agency internal disaster and consideration of ambulance diversion local EMS protocols <p>Inpatient Nursing Directors and VP:</p> <ul style="list-style-type: none"> ○ Evaluate and determine acceptance of all incoming transfers ○ Execute surge staffing plans, including mandatory overtime, staffing for boarders, and temporary staffing variances, notifying Regulatory Affairs as required ○ Review surgical schedules with the Administrative Supervisor and the Surgical Services leadership and direct delays or cancellations of elective and add-on procedures as needed. ○ Utilize PACU or ISSU for ED general holds or ED surgical holds when feasible (i.e. when staff and beds are available) ○ Coordinate with Quality and Regulatory Affairs to secure approval from regulatory agencies for alternate patient care areas |

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| | <ul style="list-style-type: none"> ○ Direct Case Management to accelerate early discharges, discharges, and interfacility transfers ○ Initiate service recovery planning as appropriate <p>Administrator on Call (AOC)-Of Hours and Weekends:</p> <ul style="list-style-type: none"> ○ Upon notification from House Supervisor, activate a Code Triage: Internal/External Alert and the Hospital Incident Command System (HICS) ○ Notify Nursing and Physician leadership of disaster conditions and operational impacts ○ Assume or delegate Incident Commander (IC) role as required to launch the Hospital Incident Command System (HICS) ○ Lead operational briefings and coordinate with House Supervisor to ensure Situational Updates are distributed, at a minimum after every Emergency Bed Control Briefing ○ Alert Regulatory Affairs and coordinate state notifications and requirements ○ Authorize opening of alternate care sites (i.e. Periop, PACU, ISSU) and activation of additional staffing. (Notify Regulatory Affairs to assess and initiate CDPH notification, if applicable) ○ Direct postponement or cancellation of elective surgeries requiring inpatient beds ○ Direct Case Management to expedite discharges and transfers ○ Deploy PACU as a step-down option for stable ICU patients to decompress ICU capacity ○ Activate the Administrative Recovery Team as indicated ○ Ensure debriefing is scheduled within 7 calendar days of incident resolution |
| <p>House Supervisors</p> | <p>HGH House Supervisor:</p> <ul style="list-style-type: none"> ○ Communicate with ED Charge Nurse and ED MD and Unit Charge Nurses- for situational awareness ○ Communicate with AOC regarding NEDOCS score - Activate: <ul style="list-style-type: none"> ○ Code Triage ○ Hospital Incident Command System (HICS) & meetings ○ Emergency Bed Huddle ○ Discuss State notification requirements. ○ Assume role of Incident Commander (IC) until relieved by AOC. Provide SBAR to AOC upon arrival. ○ Evaluate acceptance of all incoming higher level of care transfers, to include neuro patients (Trauma consideration at the direction of the Incident Commander and Trauma Program Director). ○ Reprioritize the order in which patients are granted inpatient beds based upon most urgent need. ○ Refocus EVS to priority STAT cleans for urgent needs ○ Deploy Transport with a focus on ED Admissions ○ Alert specific units to accept bedside report. Floor RNs should come to ED for report and transfer patients to floors ○ Alert units regarding placing of stable, alert and oriented admit or transfer patient to hallway of Med Surg unit when staffed bed is “In Progress” (EVS stationed in room actively cleaning. Maximum number of hallway beds allowed is one per wing. This requires notification and approval of Unit Director or Nurse Manager and will occur only when unit leadership present. ○ Initiate labor pool at the direction of the Incident Commander ○ Open alternative care sites (overflow inpatient units) on Periop, PACU or ISSU as able, in regards to bed availability and staffing - call in staf as necessary or at the direction of the Incident Commander. (Notify Regulatory Affairs to assess and initiate CDPH notification, if applicable) ○ Consult with ED Charge Nurse, ED Nurse Manager, ED Medical Director and Administrative on Call (AOC) to determine need for Surge Capacity resources (e.g. tents, cots, etc.) and potential staffing needs. |

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| | <ul style="list-style-type: none"> ○ Transfer non-neuro, non-trauma, stable, ICU patients to other facilities at the direction of the Incident Commander. Consider initiating disaster transfer response ○ Postpone elective surgeries that require a post op, inpatient bed if instructed by the Incident Commander ○ Reassign any available Nurse Manager to function as a 2nd House Supervisor (one to manage beds, 2nd to manage house) ○ Case Manager to facilitate early discharges and transfers of admitted patients to other facilities ○ Open PACU for transfers from ICU of stable patients to decompress ICU and open beds for admissions at the direction of the Incident Commander. ○ Participates in debriefing with Incident Commander (IC) (if applicable) <p>ALH/SLH House Supervisor:</p> <ul style="list-style-type: none"> ○ Communicate with ED Charge Nurse, ED MD and Unit Charge Nurses- for situational awareness ○ Communicate with AOC regarding NEDOCS score - Activate: <ul style="list-style-type: none"> ○ Code Triage ○ Hospital Incident Command System (HICS) ○ Emergency Bed Huddle ○ Discuss State notification requirements. ○ Assume role of Incident Commander (IC) until relieved by AOC. Provide SBAR to AOC upon arrival. ○ Reprioritize the order in which patients are granted inpatient beds based upon most urgent need. ○ Refocus EVS to priority STAT cleans for urgent needs ○ Alert specific units to accept bedside report. ○ Open overflow inpatient unit in Periop & PACU or other designated areas as able regarding bed availability and staffing - call in staf as necessary. (Notify Regulatory Affairs to assess and initiate CDPH notification, if applicable) ○ Consult with ED Charge Nurse, ED Nurse Manager, ED Assistant Nurse Manager, ED Medical Director and Administrator on Call (AOC) to determine need for Surge Capacity resources (e.g. tents, cots, etc.) and potential staffing needs. ○ Prepare to receive non-neuro, non-trauma, stable, ICU patients from other AHS facilities at the direction of the Incident Commander. ○ Postpone elective surgeries that require a post op, inpatient bed as instructed by the Incident Commander ○ Case Manager to facilitate early discharges and transfers of admitted patients to other facilities ○ Participates in debriefing with Incident Commander (IC) (if applicable) <ul style="list-style-type: none"> ○ SLH House Supervisor Coverage: <ul style="list-style-type: none"> ○ House Supervisor on Duty <ul style="list-style-type: none"> ■ 4p-8am M-F ■ 24/7 Weekends ○ No Coverage (Unit Managers responsible for escalation) <ul style="list-style-type: none"> ■ 8am – 4pm M-F |
| Emergency | <p>HGH ED Charge Nurse:</p> <ul style="list-style-type: none"> ○ Discuss announcing NEDOCS BLACK with House Supervisor and ED MD ○ Confirm House Supervisor (or designee) will discuss with AOC a possible need to activate Code Triage alert ○ Update NEDOCS Score and (ReddiNet/EMSystems/HAVBED/NEDOCS) at least every 2 hours or more frequently, as needed and provide additional updates to ED MD, House Supervisor (or designee) as per NEDOCS protocol |

- Contact EMS, update Reddinet/EMSystems, and request diversion if appropriate. Notify House Supervisor (or designee) of any diversion request. (Note: follow local county guidelines)
 - Review the Emergency Department Census with the Attending Emergency MD and House Supervisor to look for disposition opportunities
 - Tests/Procedures /Medications/Treatments
 - Discharge Issues (Family, Transportation, Prescriptions, Equipment, etc...)
 - Transfer of Appropriate Patients
 - Discuss opportunities and barriers with ED team leads, radiology, laboratory, security, registration, pharmacy, inpatient Charge Nurses, and other stakeholders
 - Assign additional staf to:
 - Optimize space and location of boarding patients in the ED
 - Designate specific treatment areas as needed (i.e. boarding area, Ed Treatment area, Discharge area, triage area)
 - Allocate resources to each designated area as appropriate
 - Attend emergency briefings and bed control meetings to provide ED situation reports
 - Consider expanding the Triage Staffing to include additional provider, RN and ED Technician and requesting EVS and Transport staf
 - Determine and request additional supplies a needed
 - Assure rapid transport of admissions to floor (ether by transport, ED, or floor staf)
 - Confirm with House Supervisor (or designee) opening of Surge Areas, as directed by Incident Commander (IC)
 - Facilitate patient movements appropriately
 - Discuss with ED Director to open alternative care sites (MCI tent, MOB, Urgent Care) as directed by Incident Commander
 - Reassign ED float RN and tech to designated surge areas and alternative care sites if open
 - Perform service recovery as needed
 - Participates in debriefing with Incident Commander (IC) (if applicable)
- HGH Physicians/Hospitalists/Intensivists/Surgeons:**
- Run bed board with House Supervisor and ED Charge Nurse Confirm:
 - Incident Commander (IC) is aware+
 - NEDOCs Black and/or Code Triage Internal/External will be alerted
 - If no beds, or very limited beds, available in the facility, the Lead ED Physician or the ED Medical Director may work with admitting physicians and the Administrative Supervisor to arrange and coordinate transfer of ED patients awaiting admission to other AHS facilities if applicable.
 - Discuss with ED Charge Nurse possible request for EMS diversion
 - Confirm with Hospitalist, Intensivist, and Trauma Surgeon that extra staf have been call in if indicated
 - Review the Emergency Department Census with the ED Charge Nurse and House Supervisor to look for disposition opportunities
 - Tests/Procedures /Medications/Treatments
 - Discharge Issues (Family, Transportation, Prescriptions, Equipment, etc...)
 - Conduct Rapid Medical Evaluation with Provider and RN Teams to initiate Medical Screening Exams on waiting patients as able.
 - Staf additional ED Surge Areas, if open, according to emergency response plan if code triage and the Hospital Incident Command System (HICS) are activated
 - ED Provider will coordinate with admitting physicians/services to expedite patient care; hospitalists will place order for appropriate patients including ICU admissions, per normal workflow
 - Coordinate and work together with ED Charge Nurse and ED Nurse Manager in assisting with patient flow and throughput.
 - Lead ED Physician or the ED Medical Director may contact additional ED Physicians and PAs not on duty to respond to the department to assist.

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| | <p>ALH/SLH ED Charge Nurses:</p> <ul style="list-style-type: none"> ○ Use Highland’s action plan as appropriate ○ Communicate with Incident Command Center as directed and participates in debriefing with Incident Commander (IC) (if applicable) ○ Utilize all space allocated for patient care with additional staffing support. <p>ALH/SLH ED Physicians and APPs:</p> <ul style="list-style-type: none"> ○ Contact Medical Director(s) who will attend HICS ○ Mass text to provider pool to recruit extra physician/APP <ul style="list-style-type: none"> ○ Consider resident pool as moonlighters ○ Activate alternate treatment space for boarding patients and patients pending results (ALH conference room, SLH Registration room) |
| <p>Inpatient Providers</p> | <p>Physicians/Hospitalists/Intensivists/Surgeons:</p> <ul style="list-style-type: none"> ○ Report to Hospital Incident Command System (HICS) and fulfill tasks per direction of the Incident Commander (if applicable) ○ For ICU admits, ED attending will sign out to intensivists/hospitalists for ICU patients to be transferred to ICU as soon as possible. Hospitalists/Intensivists will provide an admit order as soon as possible. ○ Prioritize discharges before and after rounds ○ Evaluate admitted patients boarded in the ED related to possible downgrades/ discharges/ transfers <ul style="list-style-type: none"> ■ Assist with the focus on prioritizing discharges and transfers ○ Facilitate and prioritize intercampus and interfacility transfers to ensure utilization of beds across the health system. ○ Communicate during rounds to RN Staf and CM/MSW potential same day and next day discharges ○ Huddle with CM/MSW early afternoon about discharges and barriers to discharge ○ Continue calling in Extra Hospitalist until census and score no longer reflects overcapacity ○ When Code Triage Internal/External Alert is activated, Physicians/Hospitalists/ Intensivists/Surgeons may be called in early for rounding as applicable. ○ Request to delay or cancel elective surgical cases until situation stabilizes. ○ Assist with potential admission to other AHS facilities. ○ Participates in debriefing with Incident Commander (IC) (if applicable) |
| <p>Inpatient Nursing: Medical Surgical, Surgical, Telemetry, Oncology, ICU, Pediatrics</p> | <p>HGH Inpatient Nurse Managers/Directors:</p> <ul style="list-style-type: none"> ○ Upon activation of Code Triage Internal/External Alert the Nurse Manager (if on-site) or Charge Nurse will complete the Departmental Disaster Status Report. ○ Assist with staffing needs and patient care on units, as needed. ○ Implement leadership rounding on departments and units with a focus on service recovery and identify unresolved problems. ○ May provide/assign departmental staf to the ED or labor pool as requested ○ Attend emergency bed control meetings/Hospital Incident Command System (HICS) meetings as requested. ○ Consider calling in additional staf to facilitate admits and discharges. ○ Enforce “no delay” reporting and patient transfer to receiving unit with bed identification and readiness ○ Assist with discharge and transfers, hold staf accountable for prompt discharge once the discharge order has been written (ASAP). ○ Implement strategies to recover services ○ Participates in debriefing with Incident Commander (IC) (if applicable) |

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| | <p>HGH Inpatient Charge Nurses:</p> <ul style="list-style-type: none"> ○ Upon activation of Code Triage Internal/External Alert the Nurse Manager (if on-site) or Charge Nurse will complete the Departmental Disaster Status Report. ○ Collaborate with CM, MD, House Supervisors, and Nurse Managers with admission/discharges <ul style="list-style-type: none"> ○ Immediate updates regarding discharges to allow for immediate bedding of ED Boarding patients or downgraded in-patients. ○ Initiate bedside report at this surge level for all transfers and ED patients ○ Report to Incident Command Center as requested. <p>SLH/ALH Inpatient Nurse Managers:</p> <ul style="list-style-type: none"> ○ If a Code Triage Internal/External Alert is called in this phase, the Department Manager, Assistant Nurse Manager, or Charge Nurse would complete the Departmental Disaster Status Report and report out to the Incident Command Center ○ Assist with staffing needs and patient care on units, as needed. ○ Implement leadership rounding on departments and units with a focus on service recovery and identify unresolved problems. ○ Attend emergency bed control meetings/Hospital Incident Command System (HICS) meetings as requested. ○ Call in additional staff to facilitate admits and discharges. ○ Enforce “no delay” reporting and patient transfer to receiving unit with bed identification and readiness ○ Assist with discharge and transfers, hold staff accountable for prompt discharge once the discharge order has been written (ASAP). ○ Implement strategies to recover services ○ Participates in debriefing with Incident Commander (IC) (if applicable) <p>SLH/ALH Inpatient Charge Nurses:</p> <ul style="list-style-type: none"> ○ Collaborate with CM, MD, House Supervisors, and Nurse Managers with admission/discharges <ul style="list-style-type: none"> ○ Immediate updates regarding discharges to allow for immediate bedding of ED Boarding patients or downgraded in-patients. ○ Initiate bedside report at this surge level for all transfers and ED patients ○ Report to Incident Command Center as requested. |
| <p>Family Birthing Center</p> | <p>Physicians:</p> <ul style="list-style-type: none"> ○ Report to Hospital Incident Command System (HICS) and fulfill tasks per direction of the Incident Commander (if applicable) ○ Coordinate with House Supervisor and/or Incident Commander (IC) on <ul style="list-style-type: none"> ○ which overflow patients to expect and staffing needs ○ providing additional interdisciplinary staffing and supplies ○ Refer to Internal/External Escalation Policy for additional physician staffing ○ Prioritize and facilitating transfers and discharges <p>Nurse Manager:</p> <ul style="list-style-type: none"> ○ Report to Hospital Incident Command System (HICS) and fulfill tasks per direction of the Incident Commander (if applicable) ○ Work with nurse staffing and supervisors to identify any increased capacity for accepting transfers from other acute care sites ○ Palliative care and subspecialty consultants to prioritize seeing patients for earlier disposition ○ Participates in debriefing with Incident Commander (IC) (if applicable) |

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| Same Day Surgery & PACU | <p>Surgery Manager:</p> <ul style="list-style-type: none"> • Report to Hospital Incident Command System (HICS) and fulfill tasks per direction of the Incident Commander (if applicable) • Coordinate with House Supervisor and/or Incident Commander on <ul style="list-style-type: none"> ○ which overflow patients to expect and staffing needs ○ providing additional interdisciplinary staffing and supplies • Prepare for potential ED overflow patient admissions • Monitor equipment and supplies • Participates in debriefing with Incident Commander (IC) (if applicable) |
| Care Management | <p>All Care Management Staf:</p> <ul style="list-style-type: none"> • Report to Hospital Incident Command System (HICS) and fulfill tasks per direction of the Incident Commander (if applicable) |
| Bed Control | <p>All Bed Control Staf:</p> <ul style="list-style-type: none"> • Report to Hospital Incident Command System (HICS) and fulfill tasks per direction of the Incident Commander (if applicable) • Reprioritize patients bed assignment based on their Level of Care (LOC) and urgency: <ol style="list-style-type: none"> 1. Prioritize inpatient code blue or Rapid Response Team (RRT) situations that require high-level of care (HLOC) transfers. 2. Prioritize the sickest/critical patients in the ED. 3. Consider HLOC transfers from AHS/SLH based on urgent needs, evaluated on a case-by-case basis. 4. Follow up with surgical patients from PACU/ISSU, considering any level of care provided there is no surge. 5. Finally, Observation (OBS) patients (elderly, dementia, frail patient). |
| Transfer Center | <p>Transfer Center Director:</p> <ul style="list-style-type: none"> ○ Report to Hospital Incident Command System (HICS) and fulfill tasks per direction of the Incident Commander (if applicable) ○ Partner with Dept of Medicine Director to revisit and communicate with patients who have declined transfer to facilitate transfers for patient safety (During office hours) ○ Also need patient centered scripting <p>Transfer Center:</p> <ul style="list-style-type: none"> ○ Notification to House Supervisors at all sites (AH & SLH) of immediate transfer ETA to open beds |
| Patient Transport Tech | <p>Director or Supervisor on Duty:</p> <ul style="list-style-type: none"> ○ Report to emergency bed control meetings/Hospital Incident Command System (HICS) meetings as needed ○ Assure adequate staffing to support ED and in-house patient needs ○ Call-in additional Transportation personnel, if requested, assist with transportation issues such as the transportation of additional needed equipment like gurneys, IV poles, monitors and other items requested at the time to the ED, ED Lobby or other locations utilized for emergency triage and treatment, such as the MCI Triage Surge Tent or other identified surge capacity locations. ○ ALH NST to be utilized to expedite patient transportation ○ Coordinate with House Supervisor to prioritize patient transport responsibilities, if applicable. ○ Provide additional personnel to as needed and available to expedite turnaround times (TAT) for patient transportation. ○ Consult with House Supervisor, ED Nurse Manager and Incident Commander (if applicable) prior to decisions of releasing staf for unit downsizing |

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| Diagnostic Imaging | <p>Radiologists:</p> <ul style="list-style-type: none"> ○ Report to Hospital Incident Command System (HICS) and fulfill tasks per direction of the Incident Commander (if applicable) ○ Receives updates regarding surge status ○ Expedites interpretation of emergency exams or inpatient exams that are pending discharge ○ Reach out to Radiologists reading at other facilities through electronic communication to help read overflow exams ○ Place preliminary results on all ER exam reads ○ Consider calling ER physician with read results <p>Director of Imaging or Imaging Admin on Call:</p> <ul style="list-style-type: none"> ○ Attend bed huddles and Hospital Incident Command System (HICS) meetings. ○ As requested, focus on other key locations in the department and vary their daily assignments. ED patients with acute needs take precedence over holding patients in department. ○ Expedite any pending imaging exams for pending discharge patients ○ Call in additional Imaging personnel if needed to ensure adequate staffing to support ED and/or in-house increased patient capacity. ○ Consult with House Supervisor, ED Nurse Manager and Incident Commander (if applicable) prior to decisions of releasing staf for unit downsizing. ○ Participates in debriefing with Incident Commander (IC) (if applicable) |
| Laboratory | <p>Laboratory Director or on-Duty Supervisor:</p> <ul style="list-style-type: none"> ○ Attend bed huddles and Hospital Incident Command System (HICS) meetings to assist with surge management when Code Triage Internal/External Alert paged overhead. ○ Expedite lab draws for pending discharge patients ○ Consider the need to call in additional laboratory personnel if requested to do so by ED Charge Nurse, House Supervisor and/or Incident Commander (IC) to ensure adequate staffing to support ED and/or in-house increased patient capacity. ○ Consider sending Phlebotomist to ED ○ Depending upon the incident, utilize Down Time forms. ○ Consult with House Supervisor, ED Nurse Manager and Incident Commander (if applicable) prior to decisions of releasing staf for unit downsizing. ○ Report to emergency bed control meetings/Hospital Incident Command System (HICS) meetings as applicable. ○ Participate in debriefing |
| Respiratory Therapy | <p>Respiratory Therapy Practitioner Lead on Duty:</p> <ul style="list-style-type: none"> ○ Contact RT Manager and Incident Commander (IC) to determine how RT can assist in this phase of surge management when Code Triage Internal/External Alert paged. ○ Report to Hospital Incident Command System (HICS) and fulfill tasks per direction of the Incident Commander (if applicable) ○ Focus on other key locations in the department and vary daily assignments to address urgent needs first, as requested by ED leadership. ED patients with acute needs take precedence over holding patients in department. ○ Assign additional RT personnel while coordinating with House Supervisor and/or Incident Commander to ensure adequate staffing to support ED and/or in-house increased patient capacity. ○ Consult with House Supervisor, RT Management Team, and/or Incident Commander (if applicable) prior to decisions of releasing staf for unit downsizing. ○ Participates in debriefing with Incident Commander (IC) (if applicable) |

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| | <p>ED Assigned Respiratory Therapist:</p> <ul style="list-style-type: none"> ○ Reports to the ED and coordinates with the ED Charge Nurse for a situation report and if they can assist with the surge situation such as modification of daily operations and prioritization of all Respiratory Therapy: <ul style="list-style-type: none"> ■ Prioritizes discharge treatments within each ED ■ Prepare patients for interfacility transfers ■ Maintain and monitor respiratory supply availability <p>Inpatient Respiratory Therapists</p> <ul style="list-style-type: none"> ○ Coordinates with the unit Charge Nurse for a situation report and if they can assist with the surge situation such as modification of daily operations and prioritization of all Respiratory Therapy: <ul style="list-style-type: none"> ■ Prioritizes discharge diagnostics, treatments, and teachings ■ Prepare patients for interfacility transfers |
| <p>Rehabilitation Services</p> | <p>Rehabilitation Services Manager:</p> <ul style="list-style-type: none"> ○ Communicate with Hospital Incident Command System (HICS) to reprioritize staffing and care as circumstances change, with direction from the Incident Commander (IC) ○ Expedite reviewing charts and accepting patients for transfer to Rehab facilities <p>Inpatient & ED Therapists:</p> <ul style="list-style-type: none"> ○ Reallocate staff with guidance from the Incident Commander (IC) ○ Therapist in the ED evaluating and assessing for Rehabilitation Needs ○ Monitor, review and treat ○ Prioritize PT / OT / SLP assess / evals pending discharge ○ Prioritize providing DMEs for discharge patients ○ Triage, assign patient referrals, and provide outcomes and updates ○ Patients will be seen in the following prioritization order: <ul style="list-style-type: none"> ○ Patients who are “discharge ready” or need an evaluation for transfer or discharge |
| <p>Pharmacy</p> | <p>All Pharmacy Managers:</p> <ul style="list-style-type: none"> ○ Assess and identify department needs related to increased staffing, support in the ED and inpatient units, inventory and medications stations. Report to Incident Command Center. ○ Attends bed huddles and Hospital Incident Command System (HICS) meetings to assist with the surge situation management when Code Triage Internal/External Alert is announced. ○ Assess the need to call in additional SAN support for management of ED patients and boarders, and medication deliveries or compounding ○ Assess inventory and shortages; borrow/loan meds between sites as needed ○ If needed, work with buyers to place emergency medication orders from Mckesson as needed ○ Check in with ED Nurse Manager/Charge Nurse to identify any medication/pharmacy related opportunities and barriers to assist throughput ○ Evaluate supply of emergency kits/transport boxes. Ensure all emergency kits/trays are replenished and sent out to their assigned locations if used. ○ If additional staff used, consult with Administrative Supervisor, ED Nurse Manager and Incident Commander (if applicable) prior to decisions of releasing staff for unit downsizing. ○ Participates in debriefing with Incident Commander (IC) (if applicable) |

HGH Inpatient Pharmacy:

- Standard operating procedures in effect for all inpatient holds in ED.
- Unit based pharmacists will check with charge nurse to expedite possible discharges
- If House Supervisor activates overflow inpatient units, run pyxis reports for Periop Overflow Pyxis and fill pyxis to max
- Ensure all pyxis medications are filled to max and stockouts refilled by the next hourly delivery
- Expedite any medications that need to be administered prior to patient discharge

HGH Outpatient/Discharge Pharmacy:

- Pharmacists will receive pending discharge medications request from nurse, nursing leadership or case manager and will prioritize assessments for IP and ED discharges.
- Pharmacy leadership will reassign staff from supporting ambulatory care patient medication processing, to ED or Discharge patient medications, if multiple discharge medication orders are concurrently requested.
 - Discharge medications, based on order of request from nursing or discharge teams, will be prioritized for processing.
- Offer medication courier delivery, offer ambulatory care patients (non-ED or IP Discharge) patients to pick up medications from outside pharmacy (if insurance allows) or next day pick up from Highland Outpatient pharmacy.

SLH Pharmacy

- **Pharmacists:**
 - Pull All Pharmacists to central pharmacy to help with production workflow
 - Call SAN's for availability, Check with Staff for OT availability.
 - Call remote services- Cardinal to be on standby to work on the production workflow if needed.
- **Technicians:**
 - Run Pyxis report and fill to max
 - Expedite any medications that need to be administered prior to patient discharge.

ALH Pharmacy

- **Pharmacists:**
 - Pull All Pharmacists to central pharmacy to help with production workflow
 - Call SAN's for availability, Check with Staff for OT availability.
 - Call remote services- Cardinal to be on standby to work on the production workflow if needed.
- **Technicians:**
 - Run Pyxis report and fill to max
 - Expedite any medications that need to be administered prior to patient discharge.

| | |
|------------------------|---|
| Environmental Services | <p>Environmental Services (EVS) System Director or Local Site Managers:</p> <ul style="list-style-type: none"> ○ At this highest escalation level, System Director or the local Site Manager will maintain direct, continuous contact with the Incident Commander (IC) and ED Leadership to manage facility safety and support alternative care sites. <p>ED EVS Technician:</p> <ul style="list-style-type: none"> ○ Checks in with the ED Charge Nurse for a situation report and expedites bed cleaning to assist with the surge situation as needed. ○ Quickly updates AHS EPIC by changing dirty rooms to clean once turnover is completed. ○ Reports to their Director or Supervisor on Duty as needed regarding the surge capacity situation. <p>Director or Supervisor on Duty:</p> <ul style="list-style-type: none"> ○ Attends bed huddles and Hospital Incident Command System (HICS) meetings as applicable ○ Coordinates with House Supervisor to prioritize in-patient bed cleaning responsibilities. ○ Assigns additional EVS staf to the ED, to assist with room cleaning or other issues in ED such as the transportation of additional needed equipment like gurneys, IV poles, monitors and other items requested at the time to the ED, ED Lobby or other locations utilized for emergency triage and treatment, such as the MCI Triage Surge Tent or other identified surge capacity locations. ○ Dispatches assigned ED EVS Personnel to next room that needs cleaning in house to expedite turnaround times (TAT) for admission to the floor ○ Consults with Administrative Supervisor, ED Nurse Manager and Incident Commander (if applicable) prior to decisions of releasing staf for unit downsizing. ○ Participates in debriefing with Incident Commander (IC) (if applicable) |
| Facilities | <p>Infrastructure Check:</p> <ul style="list-style-type: none"> ○ Direct Chief Engineer/Engineering Manager to report directly to the Hospital Incident Command System (HICS) to manage all infrastructure concerns, including medical vacuum and medical oxygen system operations. <p>Emergency Power:</p> <ul style="list-style-type: none"> ○ Ensure generator systems maintain 100% operational status; manage fuel delivery logistics with vendors. <p>Utilities:</p> <ul style="list-style-type: none"> ○ Maintain continuous monitoring of all water and sewer systems, with crews on standby for immediate repair. <p>Communication:</p> <ul style="list-style-type: none"> ● Facilities/Engineering fully integrated into the Hospital Incident Command System (HICS)/Code Triage communications flow. |
| Materials Management | <p>Materials Management (MM) Manager:</p> <ul style="list-style-type: none"> ○ Report to Hospital Incident Command System (HICS) and fulfill tasks per direction of the Incident Commander (if applicable) ○ Allocate Central Supply resources to support ED Surge with needed supplies ○ Pull Emergency supplies to replenish fast moving and other ED items as needed. ○ Report staf and supply availability to the House Supervisor. ○ If other facilities are stable, MM Manager will assess feasibility of allocating additional resources to the Highland Campus for immediate support. |

| | |
|--------------------------------------|---|
| | <p>Central Supply Staf:</p> <ul style="list-style-type: none"> ○ Be available in Central Supply to fill request and act as runners. |
| <p>Security</p> | <p>Site Lead on Duty:</p> <ul style="list-style-type: none"> ○ When Code Triage Internal/External Alert is paged overhead, reports to the ED and coordinates with the ED Charge Nurse for a situation report and if Security can assist with the surge situation. ○ May consider recall and potential posting of additional Security Personnel on-site in key locations such as the ED Waiting Area and potential posting in ED Surge Triage sites if applicable. ○ Consult with Administrative Supervisor, ED Nurse Manager and Incident Commander (if applicable) prior to decisions of releasing staf for unit downsizing. ○ Reports to emergency bed control meetings/Hospital Incident Command System (HICS) meetings as requested |
| <p>Food & Nutrition Services</p> | <p>Food & Nutrition Services (FNS) Director (or Designee):</p> <ul style="list-style-type: none"> ○ Using the department's Disaster Guide, determine a plan for responding to the particular emergency per guidelines and regulations. ○ Communicate with the Incident Commander in the Hospital Incident Command System (HICS) meetings (if applicable) concerning the plan. ○ Assess for damage and report out any findings to the command center ○ Evaluate staffing needs and fill positions as needed. Maintain the usual stafing schedule as much as possible. Use the department phone list to contact Management/Supervisory personnel. ○ Management/Supervisory personnel to contact associates they represent. If of-duty personnel are not available or insufficient, contact administration to obtain volunteers or other personnel to accomplish necessary tasks. ○ Participates in debriefing with Incident Commander (IC) (if applicable) |



EMERGENCY OPERATIONS MANAGEMENT PLAN

| | | | |
|------------------------------|--------------------------------|--------------------------------|------------------------------------|
| Site | Alameda Health System | Previous Revision Dates | 04/2014, 06/2017, 02/2020, 12/2021 |
| Effective Date | 05/2003; Not Set | Date Revised | 06/27/2022 |
| Document Owner | VP, OPERATIONAL TRANSFORMATION | Next Scheduled Review | 06/27/2025 |
| Executive Responsible | CHIEF OPERATING OFFICER | | |

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

PURPOSE

1. The purpose of the Emergency Operations Management Plan (EOP) is to describe the coordinate response and recovery to the wide range of natural and man-made events that may disrupt normal operations and require a pre-planned response to internal and external emergencies and disasters. The EOP highlights the basic strategies and mechanisms Alameda Health System (AHS) will use to mobilize resources and conduct activities to support emergencies and disasters.
2. The intention of the emergency management program is:
 - a. To protect life, property, and the environment.
 - b. To provide maximum safety and protection from injury for patients, visitors, and staff.
 - c. To attend promptly and efficiently to all individuals requiring medical attention in an emergency situation.
 - d. To provide a chain of command to enable maximum use of resources.
 - e. To maintain and restore essential services as quickly as possible following an emergency incident or disaster.
 - f. To satisfy all applicable regulatory and accreditation requirements.

SCOPE

1. The EOP applies to the continuation of patient care operations and support functions during a hospital or community-wide incident. The plan was developed as an “all-hazard” approach to be adaptable to respond to a variety of emergencies that might occur. This EOP consists of procedures and other reference data, as well as the Annexes, which address high risk hazards identified by the Hazard Vulnerability Analysis (HVA). The EOP is a living plan and will be revised as needed to reflect federal, state, or local changes in policies, procedures or regulatory requirements.
2. This EOP describes the process for coordinating six critical areas and also addresses volunteers involved in disasters and includes:
 - a. Communications Resources and Assets
 - b. Safety and Security

- c. Staff Roles and Responsibilities
 - d. Utility Management
 - e. Patient Clinical and Support Activities During Emergencies
 - f. Volunteers: Licensed and Non-Licensed Professionals in a disaster
3. The EOP and associated policies and procedures and processes are designed to comply with The Joint Commission’s Emergency Management standard requirements, The Centers for Disease Control and Prevention, the California Code of Regulations, the National Fire Protection Association and the National Incident Management System (NIMS) requirements.

ORGANIZATIONAL DATA

1. The EOP is designed to assure appropriate staff response to a wide variety of emergency situations. The primary emphasis is on short-term management of critical patient care and business operations disruptions. This program is designed to address the emergency response needs of all patient care and business operations at Alameda Health System. The EOP applies to all personnel, contractors, and vendors.

2. Business Identification

| Subject | Business Information |
|--|---|
| Hospital Address | 1411 E. 31 st Street, Oakland, CA |
| Telephone Number | 510.437.4800 |
| Website address | www.AlamedaHealthSystem.org |
| Hospital Leadership | James Jackson, Chief Executive Officer |
| Incident Command and Authorized Personnel to execute EOP | CEO or designee in consultation with CNE and Senior Attending in the Emergency Room |
| Operator Services | Contains a list of the phone numbers of all essential personnel. |
| Licensed Beds | 236 |

3. Acute Facilities and Freestanding Clinics

| NAME | ADDRESS | Telephone |
|---|--|-------------------------------|
| <i>Acute Facilities</i> | | Administrative Offices |
| <i>Highland Campus</i> | 1411 E. 31 st Street Oakland, CA | 510.535.7220 |
| <i>Fairmont Campus</i> | 15400 Foothill Blvd San Leandro, CA | 510.895.7305 |
| <i>John George Psychiatric Hospital</i> | 2060 Fairmont Drive San Leandro, CA | 510.346.1364 |
| <i>Alameda Hospital</i> | 2070 Clinton Ave., Alameda, CA | 510.814.4001 |
| <i>San Leandro Hospital</i> | 13855 E. 14 th Street San Leandro, CA | 510.667.4562 |
| <i>Park Bridge Rehabilitation</i> | 2401 Blanding Avenue, Alameda, CA | 510-522-1084 |

| NAME | ADDRESS | Telephone |
|------------------------------------|---|------------------|
| <i>South Shore Convalescent</i> | 625 Willow St., Alameda, CA, | 510-523-3772 |
| <i>Creedon Advanced Wound Care</i> | 815 Atlantic Avenue Suite 100, Alameda, CA | 510.535.7434 |

| <i>Freestanding Clinics</i> | | |
|------------------------------------|-------------------------------------|--------------|
| Eastmont Wellness Center | 6955 Foothill Boulevard Oakland, CA | 510.567.5812 |
| Winton Wellness Center | 24100 Amador Way Hayward, CA | 510.266.1744 |
| Newark Health Center | 6066 Civic Terrace Ave. Newark, CA | 510.494.7232 |

DEFINITIONS

| Terminology | Definition |
|--|--|
| All Hazards | The Homeland Security Presidential Directive defines “all-hazards” as preparedness for domestic terrorist attacks, major disasters, and other emergencies. |
| Emergency | A dangerous event that normally can be managed by the Medical Center. An emergency can be internal and/or external disruptions, natural or man-made disasters, events or catastrophes that significantly disrupt patient care and treatment, or that results in sudden or increased demands for AHS. |
| Disaster | A crisis response beyond the scope of local resources and usually overwhelms the community. Disasters are distinguished from emergencies by the greater level of response required. |
| Emergency Management Agency (EMA) | A government agency whose function is to assist during an Emergency - may be local, state, or federal. |
| Health Alert Network (HAN) | Health Alert Network (HAN) is an internet-based system designed to broadcast warnings of an impending or current emergency and links hospitals, paramedics, dispatch centers, law enforcement, public health officials and other healthcare system participants within local and regional communities. The California Health Alert Network (CAHAN) is an internet-based system deployed by California Department of Health Services, Emergency Preparedness Office. It is a secure information system restricted for California hospitals to state and local government disaster officials and response coordinators who are involved in contingency planning and management of disasters affecting public health. This system is capable of sending short message alerts to alphanumeric pagers, cell phones, e-mail addresses, faxes and telephones. Participants are alerted and directed to the CAHAN website for updated information about the emergency. |

| Terminology | Definition |
|--|---|
| Hospital Command Center | The location where the Hospital Incident Command team coordinates activities during an emergency. It is managed using the Hospital Incident Command System (HICS). |
| Hospital Incident Command System (HICS) | The management system used to manage and coordinate activities during an emergency. |
| Incident Commander | The person responsible for all aspects of an emergency response; including developing incident objectives, managing all incident operations, application of resources as well as responsibility for all persons involved. |
| Job Action Sheet | A document that includes an identification title, purpose, to who they report to, and critical action tasks. Job Action Sheets include action steps listed by time periods and the format allows for personnel to document each action undertaken and record decision timeframes. |
| Local Emergency Planning Committee (LEPC) | The Local Emergency Planning Committee (LEPC) is a forum for citizens, businesses, and government to share information and collaborate on disaster plans to improve the County's preparedness for all hazards. AHS & Research Center Oakland participates in the following community emergency management planning activities: <ul style="list-style-type: none"> • City of Oakland—Emergency Management Disaster Preparedness Committee • Alameda County Emergency Management Association • Alameda County Vision Leadership • Alameda County Emergency Medical Services— Hospital Preparedness Program • California Hospital Association: East Bay Council of Emergency Managers and Safety Officers |

| Common Acronyms | Definitions |
|------------------------|---|
| EMA | Emergency Management Agency |
| EOC | Emergency Operations Center |
| HAN | Health Alert Network Note: CAHAN is California Health Alert Network |
| HCC | Hospital Command Center |
| HICS | Hospital Incident Command System |
| IC | Incident Commander |
| ICS | Incident Command System |
| JAS | Job Action Sheet |
| JIC | Joint Information Center |
| JIS | Joint Information System |
| LEPC | Local Emergency Planning Committee |

| Common Acronyms | Definitions |
|-----------------|--|
| LIP | Licensed Independent Practitioner |
| NIMS | National Incident Management System |
| MOU/MAA | Memorandum of Understanding/Mutual Aid Agreement |
| PIO | Public Information Officer |

HAZARD VULNERABILITY ANALYSIS (HVA)

1. The Emergency Management Committee conducts a Hazard Vulnerability Analysis (HVA) of the medical center and outlying buildings to identify human, technological and natural vulnerability risks. Facility-specific risks, hazards and vulnerabilities are identified based on the probability of the occurrence. Probability is determined by the historical frequency of events in the community (e.g. fires, severe weather) as well as the consideration of the geographic location of the site to earthquake fault zones, flood plains, major transportation routes and neighboring sites. The level of preparedness, which is defined by what resources are available, offsets severity of the impact to the organization. A percentage is assigned to the hazard to make risk-based choices to address vulnerabilities, mitigate events, prepare for, respond to and recover from emergencies/disaster events. A summary of the results provide a way of prioritizing which hazards are in need of focus first and this drives the hazard specific planning. The Emergency Management Committee and Environment of Care/Safety Committee analyze the risk assessments, evaluate the reports and approve actions to address identified issues to implement procedures and to focus resources and planning efforts in the appropriate area(s).
2. Policy
See the full content of the HVA Policy on AHS Policy Tech.
3. Results
The HVA results are shared with the following community agencies:
 - a. Fire and Police Departments
 - b. Office of Emergency Services (OES),
 - c. Emergency Medical System (EMS) Services,
 - d. Alameda County and Contra Costa County Hospital Disaster Coordinators,
 - e. Alameda County Emergency Medical Services (EMS)
 - f. City of Oakland, And
 - g. Oakland Office of Emergency Services (OES).

The needed resources and vulnerabilities are communicated to the community response agencies, so the capabilities of the community are identified and are in line with the community priorities. Roles and responsibilities are discussed; funds for lacking resources are solicited (e.g., grants); and joint training and exercises are conducted to work on a coordinated and effective response. AHS has developed annexes and procedures for each high-risk hazard. The procedures include specific measures to mitigate, prepare, respond, and recover each priority emergency. Responsibilities are also outlined.

96 HOUR CAPABILITIES AND SUSTAINABILITY

AHS has conducted a 96 hour capabilities and sustainability assessment. This process is used to determine how long the medical center can sustain operations when the community cannot support the hospital. In this event, the Federal systems and the community are unable to support the medical center for at least 96 hours, the command team would assess critical supplies, medical care needs, staff resources and, in partnership with the local Emergency Management Agency, consider whether to close or evacuate portions or all of the facility, or continue under altered resources (e.g., water). The command team will make every effort to extend the use of the resources (e.g., conservation of resources, service reduction, partial staged evacuation, and full evacuation, if necessary).

See the attached charts for AHS'S 96 Hour Assessment (Assumption that no external support would be available within 96 hours).

NATIONAL INCIDENT MANAGEMENT SYSTEM (NIMS)

To align with Federal, State, and local entities, AHS has integrated the NIMS elements into the organization's plan to provide an effective and efficient structure for preparedness, incident and corresponding policies, procedures and annexes developed to address the emergency management phases:

1. The **Mitigation Phase** of emergency management involving proactive efforts to minimize the severity and impact of a potential disaster and reduce the potential for an event to occur. AHS'S activities are designed to reduce the risk and potential damage and include
 - a. Structural construction projects to mitigate the facilities by reinforcing, bracing, anchoring, bolting, strengthening or replacement of the building.

- b. Non-structural hazard mitigation efforts include segregated storage of hazardous materials in secondary containment areas; conformance to building and fire codes as well as inspection, testing and maintenance of emergency systems (e.g., uninterruptable power supply (UPS) and back up of information systems data).
- 2. The **Preparedness Phase** involves the planning and training exercises, equipment acquisition and other management activities that build AHS'S capacity to manage the effects of emergencies as well as mobilize essential resources.
- 3. The **Response Phase** involves putting preparedness plans into action. AHS mobilizes its resources and focuses on tactical activities to address a disaster event. The following response components include:
 - a. Assume command and activate the Hospital Command Center (HCC).
 - b. Recall staff through the overhead paging system, pager, etc.
 - c. Utilize the Hospital Incident Command System (HICS) to ensure there is a clear chain of command for effective management. Assign staff to hospital incident command staff positions and provide an initial briefing.
 - d. Responders view incident action plan and obtain briefing(s). Work to meet incident objectives using procedures, annexes, checklists, and forms. Initiate interim contingency plans to deal with system failures.
 - e. Allocate scarce resources and coordinate with local response agencies. Request additional assistance from mutual aid partners, as well as the State.
 - f. Request additional assistance from mutual aid partners as well as the State. In the event that response efforts in the local community cannot support the hospital, the hospital will continue to sustain services for up to 96 hours. The Medical Center Command Team will assess the situation throughout that time and determine whether evacuation or closure are feasible and reasonable based on the following criteria:
 - i. Patient and Staff Safety,
 - ii. Staffing Ratios
 - iii. Resources and Supply Availability, and
 - iv. Local Authority Mandates (e.g., Uniform Command).
- b. **Recovery Phase** involves those efforts to resume critical support functions, continue the provision of care, and secure reimbursement funds if appropriate. The facility's procedures, job action sheets and forms include demobilization/recovery actions to restore the services to normal conditions based on the manageable patient census using normal staffing patterns and resources and/or when other community responders begin their demobilization. Once the systems are restored for resuming normal treatment, the incident is evaluated to identify opportunities for improvement and develop initiatives to mitigate the effects of future incidents.

STAFF REPORTING STRUCTURE

AHS'S Emergency Operation Plan is based on these key organizational systems:

1. The Hospital Incident Command System (HICS) is utilized as an effort to coordinate with the

community responders. The Incident Command System is adaptable to meet the size and complexity of an incident by using recognized lines of authority and the model is in direct correlation with the County Emergency Operation Center, City, Fire Department, Police Department as well as neighboring hospital ICS structures. Staff report to the Incident Commander who is defined as being in charge of the response.

2. The Multi-Agency Coordination System provides interactive management components and the organization structure of supporting agencies at the Federal, State, local and regional levels through mutual-aid agreements and other assistance arrangements.
3. The Public Information System is used for communicating timely and accurate information to the public during emergency situations.
4. Unified Command is in place when more than one agency or organization has command responsibilities such as during a hazardous material release when the fire department, Environmental Protection Agency (EPA), water authority and the hospital work together to analyze the information and develop a common set of objectives.

ALL HAZARDS COMMAND STRUCTURE

The Hospital Incident Command System (HICS) is an organizational and management framework used to execute a response to an incident/event and it is consistent with the emergency management system used in the community. The specific organizational structure established for any given incident will be based upon the needs of that incident and the Incident Action Plans will be developed as appropriate to the scope and duration of the incident. The ICS organizational structure described below is consistent with NIMS requirements and identifies key positions and lines of authority in response to an internal or external disaster situation. An ICS organization is composed of the Incident Command (IC), Command Staff, and the general staff with functions as shown below. The HICS Form 207 Organizational Chart is utilized during incidents to document assigned HICS positions.



RESPONSIBILITIES AND AUTHORITY

1. The EOC/Emergency Management Coordinator/Director, Environmental health and Safety is responsible for the overall management of the emergency management program including program development; implementation and assessment; identification and control of risks; staff educational needs; and consultation, monitoring and assistance. The EOC/Emergency Management Coordinator serves as the Chairperson of the Emergency Management Committee.
2. The EOC/Emergency Management Coordinator/Director, Environmental health and Safety represents AHS at city, county, regional, state and national planning meetings and coordinates overall preparedness efforts at AHS.
3. The Emergency Management Committee is a multidisciplinary improvement team, which includes administration, leaders, medical staff, clinical and support staff who are responsible for implementing and maintaining the Emergency Operation Plan (EOP) Standardized Operating Procedures and associated annexes, the annual evaluation, the Hazard Vulnerability Analysis (HVA), Exercise documentation, After Action Reports and performance improvement activities. The Emergency Management Committee reports to the Safety/Environment of Care Committee.
4. AHS Medical Staff and Administration ensure there is involvement with the organization's leaders to plan and respond to emergencies.
5. Department Managers are responsible for orienting staff to the department and facility-wide emergency management procedures. Managers are also responsible for the development and management of specific department disaster policies and procedures (as applicable), ensuring that they are evaluated and revised (as appropriate), verifying all staff are trained on their individual roles and responsibilities consistent with the EOP; and staff participate in the implementation of the plan.
6. Employees are responsible for participating in training and demonstrating core competencies in the emergency management program. Employees receive emergency response training upon hire and annually thereafter. Employees must ensure their behaviors, work practices and operations are safe, and in accordance with departmental procedures, the provisions of the disaster plan, and clinical judgment.

COMMUNICATION PLAN

1. Modes of Communication Available

The details of the communication program are outlined in the *Communication Plan and Telephone Failure Plan*

| Type | Meaning | Annex / Policy |
|---------------------|--|-----------------------|
| Alphanumeric Pagers | Can be used to communicate with a large number of staff provided with these devices. Hospital operators keep an active list of pager numbers and assignments. | |
| Amateur Radio | In times of crisis and natural disasters , Amateur radio is often used as a means of emergency communication when wire line , cell phones and other conventional means of communications fail. Unlike commercial systems, Amateur radio is not as dependent on terrestrial facilities that can fail. It is dispersed throughout a community without "choke points" such as cellular telephone sites that can be overloaded. | |
| Cell Phones | Personal cell phones are an additional modality of communication. Some employees are provided with company cell phones. | |
| Email | Electronic mail sent and received from internal/external sources. | |
| Facsimile | Strategic departments have dedicated fax lines. The current list is maintained by telecommunications. | |
| GETS Card | Government Emergency Telephone System (GETS) provides priority handling of phone calls placed over the public phone system via a universal access phone number and a PIN which identifies the caller. GETS is simply a calling card and is used like commercial calling cards. | |
| Instant Messaging | May be used for continued one-to-one communication with one or more persons or facilities. | |
| Landline Telephones | Landlines may be used for person to person communication or facsimile transmission. | |

| Type | Meaning | Annex / Policy |
|-----------------------|---|----------------|
| Power Fail Telephones | Power fail phones are associated with the internal PBX system and dedicated communication lines. This system will bypass trunks when the power fails. | |
| Repeater Radio | Utilized for very short-range two-way radio service for business activities | |
| REDDINET | ReddiNet is a flexible emergency medical communications network linking hospitals, regional EMS directors, paramedics, dispatch centers, law enforcement, public health officials and other healthcare system participants within local and regional communities. | |
| Runner System | Utilizing staff to provide foot traffic between two or more points. For example, sending a runner from the Emergency Department to the Hospital Command Center (HCC). | |

2. Notification When Emergency Response Measures Are Initiated

- a. The Activation and termination of this plan is under the authority and direction of the Incident Commander.
- b. The Incident Commander will gather the following incident information:
 - i. Whether a chemical or radiological substance was released.
 - ii. The time of the incident.
 - iii. The location of the incident.
 - iv. The number of casualties and types of injuries.
 - v. The number of trauma victims and ones that are ambulatory.
 - vi. Whether decontamination is needed or being conducted on site.
 - vii. The types of treatment given.
- c. The Hospital Command Center (HCC) has a primary and secondary location that is delineated in the SOP located in the Emergency Management Manual.
- d. The HCC contains preprinted HICS forms, Job Action Sheets, procedures and annexes; telephones and fax machines; computers with internet access; general office supplies; and a photocopier.
- e. The Labor Pool sites are activated on each campus and the location is announced at the time the decision to mobilize them are made.
- f. Employees are notified when the plan is activated by:
 - i. Alphanumeric pagers
 - ii. Telephones: landline and cellular
 - iii. Overhead paging system
 - iv. Email
 - v. Word of Mouth
- g. Alert/Emergency management incident codes are:

| Alert / Emergency Management Incidents | Meaning |
|---|---|
| Code Red | Fire or Smoke Emergency |
| Code Blue | Adult Medical Emergency |
| Code White | Pediatric Medical Emergency |
| Code Pink | Infant Abduction |
| Code Purple | Child Abduction |
| Code Yellow | Bomb Threat/Suspicious Package |
| Code Gray | Combative Person |
| Code Orange | Hazardous Material Spill/Release |
| Code Silver | Person with a weapon |
| Code Tan | Scene Safety Initiated (Person presenting with penetration wound) |
| Code Triage Internal | Internal Disaster |
| Code Triage External | External Disaster |
| Code “C” | Emergency Cesarean Section |
| Heart Alert | Patient presenting with Heart Attach (STEMI) |
| Airway Assist | Cardiac Cath Lab requesting airway assistance |

3. Ongoing Communication of Information and Instructions to Staff

- a. Once the emergency response measures are initiated, additional staff may be called in by:
 - i. Utilizing the staff recall rosters.
 - ii. The hospital public-address system: “Code Triage”. Details are outlined in the Code Triage Activation Policy.
 - iii. Pagers, and

- iv. Telephone
- b. Information for staff and licensed practitioners can be distributed by:
 - i. Alphanumeric pagers,
 - ii. Telephones: landline and cellular,
 - iii. Overhead paging system,
 - iv. Email, and
 - v. Intranet
- c. During an area-wide disaster (e.g., earthquake), the phones may be overloaded with calls or it may be impractical to call each staff member individually, therefore, alternative communication methods include:
 - i. A recorded Disaster Information message on the AHS individual department lines.
 - ii. KCBS radio public service announcements
 - iii. Announcements placed on the AHS website.
- d. Internal communication is accomplished by obtaining information from different departments by:
 - i. Telephones,
 - ii. Cell phones,
 - iii. Two-way radios
 - iv. Pagers/text pagers
 - v. Email
 - vi. Overhead paging
 - vii. Runners, or
 - viii. Fax machines.

HICS Form 205 – Incident Communications Plan - will document what communication equipment is used and HICS Form 213 - Incident Message Form - provides a standardized approach for recording messages received.

- a. Additional communication available for communicating externally includes:
 - i. Cell phones
 - ii. Landlines
 - iii. Amateur Radio Operators (HAM)
 - iv. GETS
 - v. Reddinet
 - vi. CAHAN
 - vii. Runners
- b. During an emergency or incident, standard terminology and plain language will be used for all communications.
- c. The Incident Commander will assign responsibilities. HICS 203 Form Organization Assignment List and HICS 204 Branch Assignment List will be utilized when assignments are made.
- d. Staff utilizes and completes the HICS forms to provide regular situation updates (e.g. HICS 201 Incident Briefing Form, 202 Incident Objective Form, HICS 251 Facility Systems Status Report).

4. Notifying External Authorities of Emergencies

The Hospital Incident Commander will assign a Liaison Officer to ensure external authorities are notified and necessary communication is maintained. The local Office of Emergency Services and other appropriate external agencies (e.g., EMS, police, fire) will be notified of any incident that overwhelms or has potential to deplete local resources. The District Licensing Office will be notified of the intent of discontinuance or disruption of services as outlined in Sections 70737 and 70746 of Title 22 of the California Code of Regulations (CCR).

5. Communicating with External Authorities once Response is Initiated

To ensure connectivity between medical center and regional area once response measures are initiated. The Liaison Officer will provide regular communication updates to the Alameda County Emergency Operations Center (EOC) providing situation status and objectives, priorities and resource needs as well as resource availability (personnel and equipment). In addition, teleconferencing is utilized for communication updates.

6. Communication with Patients Including Relocation to Alternative Sites

- a. Patient communication is coordinated through the Hospital Command Center.
- b. Outpatients receive information through Ambulatory Care Sites which may include:
 - i. Messengers
 - ii. Telephone calls, or
 - iii. Press releases through the Public Information Officer (PIO).
- c. Inpatients depending on the acuity of the patient will receive briefings of pertinent information by:
 - i. Flyer delivered by designated staff or
 - ii. Overhead page announcements.
- d. If patients are relocated to an alternative site, patients and their families will receive regular briefing consistent with regulations regarding patient confidentiality information including:
 - i. The general condition of the patient
 - ii. The alternate care site name and address
 - iii. The anticipated timeframe from relocation to the alternate care site.
 - iv. The hospital will establish Family and Patient location and tracking system.

7. Communication with the News Media – Circumstances and Plans

Details of the program are outlined in the Communicating with Media, Patients and Community Policy.

- a. AHS maintains a cooperative relationship with the news media, which balances the public need for information with the responsibility to safeguard the patient's right for privacy.

- b. Communication is coordinated through the assigned PIO. The PIO is responsible for developing informational summaries for reporters so that timely and accurate information is provided to the public during emergency situations. In addition, the PIO is the spokesperson for AHS and is responsible for media and public inquiries, rumor response, and media monitoring.
- c. The media will be informed of the number of victims and types of emergencies. No names will be released without the approval of the Incident Commander.
- d. Media personnel will use their own communication systems and will be directed as to staging, interviewing, and new conference locations.
- e. Handling questions from the media is addressed according to the Administrative Policy and the Media Policy.
- f. If the Joint Information Center (JIC) is established, the PIO will participate to address communication and public education efforts.
- g. A media center will be the responsibility of the PIO. Security/designee will ensure that all members of the media have credentials, are approved to be on the AHS property and confined to the designated area as per the Hospital Commander.
- h. Media camera trucks will not be permitted on any AHS property. No media vehicles will be allowed in any other area of the hospital campus.

8. Communication with Purveyors of Essential Supplies

The Logistics Section Chief and Operations Section Chief will contact vendors that provide essential resources and supplies. The memorandums of understanding (MOU) include the vendor contact information. The list of vendors is located in the Hospital Resource Directory (HICS Form 258) and the departments that are identified as providing essential services in the Standard Operating Procedures.

9. Communicating with Healthcare Organizations in the Geographic Area and Essential Elements in Command Structure

AHS meets regularly with the Alameda County Hospital Disaster Coordinators to ensure cooperative planning among healthcare organizations that provide services to a contiguous geographic area thus facilitating the timely sharing of information about:

- a. Essential elements of their command structures and control centers for emergency response.
- b. Names, roles, and telephone numbers of individuals in their command structures.
- c. Resources and assets that could potentially be shared or pooled in an emergency response.

- d. Names of patients and deceased individuals brought to their organizations to facilitate identification and location of victims of the emergency.
- e. Usage of common communication equipment and data sources to allow for communications when the infrastructure (e.g., phone lines, computer lines) has been impacted. The Hospital Resource Director (HICS Form 258) is utilized.
- f. The above information is kept in the Hospital Command Center. To ensure that the command structure information is current, the EOC/Emergency Management Coordinator is responsible for managing this task.

10. Patients and Deceased Individuals

- a. The Alameda County Hospital Disaster Coordinators Disaster Team planning includes the sharing of names of patients and deceased individuals brought to the organizations to facilitate identification and location of victims of the emergency.
- b. At AHS, patients and deceased individuals are identified and communicated to the Patient Affairs and the American Red Cross if on site. Specific policies (e.g., Forensic Plan) outline third party communication protocols including the FBI, Alameda County Sheriff's Department, Oakland Police and the Public Health Department. After approval by the Incident Commander, the Public Information Officer provides updates and briefings to staff, visitors, families and the news media.
- c. The Mass Fatalities Procedures as well as the policies governed by the Morgue, provides guidelines for dealing with mass fatalities in Unified Command with Alameda County and to properly process human remains in a safe, secure and respectful manner and assist the decedents' family members.

11. Family Assistance Center

- a. The Community Emergency Operations Center (EOC) and the American Red Cross will coordinate, manage and staff the Family Assistance Center (FAC). Local agencies, the Salvation Army, faith-based organizations, churches and other applicable organizations work collaboratively to provide emotional support services and interpreter services (based on impacted population).
- b. AHS may provide information and resources to the local Family Assistance Center (FAC) to support the family/friends and to provide answers to questions, concerns and assist with family reunification services. In the event the Family Assistance Center has to be located at AHS, this area will be in a private location away from the media.

12. Communication with Alternate Care Sites

The Local Public Health Department is the responsible agency to establish the Alternate Care Sites for the general public. AHS has the authority to establish an Alternate Care site within its properties.

The Hospital Command Center will provide the alternate care site with briefings as to the status of the operational capability, and the anticipated need for assistance to receive or transfer patient should it become necessary.

13. Back Up Communication

In the event that the community infrastructure is damaged and/or AHS experiences a communication failure, redundant and alternative communication systems are in place and they include:

- a. Voice systems: landlines telephones, power fail (by-pass) telephones, cellular, and amateur and handheld commercial two-way radio and GETS cards (a service that allows authorized federal, state and local government, and industry personnel to complete phone calls when normal or alternate telecommunication methods are unsuccessful) will be used.
- b. Runners
- c. Data systems include computers with modems on analog lines, computers on wi-fi to access and utilize email, Reddinet.
- d. Equipment for receiving public broadcasts includes multiple televisions and AM/FM radios.
- e. The Hospital Command Center houses preprinted HICS forms, job action sheets, procedures and annexes, general office supplies, fax machine and photocopier.

AHS meets regularly with the East Bay Council of Hospital Emergency Managers and Safety Officers to ensure there is a coordination of common equipment and data sources in the event infrastructures (e.g., phone lines, computer lines) are negatively impacted. Common resources have been established with the local hospitals to be used during incident responses.

RESOURCES AND ASSETS

Obtaining Required Supplies at Onset of Response

1. Key aspects of a disaster response are pre-designated in advance through the Emergency Management Committee. During an emergency response, the Hospital Command Center will coordinate the allocation of resources, based on need and priority. The management of Logistics is managed through the logistics section within the Hospital Incident Command System. Memorandums of Understanding for additional supplies, equipment and food have been established. These include, but are not limited to:
 - a. Generators
 - b. Medications
 - c. Water
 - d. Fuel
 - e. Medical supplies

- f. Food
 - g. Batteries
 - h. Linen
 - i. Cots
 - j. Refrigeration Truck(s) and
 - k. Waste containers
2. The existing inventory will be utilized first upon activation of the HCC.
 3. If additional resources are needed, supplies for disaster response (triage, decon, etc.) are stored in caches on-site.
 4. Disaster credentialing policies for medical staff and other volunteers will be utilized to augment staff if needed through the Labor Pool and Credentialing Unit.
 5. When the existing inventory of critical supplies are at minimal PAR levels, outside vendors will be contacted. The Alameda County EOC can be contacted to facilitate requests, access and distribution of additional supplies.
 6. An updated Vendor Emergency Contact List is available in all essential service departments.

Replenishing Pharmaceutical Supplies

Chempacks, the national cache of chemical antidotes, and other drugs and medical supplies deployed after a biological, radiological, or chemical attack are housed in the facility and are available and managed by the Pharmacy, if needed. See the Bioterrorism and Chempack policies for details.

Replenishing Non-Medical Supplies

1. Food: A 96-hour food plan has been created by the Food and Nutrition Department. Additional food supplies have been ordered for the Ambulatory Care Services sites.
2. Linen: A five-day PAR level is maintained on site. In addition, an MOU is in place with the vendor.
3. Bottled drinking water in boxes in the Food and Nutrition Department. If additional drinking water is needed until normal services can be restored, arrangements have been made with such vendors. In the event 96 hours of water is not available at the time of true need and the facility is unable to obtain additional supplies, a decision will be made 24 hour prior to exhaustion of water resources by the Command Team to stage an evacuation.
4. Plans for use of water for utilities have been developed by the Engineering department and identified in the Utilities Management Plan.
5. Generators: The generators are located and housed on AHS properties. The fuel tanks for the diesel system and support equipment are buried and have double-walls as well as a system to monitor for fuel leaks. The facility has 72 hours of diesel fuel and a conservation plan to

extend to 96 hours. In the event additional fuel is needed, the Engineering Department will communicate this to the Hospital Command Center.

6. Transportation resources onsite include passenger vans.
7. Available personal protective equipment resources are housed in Materials Management and storage facilities within the properties.

Managing Volunteers and Staff

1. Disaster credentialing policies for medical staff and other volunteers will be utilized to augment staff if needed through the Labor Pool and Credentialing Unit. The Medical Staff Office and the Human Resources departments are responsible for reviewing and recommending the policies for acceptance by the Emergency Management Committee.
2. HICS Form 252 – Section Personnel Time Sheet is augmented by existing systems to record each Section’s personnel time and activity. Each department is required to have staff sign- in upon activation of the emergency plan.
3. The Incident Commander is empowered to authorize volunteer caregivers to assist hospital staff if the organization is unable to meet immediate patient needs without volunteers.
4. The Medical Staff has policies in place and is responsible for granting privileges to the Volunteer Licensed Independent Practitioners (LIP). Refer to the medical staff offices.
5. Before a volunteer practitioner (those licensed and those who are not licensed independent practitioners) is considered eligible to function as a volunteer, the hospital obtains the volunteer’s identification as outlined in the disaster credentialing policy. This policy also outlines processes for supervision, communication, and management. The Graduate Training Program maintains policies for House Staff expectations, roles and responsibilities during a disaster.
6. HICS Form 253 – Volunteer Staff Registration is used for Volunteers to sign-in for an operational period in accordance with the Hospital Command Center’s delegated authority and job action sheets.

Managing Staff Support Activities

The Support Branch Director under the Logistics section manages staff support activities. Additional resources are requested through the County EOC. Current available resources include:

1. Housing for staff will be provided where possible on the property and through use of existing contracts with local hotels.
2. Transportation resources on site include passenger vans and a fleet of vehicles. BART mass transit is located outside the facility.
3. Incident stress debriefing and counseling is coordinated through the Employee Assistance Program (EAP) as per AHS'S Human Resources policy. The Hospital Chaplain's Office will be the primary communications center for all chaplain coverage and support needs. The chaplains will help be available to assist staff when requested.

Managing Staff and Family Support Needs

Staff Family Support activities are under the jurisdiction of the logistics section. AHS strives to prepare staff personal readiness by encouraging staff to prepare for emergencies at home. One example is encouraging staff to have a readiness bag and plans for dependent care is provided during orientation and drills.

1. Employees will be able to call family to ensure their safety.
2. Staff is encouraged to be good pet care providers by making provisions prior to an emergency at kennels.
3. Childcare will be provided and coordinated through the Hospital Command Center should the need arise.

Potential Sharing of Resources and Assets with our other Hospitals

1. AHS and the community participate in statewide exercises and community-based planning. To promote inter-operability, AHS representatives meet regularly with the Alameda County Hospital Disaster Coordinators to prioritize plans to support the community. This includes identifying the resources and supplies that will be available for an emergency response and comparing it with what they may need in an emergency. Gaps between on-hand resources and needed resources are supplemented by Mutual Aid agreements with local hospitals. AHS is part of Coastal Region II, one of the six regions responsible for the coordination of disaster mutual aid designated by the California State Governor's Office of Emergency Services. During a declared local emergency, an Operational Area Emergency Operations Center (EOC) is activated to provide resources from the non-impacted areas. AHS has agreements with other hospitals in Alameda County to share facilities, supplies, equipment, and personnel resources in the event of a defined disaster in order to provide essential services to the community.
2. Biomedical Engineering will inventory all critical equipment not in use. In additional clinical equipment is needed contracts with vendors and suppliers for critical equipment and supplies are available. The establishment of contracts prior to a disaster is overseen by the Materials

Management Department.

3. In the event, resources/assets needed to be shared with other hospitals, the Command Team at AHS is responsible for making decisions on whether resources can be shared and what quantities, after reviewing what resources are needed to maintain services at AHS.
4. The Procurement Leader utilizes the HICS Form 256 Procurement Summary Report to track procurements. This document includes purchase order information, dollar amount and vendor. Requested equipment is recorded on HICS Form 257 Resource Accounting Record to document what was received, the condition of the resource and when it was returned.
5. **Requesting 1135 Waiver** - under section 1135 of the Social Security Act, the Secretary may temporarily waive or modify certain Medicare, Medicaid, and Children's Health Insurance Program (CHIP) requirements to ensure that sufficient health care items and services are available to meet the needs of individuals.

Review of 1135 Waiver requests - EH&S will provide initial consultation and completion of waiver for AHS. CMS will review and validate the 1135 waiver requests utilizing a cross-regional Waiver Validation Team. The cross-regional Waiver Validation Team will review waiver requests to ensure they are justified and supportable.

Implementation of 1135 Waiver Authority

Providers must resume compliance with normal rules and regulations as soon as they are able to do so, and in any event the waivers or modifications a provider was operating under are no longer available after the termination of the emergency period.

Potential Sharing of Resources Outside of the Community

Coordination of healthcare resources and assets outside of the operational area during an event is a State of California Regional EOC function and responsibility. The County Emergency Operations Center (EOC) ensures that those who are located at the scene have the resources (i.e. personnel, tools, and equipment) they need for the response and also acts as a liaison between local responders and the Stated.

The Chempack is one of the mutual aid resources that may be deployed to other nearby sites.

Transporting Patients, Medication and Equipment to Alternative Site

1. In the event of a surge, all inpatient cases will be assessed for the ability to discharge early to increase the bed capacity. In addition, an initiation of auxiliary treatment as outlined. See the Surge Plan for details.
2. Evacuation procedures for complete and partial evacuation of the hospital are current and are reviewed regularly (See Evacuation Plan). In the event of a fire or other internal emergency, patients will be relocated to another safe part of the hospital.

3. In the event the hospital is deemed unsuitable for continued occupancy or cannot support adequate patient care, the Incident Commander will authorize evacuation. The Operations Section Job Action Sheet and the Evacuation Plan provides guidance for preparing patient records, medications, biomedical equipment and valuables for transfers as well as confirm the transfer and timeline with accepting hospitals. Evacuation equipment includes: evacuation chairs, litters, and sheets.
4. Agreements are also in place with AMR ambulance services and neighboring facilities to transfer patients as necessary and this is coordinated through the County EOC.
5. HICS Form 255: Master Patient Evacuation Tracking Form is utilized by the Patient Tracking Manager to record information concerning all patients disposition during an evacuation. The Medical Care Branch Director utilizes the HICS Form 260 Patient Evacuation Tracking Form to document details and account for each patient transfer to another facility.

Transporting Clinical Information to Alternate Care

1. AHS has entered into a Mutual Aid Agreement with other facilities within the area, which could accept patients in the event of an evacuation.
2. The Operations Section is responsible for providing patient information as appropriate and ensuring the family is notified of the patient transfer. The Planning section tracks patients and personnel to the alternate care site. The HICS-254 Disaster Victim/Patient Tracking Form is used. Qualified hospital staff will accompany the patients. Periodic information sharing will occur between the hospital receiving victims through telephone or other communication methods (e.g. internet). AHS staff will take appropriate steps to ensure patient information remains confidential even during emergency conditions.

SAFETY AND SECURITY

Internal Security and Safety Operations

1. Safety is a priority at AHS. The assigned Safety Officer will document actions taken to mitigate hazards on HICS Form 261 Incident Action Safety Analysis.
2. Security access, crowd control and traffic functions are managed through the Security Branch Director Position of HICS. Depending on the type of incident, increased vigilance/patrolling; increased monitoring of ID badges and the securing of non-critical doors will be implemented. Ongoing security measures are in place for identifying staff, visitors and patients:
 - a. Patient wrist bands,
 - b. Staff identification badges,
 - c. HICS vests,
 - d. Visitor badges, and
 - e. Contractor badges

3. Employees are required to wear their ID badges when working in the facility. I.D. Badges can be obtained from the Security Department.
4. Security personnel may be augmented as required through the pre-arranged contract service, Securitas, and/or labor pool. Prior to working in the security role capacity, labor pool staff will receive appropriate training including protocols, handling abusive behavior, etc.
5. All employees must immediately report any suspicious person(s) or activities to Security.
6. AHS has a process for lock-down and shelter in place. See Lock-Down and Shelter In Place Policies.
7. Patient Belongings during a surge incident will be stored in labeled patient belonging bags in a locked room. Security and Transportation storage room is designated for storage.
8. In incidents of special circumstances (e.g. bomb, bioterrorism), chain-of-custody procedures will be followed. Evidence obtained from the Emergency Department (ED) is placed in the locked cage adjacent to the ED.

Identifies Roles of Community Security Agencies and Coordination

1. AHS contracts with the Alameda County Sheriff's Department for law enforcement services that are provided on a 24/7 basis on the Highland Campus. In addition, AHS contracts with Healthcare Security Services for security services on all campuses.
2. The Security department works collaboratively with the Alameda County Sheriff's Department (ACSD). The ACSD provides AHS with prompt response when needed and also shares local crime statistics and informational warnings to ensure AHS has current local information.
3. The Security Branch Director will identify material resources for rent or purchase (e.g., barriers, fencing, storage). The Hospital Command Center Liaison will notify the local EOC of the current situation.
4. Requests for law enforcement mutual aid functions will be placed through County EOC. HSS has the ability to expand its staff through their chain of command.
5. The Unified Command system will be established between AHS and the responding agencies to ensure a safe, effective response.

Process for Managing Hazardous Materials – Radioactive, Biological and Chemical

1. AHS is equipped to manage decontamination with specified chemical agents, provided the agent and concentration are known. Internal spill and know agent response plans: The Hospital has the capability for incident decontamination, using the decontamination showers and equipment. Selected staff are trained to provide decontamination. When agent is known, decontamination will be under the jurisdiction of the local emergency response agencies.

2. Radiological exposures are managed in partnership with the Radiation Safety Officer. *See Radiation Response Plan* Biological exposures will be handled in the same manner as chemically contaminated patients once the agent is known. Infection Control will be notified and provide consultation in the capacity of a Medical/Technical Specialist. Initial patients may enter the ED without knowledge of the contamination. Typically biological agents have a latent period and therefore patients presenting to the ED will no longer be contaminated and will need to be treated according to the agent involved. If the agent is communicable, the patient will be placed into an isolation room or cohorted with patients that have like symptoms/diagnosis. *See Bioterrorism/Biological Agent Guidelines from the State of California.*
3. Contaminated patient belongings will be labeled and stored in the appropriate bags to avoid cross-contamination.
4. Hazardous waste procedures for labeling, storage, and disposal are outlined in the *Hazardous Waste Management Program*.

Control Movement of Individuals within Health Care Facility

The lock down plan can be implemented to control admission to the entrance and other doors. Depending on the incident type, the Hospital Command Center will determine what controls (e.g. decontamination, isolation) will be put into place prior to patients entering the facility in regards to keeping the facility secure and safe. The Hospital has triage tags for use in emergency situations to identify, process, and triage patients and provide a means to identify clothing and other personal property. Incoming patient information will be transmitted from triage to the Hospital Command Center. Patient care updates will be transmitted to the HCC using logging system implemented at each treatment unit. The Patient Affairs Officer, working with Family Center staff will coordinate notification of the patient's family and release of patient information to family with the American Red Cross.

Control Traffic Access Health Care Facility

1. ACSO and Security will be responsible for external vehicular flow of traffic, which would prioritize emergency vehicles, and all other necessary traffic flow to the area.
2. If more help is needed than can be provided by local law enforcement agencies, who will be contacted for assistance. Additional officers are made available through normal procedures used by the ACSO, if needs arise with the County EOC.
3. In the event of closure or rerouting of the streets, staff, patients, and visitors will be notified by signs and through the public media and detour signs will be obtained and placed around the perimeter. Staff Roles and Responsibilities

Staff Roles are Defined in the EOP

Roles and responsibilities of staff are outlined in the Emergency Management Manual. The Hospital Incident Command System is used to ensure there is a clear chain of command for effective management. Positions are filled based on the size of the incident and Job Action Sheets are used for defining and performing a specific emergency response functional role.

Incident Response Plans are also used during an incident, which lists decision considerations specific to managing that situation by timeframe and complement the facility procedures.

Staff Are Trained for Assigned Roles

The Emergency Management Committee designs drills and exercises with scenarios and objectives based upon findings from the hazard vulnerability analysis as well as from critiques from past exercises and/or actual events. These events provide staff with the opportunity to practice and train for their roles during an emergency. Personnel are assigned to the various command positions and receive a briefing and Job Action Sheet that outlines the responsibilities and actions for that specific assigned job function.

1. Managers are responsible the development and management of specific department disaster policies and procedures. Managers are also accountable for ensuring that the plans are evaluated and revised and verifying staff are trained on their individual roles and responsibilities during a disaster/emergency event. Managers train staff on the emergency codes and explain the roles and duties associated with activating codes.
2. MIMS training is provided to hospital personnel that would have a role in emergency preparedness, incident management, and/or emergency response during an incident as a means of preparing personnel to competently assume one or more roles based on situational need and resources available.
3. HICS is utilized, so when personnel are assigned to the various command positions, they receive a briefing and a Job Action Sheet that outlines the responsibilities a Job Action Sheet that outlines the responsibilities and actions for that specific assigned job function.

Organization Communicates to Licensed Independent Practitioners

1. The Chief Medical Officer and/or the President of the Medical Staff represents the physicians in the Incident Command Structure.
2. The Emergency Department Staff has received documented training on HICS/NIMS and the EOP. All of the medical staff members have received information on AHS'S EOP and applicable emergency procedures.
3. Licensed Independent Practitioners (LIPs) have roles and responsibilities defined on job action sheets (e.g. Operations Branch pertaining to patient care). Process for Identifying Care Providers During Emergency
4. Employees are required to display their employee identification badges. If an employee does not have his/her badge or it cannot be located, temporary badges can be obtained through the Security Department, upon verification that they are employees.
5. Personnel are assigned through the Hospital Command Center to cover positions and functions in the Hospital Command Center to cover positions and functions in the Hospital Incident Command Center. Employees are provided with vests that clearly identify the HICS position title.

The Incident Commander is empowered to authorize volunteer caregivers to assist hospital staff in the event that the organization is unable to fully meet immediate patient needs without volunteers. Occupations that fall under Licensed Independent Practitioner (LIP) and Allied Health Professional (AHP) are covered under the Medical Staff Bylaws and Policies covering disaster privileges. The credentials of volunteer providers will be verified through the Medical Staff Office.

MANAGING UTILITIES DURING EMERGENCIES

Alternative Means of Providing for Utilities

In the event that the utility is compromised or disrupted, procedures and contingency plans are detailed in the Emergency Management manual for each specific utility. These plans are coordinated in advance to ensure the extent practicable, there is uninterrupted service. External options and contracts for essential services are coordinated through Hospital Command Center (Logistics section). The acquisition of equipment parts or outside contractors will be coordinated with the Support Branch.

1. Electricity (Emergency Power): is provided by onsite generators. Contracts are in place for backup generators.
2. Water for consumption, equipment and sanitary purposes: Food and Nutrition Services manages and stores water for patients and staff. Engineering developed plans for water use and disruption.
3. Fuel (#2 Diesel fuel) for building operations is stored onsite and contracts are managed by Engineering Services for replacement fuel.
4. Sanitary Sewer System: is maintained by Engineering Services and procedures are in place for responding to leaks or disruptions.
5. Fire Alarm or Automatic Sprinkler System is out of service: See *Interim Life Safety Measure Program*.
6. Medical Gas/Vacuum: Engineering Services manages the fixed medical gas and vacuum system. Procedures are in place for malfunctions and disruptions. Materials Management manages the contracts for the tanks and they oversee the storage process. Heating and Air Conditioning (HVAC): Engineering manages the heating and air system and has response procedures for disruptions and equipment failure.

MANAGING PATIENT CLINICAL AND SUPPORT ACTIVITIES

The Clinical Activities: Patient Scheduling, Triage, Assessment, Through Discharge

1. Scheduling, modifying or discontinuing services is done under the coordination of the Operations section. Patient care schedules are reviewed to determine if early discharges, elective surgeries can be postponed or alternative care would be beneficial to the patient(s).
2. Peri-operative Services will inform the HCC of the cases currently in surgery and expected

closure times. Surgery in progress will be completed as soon as safely possible. No new cases will be started until authorized by the IC.

3. The Labor Pool may be activated by the Incident Commander to collect and inventory staff and volunteers at a central location. The Labor Pool and Credentialing Unit will receive requests and assign available staff as needed and maintain adequate numbers of personnel to ensure patient care is appropriate.
4. The triage process generally occurs outside the Emergency Department to determine who needs further evaluation/medical care. The patient's treatment area and the severity of the injuries are documented on a triage tag. Simple Triage and Rapid Treatment (START) is used to separate the patients into four groups:
 - a. Immediate Care: Patients need advanced medical care at once and are in critical condition and would die without immediate assistance.
 - b. Delayed Care: Patients are in stable condition but require medical assistance.
 - c. Minor: Patients need first aid and not in need of advanced medical care.
 - d. Deceased: Patient not breathing and an effort to reposition the airway have been unsuccessful.
5. Staff that received training and have practiced decontamination procedures may receive patients contaminated with hazardous materials. Patients will be decontaminated prior to leaving care unless lifesaving interventions are necessary first.

Clinical Services for Vulnerable Populations

Patients that have clinical needs (e.g., chronic conditions) that fall outside of the scope of services or ability of the organization to care for them will be transferred to another healthcare facility with capable resources to provide appropriate care. In the event transferring a patient is not immediately possible, Planning and Operations will work together to obtain the appropriate resources (e.g., staff, medications for anxiety etc.) to maintain appropriate delivery of care. The activation of the HICS Mental Health Unit Leader will be implemented in the event patients with mental health needs are present.

Personal Hygiene and Sanitation Needs

The Operations Section Chief and Infrastructure Branch Director are responsible for hygiene and sanitation needs are met. Infection Control will be included in decision-making processes.

1. Procedures for bring in additional portable toilets and hand-washing facilities if the emergency toilets stored in the disaster supply cache are not sufficient.
2. Using antimicrobial soap and water, alcohol-based products located in Environmental Services (EVS). In addition, portable water trucks will be hooked up to the facility and water bladders utilized. Waterless bath packets stored on the units can be utilized when water service is lost.
3. Existing Infection Control policies will be used to support operations.

Mortuary Services

The current morgue capacity is 12 patients, and if needed to be augmented in disaster, AHS utilizes the *Mass Fatalities Procedure* and the *Alameda County Coroner's Plan* that details handling mass casualty incidents which, ensures the safe handling and storage of decedents until the Coroner can respond.

Documenting and Tracking Patient Clinical Information

1. The Casualty Care Unit Leader will coordinate triage and treatment activities. Once the patients are triaged, they are tagged with a triage tag, admitted and the clinical information is documented on the tag. Each patient is assigned and identified by a unique control number. This number is printed on the triage tag; medical forms/requisitions; patient valuables envelope; and patient wristband. HICS Form 259-Hospital Casualty/Fatality Report is used by the Patient Tracking Officer to document the number of injuries and fatalities.
2. Information Systems downtime policies and procedures for managing clinical information will be utilized to document and track patient clinical information during the event of an unplanned information technology system outage.

Victims that are Disabled and/or at Risk

1. Victims with disabilities and people who are vulnerable or at risk and cannot comfortably or safely use some of the standard resources offered in a disaster situation. All attempts will be made not to separate these victims from their families and to meet their needs. A point person(s) will be assigned to assist these victims and if possible, a hospital a staff person will be assigned to assist one or two victims. Information on all victims with special needs will be reported to the HCC. All efforts to contact organizations that represent the interests and rights of individuals with disabilities to request assistance in treatment and placement. All patients with special needs who are admitted will be referred to a social worker/case manager. All patients transferred to another facility will have a list of their special needs to accompany them and if necessary, a volunteer to assist with the transfer. All patients discharged from the hospital will be evaluated for any special needs required for home care, relocation for sheltering or temporary residence.

Curtailing Services

When services need to be curtailed due to jeopardy to patient or staff safety, the Incident Commander will develop a detailed plan and communicate the objectives of the plan both internally and externally to the appropriate parties and authorities. This plan will include reasons for curtailment, movement of patients, staging patients, tracking patients, transporting patients, and the communication process closing the hospital to new patients.

TESTS ITS EOP

1. The Organization Tests its EOP Twice a Year
Drills and exercises are conducted at least two times each year, either in response to an actual emergency or in a planned exercise. Documentation is in the Scalable Event and Disaster Drill Binder.

2. Conduct At Least One Exercise A Year That Includes Patient Influx

To ensure staff gain the opportunity of preparation for an emergency, at least one drill scenario includes an influx of patients. This process allows staff to practice using the disaster plan as well as teach them how to handle multiple patients when they are working in unusual conditions.

In addition, at least one planned exercise involves an internal disaster that may include a scenario where the hospital cannot be supported by the local community or evacuation. In addition, tabletop drills involving the community and hospital are conducted to evaluate the community's emergency response plan.

3. Exercise Scenarios Are Realistic and Related to HVA Priorities

The Emergency Management Committee designs drills and exercises with scenarios and objectives based upon findings from the hazard vulnerability analysis as well as from critiques from past exercises and/or actual events. In addition, AHS participates in exercises designed by the State or local community that have scenarios based on risk in the geographical location. During Planned Exercises, An Individual Monitors Performance

During planned exercises, the hospital designates an evaluator to observe at least the following core performance:

- a. Communication: the effectiveness of communication internally, as well as external communication with emergency response agencies, public health and other healthcare organizations within the community.
- b. Resource mobilization and availability including assets, personal protective equipment and supplies.
- c. Safety and security.
- d. Event notification: including activation of the Hospital Incident Command System (HICS); notification of staff and external authorities and staff roles and responsibilities.
- e. Patient management: including triage activities, patient identification and tracking and support, staff roles and responsibilities.
- f. Utility systems.
- g. Patient, clinical and support care activities.

4. Exercises/Real Events are Critiqued to Identify Deficiencies and Improvement

Once the exercise is concluded or real events occur, they are critiqued through a multi-disciplinary process that includes administration, clinical staff, medical staff and support staff. Deficiencies or improvements are identified and documented in an After Action and Corrective Action Report. The findings from the critiques including strengths and weaknesses are communicated to the Environment of Care/Safety Committee and forward through for review by other committees.

REFERENCES

Applicable and Regulatory Standards:

1. California Code of Regulations, Title 22
2. Centers for Medicare and Medicaid (CMS)
3. The Joint Commission Comprehensive Accreditation Manual for Hospitals EM.01.01.01, EM.02.01.01, EM.02.02.01, EM.02.02.03, EM.02.02.05, EM.02.02.07, EM.02.02.09, EM.02.02.11, EM.02.02.13, EM.02.02.15, EM.03.01.03
4. National Incident Management System
5. NFPA 1600

APPROVALS

| | | System | Alameda | AHS/Highland/John George/San Leandro |
|--|--------------|---------------------|----------------|---|
| Department | Date: | 04/2022 | 02/2020 | 02/2020 |
| Clinical Practice Council (CPC) | Date: | 06/2020, 05/2022 | N/A | N/A |
| Medical Executive Committee | Date: | N/A | 07/2020 | 07/2020 |
| Board of Trustees | Date: | 08/2020 | N/A | N/A |



Highland Hospital Ambulance Patient Offload Time (APOT) Reduction Protocol

| HOSPITAL NAME | Highland Hospital |
|--|--|
| CDPH Hospital Licensing Number | License #: 140000046 Facility ID: 140000034 |
| Hospital ED Address | 1411 E 31st St, Oakland, CA 94602 |
| Hospital ED Phone | (510) 437-4800 |
| Chief Executive Officer (CEO) | James Jackson |
| CEO Email Address | jackson@alamedahealthsystem.org |
| CEO Phone Number | (510) 513-1137 |
| Chief Nursing Officer (CNO) | Romoanetia Lofton |
| CNO Email Address | rlofton@alamedahealthsystem.org |
| CNO Phone Number | (510) 418-6073 |
| Associate CNO (ACNO) | Terrance Fitzgerald-Shaw |
| ACNO Email Address | tfitzgerald@alamedahealthsystem.org |
| ACNO Phone Number | (510) 437-4871 |
| VP Patient Care Services Contact | Salma Adin <i>Vice President, Patient Care Services (inc. ED)</i> |
| VP Patient Care Services Email | saadin@alamedahealthsystem.org |
| VP Patient Care Services Phone Number | (510) 507-5131 |
| Emergency Department Primary Contact (Director, Patient Care Services) | Yangchen Johnson <i>Director, Patient Care Services (inc. ED)</i> |
| Emergency Department Director Email | yjohnson@alamedahealthsystem.org |
| Emergency Department Director Phone Number | (510) 495-4416 |

Highland Hospital Ambulance Patient Offload Time (APOT) Reduction Protocol

Updated 11/2025

Purpose

To ensure timely EMS offloading, support ED patient flow, maintain safety, and achieve compliance with AB-40 standards, prioritizing release of EMS crews within **30 minutes** or as soon as safely possible, the following protocol is enacted.

Real-Time APOT Escalation Path when APOT > 30 minutes:

Charge Nurse → Nursing supervisor → ED Manager → ED Director → Administrator On-Call

- Refer to the Surge Overcapacity Escalation Policy and Action Plan appropriate to the current NEDOCS to support maintaining ambulance patient offload times (APOT) at less than 30 minutes.

EMS Patient Holding, Triage, and Waiting Procedures - Surge Plan Activation and Hospital Coordination

EMS Patient Holding Areas

- The Ambulance Bay may hold up to two patients pre- or post-triage, provided there are no safety concerns for patients or staff.
- If safety concerns arise, the charge nurse or desk nurse should relocate the appropriate patient to a safer area while awaiting an ED bed.

Triage Process

- All patients triaged by the desk nurse will wait in one of the following areas:
 - Ambulance Bay
 - Asthma Lounge

- ED Hallway (Station 1 or 2)
- EMS should not keep patients in the rig during triage unless:
 - There is a confirmed safety concern, or
 - Immediate isolation is required.
- EMS crews must stay with their patient in hallways until an ED bed is assigned.
- Do not triage patients who are not physically in the ED, unless required for patient safety.

EMS Waiting Areas

- EMS crews may wait in the Ambulance Bay, Asthma Lounge, or ED hallways, as directed by the desk/charge nurse.
- EMS crews waiting in Ambulance Bay or hallways must remain with their patient until an ED bed is assigned.

Security Protocol

- Security will not turn EMS away, even when the Ambulance Bay is full.
- Any safety concern must be escalated immediately to the charge nurse and desk nurse.

Rapid Medical Evaluation (RME) & Waiting Room Workflow

- Patients appropriate for the Waiting Room (WR) should receive Rapid Medical Evaluation (RME) by an attending physician.
- After triage and RME, EMS should escort the patient to the WR and give a brief handoff to the Triage or Pit RN.
- Refer ED patients to the appropriate outpatient subspecialties and imaging/laboratory services to ease patient flow

Surge Plan Activation and Hospital Coordination

Highland Hospital will activate Surge Overcapacity Escalation Action Plan to improve coordination between the emergency department and other hospital departments, as needed, to support timely decompression and reduce APOT delays. Components of the action plan include:

- Expediting inpatient discharges or transfers through notification / collaboration with nursing staff, medical staff, and case management staff
- Stat clean rooms for rapid turnover
- Notification to ancillary departments to expedite services and update staffing plans
- Notification to hospital Administrator on Duty (AOD)

- Run NEDOCS and reassess every two hours
- Refer inpatients to the appropriate outpatient subspecialties and imaging/laboratory services to expedite discharges/ transfers and facilitate patient throughput
- Suspension of elective admissions when possible

| Status | Green | Yellow | Orange | Red | Black |
|--------|---|--|---|--|--|
| NEDOCS | 0-60 | 61-100 | 101-140 | 141-180 | 181-250 |
| | <p>Normal Operations</p> <p>APOT ≤ 30 minutes</p> <p>0 ED Boarders</p> <p>Effective Patient Flow. Occurs when no capacity issues exist.</p> <p>Response: ED Charge Nurse to use the NEDOCS tool to generate a score at least once per shift or more frequently as needed.</p> | <p>Daily Operations</p> <p>APOT ≤ 30 minutes</p> <p>1-10 ED Boarders</p> <p>Not exceeding current capacity/ resources.</p> <p>Response: ED Charge Nurse to make notification to ED personnel advising of capacity status and use NEDOCS more frequently as situation dictates.</p> | <p>Overcrowded</p> <p>APOT > 30 minutes</p> <p>11-20 ED Boarders</p> <p>Need for hospital/ emergency services is nearing the limitations of available resources.</p> <p>Response: ED Charge Nurse and Nursing Supervisor validate scoring and implement the Surge Plan as appropriate. ED Charge Nurse to update NEDOCS tool at least every 4 hours and more frequently as the situation dictates and engage Nursing Supervisor, who may notify Administrator-on-Call (AOC).</p> | <p>Over Capacity</p> <p>APOT > 30 minutes</p> <p>21-24 ED Boarders</p> <p>Need for hospital/ emergency services exceeds available resources.</p> <p>Code Triage Internal Alert and Hospital Incident Command System (HICS)</p> <p>Response: ED Charge Nurse and Nursing Supervisor validate scoring and implement the Surge Plan as appropriate. Nursing Supervisor may contact AOC to determine if the Hospital Incident Command System should be activated. ED Charge Nurse or designee shall calculate NEDOCS score at least every 2 hours.</p> | <p>Critical Over Capacity (Internal/External Disaster)</p> <p>APOT > 30 minutes</p> <p>25+ Boarders</p> <p>Code Triage Internal Activation, and Hospital Incident Command System (HICS) are strongly recommended.</p> <p>Response: ED Charge Nurse and Nursing Supervisor validate scoring and implement the Surge plan as appropriate. Nursing Supervisor shall contact AOC to determine if the Hospital Incident Command System should be activated. ED Charge Nurse to use NEDOCS tool as determined by Incident Command.</p> |

Staff Education and Training

- ED and hospital staff will receive ongoing training on:
 - APOT reduction strategies
 - Updated EMS triage and holding processes
 - AB-40 regulatory compliance
- Charge Nurses and Nurse Shift Managers will receive expanded training to ensure protocol adherence.

APOT Monitoring, Reporting, and Quality Oversight

Metrics Review

- APOT metrics reviewed monthly.
- If APOT > 30 minutes more than 10% of the time, an action plan and gap analysis will be initiated.

Quality Department Support

- Analysis of APOT data; assists in developing performance improvement strategies.

Alameda County Coordination

- Highland Hospital will participate in regularly scheduled meetings with Alameda County EMS and stakeholders to share best practices, review APOT data, and optimize system performance.

Review and Revision

- This protocol will be reviewed annually and revised as needed to maintain AB-40 compliance and continuous operational improvement.

Final Note

Always prioritize rapid offloading and securing ED placement for ambulance patients to ensure timely release of EMS crews back into the community.

San Leandro and Alameda Hospital APOT Mitigation Protocol

I. Setting

San Leandro Hospital and Alameda Hospital Emergency Department

II. Purpose

The purpose of this protocol is to meet ambulance patient offload time (APOT) standards outlined in Assembly Bill 40 (AB40) referenced in the appendix below with a goal 90th percentile APOT time within 30 minutes.

III. Definitions

Adapted from Alameda County EMSA 911 Patient Offload and Ambulance Availability Policy

- a. **APOT:** Ambulance Patient Offload Time. This is the amount of time it takes to transfer a patient off the gurney at the receiving hospital. It is the measurement of time between arrival of the EMS transport unit at the facility and the transfer of care.
- b. **Transfer of Care:** Transfer of care is the time at which the patient is transferred off the ambulance gurney and is considered complete once the receiving facility receives a verbal report and a signature from the facility is obtained.
- c. **Offload Standard:** Transfer of care to the staff at the receiving hospital occurs within 30 minutes of arrival.
- d. **Offload Delay:** Transfer of care has exceeded 30 minutes.
- e. **EMS Offload:** The process implemented when the 45-minute threshold without transfer of care has been exceeded. Transport provider staff, under the authority of the County EMS Medical Director, are empowered to offload patients from the ambulance gurney and find a suitable place to stage the patient. This process shall only occur under the direct supervision of an EMS Supervisor who shall be in contact with facility management staff and ensure advisement to a registered nurse that the patient has been offloaded.

IV. APOT Protocol

- This protocol is triggered once the 90th percentile APOT exceeds 30 minutes in the most recent county APOT report. It will be initiated by ED nurse manager.
- This protocol also includes ongoing quality improvement initiatives.
- In addressing the various factors leading to prolonged APOT, San Leandro and Alameda Hospital continue to advocate for active destination management to balance EMS traffic relative to the size of each receiving facility.

a. Arrival Management

- i. Direct to waiting room (WR): Patient are taken directly to the ED WR if they meet EMS criteria or if deemed stable for WR by the ED provider.
- ii. Direct to bed: When a bed is immediately available, EMS will be directed to offload patient directly to room. Patient may be triaged by bedside nurse or charge nurse.
- iii. EMS waiting bed: Patients who are unable to be directed to the WR and do not need immediate resuscitation (airway or hemodynamic compromise) will be directed to a hallway bed for offloading pending bed or nurse availability. Care can begin on these patients provided by ED providers, ED technicians, lab, and x-ray.

b. Throughput Management / Capacity

- i. To accommodate higher volumes, we are adding 9 hours of physician staffing to San Leandro Hospital and 9 hours of APP coverage to Alameda Hospital.
- ii. Activate Surge Plan based on daily conditions

c. Discharge Management

- i. The ED has arranged an expedited outpatient subspecialty referral process to arrange outpatient follow-up for patients discharged from the ED.

d. Surge Planning

- i. AHS has committed to a robust plan to accommodate patient surges with triggers including: NECOCS, ED census, boarding patients, EMS waiting time. The plan facilitates:
 - 1. System load leveling
 - 2. Expediting inpatient discharges
 - 3. Stat room turnarounds
 - 4. Calling in additional care staff

V. Quality Assurance

- a. ED and hospital staff will receive ongoing education around AB 40 and APOT reduction strategies
- b. APOT metrics will be reviewed monthly with associated audits.
- c. This protocol will be reviewed and updated annually.
- d. AHS will continue to participate in Receiving Hospital Meetings.

Appendix

California Assembly Bill 40 (AB40)

SEC. 2. Section 1797.120.6 is added to the Health and Safety Code, to read:

1797.120.6. (a) A licensed general acute care hospital with an emergency department shall, by September 1, 2024, develop, in consultation with its emergency department staff, and its exclusive employee representatives, if any, an ambulance patient offload time reduction protocol that addresses all of the following factors:

(1) Notification of hospital administrators, nursing staff, medical staff, and ancillary services that the local EMS agency standard for ambulance patient offload time has been exceeded for one month.

(2) Mechanisms to improve hospital operations to reduce ambulance patient offload time, which may include, but are not limited to, activating the hospital's surge plan, transferring patients to other hospitals, suspending elective admissions, discharging patients, using alternative care sites, increasing supplies, improving triage and transfer systems, and adding additional staffing.

(3) Systems to improve general hospital coordination with the emergency department, including consults for emergency department patients.

(4) Direct operational changes designed to facilitate a rapid reduction in ambulance patient offload time to meet the local EMS agency standard adopted pursuant to subdivision (b) of Section 1797.120.5.

ED Referrals Process for Internal Medicine

Subspecialties

Hematology & Oncology

A. Emergency/Urgency - Page or call the attending on call (numbers listed on Amion):

- Suspected Acute Leukemia: Order TLS labs (uric acid, phosphorus) in addition to CMP; order DIC labs (PTT, PT/INR); for WBC >100k, assess for leukostasis symptoms (altered mentation, hypoxia, AKI) may require leukapheresis.
- Immune Thrombocytopenia: Order CT head if symptoms suggest CNS bleed.
- Suspected TTP: Order reticulocyte count, haptoglobin, indirect bilirubin, PT/INR, and PTT (to calculate PLASMIC score).
- Known hemophilia with active bleeding: Obtain targeted imaging (bedside US for joint bleeding acceptable).
- Suspected cord compression - notify immediately.
- Suspected high-grade lymphoma with high disease burden: Order TLS labs.

B. Non-Urgent Follow-Up - Send EPIC chat to person listed on Amion for these conditions:

- New diagnosis of DVT or PE in stable patients & start DOAC if appropriate.
- Severe iron-deficiency anemia requiring outpatient IV iron.
- Known cancer patients with symptoms or complications not meeting admission criteria.

C. Suggested Workflow for Patients with Suspected Cancer and No PCP:

- Perform staging imaging in ED to determine urgency and referral pathway.
- CT chest/abdomen/pelvis with IV contrast for most cancers.
- Breast mass without metastases - refer to Breast Surgery.
- Single lung nodule/mass without metastases - refer to Pulmonary.
- Colon/gastric mass without metastases - refer to Surgical Oncology.
- Liver mass without metastases - refer to Surgical Oncology.
- Kidney mass without metastases - refer to Urology.
- Multiple lytic bone lesions without primary tumor - refer to Heme/Onc via EPIC chat; order TLS and DIC labs; assess for leukostasis if WBC >100k.

Dermatology

A. Urgent Cases:

- Monday-Friday send EPIC chat to on-call provider. Derm provider will review, document, place follow-up order and coordinate scheduling.
- Off-hours: Send EPIC chat to person listed on Amion for next business day.

B. Non-Urgent Cases:

- If patient has PCP, instruct them to get referral from PCP. ED may still request recommendations via EPIC chat but must be available the next day for response to/from dermatologist.

C. Subspecialty Clinic referral regardless of PCP status, send EPIC chat for these conditions:

- Blistering disorders
- Autoimmune conditions with new rash
- Nevus concerning for melanoma
- High-grade malignancy concern

Rheumatology

A. Monday-Friday, send an EPIC chat to the provider listed on Amion to request help with a new referral into clinic. Send an EPIC chat overnight or on weekends to the provider listed for the next business day asking for clinical follow-up for these conditions regardless of PCP status:

- Anyone with a history of a diagnosed rheumatic disease, on or off DMARDs, who is new to our system (e.g., recent immigrant, moved from another county/state, changed insurance such as former Kaiser).
- Patients with uncontrolled gout/CPPD who have recurrent ED visit for flares.
- Patients with concern for new SLE, scleroderma, or inflammatory arthritis.

Cardiology

A. There are no emergencies or urgent referrals. Please send an EPIC chat to person listed in Amion for the next business day after hours, or the person listed on Amion during daytime hours.

B. Patients who would benefit from direct cardiology evaluation, regardless of PCP status include the following. Send an EPIC chat for these conditions:

- SVT
- New AF
- New Aflutter

Pulmonary & Critical Care

A. Please send EPIC chat to the Pulmonary attending listed on Amion:

- Lung nodule greater than 1 cm, especially in a former smoker, new or enlarging.
- New or enlarging hilar lymph node.
- Non-resolving pneumonia with moderate to severe clinical features (ongoing cough, dyspnea, hypoxia).
- New PE that is clinically significant.
- Suspected TB with pulmonary cavitation or extensive nodules should be admitted for R/O TB work-up.

If you have any questions, call or EPIC Chat Pulmonary attending 7 am-7 pm, Monday - Friday. All other EPIC chats fitting the above criteria will be seen and reviewed next business day.

B. Please flag that the message is coming from the ED to prevent a bidirectional dialogue.

Geriatrics - On Hold as currently no geriatric service

A. Geriatric patients should have a primary care physician to manage active medical problems and concerns. Send EPIC chat to geriatrics for the following:

- Recurring ED visits due to repeated falls with concern for severe frailty, polypharmacy, or cognitive impairment
- Suspicion of severe cognitive impairment
- Polypharmacy
- Contact geriatrics via EPIC messaging or EPIC chat

Palliative Care

A. Send an EPIC chat to the inpatient palliative care consultant listed in Amion for your site (HGH, AH, SLH). Consultants are available Monday-Friday, 9 AM-5 PM. Outside these hours, EPIC chat the consultant covering for the next business day.

Outpatient referral criteria include:

- A. Any patient with a serious illness who is likely to, or has begun, use the ED to manage their illness.
- Condition - Timing (4 weeks): Advanced cancer, end-stage cardiac disease (e.g., CHF), end-stage pulmonary disease (e.g., COPD, ILD), advanced liver and kidney disease (e.g., cirrhosis, ESRD), end-stage dementia, or advanced neurological diseases.
- B. Pain and/or symptoms related to advanced conditions.
- C. Advanced care planning and/or goals of care conversations.

Nephrology

A. Call or send EPIC chat to the on-call attending for the following cases. For cases outside these indications, refer to the PMD:

- Acute kidney disease: Rise in creatinine of 0.3-0.5 mg/dL from a known baseline within the past 90 days.
- CKD 5 without an outpatient nephrologist, no uremic signs or symptoms, and stable electrolytes.
- Resistant hypertension: Difficult to control despite three antihypertensive drugs from different classes, including a diuretic.
- Non-urgent electrolyte abnormalities:
 - Hypokalemia: 3-3.5
 - Hyperkalemia: 5.5-5.7
 - Hyponatremia: Sodium <132
 - Chronic hypomagnesemia or hypophosphatemia
- New-onset glomerulonephritis: Hematuria/proteinuria with rise in creatinine.

Neurology

A. Epilepsy patients (with restrictions, e.g., no ongoing alcohol use or provoking factor that will not respond to meds), please send EPIC chat to our clinic medical director Brigitte Hurtubise.

B. Most neurology patients seen in the ED are either safe to discharge for PCP follow-up or require urgent evaluation, so few cases meet criteria for this pathway.

Gastroenterology & Hepatology

This applies to patients with the following conditions who are without a PCP, without established GI care, and are not being admitted to the inpatient service.

A. Decompensated cirrhosis with complications such as ascites, history of variceal bleeding, hepatocellular carcinoma, hepatorenal syndrome, or hepatic encephalopathy.

B. Established inflammatory bowel disease (ulcerative colitis, Crohn's disease).

C. Suspected gastric or colonic malignancy needing urgent endoscopic workup.

Standard referral process (Monday-Friday, 7 AM-5 PM):

- ED confirms insurance is accepted by AHS.
- ED attending pages the GI consulting on Amion for the respective hospital.
- ED attending also sends an EPIC chat to the GI consultant attending with patient details.

- GI consult attending discusses the referral with ED attending.
- If appropriate, GI consult attending places an eConsult or urgent procedure order.

After hours/weekends/holidays: EPIC chat or notify the GI consult attending (listed on amion for the next business day). Please do not contact the on-call GI attending for these requests.

Endocrinology

Weekdays: Send EPIC chat or page on call physician listed on amion. Case will be reviewed, recommendations provided, and patient will be triaged.

After hours: Send an EPIC chat which will be reviewed on the next business day

Adult Immunology

A. For HIV primary care within AHS: Send an EPIC chat to 'AIC HIV Primary Care.' The team (nurses, social worker, pharmacist, physician, community health outreach worker) will respond in real time during business hours and will visit patient at bedside when possible. After-hours, referrals are reviewed on the next business day.

B. For HIV primary care in the community (not AHS): Send an EPIC chat to ED HIV/Hepatitis C/Syphilis navigators, who will triage the referral.

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

February 27, 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: A1

Meeting Date: February 27, 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 Credentialing and Privileging of Providers
- Medical Staff Immunization and Vaccination
- Medical Staff Ongoing Monitoring of Expiring Items

Alameda Health System

MEDICAL STAFF CREDENTIALING AND PRIVILEGING OF PROVIDERS

| | | | |
|---|---------------|------------------------------|---|
| <i>Department</i> | Medical Staff | <i>Effective Date</i> | 5/2011 |
| <i>Campus</i> | AHS, AH | <i>Date Revised</i> | 5/2011, 6/2014, 6/2017, 6/2019, 2/2020, 1/2022, 4/2022; 4/2023; 5/2023; 10/2023; 11/2023; 2/2024; 3/2024; 3/2025; 4/2025; 8/2025; 11/2025; 3/2026 |
| <i>Unit</i> | Medical Staff | <i>Next Scheduled Review</i> | 3/2029 |
| <i>Manual</i> | Medical Staff | <i>Author</i> | Manager, Medical Staff Services |
| <i>Replaces the following Policies:</i> | | <i>Responsible Person</i> | Chief of Staff |

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

Purpose

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

Policy Statement

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

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

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

Nondiscriminatory Statement and Audit Process

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

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

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

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

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

Procedure

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

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

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

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

Pre-Application

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

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

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

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

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

Initial Application for Appointment

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

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

The following forms must be completed and signed:

1. Background Investigation Acknowledgement Form
2. Information Release/Acknowledgment
3. AHS/AH Medical Staff Sharing Agreement
4. Confidentiality and Security Agreement
5. Confidentiality Agreement form for Medical Staff Affairs
6. Medical Staff Quality and Assessment and Peer Review Agreement
7. Information Services (IS) Epic Training Data Collection Form
8. Electronic Signature authorization
9. Photography and Videotaping Attestation
10. Medicare and Tricare Acknowledgement
11. Professional Code of Conduct Agreement

12. Attestation Questionnaire: including applicant attesting to perform privileges as requested, lack of present illegal drug use, history of loss of license and/or felony convictions, and history of loss of limitation of privileges or disciplinary activity.
13. Relevant APP agreements and standardized procedures as applicable.

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

Reappointments

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

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

The following forms must be completed and signed.

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

Reappointment Applications will be sent via the Practitioner Portal to providers approximately four (4) months prior to their appointment expiration date and are expected to be completed on-line and submitted within 35 days.

Three reminders will be made, sent approximately every 10 days, for unreceived reapplications. If the provider fails to submit a completed application in the timeframe outlined on the written notice, a phone call/text will be made to the provider and a final email reminder will be sent. See Attachment A for template reminders. Failure to submit reappointment application shall be deemed to have voluntarily resigned their Medical Staff membership. The procedural rights set forth in the Medical Staff Bylaws shall not apply to a voluntary resignation under this section.

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

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

Verification and Processing

When the application for appointment or reappointment is submitted, a review for completeness is performed by Medical Staff Services. If additional information is required, or if questions are left blank, the applicant is contacted and informed that processing will not begin until the application is entirely complete. The applicant is responsible for providing the information to satisfy the process, including resolution of any discrepancies. Failure to submit the requested information within thirty (30) days shall be considered a withdrawal of the application. Such withdrawal shall not give rise to hearing and appeal rights pursuant to the Bylaws. In accordance with the Bylaws, the Medical Staff will not take action on an application that is not “complete”.

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

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

1. California Professional License/Professional Licenses from Other States

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

2. DEA Certification

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

3. Fluoroscopy or Radiography Certification

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

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

4. Hospital Affiliations and/or Work History

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

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

5. Graduation from Medical/Professional School and Completion of Residencies and Fellowships

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

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

6. Board Certification

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

Advanced Practice Registered Nurses and Physician Assistants are required to maintain national certification by any of the following bodies:

- American Academy of Nurse Practitioners (AANP)
- American Nurses Association – American Nurses Credentialing Center (ANCC)
- Pediatrics Nursing Certification Board (PNBC)
- National Certification Corporation (NCC) for Nurse Practitioner certification
- American Association of Critical-Care Nurses (AACN)
- American Midwifery Certification Board (AMCB)
- National Board of Certification & Recertification for Nurse Anesthetist (NBCRNA)
- National Commission on Certification of Physician Assistants (NCCPA)

7. Current, Adequate Malpractice Insurance

Professional Liability Insurance coverage and the amount of coverage must be verified directly with the carrier.

8. Professional Liability Claims History

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

9. Background Checks

Background checks will be conducted on all applicants at the time of initial appointment and reappointment in accordance with state and federal laws. Applicants must consent to this process by signing and submitting the Notice Regarding Background Check Investigation. Failure to complete this form shall result in the application being deemed incomplete.

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

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

10. National Practitioner Data Bank (NPDB)

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

11. Medicare/Medicaid Sanctions

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

12. Centers for Medicare & Medicaid Services (CMS) Opt Out

CMS will be queried for all new appointments and reappointments to confirm whether a provider has opted out of participating in the Medicare program.

13. Professional References

Three (3) professional references for providers with the same credentials are required for new applicants and two (2) for reappointments. These references must be from individuals familiar with the applicant's work, either via direct clinical observations or through a close working relationship within the prior two years and preferably someone from the same

specialty area. Relatives or spouses may not be used as a reference. References should also include the following:

- At least one provider from each medical staff for which the applicant holds privileges;
- A provider outside of the applicant's practice group or with whom they have no financial relationship, if applicable.
- A provider that holds the same credentials as the applicant (i.e., DPM must list one DPM; PA must list one PA); and
- For an Advanced Practice Provider (APP), one reference from a physician within the same department that has direct observation of care provided (i.e., supervising physician).

All other references must hold a physician/surgeon license to practice medicine (exception for Ph.Ds who may list all Ph.D licensed references).

14. Continuing Medical Education

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

15. Provider Enrollment

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

16. Ongoing Professional Practice Evaluation (OPPE)

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

17. Additional Information

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

18. Timeliness of Information

The established processing time is estimated at 60-90 days following receipt of completed application. Applications for Behavioral Health providers will be assessed for completion and verification of qualifications within 60 days of receipt of an application. Such applicants will be notified within seven (7) business days of receipt and confirmation of whether the application is complete. An application must be signed within 120 days of Credentials Committee review. The attestation must be signed within 180 days of Credentials Committee

review. Verification of licensure, board certification, sanctions, current work history, malpractice claims history must be verified within 120 days of Credentials Committee review.

Requests for Modification of Privileges

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

1. The provider must complete the request for a modification of privileges request and privilege form along with any supporting documentation regarding training or experience, as required.
2. The following primary source verification will be conducted:
 - CA Medical or Professional License(s)
 - LVS 805 Report
 - NPDB
3. FPPE/Proctoring shall be considered by the Department Chair at the time of a request for additional privileges.
4. The privileges requested and supporting documentation is made available to the appropriate Division Chief and/or Department Chair/designee for review and recommendation to the Credentials Committee with final review and recommendation for approval by the Medical Executive Committee (MEC) to the Governing Board.

Appointment/Privilege Approval Notifications

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

Application Fees

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

1. Medical Staff Fees:
 - a. AHS/AH application fee for Temporary Privileges ONLY of \$100.00.
 - b. AHS application fee of \$300.00 and reappointment fee of \$500.00.
 - c. AH application fee of \$300.00 and reapplication fee of \$500.00.
2. Advanced Practice Provider (APP) e.g., PA, NP, etc. Fees:
 - a. AHS application fee of \$150.00 and a reappointment fee of \$150.00.
 - b. AH application fee of \$200.00 and a reappointment fee of \$200.00.

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

AHS and AH Category Assessments

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

Voluntary Resignation

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

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

PROVIDER RIGHTS TO AMEND APPLICATION AND REVIEW CREDENTIALS FILE

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

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

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

RELATED DOCUMENTS

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

Approvals:

| | | AHS | AH |
|------------------------------------|--------------|----------------|----------------|
| Credentials Committee | Date: | 2/12/26 | |
| Medical Executive Committee | Date: | 2/18/26 | 2/20/26 |
| QPSC | Date: | 2/25/26 | |
| Board of Trustees | Date: | 3/11/26 | |

Medical Staff Credentialing and Privileging of Providers
Attachment A

The email templates below will be used as reminders and final notices.

First reminder to provider (*if reappointment application was not submitted after 10 days of invitation*):

*Subject: ****Action Needed**** Application for Reappointment Alameda Health System and/or Alameda Hospital*

Dear <Full Name>,

Please consider this a friendly reminder that your application for reappointment to the Alameda Health System and/or Alameda Hospital Medical Staff has not been received. Please submit this information to Medical Staff Services using the below link to access the application portal:

<https://onlineapp.alamedahealthsystem.org/PractitionerPortal/Login.aspx?ReturnUrl=%2fPractitionerPortal%2fmain.aspx>

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

Second/Third reminders to provider, copied to chief and chair (*if reappointment application was not submitted after 20 days/30 days of invitation*):

*Subject: ****Action Needed - 2nd (or 3rd) Reminder**** - Application for Reappointment AHS / AH*

Dear <Full Name>,

This is a second reminder to notify that your application for reappointment to the Alameda Health System/Alameda Hospital Medical Staff has not been received. It has been 20 (or 30) days since the initial notification to apply for reappointment was sent. Your application for reappointment is due within 35 days from the date of initial notification. Should your application not be submitted, it will be considered a voluntary resignation of medical staff membership and privileges at Alameda Health System/Alameda Hospital.

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

If you wish to maintain your membership and privileges, please submit the application using the below link to access the Practitioner Portal:

<https://onlineapp.alamedahealthsystem.org/PractitionerPortal/Login.aspx?ReturnUrl=%2fPractitionerPortal%2fmain.aspx>

**Note: Mozilla Firefox Browser is NOT supported by the vendor. Please do not attempt to complete your application using this browser.*

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

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

Dear (insert provider's name),

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

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

- First reminder – [enter month/date/year]
- Second reminder - [enter month/date/year]
- Third reminder – [enter month/date/year]

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

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

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

Please contact your Department Chair, regarding the above.

Partial Action on Application for Reappointment: *Used if the application has been started but was not completed/submitted.*

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

Dear (insert provider's name)

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

Alameda Health System

MEDICAL STAFF IMMUNIZATION AND VACCINATIONS

| | | | |
|---|----------------------|------------------------------|---|
| Department | Medical Staff | Effective Date | 06/2019 |
| Campus | AHS & AH | Date Revised | 6/2022; 10/2022; 10/2023; 1/2024; 3/2026 |
| Unit | Medical Staff Office | Next Scheduled Review | 3/2029 |
| Manual | Medical Staff | Author | VP, Physician 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

The purpose of this policy is to describe the guidelines for Alameda Health System (AHS) and Alameda Hospital (AH) Medical Staff and Advanced Practice Providers health status immunizations and vaccinations.

Policy

All members of the Medical Staff and Advanced Practice Providers (APPs) who provide patient care within any of the facilities comprising the Alameda Health System and/or Alameda Hospital are required to submit documentation to the Medical Staff Office of their health immunization and vaccination status as required for credentialing and privileging.

Compliance with this policy is a condition to physical access to the Alameda Health System facilities and does not constitute a restriction of clinical privileges or disciplinary action.

The Employee Health department of Alameda Health System will maintain all required immunization/vaccination records for Alameda Health System employed providers.

Procedure

For providers who are not otherwise employed by Alameda Health System, with the exception of physicians practicing exclusively in telemedicine (Teleneurology and Teleradiology), each applicant to the medical staff is required on a one-time basis to submit proof of immunity to Rubeola, Rubella, Mumps and Varicella.

1. **Rubeola** documentation must be provided in the form of:
 - A. Laboratory evidence of disease or immunity or
 - B. Documented receipt of two (2) doses of MMR.
2. **Rubella** documentation must be provided in the form of:
 - A. Laboratory evidence of disease or immunity or
 - B. Documented receipt of one dose of MMR.
3. **Mumps** documentation must be provided in the form of:
 - A. Laboratory evidence of immunity or disease or

- B. Physician diagnosed mumps or
 - C. Documented receipt of two doses of MMR.
4. **Varicella: (chicken pox)** documentation must be provided in the form of:
- A. Laboratory evidence of immunity or disease or
 - B. Documentation of receipt of two doses of Varicella vaccine.

For providers who are not otherwise employed by Alameda Health System, with the exception of physicians practicing exclusively in telemedicine (Teleneurology and Teleradiology), each applicant to the medical staff is required to submit proof of the following vaccines/immunizations described below:

1. **Tuberculosis Skin Testing (PPD, IGRA, Quantiferon-TB Gold or T-spot test)** status is required at time of initial application & annually.
 - A. Initial screening must comply with the Alameda Health System Infection Control – Employee Health Program policy, which requires a two-step skin test (proof of negative result within last 12 months accompanied by a 2nd negative skin test result within the last three months *OR* a QuantiFERON TB Gold test *OR* a T-Spot Blood test).
2. **Influenza** is required annually through documentation of influenza vaccination. Masking may be required during the season in accordance with County guidelines.
3. **Tdap (tetanus, diphtheria, and acellular pertussis)**, upon initial appointment, requires documentation of receipt of a single dose within the last 10 years or a signed declination.
4. **COVID-19 Vaccination** documentation is strongly encouraged.
5. **Hepatitis B vaccination** is recommended. Declination must be in writing.

Approvals

| | | AHS | AH |
|-----------------------------|-------|---------|---------|
| Credentials Committee | Date: | 2/12/26 | |
| Medical Executive Committee | Date: | 2/18/26 | 2/20/26 |
| QPSC | Date: | 2/28/26 | |
| Board of Trustess | Date: | 3/11/26 | |

Alameda Health System

MEDICAL STAFF ONGOING MONITORING OF EXPIRING ITEMS

| | | | |
|---|---------------|------------------------------|---------------------------------|
| Department | Medical Staff | Effective Date | 3/2025 |
| Campus | AHS, AH | Date Revised | 3/2026 |
| Unit | Medical Staff | Next Scheduled Review | 3/2029 |
| 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

As an extension of the Alameda Health System (AHS) and Alameda Hospital (AH) Medical Staff Bylaws this policy will establish the mechanism for ongoing monitoring of relevant expiring items, which involves the collection, verification and assessment of specified licenses, registrations, and permits/certifications as required for licensed independent practitioners and Advanced Practice Providers (APP) who provide patient care services within the Alameda Health System.

Policy Statement

It is the policy of the AHS/AH Medical Staff to ensure that licensed practitioners and APPs continuously meet minimum credentialing and privileging standards for membership and/or privileges/practice prerogatives as outlined in the Medical Staff Bylaws, Rules and Regulations, policies and privileges.

It is the responsibility of each provider to submit evidence of current licensure, certification, registration and malpractice coverage relevant for the membership and/or privileges granted.

Definitions

Expirable Process is a Process that can autonomously check practitioners ID numbers for their expiration date within MSOW and perform an action based upon how close the ID number is to expiring, as well as upon expiration. Expirable Processes are essentially always active for all practitioners when in use.

When the Expirable Process runs, it will run all active jobs and tasks within it. All tasks within an expirable process will check the documents associated with them. When a document is nearing its expiration date, it will perform the actions associated to the task depending upon the number of days left until it expires.

Web Crawler is an automated program that systematically browses the World Wide Web using a specific URL to find relevant information by communicating with web servers.

Procedure

The Medical Staff Office will conduct ongoing monitoring of expirable items via primary source verification to ensure continued compliance.

When applicable, the credentialing database will be utilized to automate the process via the Expirable Process.

The credentialing database is set up to automatically query State License, DEA and Radiologic Health Branch through a Web Crawler. All queries will return a result that will be automatically uploaded in the credentialing system as a response image. If the result produces an updated expiration date the system will replace the expiring date with an updated expiration date.

Expirable items, primary source and courtesy notifications are described below:

| Expirable Item | Primary Source/Method | Courtesy Notice to Provider |
|---|--|--|
| California Medical/Professional License (i.e., State License) | California Department of Consumer Affairs Licensing Board Website. | Automated reminder notifications are generated through the credentialing database and emailed to the provider at 60 days, 30 days, and 10 days prior to expiration. Notification email is sent to the Division Chief (when applicable) and Department Chair 10 days prior to license expiration. |
| Drug Enforcement Agency (“DEA”) Registration | DEA Controlled Substances Act Registration Information Database. | Automated reminder notifications are generated through the credentialing database and emailed to the provider 60 days, 30 days, and 10 days prior to expiration. Notification email is sent to the Division Chief (when applicable) and Department Chair 10 days prior to expiration. |
| Board Certification | American Board of Medical Specialties (ABMS) on-line database (<u>Direct Connect Select (DCS)</u> or <u>CertiFACTS</u>), American Osteopathic Association (AOA), or primary source verification directly from the certification board. | Automated reminder notifications will be emailed to the provider 180 days, 90 days, and 30 days prior to expiration. Notification email is sent to the Division Chief (when applicable) and |

| | | |
|--|---|---|
| | Providers are granted a 30-day grace period from the date the lapse in certification is identified to allow for reinstatement if the provider can produce evidence that they are actively seeking reinstatement. | Department Chair upon expiration. |
| Advanced Practice Provider National Certification | National Board website. | Automated reminder notifications will be emailed to the provider 60 days, 30 days, and 10 days prior to expiration. Notification email is sent to the Division Chief (when applicable) and Department Chair 10 days prior to expiration. |
| Malpractice Insurance | A copy of the certificate of insurance. | Reminder notifications are emailed to the provider approximately 30 days, 15 days, and 5 days prior to expiration. Notification email is sent to the Division Chief (when applicable) and Department Chair 5 days prior to expiration. |
| Radiologic Health Branch Permit/Certificate | A copy of the certificate. A temporary verification may be obtained on-line, however, in accordance with the California Department of Public Health (CDPH) Radiologic Health Branch (RHB), the online verification serves only as a temporary authorization. | Automated reminder notifications will be emailed to the provider 60 days, 30 days, and 10 days prior to specified RHB Permit/Certificate expiration. Notification email is sent to the Division Chief (when applicable) and Department Chair 10 days prior to the expiration. |
| Life Support Certifications (ACLS, ATLS, BLS, PALS, and NPR) | A copy of the certificate. | Automated reminder notifications are emailed to the provider approximately 60 days, 30 days, 15 days, and 7 days prior to expiration. Notification email is sent to the Division Chief (when applicable) and Department Chair 7 days prior to expiration. |

| | | |
|---|--|--|
| General Anesthesia Permit/Moderate Sedation Permit (dental/oral surgeons) | A copy of the certificate. | Automated reminder notifications are emailed to the provider approximately 60 days, 30 days, and 10 days prior to expiration. Notification email is sent to the Division Chief (when applicable) and Department Chair 10 days prior to expiration. |
| Immunizations/Vaccines | A copy of the immunization/vaccine record in accordance with policy. | Reminders are emailed to the provider approximately 30 days prior to expiration. |
| HIV Specialist Designation | Signed specialist designation form. | Annual attestation requested from provider. |

Approvals:

| | | AHS | AH |
|------------------------------------|--------------|----------------|----------------|
| Credentials Committee | Date: | 2/12/26 | |
| Medical Executive Committee | Date: | 2/18/26 | 2/20/26 |
| QPSC | Date: | 2/25/26 | |
| Board of Trustees | Date | 3/11/26 | |

ACTION / DISCUSSION: Contracts

Contract Approvals

March 2026

1) New agreement with Fisher Scientific Company LLC dba Fisher Healthcare for provision of laboratory supplies. The term of this agreement is effective April 1, 2026 through March 31, 2029. The estimated impact of this agreement is \$6,600,000.

Mark Fratzke, Chief Operating Officer

2) New agreement with Hill-Rom Company, Inc. for provision of a new nurse call system at our skilled nursing facilities. The term of this agreement is effective March 12, 2026 through March 11, 2027. The estimated impact of this agreement is \$1,430,000.

Mark Fratzke, Chief Operating Officer

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

Board of Trustees Contract Summary | 2026

| | |
|--------------------------------|---|
| Contractor/Vendor Name: | Hill-Rom Company, Inc. (“Hill-Rom”) |
| Description: | <p>Hill-Rom is a leading American medical technology company specializing in hospital smart beds, patient monitoring, care communications, and digital health solutions, now operating as a subsidiary of Baxter International. Acquired by Baxter in 2021, its headquarters is in Chicago, IL.</p> <p>The nurse call systems at Fairmont Hospital, South Shore Rehabilitation and Wellness, and Park Bridge are all at the end of their useful life and need replacement. A survey was conducted among Clinical and Engineering site leaders to gather the necessary business requirements necessary for a replacement call system. A request for quote was sent out to 3 vendors, Comtel, Ascom, and Hill-Rom.</p> <p>Hill-Rom was selected as they best met all requirements. This vendor performed in-person walkthroughs to provide more accurate quotes rather than a virtual floor plan-based assessment as used in the other quotes. A key element supporting selection of Hill-Rom was the inclusion of an integrated repair ticketing system. This facilitates timely identification of issues and requests for repair. Other vendors sub-contract maintenance and repairs to 3rd party providers. Our experience with vendors relying on sub-contracted maintenance and repairs has been poor with respect to quality of workmanship and timeliness.</p> <p>Additionally, Hill-Rom utilizes a “homerun cabling” method vs the standard daisy chain method used by other vendors. This will allow the call system in individual rooms on a floor to continue functioning in the event 1 room is experiencing a connection issue, whereas with the daisy chain method 1 room experiencing a fault in wiring will affect subsequent rooms on the same chain, leaving multiple rooms without nurse call until the broken link in the chain is repaired. Equipment and hardware pricing is optimized through Vizient, our Group Purchasing Organization.</p> <p>AHS has selected Hill-Rom to provide its nurse call system for the system’s skilled nursing facilities, upgrading the current system in use. Hill-Rom manufactures, installs and services the Voalte Nurse Call System. The benefits include</p> <ol style="list-style-type: none"> 1. Enhanced communication and collaboration among care teams, ensuring that critical information is shared quickly and efficiently. 2. Support efficient clinical workflows, leading to improved patient outcomes and satisfaction. 3. Provides a secure platform for communication, reducing the risk of medical errors and improving patient safety. 4. Designed to grow with AHS making it adaptable to future needs. <p>Senior Leadership recommends implementation of the Voalte system to increase patient safety, better system reliability, and efficient staff communication.</p> |
| Contract Type and Term: | Statement of Work (March 12, 2026 – March 11, 2027). General Terms and Conditions of the SOW are governed by Baxter Master Purchase and License Agreement (“MPLA”). |

Board of Trustees Contract Summary | 2026

| | | | | | | |
|---|---|-----------------|---------------------------|--------------------|--------------------|---|
| Termination Clause: | Without cause termination upon 30 days' written notice. | | | | | |
| Total Spend with Vendor: | Description | | Board Approval | | Total | |
| | 3/12/2026-3/11/2027 | | | | \$1,300,000 | |
| | 10% Contingency | | | | \$ 130,000 | |
| | Total Estimated Spend: | | Approval Requested | | \$1,430,000 | |
| Estimated Cost Savings: | There are no clearly identifiable cost savings associated with the Hill-Rom system, however there will be noticeable improvements to patient care, patient safety, system uptime and maintenance quality. | | | | | |
| Fiscal Implications: | The proposed purchase is in capital budget for FY26 and will be accounted for in future budget requests. | | | | | |
| Quotes Received | AHS obtained quotes from 3 vendors. | | | | | |
| Reasons for Recommendation: | The current system has reached its end-of-life and its maintenance has become increasingly more difficult to sustain. The Hill-Rom solution offers adaptability and standardization across the system | | | | | |
| Impacted Facilities: | JGPH | Highland | Fairmont | San Leandro | Alameda | Clinic(s) |
| | | | X | | | Park Bridge South Shore Rehab & Wellness |
| 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 | | | | | |

Board of Trustees Contract Summary | 2026

| | |
|--------------------------------|--|
| Contractor/Vendor Name: | Fisher Scientific Company LLC dba Fisher Healthcare (“Fisher”) |
| Description: | <p>AHS is seeking Board approval to enter into a three-year local pricing agreement under the Vizient – West Coast Sourcing Solutions Group Purchasing Organization (“GPO”) with Fisher for the period of January 1, 2026 through December 31, 2028, at an estimated annual cost of \$2,200,000. Fisher is a nationally recognized distributor of laboratory supplies and is part of Thermo Fisher Scientific, a global life sciences company originally founded in the United States in 1902. Through this long-standing history, Fisher has developed extensive expertise in supporting hospitals, health systems, and laboratory operations with reliable access to essential laboratory products. Under the proposed agreement, Fisher will serve as AHS’ distributor of choice for laboratory supplies across all sites, providing pricing stability, supply continuity, and long-term operational support for laboratory services that are critical to patient care and clinical decision-making.</p> <p>Under the proposed GPO agreement, Fisher will provide timely and dependable delivery of laboratory supplies to all organizational sites and is expected to supply approximately 90% of the laboratory supplies required for routine laboratory operations. By consolidating procurement through a single primary distributor, the organization can significantly reduce reliance on multiple vendors, minimize supply chain complexity, and improve inventory management and standardization across sites. This approach supports consistency in laboratory testing materials, which is important for quality, efficiency, and regulatory compliance.</p> <p>The laboratory supplies covered under this agreement are essential to support diagnostic testing, disease monitoring, and clinical decision-making across inpatient, outpatient, and ancillary care settings. Reliable access to these supplies is necessary to maintain uninterrupted laboratory operations and avoid delays in patient care that could result from shortages or inconsistent sourcing.</p> <p>From a financial and operational perspective, the proposed agreement provides cost savings of approximately \$200,000/year, price predictability and budget stability over the 3-year term, with an estimated annual spend of \$2,200,000 consistent with historical and anticipated laboratory supply usage. Centralizing laboratory supply purchasing through Fisher is expected to generate efficiencies in procurement, ordering, and vendor management while supporting system-wide standardization initiatives.</p> <p>Based on the vendor’s capabilities, the critical nature of the supplies involved, and the efficiencies gained through a GPO-aligned distributor-of-choice model, AHS recommends Board approval to enter into the proposed GPO agreement with Fisher for the period of April 1, 2026 through March 31, 2029.</p> |
| Contract Type and Term: | New Group Purchasing Organization Agreement April 1, 2026 through March 31, 2029 |
| Termination Clause: | Either Party may terminate the Agreement at any time without cause upon 180 days prior written notice. |

Board of Trustees Contract Summary | 2026

| | | | | | | |
|---|--|-----------------|---------------------------|--------------------|--------------------|------------------|
| Total Spend with Vendor: | Description | | Board Approval | | Total | |
| | Laboratory Supplies | | \$6,600,000 | | \$6,600,000 | |
| | Total Requested Amount: | | Approval Requested | | \$6,600,000 | |
| Estimated Cost Savings: | Savings of \$200,000/year. | | | | | |
| Fiscal Implications: | Cost has been included in FY 26 budget. | | | | | |
| Reasons for Recommendation: | We recommend Fisher because of its long-established presence, national scale, and proven ability to reliably supply a comprehensive range of laboratory products across multi-site healthcare systems. The vendor's broad product coverage, dependable distribution network, and GPO-negotiated pricing provide operational stability, cost predictability, and reduced supply-chain risk for essential laboratory services. | | | | | |
| Impacted Facilities: | JGPH | Highland | Fairmont | San Leandro | Alameda | Clinic(s) |
| | X | X | X | X | X | X |
| Coordination with Medical Staff: | Reviewed by Chair Pathology (Harris Goodman, MD) | | | | | |
| Administrative Review: | Vice President, Support Services | | | | | |
| Prior BOT Review/Action: | N/A | | | | | |
| Executive Sponsor | Chief Operating Officer | | | | | |

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 |
| 23 | Roelz Enterprises, LLC dba ELS Prestige Home Care | \$2,200,000 | 10/15/2025 | 10/14/2027 | FC - 2-4-26 BOT Approved 2-11-26 | SNF sitter services. | | Chief Operating Officer |

Total Amount for FY 26 year to date \$535,554,676

ACTION/DISCUSSION: Diagnostic Imaging Equipment Replacement Plan

Imaging equipment replacement plan

Fredrick Lee, System Director
Albert Roh, Chair
Department of Radiology
March 11, 2026

How it started

Alameda Health System Radiology/Imaging Report to Medical Executive Committee

Albert Roh, MD
October 15, 2025



Radiology/Imaging Report

Strengths

- The people
- Increasing imaging volumes

Weaknesses

- Inconsistent leadership

Threats

- Aging equipment

Opportunities

- Enterprise imaging



Since then...

- **11/30/2025:** ALH CT down for **9 days**
- **1/25/2026:** HGH ED CT down for **3 days**
- **1/25/2026:** HGH ED CT contrast injector down
- **1/30/2026:** SLH CT contrast injector down
- **2/9/2026:** ALH CT contrast injector down
- **2/28/2026:** All 4 HGH portable X-ray units went down
- **3/2/2026:** HGH 1.5T MRI down (**ongoing** as of 3/6/2026)
- **3/5/2026:** HGH ED X-ray down (**ongoing** as of 3/6/2026)

The plan

| FY2026 New Requests | | | | |
|----------------------|----------------|--------|---|------------------|
| Approved (Y or N) | Requestor Name | Dept # | Brief Description of capital request | Total Amount |
| YES | Fredrick Lee | 1763 | | |
| YES | Fredrick Lee | 1763 | GE Portable X-ray Units | 683,194 |
| YES | Fredrick Lee | 6763 | | |
| YES | Fredrick Lee | 67630 | GE Mammo upgrade to 3D (FDN cover) | 483,499 |
| YES | Fredrick Lee | 77630 | GE R&F Room replacement w/room construction | 830,625 |
| Grand Total | | | | 2,136,396 |

Expected arrival on
3/31/2026

- 2/18/2026
 - Request submitted to replace all **CT contrast injectors** and to also have **2 spares**

The plan

| FY2026 New Requests | | | | |
|----------------------|----------------|--------|---|------------------|
| Approved (Y or N) | Requestor Name | Dept # | Brief Description of capital request | Total Amount |
| YES | Fredrick Lee | 17630 | GE Mini Carm | 69,539 |
| YES | Fredrick Lee | 17630 | GE Portable X-ray Units | 683,194 |
| YES | Fredrick Lee | 67630 | GE Mini Carm | 69,539 |
| YES | Fredrick Lee | 67630 | GE Mammo upgrade to 3D (FDN cover) | 483,499 |
| YES | Fredrick Lee | 77630 | GE R&F Room replacement w/room construction | 830,625 |
| Grand Total | | | | 2,136,396 |

Table 1 FY2027–FY2030 Stabilization Phase

| Fiscal Year | Focus | Estimated Investment |
|---------------|--------------------------------------|----------------------|
| FY2027 | High-Risk Stabilization | ~\$9.4M |
| FY2028 | Construction-Dependent Modernization | ~\$11.4M |
| FY2029 | Planned Lifecycle Refresh | ~\$5.4M |
| FY2030 | Long-Range Transformation | ~\$9.5M |

The plan

| FY2026 New Requests | | |
|----------------------|----------------|------|
| Approved (Y or N) | Requestor Name | Dept |
| YES | Fredrick Lee | 17 |
| YES | Fredrick Lee | 17 |
| YES | Fredrick Lee | 67 |
| YES | Fredrick Lee | 67 |
| YES | Fredrick Lee | 77 |
| Grand Total | | |

Table 6: 10-Year Rolling Imaging Capital Forecast (FY2031–FY2040)

| Fiscal Year | Primary Modalities Scheduled | Planning Capital Focus | Estimated Capital Range |
|-------------|---------------------------------------|---|-------------------------|
| FY2031 | None (stabilization year) | No major lifecycle replacements | \$0–\$1.0M |
| FY2032 | Portable ultrasound (early wave) | Fleet refresh (select units) | \$1.0M–\$2.0M |
| FY2033 | Mammography | mammo refresh | \$3.0M–\$4.5M |
| FY2034 | Portable ultrasound (late wave) | Core ultrasound lifecycle replacements | \$2.5M–\$4.0M |
| FY2035 | CT systems (early wave) | Advanced imaging renewal | \$4.0M–\$6.0M |
| FY2036 | Fixed DR rooms, portable fluoro | Radiography and procedural mobility | \$3.5M–\$5.0M |
| FY2037 | CT systems (late wave), imaging IT | Advanced imaging and platform refresh | \$4.5M–\$6.5M |
| FY2038 | IR suites, Cath Labs, fixed R/F rooms | Construction-dependent modernization | \$6.0M–\$9.0M |
| FY2039 | Mammography, portable Xray | Women’s imaging and portable Xray refresh | \$3.0M–\$4.5M |
| FY2040 | MRI systems | High-field MRI lifecycle replacement | \$6.0M–\$8.0M |

Table 1 FY2027–FY2030 Strategic Initiatives

| Fiscal Year | Strategic Initiative |
|---------------|-------------------------|
| FY2027 | High-Risk Stabilization |
| FY2028 | Construction |
| FY2029 | Planned Lifecycle |
| FY2030 | Long-Range Transition |

High risk

Table 2 – FY2027 Replacement Cycle (High Risk)

| Location | Modality | Equipment Description | # of Devices | Age (Years) | Useful Life (Years) | Estimated Equipment Cost | Estimated Construction Cost | Total Estimated Cost |
|----------------------|-----------------------|--------------------------|--------------|-------------|---------------------|--------------------------|-----------------------------|----------------------|
| Alameda Hospital | Bone Densitometry | GE Lunar DEXA | 1 | 23 | 0 | \$75,000 | N/A | \$75,000 |
| Alameda Hospital | Fixed | GE Silhouette | 1 | 14 | 8 | \$300,000 | \$300,000 | \$600,000 |
| Alameda Hospital | Computed Tomography | GE Revolution EVO | 1 | 7 | 8 | \$1,000,000 | \$500,000 | \$1,500,000 |
| Hospital | General | GE LOGIQ E9 | 1 | 10 | 7 | \$200,000 | N/A | \$200,000 |
| Newark Health Center | Fixed Radiography | GE Definium 5000 DR Room | 1 | 15 | 8 | \$300,000 | \$300,000 | \$600,000 |
| Newark Health Center | Ultrasound – Portable | GE Voluson i | 1 | 12 | 7 | \$60,000 | N/A | \$60,000 |
| Highland Hospital | Mobile Fluoroscopy | OEC 9900 Elite | 3 | 11 | 10 | \$225,000 | n/a | \$675,000 |
| Highland Hospital | Fixed Radiography | GE Proteus XR/a DR Rooms | 2 | 23 | | \$600,000 | \$600,000 | \$1,200,000 |
| Highland Hospital | Computed Tomography | GE Optima CT660 | 2 | 12 | 8 | \$2,000,000 | \$1,000,000 | \$3,000,000 |
| Highland Hospital | General | GE Voluson E8 | 1 | 12 | 7 | \$175,000 | N/A | \$175,000 |
| Highland Hospital | Ultrasound – General | Philips iU22 (EOS) | 1 | Aged | 7 | \$175,000 | N/A | \$175,000 |

| Location | Modality | Equipment Description | # of Devices | Age (Years) | Useful Life (Years) | Estimated Equipment Cost | Estimated Construction Cost | Total Estimated Cost |
|--------------------------|----------------------------|--------------------------|--------------|-------------|---------------------|--------------------------|-----------------------------|----------------------|
| Highland Hospital | Ultrasound – Intravascular | Volcano IVUS S5i | 1 | Aged | 5 | \$200,000 | N/A | \$200,000 |
| Highland Hospital | Ultrasound – Portable | SonoSite Edge II | 2 | 7 | 7 | \$120,000 | N/A | \$120,000 |
| Highland Hospital | Ultrasound – Portable | SonoSite MicroMaxx (EOS) | 1 | 19 | 7 | \$60,000 | N/A | \$60,000 |
| Highland Hospital | Ultrasound – Portable | GE LOGIQ e | 1 | 17 | 7 | \$60,000 | N/A | \$60,000 |
| Highland Hospital | Ultrasound – Portable | GE Voluson i | 1 | 12 | 7 | \$60,000 | N/A | \$60,000 |
| San Leandro Hospital | Ultrasound – General | GE LOGIQ E9 | 2 | 10 | 7 | \$400,000 | N/A | \$400,000 |
| Eastmont Wellness Center | Ultrasound – General | GE LOGIQ E9 | 1 | 12 | 7 | \$200,000 | N/A | \$200,000 |

Medium risk

Table 3 – FY2028 Replacement Cycle (Medium Risk)

| Location | Equipment Type / Modality | Equipment Description | # Devices | Avg. Age (yrs) | Useful Life (yrs) | Est. Equipment Cost | Est. Construction ROM | Total Est. Cost |
|--------------------------|------------------------------|-----------------------------|-----------|----------------|-------------------|---------------------|-----------------------|-----------------|
| Highland Hospital | Fixed Digital Radiography | GE Discovery XR656 DR Rooms | 4 | 10-12 | 8 | \$1,200,000 | \$1,000,000 | \$2,200,000 |
| Eastmont Wellness Center | Fixed Digital Radiography | GE Discovery XR656 DR Room | 1 | 11 | 8 | \$300,000 | \$250,000 | \$550,000 |
| Newark Health Center | Mammography | GE Senographe Essential | 1 | 13 | 7 | \$500,000 | — | \$500,000 |
| Highland Hospital | Interventional Radiology | GE Innova IGS 530 | 1 | 10 | 7 | \$1,500,000 | \$750,000 | \$2,250,000 |
| Highland Hospital | Interventional Radiology | GE Innova IGS 630 | 1 | 10 | 7 | \$2,000,000 | \$750,000 | \$2,750,000 |
| Highland Hospital | Cardiac Cath Lab | Philips Allura Xper FD20 | 1 | 10 | 7 | \$1,500,000 | \$750,000 | \$2,250,000 |
| Highland Hospital | Ultrasound – General Purpose | LOGIQ E9 / Voluson E10 | 2 | 10 | 7 | \$375,000 | — | \$375,000 |
| Alameda Hospital | Ultrasound – General Purpose | Mindray DC-8 | 1 | 11 | 7 | \$175,000 | — | \$175,000 |
| Highland Hospital | Ultrasound – General Purpose | Philips CX50 | 1 | 10 | 7 | \$175,000 | — | \$175,000 |
| Highland Hospital | Portable Ultrasound | SonoSite Edge II | 2 | 7 | 7 | \$120,000 | — | \$120,000 |
| Highland Hospital | Vascular Access Ultrasound | Site-Rite V | 2 | Aged | 7 | \$80,000 | — | \$80,000 |

Low risk

Table 4 – FY2029 Replacement Cycle (Low Risk)

| Location | Equipment Type / Modality | Equipment Description | # Devices | Avg. Age (yrs) | Useful Life (yrs) | Est. Equipment Cost | Est. Construction ROM | Total Est. Cost |
|------------------------------|---------------------------|---------------------------------|-----------|----------------|-------------------|---------------------|-----------------------|-----------------|
| Highland Hospital | Mammography | GE Senographe Essential | 3 | 10 | 7 | \$1,500,000 | — | \$1,500,000 |
| Highland Hospital | Radiography / Fluoroscopy | GE Precision 500D R/F Room | 1 | 10 | 10 | \$525,000 | \$350,000 | \$875,000 |
| San Leandro Hospital | Mobile Xray | Optima XR240amx | 2 | 9 | 7 | \$150,000 | — | \$300,000 |
| Highland Hospital | Cardiac Ultrasound | GE Vivid E90 / E95 | 3 | 8 | 7 | \$675,000 | — | \$675,000 |
| Alameda Hospital | Cardiac Ultrasound | GE Vivid E95 | 1 | 9 | 7 | \$225,000 | — | \$225,000 |
| Alameda Hospital | General Ultrasound | GE LOGIQ E9 | 1 | 8 | 7 | \$200,000 | — | \$200,000 |
| San Leandro Hospital | General Ultrasound | GE LOGIQ E9 | 1 | 8 | 7 | \$200,000 | — | \$200,000 |
| Highland Hospital | General Ultrasound | GE LOGIQ E9 / Voluson P8 | 4 | 8-9 | 7 | \$750,000 | — | \$750,000 |
| Systemwide (ALH / SLH / HGH) | Portable Ultrasound | SonoSite Edge II / PX / X-Porte | 10 | 7-13 | 7 | \$600,000 | — | \$600,000 |

Table 5 – FY2030 Replacement Cycle

The FY2030 replacements represent planned, lifecycle-based investments scheduled in advance of end-of-life thresholds to maintain system reliability and avoid failure-driven or emergency capital requests.

| Location | Equipment Type / Modality | Equipment Description | # Devices | Avg. Age (yrs) | Useful Life (yrs) | Est. Equipment Cost | Est. Construction ROM | Total Est. Cost |
|-------------------|---------------------------|------------------------|-----------|----------------|-------------------|---------------------|-----------------------|-----------------|
| Highland | MRI | GE SIGNA | 1 | 5 | 10 | \$3,500,000 | \$750,000 | \$4,250,000 |
| Highland Hospital | MRI | GE SIGNA Explorer 1.5T | 1 | CND | 10 | \$3,000,000 | \$750,000 | \$3,750,000 |
| Highland Hospital | Cardiac Ultrasound | GE Vivid E95 | 2 | 1-2 | 7 | \$450,000 | — | \$450,000 |
| Highland Hospital | Specialty Ultrasound | FibroScan 530 Compact | 1 | 3 | 7 | \$150,000 | — | \$150,000 |
| Highland Hospital | General Ultrasound | Fujifilm Arietta 65 | 1 | 1 | 7 | \$200,000 | — | \$200,000 |
| Highland Hospital | Imaging IT / PACS | TIMS 2000 DICOM System | 1 | 5 | 7 | \$75,000 | — | \$75,000 |
| Alameda Hospital | Mobile Xray | Optima XR240amx | 2 | 8 | 7 | \$150,000 | - | \$300,000 |

The ask

- Your support
 - We are asking for **\$36M** over the next 4 years
 - Your patience
 - We have an aging fleet and it will take time to replace everything
- EOL equipment fail **2-3x** more
 - Unplanned downtimes cost ~**\$3-8k/hour** (or **\$72-192k/day**)