QUALITY PROFESSIONAL SERVICES COMMITTEE MEETING

Wednesday, April 22, 2026
5:00pm-7:00pm

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

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

Members of the public may also participate at the following ZOOM Meeting Link:[1]
https://alamedahealthsystem.zoom.us/j/9361457125?pwd=4JnAmhDnBaLqY4GWf4PQBwp3w0Puy2.1&omn=81584776793
Meeting ID: 936 145 7125
Password: 20200513

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

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

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

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

QUALITY PROFESSIONAL SERVICES COMMITTEE MEETING AGENDA

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

Public Comment Instructions
If you 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 prior to or at the beginning of the meeting. Time limitations shall be at the discretion of the Chair. Signups for public comment will close 10 minutes after public comment begins.

OPEN SESSION / ROLL CALL

PUBLIC COMMENT

A. **Chair's Report**
Alameda County Health Care Services Community Health Needs Assessment 2022-2025
Lilavati Indulkar, Chair

B. **ACTION: Consent Agenda**

B1. Approval of the Minutes of the March 25, 2026 Quality Professional Services Committee Meeting

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

AHS and AH Medical Staff:
- False Claims Act
- Compliance Hotline Policy
- Responsibilities for Compliance Reporting
- Disclosure of Protected Health Information for Treatment, Payment and Health Care Operation
- Notice of Privacy Practice
- Release of Patient Information: Complying with ONC Final Rule Policy – Patient Access
- Privacy: Use and Disclosure of Limited Data Set (LDS)
- Privacy: AHS Directory
- Privacy Notification
- Mitigation of Improper Disclosures
- Patient Rights to Request Restrictions on Certain Uses and Disclosures of Protected Health Information
- Parking Policy
- FBC Scope Of Service Plan
- FNS Screening and Assessment/Clinical Nutrition Screening and Assessments (Acute Care)

- Stroke Center Program PLAN
- Clinical Nutrition Neonatal Initial Assessment and Prioritization
- Hazard Vulnerability Analysis Policy
- Patient Rights
- Drug Product Problem Reporting
- Medication – After Hours Retrieval of Medications
- Anticoagulant Therapy in Patients Undergoing PCI
- Vaccines for Children Program
- Adult Medicine Refill Clinics – Clinical Pharmacist Duties and Function
- Direct Oral Anticoagulation Policy
- Theft or Impairment of Pharmacy Employees
- Intra-Coronary Nitroglycerine
- Intra-Coronary Nitroprusside (Dr. Xin Yang)
- IV Adenosine for Fractional Flow Reserve in Interventional Services
- Pregnant Patients and IV Contrast Administration
- Radiopharmaceuticals: Radioactive Kit Preparation
- Highland Outpatient Pharmacy Automatic Quantity Change Policy

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

AHS Medical Staff:

- Standardized Procedures for Advanced Practice Providers in the Department of Obstetrics, Midwifery and Gynecology
- FBC Nurse Standardized Procedures for Newborn Admission Order Entry

AHS and AH Medical Staff:

- AHS & AH Medical Staff Credentialing Information Integrity and Data Security
- AHS & AH Medical Staff Credentialing and Privileging of Providers

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

Medical Staff Application Form for AHS & AH:

- Demographic Grid/Application Request

Privilege Form for AHS & AH:

- Gastroenterology

Privilege Form for AHS:

- Ob/Gyn APP

Privilege Form for AH:

- Wound Care

Recommendation: Motion to Approve

END OF CONSENT AGENDA

C. REPORT/DISCUSSION: Medical Staff Reports
AHS Medical Staff: Berenice Perez, MD, Chief of Medical Staff
AH Medical Staff: Manasa Kalluri MD, Chief of Medical Staff

D. REPORT/DISCUSSION: Quality Reports

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

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

E. DISCUSSION: Clinical Institutes: A Model of Multi-Disciplinary Care Delivery to Achieve the IHO Quadruple Aim While Aligning with Organizational Strategic Growth
Lisa Laurent, MD, Chief Medical Officer

F. DISCUSSION: STEMI and Stroke Certification
Marina Trilesskaya, MD, Cardiology Chief
Nathan Gaines, MD, Neurology Chief

G. CLOSED SESSION

G1. Consideration of Confidential Medical Staff Credentialing Reports
Chief of Staff, AHS Medical Staff
Chief of Staff, AH Medical Staff

G2. Regulatory Affairs, Risk Management, Patient Safety
[Health and Safety Code 101850(ai) (1)]

(Reconvene to Open Session)

H. OPEN SESSION

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

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
The Meeting Rooms are wheelchair accessible. Assistive listening devices are available upon request at the Clerk of the Board's Office. To request accommodation or assistance to participate in the meeting, please contact the Clerk of the Board. Requests made at least 48 hours in advance of the meeting will help to ensure availability.
In order to accommodate persons with severe allergies, environmental illness, multiple chemical sensitivity or related disabilities, attendees at public meetings are reminded that other attendees may be sensitive to perfumes and various other chemical-based scented products. Please help us to accommodate these individuals.

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

ALAMEDA COUNTY HEALTH CARE SERVICES AGENCY
PUBLIC HEALTH DEPARTMENT

Community Health Needs Assessment

2022-2025

Director Kimi Watkins-Tartt
Alameda County Public Health Department

I am pleased to share with you the Alameda County Public Health Department's 2022 Community Health Needs Assessment (CHNA).

In the following pages, you will find an informative, data-rich roadmap for continued health improvement throughout Alameda County.

The CHNA takes a comprehensive look at the health of Alameda County residents by studying a combination of the social determinants of health and specific health outcomes of individuals, neighborhoods, and populations.

The CHNA is completed once every three years and is an important tool for informing the community about Alameda County residents' health, identifying key priorities for the county, and gaining a better understanding of health inequities. This year, we expanded our work to provide insights regarding the impact of COVID-19 on the health and well-being of our residents.

The report paints a compelling and broad picture of health and the challenges to achieving health in Alameda County; from life expectancy to differences in health status by place (i.e., cities and neighborhoods) and racial and ethnic groups to the impact of COVID-19.

The CHNA is also a key part of Alameda County Public Health Department (ACPHD) achieving and maintaining national Public Health Accreditation, which we earned in March 2022. Accreditation means that the department meets national standards for ensuring essential public health services and improving and protecting the community's health.

With the CHNA, we demonstrate our ongoing collaboration with the local health systems that include Kaiser Permanente, Sutter Health, Stanford ValleyCare, John Muir, St. Rose Hospital, UCSF Benioff Children's Hospital, and the Hospital Council of Northern and Central California.

I commend the ACPHD team for this outstanding report and extend my gratitude to the numerous community members and partners who also contributed. Our enduring efforts are essential to fulfill our mission to protect and promote the health and well-being of all in Alameda County.

Kimi Watkins-Tartt
ACPHD Director

Acknowledgments

This Community Health Needs Assessment (CHNA) is conducted every three years in partnership with local health systems. This CHNA meets the hospital's Affordable Care Act IRS requirements as well as the Public Health Accreditation Board requirements.

The health systems that worked in partnership with ACPHD and their respective staff are recognized below.

Hospital Council Northern and Central California
Rebecca Rozen, Regional Vice President

Kaiser Permanente—Diablo and East Bay
Molly Bergstrom, MS, Community Health Manager, External and Community Affairs

Sutter Health Bay Area
Mindy Landmark, Regional Manager
Bryden Johnston, MPH, Community Health Coordinator

UCSF Benioff Children's Hospitals
Baylee Decastro, MPP, Executive Director, UCSF Center for Child and Community Health

John Muir Health
Jamie Elmasu, MPH, Director, Community Health Improvement
Stephanie Rivera, MPH, Former Director, Community Health Improvement Community Affairs

Kaiser Permanente—East Bay and Greater Southern Alameda
Susanna Osorno-Crandall, MPA, Community Health Manager, External and Community Affairs

Stanford Health Care Tri-Valley
Denise Bouillerce
Senior Director – Government & Community Relations, PR/Marketing

St. Rose Hospital
Michael Cobb, Foundation Executive Director

In addition to the health systems, the following consultant groups provided technical assistance in data collection, analysis, and report writing.

Applied Survey Research
Susan Brutschy, President
Kimberly Carpenter, PhD, Project Director
Kimberly Gillette, MPH, Senior Research Analyst II
Sara Vega, PhD, Senior Research Analyst

Actionable Insights, LLC.
Melanie Espino, Co-Founder and Principal
Jennifer van Stelle, PhD, Co-Founder and Principal

Ad Lucem Consulting
Lisa Craypo, MPH, RD, Principal
Liz Schwarte, MPH, Principal

ACPHD convened an Internal CHNA Advisory Board where staff from different divisions participated to inform and guide the CHNA process. Participating staff are as follows.

Chair: Kimi Watkins-Tartt
Director
Alameda County
Public Health Department

George Ayala, PsyD
Deputy Director
Alameda County
Public Health Department

Nicholas J. Moss, MD, MPH
Alameda County Health Officer
Public Health Department,
Alameda County Health Care Services Agency

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Director
Quality Improvement and Accreditation Division
Office of the Director
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Alameda County Public Health Department, Health Care Services Agency

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DREAMS Program
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Older Adults and Life Care Planning Programs
Chronic Disease Program
Community Health Services

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Perinatal Services Coordinator
Perinatal and Reproductive Equity
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Sandi Galvez
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Kelly Morgenroth
RBA Program Specialist, Performance Management
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Ieshia Sheppard
Program Specialist
Community Capacity-Building Program Manager
STD/HIV Control and Prevention
Division of Disease Control and Prevention

Gabriela Castillo
Program Specialist
Quality Improvement and Accreditation Unit
Office of the Director

Carolina Guzman
Quality Improvement Manager
Quality Improvement and Accreditation Unit
Office of the Director
Served as a Project Manager for the CHNA on behalf of ACPHD

Jessica Scully
Copyedited this document

Mena Kamel
Designed this document

An empty Niles Blvd in Fremont California allows the old buildings to show their beauty. Photo by John Roche. Fremont, CA.

Community Health Needs Assessment

2022-2025

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Introduction

Welcome to the 2022 ACPHD Community Health Needs Assessment (CHNA).

The CHNA takes a broad view of health conditions and status in Alameda County. In addition to providing local disease and death rates, this CHNA also provides data and information on social determinants of health: social structures and economic systems, which include the social environment, physical environment, health services, and structural and societal factors.

The CHNA is the foundation for Alameda County's nonprofit hospitals' comprehensive community health needs assessment and is one of the requirements for public health accreditation. This document intends to inform our department's work to better serve the people of Alameda County. Understanding why health outcomes exist here in Alameda County can help gear our efforts toward addressing root causes and developing better interventions, policies, and infrastructure.

The CHNA involves four steps:

Community health status assessment

Review of prior assessments

Community engagement

Health needs identification and prioritization

Report Availability, Comments, and Adoption

The ACPHD's CHNA is available on its website. The full report and accompanying data tables, maps, and presentations are available. In addition, the public is welcome to request data or reports from the CHNA by completing a data request form. The CHNA was also shared with the public through community health events, key collaborators and stakeholders, the Public Health Commission, and the Alameda County Board of Supervisors, and various human services organizations and agencies throughout the county.

ACPHD provided opportunities for the public to comment on the CHNA report through a series of community listening sessions conducted across the county during the 2021 fall months (October through November). These listening sessions were convened with the community partners who participated in the key respondent interviews (Appendix 1) and included residents who participated in the community focus groups. These comments were incorporated in the final adoption of the 2022–2025 CHNA.

Community Served

Alameda County is one of nine counties that comprise the San Francisco Bay Area. It is rich in the arts, political activism, world-famous higher education institutions, entrepreneurship, and breathtaking natural terrains, and it has an enviable Mediterranean climate. Alameda County is home to 1.6 million people and is the most racially and ethnically diverse county in the San Francisco Bay Area.

It is the seventh-most populous county in California[1] and one of the most ethnically diverse regions in the Bay Area[2] and the nation. More than 30 percent of the students in the Oakland Unified School District are English language learners[3].

People who live in or are interested in moving to Alameda County can choose from 14 incorporated cities and six census-designated places to reside. A map of the county by zip code is shown in Figure 1.

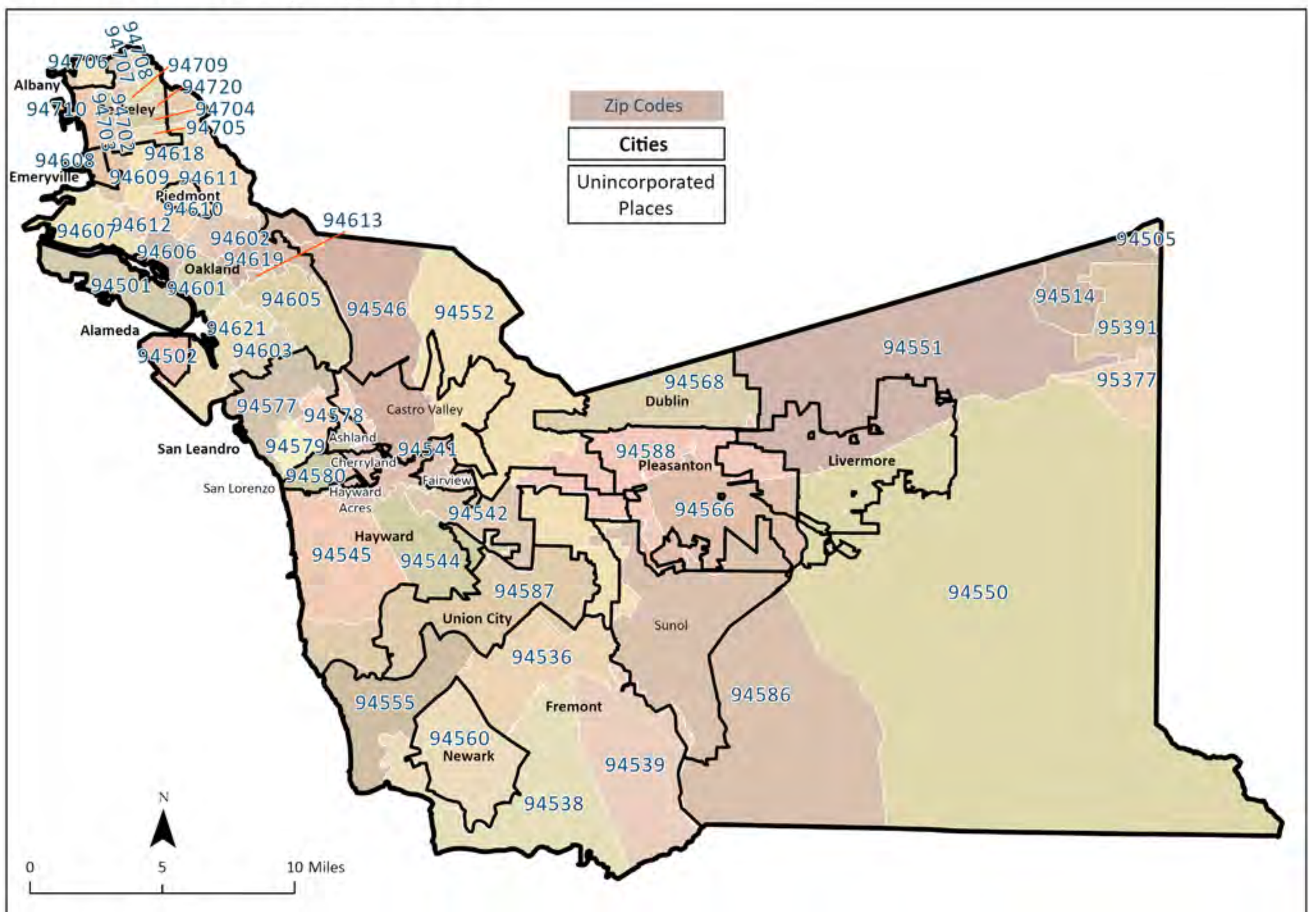


Figure 1: Alameda County by city and zip code

County Demographic Profile

Population and Socioeconomic Data

Total Population

Population Estimates, July 1, 2021

1,648,556

Persons in Poverty

8.6%

Median Household Income

in 2020 dollars

$104,888

Per Capita Income in the past 12 months

in 2020 dollars

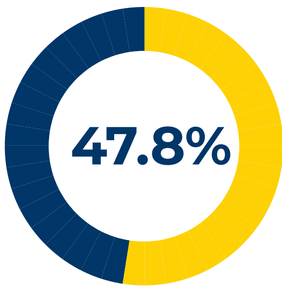
$49,883

Income

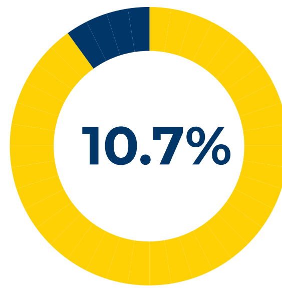
Compared with the state of California, Alameda County has a lower poverty rate (8.6 percent compared with 12.3 percent) and a higher median household income ($104,888 to $78,672). It also is significantly more diverse, with a much smaller white population (47.8 percent to 71.1 percent), a larger Asian population (33.8 percent to 15.9 percent), a larger Black population (10.7 percent to 6.5 percent), and a lower percentage of people with Hispanic heritage (22.4 percent to 40.2 percent).

Race & Hispanic Origin

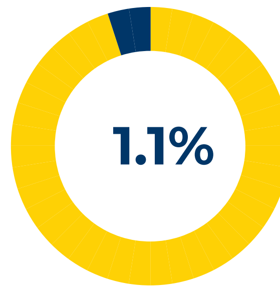
Source: US Census Bureau QuickFacts[4]



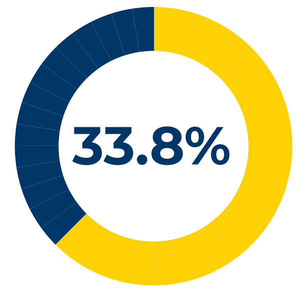
White alone



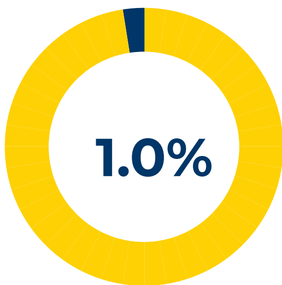
Black or African American alone



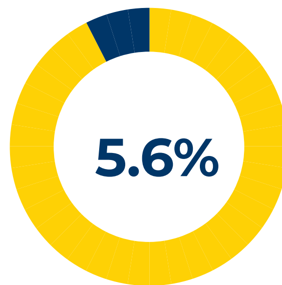
American Indian & Alaska Native alone



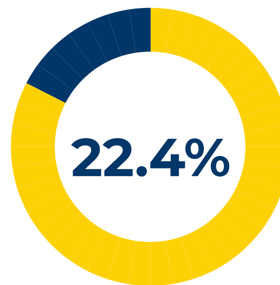
Asian alone



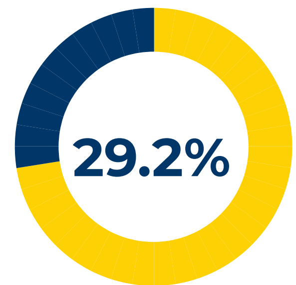
Native Hawaiian & Other Pacific Islander alone



Two or more races



Hispanic or Latino



White alone, not Hispanic or Latino

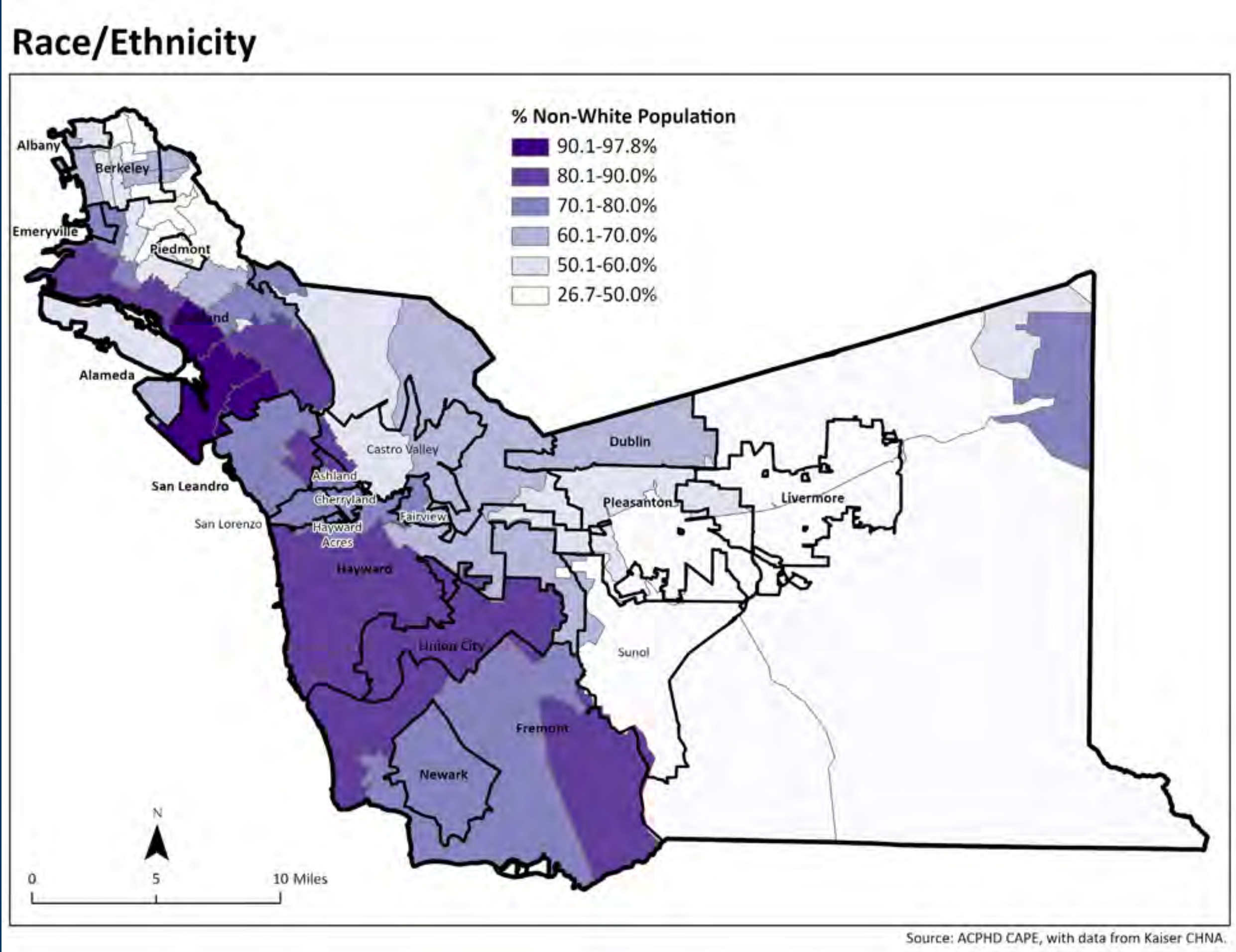
Structural Racism and Inequities

Over the past 50 years, the health and well-being of Alameda County residents has improved. These benefits, however, are not experienced equally within the county and across population subgroups. Profound and persistent inequities exist by race, and structural conditions of inequality have concentrated resources and opportunities for health and well-being in certain places. Figures 2 and 3 demonstrate this.

Figure 2 shows the percentage of the non-white population by ZIP code in Alameda County, while figure 3 shows the neighborhood deprivation index (NDI) by ZIP code.

Comparing the two figures clearly shows the overlap between a number of communities with largely non-white populations and higher levels of neighborhood deprivation. NDI measures the socioeconomic status of a neighborhood by identifying the following key variables: wealth and income, education, occupation, and housing conditions.

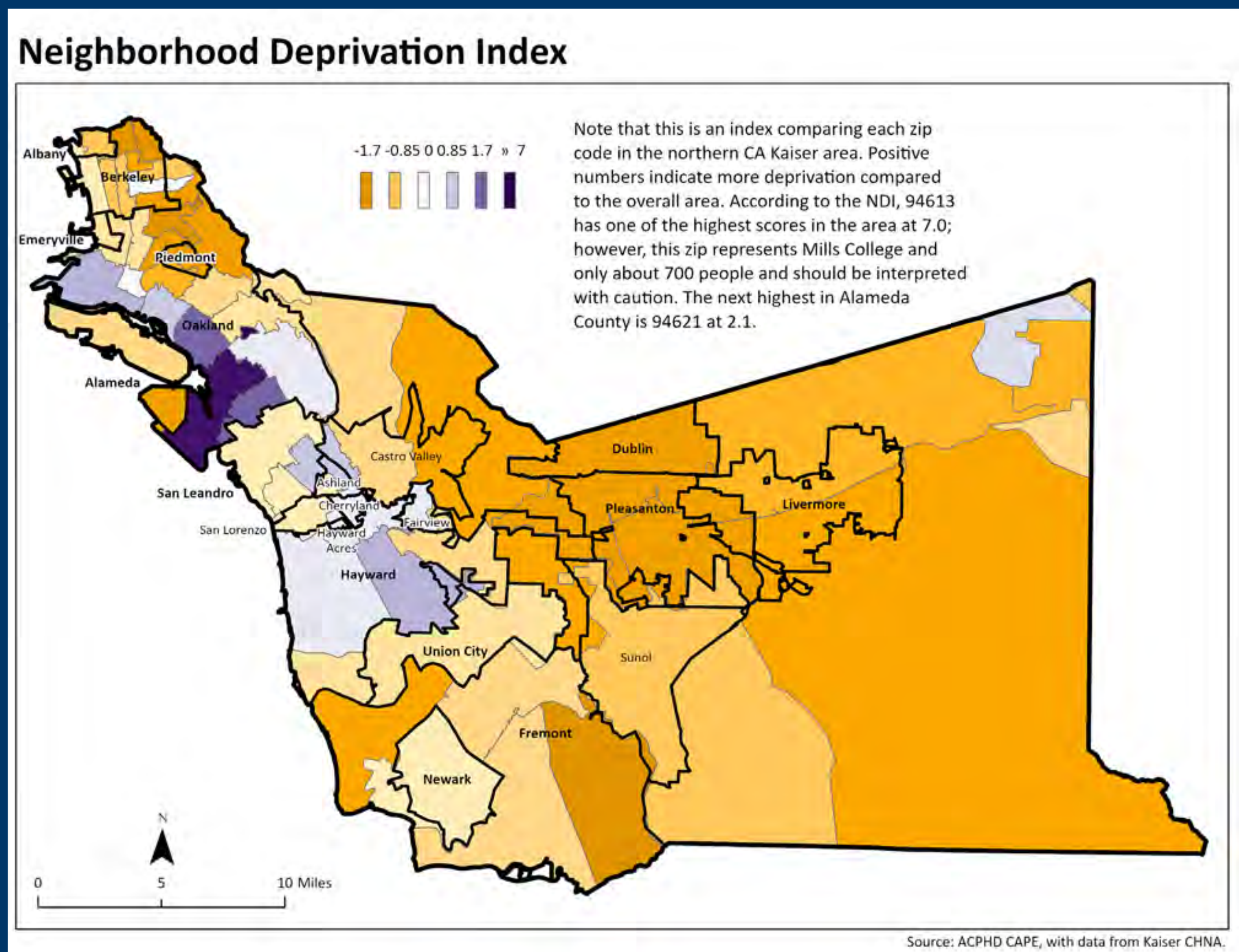
Figure 2: Non-white population by ZIP code



The inequities that have existed for people of historically under-represented groups, such as communities of color, women, and low-income communities, have been made more visible by the COVID-19 pandemic. Data show that Hispanic, Black, and Indigenous populations are disproportionately affected by the disease and its economic impacts.

In addition to the health crisis and amplification of existing health disparities, COVID-19 has also brought troubling reports of bias and discrimination against Asian Americans and others. Specific data on disparities for each city covered in this report is provided in the "Identification and Prioritization of the Community's Health Needs" section.

Figure 3: Alameda County NDI by ZIP code



Process and Methods

The CHNA process includes data collection and interpretation; identification, prioritization, and selection of health needs; and the creation of the final CHNA report.

ACPHD joined Kaiser Permanente, Stanford Health Care, John Muir Health, Sutter Health, UCSF Benioff Children's Hospitals, and other organizations in the planning, implementation, and completion of this CHNA. Primary data, i.e., focus groups and key respondent interviews, were collected by ACPHD staff and the hospitals' consultants. Sources of secondary data included data collected by ACPHD and Kaiser Permanente's data platform.

Methods Used to Identify and Prioritize Needs

Community Input

The CHNA collected primary data through key respondent interviews with individuals and groups of individuals. To identify issues that most impact the community's health, local public health experts, community leaders with expertise on local health needs, and individuals with knowledge and/or lived experience of racial health inequities were recruited to participate in focus groups or key respondent interviews.

Secondary Data

ACPHD's Community Assessment, Planning, & Evaluation (CAPE) Unit provided secondary data on relevant morbidity and mortality trends. These data were augmented by Kaiser Permanente's data platform. The data platform provides access to a core set of approximately 100 publicly available indicators to understand health using the County Health Rankings population health framework, which emphasizes social and environmental determinants of health. The data platform is available to the public at kp.org/chnadata. Specific sources and dates of secondary data are listed in Appendix 2.

Identification and Prioritization of the Community's Health Needs

The following criteria were used by residents and participants in the community input sessions to prioritize the list of health needs:

Severity and magnitude of need	Community priority	Clear disparities or inequities
How measures compare to national or state benchmarks, the relative number of people affected, impact of COVID-19 on the need.	Where the community ranked the health need in relation to others that were observed.	Differences in health factors or outcomes by geography, race/ ethnicity, economic status, age, gender, or other factors.

These criteria were used when reviewing the secondary, population-level data.

Prioritized Health Needs

The following sections describe the priority health needs identified through the assessment. These sections focus on Oakland for several reasons. It is the largest city in Alameda County, and its larger size provides the most data and prevents generalization that could occur with smaller numbers. Oakland's population is also the county's most diverse.

There are 5 priority health needs:

Employment

Housing

Access to Care

Community Safety

Mental and Behavioral Health

Income and Employment

Economic opportunity provides individuals with jobs, income, a sense of purpose, and chances to improve their economic circumstances over time. Residents in Oakland, for example, experience higher unemployment rates and greater levels of income inequality compared with the state. Oakland youth experience higher rates of being neither in school nor working compared with the state, and some neighborhoods suffer alarmingly high rates of poverty. Disproportionality is found among youth, not in school and not working, with higher prevalence in ZIP codes that tend to have higher Black populations. Key respondents reported that because of the COVID-19 pandemic, many people lost their jobs, and some communities were disproportionately affected, such as people of color and people with undocumented status.

Housing

Having a safe place to call home is essential for the health of individuals and families. Soaring housing costs across the Bay Area push affordable housing out of reach for many, including those in Alameda County. Residents in Oakland experience a high housing burden, measured as a household that spends more than 50 percent of its members' income on housing, and high rates of overcrowded housing compared with California. Overcrowded households are households where the number of people exceeds the number of rooms. Neighborhoods of West Oakland, Chinatown and Downtown, San Antonio, Fruitvale, and East Oakland, along with Central, Downtown, and South Berkeley, tend to experience higher rates of severe housing burden than other regions throughout Oakland. Key respondents noted the growing number of homeless encampments, especially in Oakland, and that transgender people, Black persons, and older adults face discrimination when they try to rent an apartment. Those who identified in more than one of these groups have the hardest time.

Access to Care

Access to comprehensive, quality health care services—including having insurance, local care options, and a usual source of care—is important for ensuring the quality of life for everyone. Despite record high rates of insured populations for California at the end of 2021, many residents still lack adequate access to care. Within Alameda County, rates of physicians and dentists are higher than state and national rates. Even with higher unemployment and greater income inequality, Medi-Cal participation rates are lower in Oakland compared with national and state rates. Neighborhoods of color, including Hispanic neighborhoods and Black neighborhoods, have higher rates of uninsured populations (including children), worse outcomes for COVID-19 (higher rates of death and lower vaccination rates), as well as higher rates of infant mortality, which is a key measure of maternal care. Key respondents reported barriers to accessing care, such as transportation, the cost of insurance, and the cost of health care.

Community Safety

The level of risk of violence and injury in a community affects the ability of its residents to prosper and thrive. Community safety issues, including gun violence, premature death by injury, and pedestrian accident death, present major health barriers in the Oakland area, especially for Black populations. Premature death, particularly due to injuries from gun violence, work-related incidents, and car crashes, is higher in the Oakland area compared with Alameda County. Between 2016 and 2020, the injury death rate was twice as high for Black residents of Oakland than for Oakland residents overall. According to key respondents the COVID-19 pandemic and shelter-in-place orders increased gun violence, domestic violence, and anti-Asian hate crimes.

5

Mental and Behavioral Health

Mental health affects all areas of life, including a person's physical well-being, ability to work and perform well in school, and participation in family and community activities. One reason for concern is higher suicide rates in Oakland than in Alameda County. Further evidence indicates that American Indian residents in Oakland experience a rate of deaths of despair—those due to suicide, drug overdose, and alcoholism—five times higher than Oakland in general.

Another reason for concern is that Alameda County seventh graders report being bullied at school more often than California seventh graders. Black and Asian high school-aged youth report being bullied at higher rates than youth of other ethnicities. Key respondents reported that residents are traumatized due to over-policing, anti-Asian hate crimes, fear of being deported, and intergenerational trauma. Respondents cited evidence that COVID-19 exacerbated the mental and behavioral health needs in Oakland, highlighting how youth and older adults experienced isolation because of the shelter-in-place orders.

Detailed descriptions of the significant health needs identified through the Community Health Assessment follow. These data sections are provided by Kaiser Permanente and Stanford Valley Care hospitals.

Income and Employment

Economic opportunity provides individuals with jobs, income, a sense of purpose, and opportunities to improve their economic circumstances over time.

People with steady employment are less likely to have an income below poverty level and more likely to be healthy.

Currently, around 11 percent of people living in Kaiser Permanente communities—and 14 percent of children—live in poverty. Those without adequate resources to meet daily needs, such as safe housing and enough food to eat, are more likely to experience health-harming stress and die at a younger age. Americans with lower incomes are more likely to live in neighborhoods lacking access to healthy food and safe physical activity and have higher exposure to environmental pollutants. Compared with white Americans, those who identify as Black, Hispanic, or American Indian are more likely to have lower incomes, fewer educational opportunities, and shorter life expectancies.

Income inequality has been increasing over recent decades. During the first year of the COVID-19 pandemic, higher levels of economic inequality were associated with higher levels of COVID incidence and death.

County & City-Specific Data

Income and employment are significant issues for Alameda County residents. Education generally correlates with income; therefore, educational statistics that differ by race/ethnicity are particularly concerning. Smaller proportions of Alameda County's Black, Latinx, Native American, and Pacific Islander 11th graders meet or exceed grade-level English language arts standards compared to California 11th graders overall. Also, a smaller percentage of Black, Latinx, and Pacific Islander 11th graders meet or exceed math standards versus California's 11th graders. Related to these statistics, much smaller proportions of Alameda County's Black and Pacific Islander high school graduates completed college-preparatory courses compared with high school graduates statewide. The high school drop-out rate is particularly high among Alameda County's Latinx youth compared with all California youth. Building on these figures, in its 2019 CHNA report, Stanford Health Care found a higher proportion of the Tri-Valley area's Latinxs, Pacific Islanders, and residents of other ethnicities over ages 24 without a high school diploma compared with all Californian adults over age 24.

In Oakland, residents experience higher unemployment rates[5] and greater levels of

income inequality compared with the state. In some neighborhoods, poverty rates are 22 to 24 percent. Oakland youth experience higher rates of being neither in school nor working compared with the state, and some neighborhoods suffer alarmingly high rates of poverty.

Disproportionality is found among youth not in school and not working, with higher prevalence in ZIP codes that tend to have higher Black populations. In 2020, unemployment affected more ZIP codes with higher Black populations compared with the city of Oakland in general.

In San Leandro, the geographic accessibility to jobs, as measured by the job proximity index, presents a major barrier for residents in the labor force, who must travel for employment[6]. Additionally, San Leandro contains higher rates of students eligible for free and reduced-price lunch[7] along with higher rates of poverty within some neighborhoods compared with the state[8], highlighting the need for income and employment supports.

Residents in some neighborhoods experience poverty rates of 28 percent and 21 percent, compared with the average rate of poverty for San Leandro overall at 10 percent[9]. San Leandro neighborhoods with relatively high Black populations also experience lower median income levels. The two ZIP codes with the highest proportions of Black residents (31 percent) have the lowest median incomes in San Leandro ($43k and $53k, respectively, compared with $89k)[10].

Fremont residents benefit from higher employment rates[11] and higher median income levels than the state of California, along with lower rates of poverty[12]. However, access to jobs, as measured by the job proximity index for Fremont, is 31 percent worse than Alameda County and 33 percent worse than the state of California[13]. The index measures the distance of jobs from a neighborhood or city. As a bedroom community to Silicon Valley, Fremont does not have a high concentration of jobs. Respondents reported that few jobs are available that enable residents to afford the high cost of living. Some neighborhoods within Fremont experience higher rates of students eligible for free and reduced-price lunch[14], highlighting greater need for income support.

Respondent Perspectives

Respondents shared that residents working in low-wage jobs often make too much to qualify for Medi-Cal but too little to be able to afford private insurance, and so remain uninsured. Not being able to pay for basic needs results in feelings of shame, trauma, stress, depression, and even suicide for some. Respondents advocated for employers to provide jobs with livable wages and health care.

Respondents suggested investing in more job training in Alameda County. They also promoted universal basic income, describing that it will help people be able to live in Alameda County

and help to balance inequities of structural racism.

Key Fremont respondents reported few jobs are available that enable residents to afford the high cost of living in Fremont, suggesting residents need advanced degrees or specific skills to earn a livable wage. Therefore, they recommend investing in workforce training for careers in well-paying industries. The residents most affected by income disparities in Fremont—as noted by the respondents—are people with undocumented status, Black, Hispanic, and American Indian people, and people with disabilities.

Focus group participants believed there were not enough employment opportunities in the Tri-Valley area that paid enough to afford the expensive rents in the area. Key respondents pointed to significant disparities in income and stated that many families are struggling to stay in the area for jobs and school, despite it being difficult to afford the cost of living.

Respondents shared that before the COVID-19 pandemic, certain populations found it harder to get a job and were being paid less (e.g., transgender women, people with physical disabilities, and the Hispanic population) and this became even worse during the pandemic. Other populations that the respondents highlighted as having a difficult time finding a job are older adults, people who were formerly incarcerated, youth, and people who are undocumented. The respondents noted that many residents lost their jobs due to the COVID-19 pandemic and that it disproportionately affected residents who are Hispanic, Asian, and Pacific Islander.

The costs of housing are going up, and there aren't any jobs, especially for those who have 'no skills.' Fremont is part of Silicon Valley, and you have to be an engineer or very well educated to afford to live here.

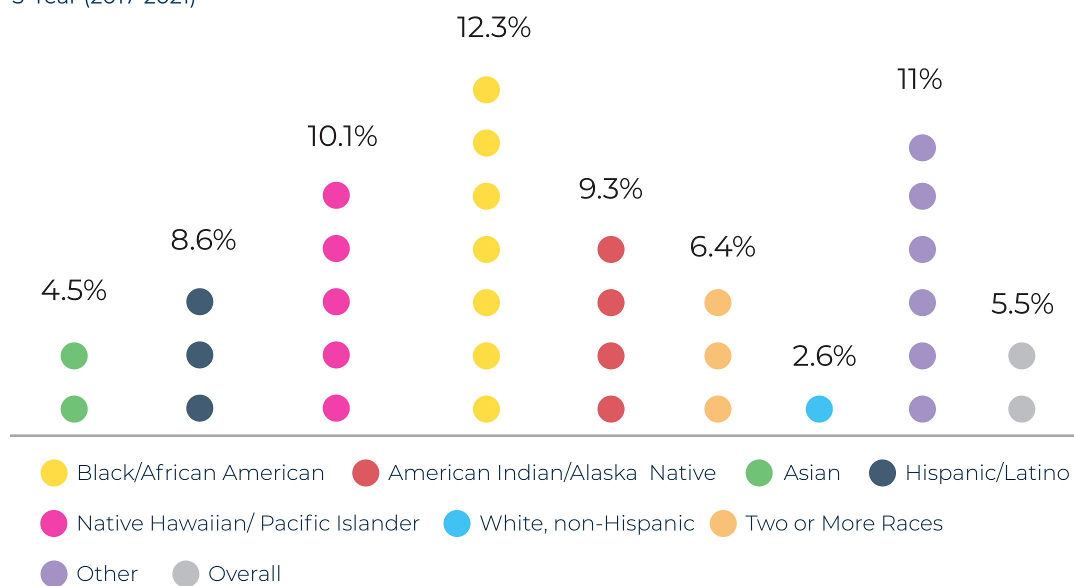
–Nonprofit organization leader

Focus group participants said that small businesses struggled to survive the pandemic. This had a ripple effect throughout the economy, leading to loss of income and unemployment and subsequently a loss of housing. According to key respondents, pandemic-related job loss was a significant issue in the community that had broad effects, including increased food insecurity, homelessness, and significant mental health issues. Respondents shared that due to loss of income residents had to choose between paying rent, buying food, or paying for health care. This created a huge spike in the need for food and people accessing food banks.

It was also noted that parental job loss due to the COVID-19 pandemic had a trickle-down effect on families contributing to students who withdrew from school due to stressors at home. Further, the virtual learning environment left many students behind academically. Statistics from before the pandemic indicated greater proportions of Black students in Alameda County experienced low school connectedness compared with all California students. Key respondents also stated that childcare continues to be a major issue. Affordable care is limited for low-income parents, and fear of exposure to COVID-19 has kept many parents wary of using childcare services. Additionally, childcare facilities that can support children who have experienced homelessness or other trauma are needed.

Families Living Below Poverty Level by Race/ Ethnicity in Alameda County

Source: American Community Survey 5-Year (2017-2021)



Housing and Homelessness

Having a safe place to call home is essential for the health of individuals and families.

American families' greatest single expenditure is housing, and for most homeowners, their most significant source of wealth. Because of historic discriminatory lending policies and some current lending practices, people of color—especially Black community members—have been denied the opportunity to purchase a home, leading to enduring inequities.

Housing costs have soared in recent years, with many families having trouble paying for housing. Black and Hispanic renters are more likely to live in cost-burdened households and face housing instability. Job loss associated with the COVID-19 pandemic coupled with expiration of the federal eviction moratorium has made many renters' situations even more precarious.

Homelessness across the US was on the rise before the pandemic, including for families with children. In 2020, the number of single adults living outdoors exceeded the number living in shelters for the first time. Even more individuals and families moved outside because of the pandemic, leading to a crisis in street homelessness in many American cities.

County & City-Specific Data

Housing prices have soared in recent years across Alameda County, which has pushed affordable housing out of reach for many. In Oakland, residents experience high housing burden and high rates of overcrowded housing compared with California[15].

Neighborhoods more heavily populated by people of color, including West Oakland, Chinatown and Downtown, San Antonio, Fruitvale, and East Oakland, tend to experience higher rates of severe housing burden, measured as a household whose members spend more than 50 percent of their income on housing, than other regions of Oakland[16]. Overcrowded households are households where the number of people outnumber the number of rooms. Fruitvale, a heavily Hispanic neighborhood, experiences an overcrowded housing rate of 21 percent, compared to 6 percent for Oakland in general[17].

In San Leandro, rates of overcrowded housing, rental cost, and housing burden, the percentage of income residents pay for housing, are all higher than California[18]. Rates of overcrowded housing is 38 percent higher in San Leandro (11 percent of households) than California (8 percent of households)[19]. Homeownership, a powerful means of building wealth, is lower for some neighborhoods with higher Black and Hispanic populations. San Leandro's rate of

homeownership is 56 percent, but home ownership in the ZIP code with the largest Black population and the second largest-Hispanic population is the lowest of all ZIP codes in San Leandro at 46 percent.[20]

In Fremont, although housing affordability is on par with the state of California, the median rental cost is higher. Measures of housing burden, such as overcrowded households (people outnumber rooms) are also higher:[21]

Median rental cost for Fremont ($2,356) is 40 percent higher compared with the state ($1,689).

ZIP code 94539 has the highest median rental cost ($2,652) out of all Fremont.

Over one in 10 (11 percent) of households in Fremont are overcrowded, higher than rates across the state of California (8 percent) and the nation (3 percent).

Fremont neighborhoods with higher Hispanic populations also experience a higher rate of moderate housing burden. This occurs when households pay between 30 and 50 percent of their income for housing.

Respondent Perspectives

Key respondents noted the growing number of homeless encampments, especially in Oakland. Additionally, transgender people, Black persons, and older adults face discrimination when they try to rent an apartment, and those identified in more than one of these groups have the hardest time. Many noted that increasing numbers of older adults are experiencing homelessness and that foster youth often face unstable housing.

> **We have an aging population in our permanent supportive housing, and we are seeing more medical needs and supporting older adults in permanent supportive housing.**
>
> **–Nonprofit organization leader**

The respondents pointed out that without shelter, already vulnerable populations are at even higher risk of experiencing significant challenges because of crises like COVID-19 and wildfires. For example, during the COVID-19 shelter-in-place mandate, many programs and services did not go to homeless encampments to provide much-needed health and wellness checks or distribute food.

Respondents emphasized the importance of the relationship between housing, mental health, and substance use. For example, they shared that during the COVID-19 shelter-in-place mandate, people experiencing homelessness who were provided hotel-style housing with wrap-around services (including primary care, mental health, and case management) were much more likely to move into stable

housing. Therefore, respondents felt it is important to continue to offer individual housing units with on-site resources and services, in addition to investing in permanent housing.

Respondents shared that demand for affordable housing and housing for people with lower incomes has increased. They highlighted that people with disabilities and older adults are most in need of housing assistance.

In addition, the respondents noted in Fremont multiple families are living together in small apartments, and living in close quarters made it more likely to spread COVID-19.

The respondents suggested investing in ways to help keep residents in their homes, including rental assistance, in addition to creating affordable housing options.

If folks aren't being stably housed, it affects their whole health, and that's been a huge issue here in Alameda County, specifically Oakland. It's affecting people's health across the board. That's why we're seeing a lot of disparities with health, mental health, substance use, because of housing.

–LGBTQ focus group participant

Access to Care

Access to comprehensive, quality health care services—including having insurance, local care options, and a usual source of care—is important for ensuring quality of life for everyone.

The Affordable Care Act (ACA) helped extend insurance coverage to many previously uninsured individuals and families, especially in Medicaid expansion states. Still, families with low incomes and people of color are more likely to be uninsured, and even with the ACA, many find insurance unaffordable.

Health insurance coverage increases use of preventive services and helps ensure people do not delay seeking medical treatment. Having an adequate number of primary care resources in a community also is important, including Federally Qualified Health Centers (FQHC), which serve patients regardless of ability to pay.

Insurance by itself does not guarantee access to appropriate care, and many community members experience barriers related to language, transportation options, and differential treatment based on race, as well as access to fewer health care resources. Furthermore, the COVID-19 pandemic has disrupted health care for millions of Americans as health care resources were diverted from primary and preventive care, with telehealth becoming an increasingly important source of care. Existing racial and health inequities have been brought to light by the pandemic, with people of color accounting for disproportionate shares of COVID-19 cases, hospitalizations, and deaths.

County & City-Specific Data

Access to comprehensive, quality health care services is important for ensuring quality of life for everyone in Alameda County.

Oakland has fewer uninsured residents compared with other areas of the state, but some measures such as Medi-Cal enrollment are lower despite higher levels of poverty.[22] Oakland has lower Medi-Cal enrollment rates (32 percent) than both the state (38 percent) and the nation (35 percent), despite a poverty rate of 14 percent, which is higher than the state rate (13 percent). [23]

Two Oakland neighborhoods with higher Hispanic populations (53 percent) have higher rates of uninsured children (5 percent) compared with Oakland in general (17 percent of Hispanic and 3 percent of uninsured children).[24 25]

Rates of infant mortality are 200 percent worse for Multiracial infants (10.5 per 1,000 live births) and 165 percent worse for Black infants (9.2 per 1,000 live births), compared with the city as a whole (3.5 per 1,000 live births).[26]

San Leandro experiences better outcomes across many measures of access to care. These include higher rates of insured populations compared with California[27] and other measures such as infant mortality,[28] which are on par with Alameda County. However, rates of these measures differ across racial and ethnic groups and neighborhoods. Black residents experience higher rates of infant mortality than San Leandro generally. COVID-19 death rates were highest among Multiracial and Black residents, compared with all other racial and ethnic groups.[29] The ZIP code with the highest proportion of Hispanic residents had the highest rate of uninsured, both for total population and for children.[30]

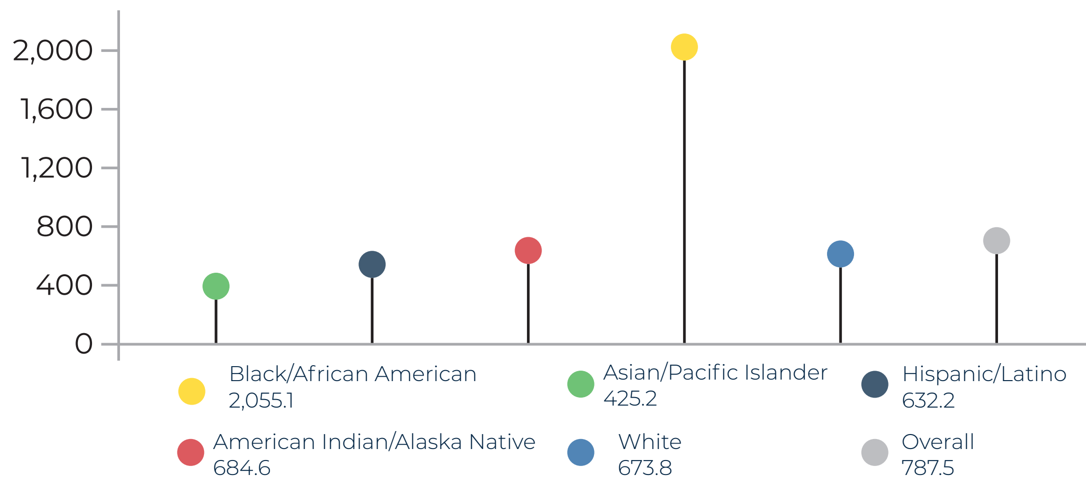
Though Fremont experiences low rates of uninsured residents, other measures highlight access to care barriers for maternal care and the impact of the COVID-19 pandemic for certain groups. Across 2016 to 2020, premature birth rates as a percentage of all live births were higher for Black (11 percent), Multiracial (9 percent), and Hispanic (8 percent) residents, compared with Fremont overall (7 percent).[31]

Rates of low birth weight for all live births were highest for Black infants (7 percent) between 2016 and 2020 in Fremont, higher than both Fremont overall (6 percent) and for Alameda County (6 percent).[32]

Pacific Islander residents had the highest rate of COVID-19 cases across the Fremont (8,643 per 100,000 people), as of November 2021, while white residents had the highest rate of death (91 per 100,000 people). Fremont's overall case rate was 5,127 per 100,000 people, and the death rate was 63 per 100,000 people.[33]

Chronic Preventable Hospitalizations by Race/ Ethnicity in Alameda County

Source: Office of Statewide Health Planning and Development (OSHPD) (2000-2011)



Respondent Perspectives

Key respondents reported barriers to accessing care, such as transportation and the cost of insurance and health care. Oakland respondents appreciated that community clinics are easily accessible and that their staff reflect the cultural diversity of the community. However, respondents highlighted that, in East Oakland in particular, there are no major hospitals, pharmacies, or specialty care services, and without personal transportation it is difficult to access these needed services.

Respondents spoke about the limited dental services in Oakland, and that people who are undocumented cannot get dental insurance. Respondents shared stories about people with serious dental pain who are not getting care or are going to the emergency room to be treated.

> **"It's very expensive, they can't afford the insurance. Some families are not eligible for Medi-Cal but Covered California is so expensive.**
>
> **–Nonprofit organization leader**

Respondents mentioned LGBTQ community members were choosing to go without health care because they reported being judged and misgendered. During the height of the COVID-19 pandemic, a lot of preventive health did not happen, especially for people who are unsheltered, according to respondents. They noted that there is distrust in the COVID-19 vaccine, especially in the Black and Hispanic communities.

The COVID-19 pandemic brought on numerous access challenges. While the shift to telemedicine helped increase access for some, the respondents highlighted that other residents, especially older adults, struggle with the technology. It was also noted that residents were not getting preventive health screenings during the pandemic.

The pandemic exacerbated existing racial and health inequities, with people of color accounting for a disproportionate share of COVID-19 cases, hospitalizations, and deaths. Focus group participants agreed that the pandemic disproportionately impacted communities of color. Key respondents mentioned that some communities are not accessing the vaccine because of their legal status.

Respondents pointed out the importance of considering the social determinants of health, and the need for providers to look at factors like housing, job stability, and food security, rather than a simple medical approach, to address structural racism's impact on health. Respondents suggested that health care providers employ mobile health vans or pop-up clinics to increase access in communities. Respondents also reported that telehealth appointments are helpful for some, but for those without access to the Internet or a private space, other options need to be available. They mentioned that all services (including websites and forms) need to be offered in multiple languages, especially in Asian languages. In addition, they suggested that providers be trained in cultural humility.

Respondents recommended using case managers to direct people to various resources. They also proposed cross-sector partnerships between hospitals and nonprofit organizations to integrate services, to include other methods of care, such as healthy food and acupuncture, and to increase access to care and utilization. Respondents highlighted the "food as medicine" model as an example of a collaborative model that addresses multiple needs, especially if the food is grown locally.

Key respondents noted the high costs of health care as a barrier to accessing care. They shared that some families are making too much to qualify for Medi-Cal, but not enough to afford Covered California. As a result, they are choosing to go without health insurance. According to the respondents, those who do qualify for Medi-Cal have a difficult time finding quality providers accepting new patients and even a harder time if they want a provider in a language other than English. They also shared concern that providers are using family members as translators. Therefore, the respondents recommended investing in a diverse health care workforce as well as cultural humility training for health care providers.

The respondents advocated for lower-cost health insurance options. They pointed out that methods deployed during the pandemic were very successful and suggested these continue. These include partnering with trusted leaders (e.g., faith based) to connect with populations less likely to be early adopters of health care. They also requested deeper partnerships between hospitals and nonprofit organizations for collaboration in addressing all residents' needs.

San Leandro respondents said that residents can be on hold for hours trying to schedule an appointment, or when they do get an appointment, it is via phone, which makes it difficult to show where they are in pain. Additionally, they noted that people who are seeking asylum or have undocumented status are afraid to get care.

When you come to the clinic and they are misgendering you in 2021, you're not coming back.

–Transgender focus group participant

Focus group participants linked transportation with health, stating that traffic, road work, and a lack of cheap public transportation options made it difficult for them to access health care / get to their appointments. Key respondents noted that many specialty services are in Oakland or San Francisco. This is a barrier to access for many who do not have adequate transportation.

Multiple key respondents pointed to a disparity in infant mortality in the Black community. They cited factors like a lack of culturally competent care, having to choose between significant others and doulas in the delivery room due to the pandemic, shortcomings in post-natal care, and racial tension and anxiety due to the pandemic. Statistics corroborate these observations: Infant mortality is higher among Alameda County's Black, Latinx, and multi-ethnic populations than in California overall. Low birth weight was a concern for the Alameda County Pacific Islander and multi-ethnic populations. Finally, breastfeeding rates are especially low among Pacific Islander mothers compared to mothers statewide.

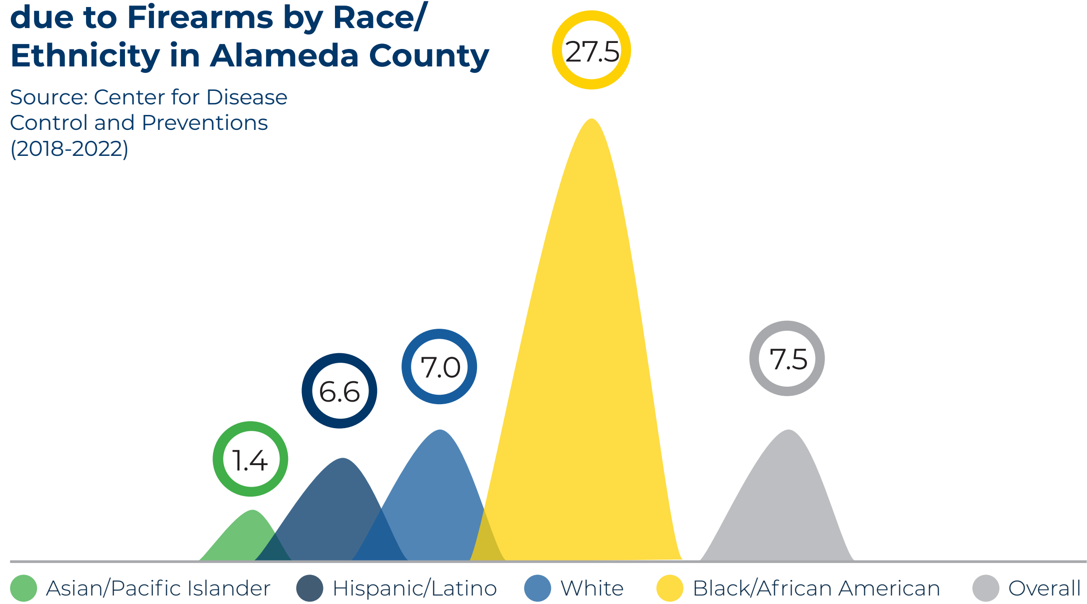
Community Safety

The level of risk of violence and injury in a community affects the ability of its residents to prosper and thrive.

People can be victims of violence, witness violence or property crimes, or hear about crime and violence from others. Children and adolescents exposed to violence are at risk for poor long-term behavioral and mental health outcomes. Within families, intimate partner violence (IPV) and child maltreatment frequently occur together, each with adverse health effects. One in four American women reports IPV during her lifetime.

Communities that have been systematically marginalized experience higher rates of violence, including deaths and injuries from firearms. Chronic stress from living in unsafe neighborhoods can have long-term health effects, and fear of violence can keep people indoors and isolated. In addition, the physical and mental health of youth of color—particularly males—is disproportionately affected by juvenile arrests and incarceration related to local policing practices.

Community safety also reflects injuries caused by accidents—unintentional injuries are the leading cause of death for children, youth, and younger adults and account for nearly 30 percent of emergency department visits.


Age-Adjusted Death Rate due to Firearms by Race/ Ethnicity in Alameda County
Source: Center for Disease Control and Preventions (2018-2022)
27.5
6.6
7.0
7.5
1.4
Asian/Pacific Islander
Hispanic/Latino
White
Black/African American
Overall

County & City-Specific Data

Community safety issues including gun violence, premature death by injury, and pedestrian accident death present major health barriers in Oakland, especially for Black populations.[34]

Premature death, particularly due to injuries from gun violence, work-related incidents, and car crashes is higher in Oakland (45.9 per 100,000 people) compared with Alameda County (40.3 per 100,000 people).[35]

Between 2016 and 2020, the injury death rate was twice as high for Black residents of Oakland (95.5 per 100,000 people) than for Oakland overall (45.9 per 100,000 people).[36]

The motor vehicle crash death rate is two and a half times higher (12.9 per 100,000 people) for Black residents compared with both Oakland and the rate for Alameda County (both 5.3 per 100,000 people).[37]

San Leandro experiences higher rates of injury death (for example, death from gunshot or a work-related incident) and motor vehicle crash death compared with Alameda County, with a rate of injury death (44.9 per 100,000 people) 11 percent higher than Alameda County as a whole.[38]

Black residents experience the highest rates of motor vehicle crash death (12.7 per 100,000) compared with all other ethnic groups in San Leandro for which data are available, and this is higher than San Leandro overall (6.9 per 100,000 people).[39]

Native Hawaiian / other Pacific Islander residents experience injury death rates (69.5 per 100,000) 72 percent higher than San Leandro overall (44.9 per 100,000).[40]

Respondent Perspectives

Key respondents reported that violence disproportionately affects young, Black men. They noted the connection between mental health (especially trauma, depression, stress, and anxiety) and community safety and that individuals and communities that have experienced trauma (including intergenerational trauma) are more likely to suffer from poor mental health. In addition, the respondents highlighted that criminalization of Black people coupled with over incarceration has increased trauma and fear of the police.

In Hayward, [students] see their parents being carted off, they hear shootings every night, they see their parents in jail, etc.

–School leader

Respondents shared stories of how over-policing is making people, especially people of color and LGBTQ communities, afraid to walk down the street. At the same time, other respondents spoke about

victims of violence not being able to call the police because they cannot speak English (e.g., monolingual Cantonese).

Key respondents discussed fear and anxiety surrounding contracting COVID-19 as a threat to community safety. Respondents said that residents had been afraid to send their children to school, visit their doctor to receive care, go into public spaces like the grocery stores, and to take public transportation. Key respondents believed that the fear was subsiding, but trauma from these experiences remained. The respondents shared that during the COVID-19 pandemic, domestic violence increased as there was additional stress, and residents were trapped in the house with their abuser. Also, they spoke about the increase in anti-Asian hate crimes, which caused trauma and left residents afraid to leave their homes.

The respondents recommended implementing adverse childhood experiences (ACE) screening to support early detection of risk and intervention, to help interrupt cycles of violence and trauma. They suggested promoting anti-violence messages and policies, continuously and not just after a crisis.

Because of the connection between unemployment and violence, respondents suggested investing in education and workforce training to prevent violence. They proposed putting out prevention messages in the community, such as on billboards, to try to change social norms. They also suggested investing in proven violence intervention programs.

Shootings are up 70 percent. Oakland saw sustained progress over 10 years and that progress is wiped out. Violence is both a symptom and cause of mental health issues. Forty-four percent of people who get shot will get shot again within a year.

–Nonprofit organization leader

Alameda County's Black children (ages 0–20) are at higher risk to be placed in foster care than are California children on average. Many researchers have noted that children placed in foster care are at greater risk of contact with the juvenile justice system.[41] These disparities for young people can lead to inequities, not just in their experience of community safety but in their ability to succeed in school and in life.[42]

Additionally, structural racism was mentioned by key respondents as contributing to concerns of community safety. Comments and incidents of "Asian hate" were specifically mentioned, as well as students and parents of color not feeling like schools are safe and welcoming places for them.

In Livermore, key respondents discussed a lack of safe outdoor spaces to exercise and recreate as primary concerns about community safety. One focus group ranked community safety as a high priority. Several focus group participants believed that many community parks had become places of illicit activities, specifically alcohol and drug use, that made their neighborhoods less safe. While many community safety statistics are better in the Tri-Valley than the state, the rate of violent crimes is higher.

Mental and Behavioral Health

Mental health affects all areas of life, including a person's physical well-being and ability to work, perform well in school, and participate fully in family and community activities.

Anxiety, depression, and suicide ideation are on the rise due to the COVID-19 pandemic, particularly among Black and Hispanic Americans.

Those facing challenges related to lower economic opportunity often experience high levels of stress in their daily lives, coupled with fewer resources for coping.

Children and youth experiencing stress have an increased likelihood of poorer mental and physical health.
Deaths of despair—those due to suicide, drug overdose, and alcoholism—are on the rise, and males, American Indians/ Alaska Natives, and the unemployed are at greater risk.

Communities across the country are experiencing a critical lack of capacity to meet the increased demand for mental health services. At the same time, rapid adoption of digital platforms for behavioral health services has helped reduce barriers to in-person mental health care.

County & City-Specific Data

Alameda County has 614 (per 100,000 people) mental health providers compared with a rate of 352 (per 100,000 people) for California and 247 (per 100,000) for the nation.[43] However, mental health remains a serious issue in the county.

One reason for concern is higher suicide rates in Oakland than Alameda County.[44] American Indian residents in Oakland experience a rate of deaths of despair—those due to suicide, drug overdose, and alcoholism—five times higher (151.1 per 100,000 people) than Oakland in general (31.5 per 100,000 people).[45]

High school-aged youth who are of Black and Asian ethnicities report being bullied at higher rates than youth of other ethnicities.[46] The racial disparities around youth connectedness and safety[47] coupled with the disparities in suicide, drug overdose, and alcoholism,[48] suggest a need to equitably address mental and behavioral health services and programs, especially for youth.

Seventh graders in Alameda County report being bullied at school nearly 40 percent more often than seventh graders in the state of California. Over a third of seventh graders (36 percent) report experiencing

bullying in Alameda County, and the percentage is much higher for the seventh graders who identify as Black or Asian (46 percent) in Alameda County compared with the state average (26 percent).[49]

Cyberbullying is experienced by greater percentages of Pacific Islander youth in Alameda County than by all youth statewide. Pacific Islander youth in Alameda County also experience depression-related feelings in higher proportions than California youth overall. In Alameda County, the proportion of teens contemplating suicide is higher than teens statewide for Native American, Pacific Islander, multi-ethnic, and "other" youth. Experts note that "racial and ethnic minorities have less access to mental health services than do whites, are less likely to receive needed care and are more likely to receive poor quality care when treated."[50] An expert on the historical context of such disparities suggests that "racism and discrimination," as well as "fear and mistrust of treatment," pose barriers to Black, Indigenous, and People of Color (BIPOC) community members seeking help for behavioral health issues.[51]

Black students in Oakland and Alameda unified school districts, compared with students of other race and ethnicities, report the lowest rates of schoolconnectedness, which measures feeling close to people, safe, and happy at school. This rate tends to decrease even further as students move from seventh to eleventh grade.[52]

People in San Leandro, especially Black residents, have a high need for access to mental and behavioral health services that combat opioid overdose and mental health issues resulting in deaths of despair. Opioid overdose death rates are twice as high for Black residents (12.2 per 100,000 people) than San Leandro overall (4.9 per 100,000 people).[53] Deaths of despair, those due to suicide, drug overdose, and alcoholism, are higher for Black (53.9 per 100,000 people) and White (46.5 per 100,000 people) San Leandro residents compared with other racial and ethnic groups for which data are available, as well as for San Leandro generally (30.7 per 100,000 people).[54]

In Fremont, deaths of despair—those due to suicide, drug overdose, and alcoholism—are lower than the state[55] and Alameda County.[56] Disparities exist, however. White Fremont residents experience rates of deaths of despair (32 per 100,000 people) higher than Fremont in general (18 per 100,000 people) and Alameda County (28 per 100,000 people). This rate is the highest among any ethnic group in Fremont.[57] Hispanic residents of Fremont experience the second-highest rate of deaths of despair (25 per 100,000 people).[58]

Behavioral health, which includes mental health and trauma, as well as consequences such as substance use, ranked high as a health need in Livermore, being prioritized by nearly all key respondents and two out of five focus groups.

Binge drinking is higher in Livermore than it is statewide. The impaired driving mortality rate is higher in the Tri-Valley area than in California. In addition, the rate of visits to emergency departments for substance use has been trending up in Alameda County overall.

Respondent Perspectives

Key respondents agreed that mental and behavioral health is a critical need. They reported that residents are traumatized due to over-policing, anti-Asian hate crimes, fear of being deported, and intergenerational trauma. Others are suffering from mental health illness due to lack of housing. The respondents explained that because of these stressors, residents are turning to substance use, suicide, and violence.

> **African American, Latinx, and Asian American community members are struggling in sharing their stories to people who do not understand their customs, culture, etc.**
>
> **–Nonprofit organization leader**

The respondents stated that those particularly affected by mental and behavioral health and trauma are Black and Hispanic persons, smaller ethnic groups like Burmese and Mongolian residents, youth, and LGBTQ communities. They also reported that mental health is worse because many residents' basic needs are not being met. For example, they are in crisis from being unhoused or losing their job. The respondents noted an increase in rates of suicide and overdosing as a coping mechanism for mental and behavioral health needs.

The respondents shared that many residents are deterred from accessing mental and behavioral health services because of the associated stigma; and when people do try to access services, there is a three- to six-month wait list. This wait is longer if someone is seeking counseling in Spanish and even longer for languages such as Arabic, Amharic, and Mam. Respondents shared that many people do not know how to seek help and cannot find bilingual or bicultural therapists that understand their experiences.

Therefore, the respondents advocated for hiring more mental and behavioral health providers, especially bilingual and bicultural therapists that mirror the population. They also recommended investing in more school therapists able to counsel youth regardless of their insurance and more counselors to support the mental health of students.

The respondents noted that the increase in telehealth during the COVID-19 pandemic helped many to access services. However, some residents did not have access to a computer with Internet or a private space for online appointments. Therefore, they suggested continuing to offer in-person visits and to increase Internet access for residents.

The respondents felt that it was important to get mobile care out to people experiencing homelessness and to homebound older adults. They suggested implementing the ACE screening to detect and prevent additional trauma. Other respondents suggested destigmatizing mental health. They proposed spreading messages that people do not have to manage mental health on their own, and to use community approaches (besides traditional one-on-one therapy) that may resonate more with people of color.

According to key respondents, mental health, which was already bad, is now at a critical level after the fear, anxiety, stress, job loss, isolation, and lack of trust that resulted from the COVID-19 pandemic. They noted that not only was there fear around contracting COVID-19, there was also an increase in loneliness and isolation (especially among older adults and youth) due to the stay-at-home orders. There was also stress because many residents lost their jobs and Asian residents were afraid to leave their homes due to the escalating anti-Asian hate crimes. Focus group participants stated that the COVID-19 pandemic negatively impacted mental health due to fear of being out in public, using public transportation, and a stigma about mask-wearing. Key respondents stated that mental health does not discriminate based on age, race, or socioeconomic status. Especially after the trauma of the pandemic, mental health is a crisis across all populations.

Focus group participants felt that children faced significant stress and anxiety because of the pandemic. According to key respondents, school systems do not adequately support students of color and need to make schools more welcoming, inclusive, and safe places for children. Key respondents stated that the pandemic had a major impact on the mental health of youth, citing an increase in suicide attempts, suspensions, and behavioral issues.

Focus group participants in Livermore believed that drug and alcohol users made public spaces less safe for the community. Key respondents mentioned a particular need to address substance use within the unhoused community. Livermore respondents explained that many mental health providers are centralized in Oakland and San Francisco and not in the Tri-Valley area. Participants corroborated this, explaining that there is often a long waiting list to see a mental health provider, specifically citing a shortage of Spanish-speaking therapists.

It [mental health] crosses race, gender, and socioeconomic status. Destigmatize mental health. There is a huge stigma around mental illness; mental health needs should be treated the same as any other medical condition. There are never enough counselors at the school.

–School leader

Next Steps

Our next step is to develop a Community Health Improvement Plan (CHIP) using the CHNA findings. CHNA's are valuable tools in helping determine where to focus health improvement efforts, targeting specific demographics or geographic locations experiencing health inequities. The CHIP, or the Community Health Improvement Plan, is a long-term systemic effort to address the public health problems of Alameda County based on the results of the CHNA.

This process will start by prioritizing our health needs, gathering data, and convening a group of stakeholders who will develop activities and objectives that will address the health needs findings from the CHNA. They will also be responsible for tracking the work and measuring its progress.

The Community Health Improvement Plan is meant to be community driven, by tapping into existing efforts and developing new efforts needed to address the priority areas. ACPHD will be responsible for engaging community partners who are stakeholders in this work and for creating work groups and a steering committee to help drive the work and oversee the overall process. ACPHD will engage stakeholders that address the root causes of inequity, address the social determinants of health, prioritize health behaviors, and promote behaviors that reduce individual-level risk factors for disease and injury. The intention is to have a clear, equity-centered, community-driven plan with clear measurable objectives and strategies that promote the health of all people in Alameda County.

Lastly, the CHIP would align with any other internal or external plans that uplift efforts that contribute to our priority areas. Internal plans include our strategic plan and equity plan.

External plans include state-wide initiatives like the State-wide Department of Health Violence Prevention initiative or the national Healthy People 2030.

2021-2022
- Community Health Needs Assessment

Feb-Mar 2023
- CHIP Planning
- Steering committee
- Workgroup

Apr-Jul 2023
- CHIP Implementation
- Data collection & QI projects

Sunset view of residential and industrial areas in East San Francisco Bay Area; green hills visible in the foreground. Photo by Sundry Photography. Hayward, CA.

Footnotes

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Footnotes

32. Alameda County Public Health, California Comprehensive Birth & Death Files, 2016–2020.

33. Alameda County Public Health, CalREDIE and CAIR, November 2021.

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Appendix 1. Community Leaders, Representatives, and Members Consulted

The list below contains the details of leaders, representatives, and members who were consulted for their expertise in the community. Leaders were identified based on their professional expertise and knowledge of target groups, including low-income populations, minorities, and the medically underserved.

Data collection method	Affiliation	Number	Perspectives represented	Role	Date
Key Respondent Interview	Association of Bay Area Governments (ABAG)	1	Older adults and transit-riding adults	Leader	08.04.21
Key Respondent Interview	Abode Services	1	People experiencing homelessness in the Bay Area	Leader	08.20.21
Key Respondent Interview	Alameda County Public Health Department (ACPHD)	1	Pregnant women, families, immigrant populations, uninsuredand underinsured populations	Representative	08.09.21
Key Respondent Interview	Alameda County Community Food Bank	1	Food insecure residents	Leader	07.27.21
Key Respondent Interview	Alameda County Transportation Commission	1	Transit-reliant and transit-riding populations in Alameda County	Leader	07.14.21
Key Respondent Interview	ALL In Alameda County	2	Youth and adults with lower incomes in Alameda County, specifically residents of San Antonio, Fruitvale, and unincorporated areas (Ashland/Cherryland)	Leaders	08.26.21
Key Respondent Interview	Greenlining	1	Communities of color	Leader	08.12.21
Key Respondent Interview	Asian Health Services	1	Asian, Pacific Islander residents and families	Leader	08.20.21
Key Respondent Interview	Building Opportunities for Self-Sufficiency (BOSS)	1	Residents experiencing or at risk of homelessness, residents with lower incomes	Leader	08.10.21
Key Respondent Interview	Community Clinic Consortium/Alameda Health Consortium/La Clinica de la Raza	3	Medi-Cal recipients, individuals and families with lower income, Hispanic populations	Leaders, Representative	08.18.21
Key Respondent Interview	Daily Bowl	1	Food insecure adults and families	Leader	08.12.21
Key Respondent Interview	Day Break Adult Day Center & Alameda County Age-friendly Coalition	2	Older adults	Leaders	08.03.21

Appendix 1. Community Leaders, Representatives, and Members Consulted

Data collection method	Affiliation	Number	Perspectives represented	Role	Date
Key Respondent Interview	East Bay Asian Local Development Corporation (EBALDC)/Berkeley Food and Housing Project/Bay Area Community Services (BACS)	3	Residents experiencing or at the risk of homelessness	Leaders	08.24.21
Key Respondent Interview	East Oakland Collective	1	Older adults, people with disabilities, food insecure residents	Leader	08.20.21
Key Respondent Interview	Eden Housing Resident Services, Inc.	1	Older adults with lower incomes, families, and persons with disabilities	Representative	08.17.21
Key Respondent Interview	Family Support Services	1	Caregivers with children	Leader	08.12.21
Key Respondent Interview	Fred Finch Youth Center & Lincoln	5	Youth, especially Hispanic and Black youth	Leader, Representatives	07.29.21
Key Respondent Interview	Health Care Services Agency (HCSA) Homeless and Coordination & Everyone Home	2	Residents experiencing homelessness	Leader	08.19.21
Key Respondent Interview	HOPE Collaborative	1	Residents with lower income, are food insecure, youth	Representative	07.26.21
Key Respondent Interview	NAMI	2	Families and residents impacted by mental illness	Leaders	07.30.21
Key Respondent Interview	Oakland Unified	1	School-aged youth (K- 12)	Leader	08.19.21
Key Respondent Interview	Ombudsman/Empowered Aging	1	Older adults in residential care and skilled nursing facilities	Leader	08.23.21
Key Respondent Interview	Pacific Center for Human Growth	1	Refugees and asylum seekers	Leader	08.18.21
Key Respondent Interview	Partnership for Trauma Recovery	1	Residents who were incarcerated, people with lower income	Leader	07.22.21
Key Respondent Interview	Planting Justice	1	Residents who were incarcerated, people with lower income	Leader	07.22.21
Key Respondent Interview	Roots Health Center	1	Black residents of East Oakland	Representative	07.23.21

Appendix 1. Community Leaders, Representatives, and Members Consulted

Data collection method	Affiliation	Number	Perspectives represented	Role	Date
Key Respondent Interview	Rubicon	1	Adults and parents with children experiencing unemployment and underemployment	Leader	07.26.21
Key Respondent Interview	Side by Side (TAY)	1	Transitional Age Youth	Representative	08.31.21
Key Respondent Interview	SparkPoint	3	Residents with lower income, especially people of color, including Asian, South Asian, Indian, Hispanic, and women of color	Representatives	08.06.21
Key Respondent Interview	Unity Council	1	Food insecure or unemployed adults, children, and older adult populations	Leader	09.01.21
Key Respondent Interview	Urban Peace Movement	1	Black residents and youth	Representative	09.01.21
Key Respondent Interview	Youth Alive!	1	Survivors of community and gun violence, especially youth in Northern Alameda County	Leader	08.16.21
Focus Group	Oakland residents, conducted by Alameda County Public Health Department	8	Hispanic women with children	Members	09.08.21
Focus Group	Oakland residents, conducted by Alameda County Public Health Department	12	Older adults (65 and over)	Members	09.02.21
Focus Group	Oakland residents, conducted by Alameda County Public Health Department	9	LGBTQ adults	Members	10.01.21
Focus Group	Oakland residents, conducted by Alameda County Public Health Department	13	Cantonese adults	Members	10.06.21
Focus Group	Oakland residents, conducted by Alameda County Public Health Department	8	Vietnamese adults	Members	10.07.21
Focus Group	Oakland residents, conducted by Alameda County Public Health Department	10	Transgender adults	Members	10.21.21
Focus Group	Oakland residents, conducted by Alameda County Public Health Department	11	Indigenous Mam families with young children	Members	09.30.21

Appendix 2. Secondary Data Sources

Kaiser Permanente Community Health Data Platform

Source	Dates
American Community Survey	2015–2019
Behavioral Risk Factor Surveillance System	2020
CDC, Interactive Atlas of Heart Disease and Stroke	2016–2018
Center for Medicare & Medicaid Services	2018
CMS National Provider Identification	2019
Dept of Education ED Facts & state data sources	Varies
EPA National Air Toxics Assessment	2014
EPA Smart Location Mapping	2013
Esri Business Analyst	2020
Esri Demographics	2020
FBI Uniform Crime Reports	2014–2018
Feeding America	2018
FEMA National Risk Index	2020
Harvard University Project (UCDA)	2018
HRSA Area Resource File	2019
HUD Policy Development and Research	2020
National Center for Chronic Disease Prevention and Health Promotion	2018
National Center for Education Statistics	2017–2018
National Center for Health Statistics	2018
National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention	2018
NCHS National Vital Statistics System	2015–2019
NCHS US Small-area Life Expectancy Estimates Project	2010–2015
NCI State Cancer Profiles	2013–2017
NCI United States Cancer Statistics	2013–2017
NHTSA Fatality Analysis Reporting System	2014–2018
US Geological Survey; National Land Cover Database	2016
USDA Food Environment Atlas	2016

Additional Secondary Data Sources

Source	Dates
Alameda County Public Health	2016–2021
California Health Interview Survey (CHIS)	2020
California Healthy Kids Survey (CHKS)	2017–2019
Bay Area Equity Atlas	2019

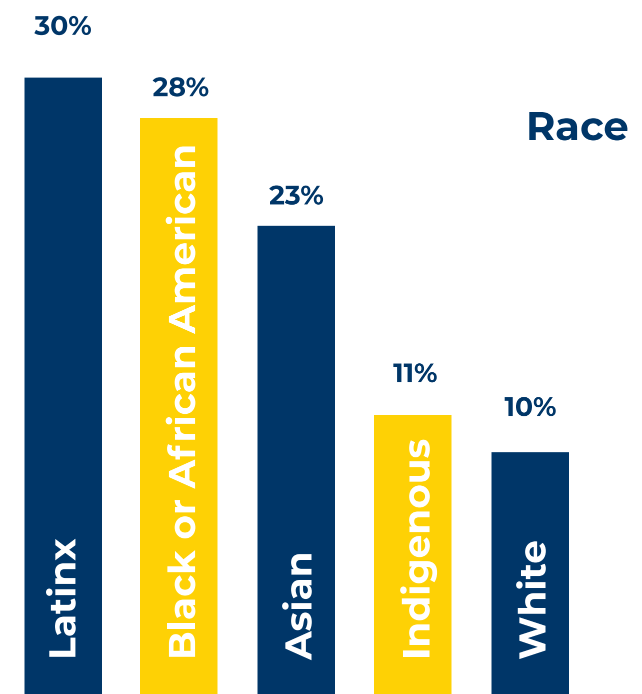
Appendix 3. Alameda County Focus Group Demographics

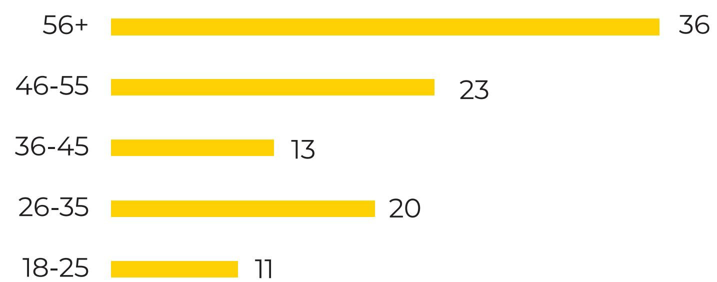
Alameda County Focus Group Demographics

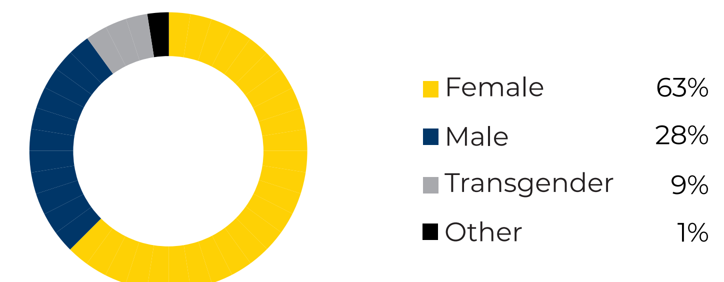
Ad Lucem Consulting

Total Participants

104







Uptown Neighborhood of Oakland, California. Uptown is the art and entertainment center of Oakland featuring many bars, cafes, restaurants and live music venues. Photo by Eddie Hernandez. Oakland, CA.

ALAMEDA COUNTY HEALTH CARE SERVICES AGENCY
PUBLIC HEALTH DEPARTMENT

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San Leandro, Ca 94577

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ACTION: Consent Agenda

QUALITY PROFESSIONAL SERVICES COMMITTEE MEETING

Wednesday, March 25, 2026
5:00pm-7:00pm

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

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

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

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

QUALITY PROFESSIONAL SERVICES COMMITTEE MEETING MINUTES

THE MEETING WAS CALLED TO ORDER AT 5:03 pm

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

ABSENT: None

A. Chair's Report
Continuing the Conversation, January 2026 Article: Covering the Uninsured: Considerations for California as It Prepares for Coverage Losses
Lilavati Indulkar, Chair

Trustee Moss said his agency did a lot of work around the system level issues for this population and engaged a lot with Alameda Alliance for Health. They were interested in engaging on this subject.

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

Trustee Indulkar asked if they needed to invite stakeholders to QPSC, to the full Board, or perhaps it should be parsed out based on the specific subject matter. Mr. Jackson said the latter would be a good start to help determine which body should hold the discussion.

Trustee Linton said the questions posed in the article were good. The one she'd like some feedback on was about the populations they wanted AHS to serve and what services they wanted us to provide. It was a different array of services than in surrounding counties. She attended a webinar that encouraged governing board members to lean into the services and programming of the hospital systems.

Trustee Indulkar said that Dr. Swift and Mr. Jackson have discussed with her where they were in terms of HealthPac. Dr. Swift said that HealthPac operationally sat under Finance. They were organizing the different work paths. Under Sherri Johnson's leadership they were looking at utilization patterns, eligibility, enrollment, and referrals. They were working to understand the system. They were creating dashboards to refine the internal referral process. There was tremendous activity around shoring up all of the documentation and data systems. They were also working on a communication strategy. They've been meeting with various healthcare services partners as well.

Trustee Linton said they were challenged to put together a budget. They also had to preview it to the County. In terms of the timeline, would it be completed in time to inform the budget. Dr. Swift said there will be several things happening in parallel including the conversation and negotiation about the HealthPac contract and that block grant. They may not have the level of specificity to know about the needs of these various populations. They would not slow down with the budget process.

Trustee Indulkar said this would be a good topic to have a follow up report at some point.

B. ACTION: Consent Agenda

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

B1. Approval of the Minutes of the February 27, 2026 Quality Professional Services Committee Meeting

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

AHS and AH Medical Staff:

- Licenses + Certifications Policy
- HR Policy – Extended Sick Leave – Directors and Above
- AHS Clostridioides difficile (CDI) Prevention Policy
- Pandemic Influenza Preparedness and Response Policy
- Hand Hygiene Policy
- Scope of Hydrocollator and Hydrotherm Cleaning and Disinfection Policy
- WORKPLACE VIOLENCE PREVENTION AND RESPONSE PLAN IN THE WORKPLACE
- AHS Heat Illness Prevention Plan and Policy

- Proactive Emergency Generator Testing Notification
- FIRE PROCEDURE: HAYWARD WELLNESS CENTER
- Utility Systems Management Plan
- Fire Procedure John George Psychiatric Pavillion
- Carboard Box IPC Policy
- Provision of Care Policy – Highland
- Hemodialysis Patient Management Policy
- Suicide Prevention Policy
- Restraints and Seclusion Policy
- AHS EMTALA Policy
- Patient Rights Policy
- Patient Visitor Cell Phone Electronic Device Policy
- Electronic Health Information Secure Messaging of PHI
- Patient Privacy Protection Policy
- Food and Nutrition Food Drug Interactions Education
- INTRAVENOUS ADMIXTURE PROGRAM POLICY (34517_-1)
- CASH CONTROL AND TRANSACTIONS
- PHARMACY THERAPEUTIC DRUG MONITORING POLICY
- MEDICATION ADMINISTRATION: CHEMOTHERAPEUTIC AGENTS
- FEMA_OAKLAND_URBAN_SEARCH_AND_RESCUE_TASK_FORCE_(34522_-1)
- Medication_Error_Reduction_Plan_2026_(SB_1875)_Alameda Hospital
- SYSTEM_MEDICATIONS LOOK ALIKE, SOUND ALIKE_(34528_-1)
- MEDICATIONS: BOTULISM ANTI-TOXIN
- LIDOCAINE INFUSION FOR PAIN CLINICAL PRACTICE GUIDELINES
- LIDOCAINE INFUSION FOR PAIN POLICY
- TNK For Acute Ischemic Stroke
- Code Stroke Policy
- Elopement and Medical Incapacity Hold Policy

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

AHS and AH Medical Staff:
- Medical Staff Credentialing and Privileging of Providers
- Medical Staff Application Levels
- Medical Staff Peer Case Review

Trustee Indulkar spoke regarding the Elopement and Medical Incapacity Hold Policy. Not very many systems have this type of policy. It was a big milestone.

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

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

ABSTENTION: None

END OF CONSENT AGENDA

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

Trustee Linton asked about the red alert at Alameda Hospital over the weekend. Mr. Jackson explained that it was a stop on a national tour and was about HR1, not about Alameda Hospital specifically.

Trustee Moss asked about the Peer Review and what it was before. Dr. Perez said it used to be individual peer reviews in each department with the quality improvement and scoring positions as one process. Now it was separated out. A multidisciplinary body will look at all cases as one centralized entity.

D. REPORT/DISCUSSION: Quality Reports

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

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

Trustee Moss asked about the progress of the SNF at St. Rose. Mr. Espinoza said they received the Medicare certification in December which then allowed them to finalize the Medi-Cal certification application. There have been some delays. They had a call with the Department of Healthcare Services, and they were providing some additional information. They expected the certification to be in place within a week or two.

Trustee Moss asked what impact the rating has on stays or the time frame he was talking about. Mr. Espinoza said there was no revenue impact. A facility that was three stars or above, as AHS always was, they no longer had to have the 3-day pre-qualifying stay for Medicare patients.

E. DISCUSSION: Regulatory Requirements for Health Equity
U. Mini B. Swift, MD, Chief Mission Integration Officer

Trustee Garrett said they didn't really hear the equity element as part of the quality reports.

Trustee Garrett said he was thrown off by the complexity. He was focused on equity, and this was on complexity. Dr. Swift said they have approached equity in a linear way as a simple problem when it was actually very complex. They had to shift their thinking to recognize that they could not divorce the outcomes from the process.

Trustee Indulkar said for a lot of them equity equaled access and access equaled equity – how the patient population they were trying to capture had access to all services. She said she was trying to frame the presentation around how they got to a point where they could say yes, equity

was access and they were delivering on that. Dr. Swift said equity was not only access. Access was an outcome that they wanted. Equity was for whom they wanted to have that access. Everybody getting access was equality. The complex part, the equity part, was that there was not one way to provide access. Did everyone have access here? Was there a priority population? What's the mission? What's most essential? Those were complex considerations.

Truste Linton said they spoke about the mission statement at the retreat and how they could bring it down into the set of services they were going provide. The idea of mission integration didn't always connect to equity. The Trustees talked about community forums to clarify how they achieved the mission statement. A lot of this should be part of that strategic vision and should be Board led or at least involved. Dr. Swift said she didn't mean to suggest otherwise. At this point they were talking about bringing the methodology into our equity, quality, and quality improvement approach to equity.

Trustee Moss agreed with the broadened view approach. He said thinking about the unintended consequences of these decisions and how it was impacting the people they service, and worsening disparities was complex. Dr. Swift said there were some problems that were so complex they needed to start by not even talking about the problem. There were also some problems where they just needed to roll a solution out.

Trustee Garrett said when you think about the process of integrating equity into the health system, it was a complex problem, and they needed to look at it from the framework of managing problems from a complexity perspective to help us achieve the equity. Dr. Swift said that was correct. She advocated for them to include a complexity mindset into their thinking. And the concept of mission integration around the mission statement and how that impacts our outcomes.

Trustee Garrett asked what she meant by an equity process. Dr. Swift said inclusion was a process not necessarily an outcome. They wanted to design an intervention to increase mammography rates for Black patients. They started by bringing staff together per normal. But they included the people they were designing for. This created a system that allowed a patient to share their experience and staff was able to accept that. Then they created voting that allowed staff to have one vote and patients to have two votes to balance the power.

Trustee Linton said the appendix included a slide on the credo and one on access to information was a condition of trust. This was important to consider as they went through the process of setting up a strategic vision and plan. Trust was an issue.

F. DISCUSSION: Trauma Certification

Gegory Victorino, MD, Chief Surgery
April Mendoza, MD, Trauma Medical Director

Mr. Azizi announced the Committee would meet in closed session and discuss the items as set forth on the agenda.

G. <u>CLOSED SESSION</u>

G1. Consideration of Confidential Medical Staff Credentialing Reports

Chief of Staff, AHS Medical Staff
Chief of Staff, AH Medical Staff

G2. Regulatory Affairs, Risk Management, Patient Safety
[Health and Safety Code 101850(ai) (1)]

(Reconvene to Open Session)

H. OPEN SESSION

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

Mr. Azizi announced the Committee met in closed session, approved the credentialing reports and took no additional reportable action.

ADJOURNMENT: 9:15pm

Alameda Health System			CPC Executive Summary to AHS and AH Medical Executive Committee(s) – April 2026			
Policies and Procedures				Chairs: Kelley Bullard, MD & Salma Adin, MBA, BSN, RN		
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						
False Claims Act	**Akemi Renn, CHC, CHPC, CPC** | System Director, Compliance	• Revised Policy renewal with minor edits.		04/2029		• CPC 4/2/2026 • MEC 4/15/2026
Compliance Hotline Policy	**Akemi Renn, CHC, CHPC, CPC** | System Director, Compliance	• Revised • Policy renewal with minor edits		04/2029		• CPC 4/2/2026 • MEC 4/15/2026
Responsibilities for Compliance Reporting	**Akemi Renn, CHC, CHPC, CPC** | System Director, Compliance	• Renewal with no revisions. •		04/2029		• CPC 4/2/2026 • MEC 4/15/2026
Disclosure of Protected Health Information for Treatment, Payment and Health Care Operation	**Akemi Renn, CHC, CHPC, CPC** | System Director, Compliance	• Renewal with no revisions		04/2029		• CPC 4/2/2026 • MEC 4/15/2026
Notice of Privacy Practice	**Akemi Renn, CHC, CHPC, CPC** | System Director, Compliance	• Renewal with no revisions		04/2029		• CPC 4/2/2026 • MEC 4/15/2026
Release of Patient Information: Complying with ONC Final Rule Policy – Patient Access	**Akemi Renn, CHC, CHPC, CPC** | System Director, Compliance	• Renewal with no revisions		04/2029		• CPC 4/2/2026 • MEC 4/15/2026

Alameda Health System			**CPC Executive Summary to AHS and AH Medical Executive Committee(s) – April 2026**			
Policies and Procedures				**Chairs: Kelley Bullard, MD & Salma Adin, MBA, BSN, RN**		
TOPIC or TITLE OF POLICY	**Document Owners**	**Summary of Changes**	**Last Approved Date**	**Next review date after BOT approval**	**Purpose**	**History of Review Committee**
Privacy: Use and Disclosure of Limited Data Set (LDS)	**Akemi Renn, CHC, CHPC, CPC** | System Director, Compliance	• Renewal with no revisions		04/2029		• CPC 4/2/2026 • MEC 4/15/2026
Privacy: AHS Directory	**Akemi Renn, CHC, CHPC, CPC** | System Director, Compliance	• Renewal with no revisions		04/2029		• CPC 4/2/2026 • MEC 4/15/2026
Privacy Notification	**Akemi Renn, CHC, CHPC, CPC** | System Director, Compliance	• Renewal with no revisions		04/2029		• CPC 4/2/2026 • MEC 4/15/2026
Mitigation of Improper Disclosures	**Akemi Renn, CHC, CHPC, CPC** | System Director, Compliance	• Renewal with no revisions		04/2029		• CPC 4/2/2026 • MEC 4/15/2026 •
Patient Rights to Request Restrictions on Certain Uses and Disclosures of Protected Health Information	**Akemi Renn, CHC, CHPC, CPC** | System Director, Compliance	• Renewal with no revisions		04/2029		• CPC 4/2/2026 • MEC 4/15/2026
Parking Policy	**Doug Johnson, MBA, C.P.M.** | Vice President, Support Services	• Revised •		04/2029		• CPC 4/2/2026 • MEC 4/15/2026
FBC Scope Of Service Plan	**Rebecca Barbosa,** MBA-HCA, BSN-RN, PHN, RNC-NIC, LSSYB	• Revised		04/2029		• CPC 4/2/2026 • MEC 4/15/2026

Alameda Health System			CPC Executive Summary to AHS and AH Medical Executive Committee(s) – April 2026			
Policies and Procedures				Chairs: Kelley Bullard, MD & Salma Adin, MBA, BSN, RN		
TOPIC or TITLE OF POLICY	**Document Owners**	**Summary of Changes**	**Last Approved Date**	**Next review date after BOT approval**	**Purpose**	**History of Review Committee**
FNS Screening and Assessment/ Clinical Nutrition Screening and Assessments (Acute Care	Rosylan M Rojas | MS, RD *(she/her)* System Director, Food & Nutrition Services	• Revised This policy combines 2 existing FNS policies listed below for a more streamlined comprehensive approach to screening and assessment in the acute care setting. • Food and Nutrition Services: Clinical Nutrition Assessment, Diagnosis, Intervention, Monitoring and Evaluation Acute Care) • Food and Nutrition Services: Initial Nutrition Screening Assessment and Prioritization		04/2029		• CPC 4/2/2026 • MEC 4/15/2026
Stroke Center Program PLAN	**Cheryl Evans Cobb MSN RN PHN** System Stroke Program Manager/*Interim* Highland Hospital	• Revised • Overarching plan to meet Program Management (PR) standards for Primary Stroke Certification. Defines mission statement; changes verbiage from Alameda Hospital to the Alameda Health System; adds “or designee” to several departmental stroke committee members, rather than specify the director; add Step Down Unit to units accepting strokes; references Clinical Practice Guidelines (CPG’s) as per Joint Commission standards; changes meeting times to at least 4 times per year, to meet TJC standards • More appropriate and less restrictive definition of core stroke team vs stroke committee members. Matches committee members to TJC submissions		04/2029		• CPC 4/2/2026 • MEC 4/15/2026

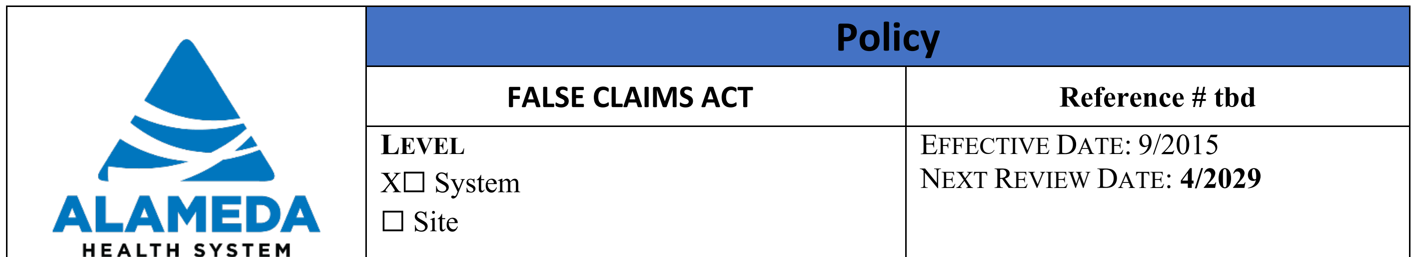
Alameda Health System			**CPC Executive Summary to AHS and AH Medical Executive Committee(s) – April 2026**			
Policies and Procedures				**Chairs: Kelley Bullard, MD & Salma Adin, MBA, BSN, RN**		
TOPIC or TITLE OF POLICY	**Document Owners**	**Summary of Changes**	**Last Approved Date**	**Next review date after BOT approval**	**Purpose**	**History of Review Committee**
Clinical Nutrition Neonatal Initial Assessment and Prioritization	**Rosylan M Rojas | MS, RD** *(she/her)* System Director, Food & Nutrition Services	• Revised • Due for review		04/2029		• CPC 4/2/2026 • MEC 4/15/2026
Hazard Vulnerability Analysis Policy	**Nilda Perez** - Director of Regulatory Affairs	• Revised • AHS will conduct an annual Hazard Vulnerability Analysis (HVA) to identify risks, determine operational impacts, and guide emergency preparedness planning across all system facilities		04/2029		• CPC 4/2/2026 • MEC 4/15/2026
Patient Rights	**Nilda Perez** - Director of Regulatory Affairs	• Revised • Keywords: Rights/ Patient Rights • Policy updated to meet requirements by organization to demonstrate respect for patient rights and assure staff are aware of our obligations to provide education on patient rights.		04/2029		• CPC 4/2/2026 • MEC 4/15/2026
Drug Product Problem Reporting	**Priya Patel, PharmD**	• TJC Triennial review • Add language on counterfeit drug products to align with State Board of Pharmacy • Consent Item - PolicyTech		04/2029		• System P&T 3/2026 • CPC 4/2/2026 • MEC 4/15/2026
Medication – After Hours Retrieval of Medications	**Priya Patel, PharmD**	• TJC Triennial review • Revise to align with current after-hours process for JG/FM/SLH/AH • Consent Item - PolicyTech		04/2029		• System P&T 3/2026 • CPC 4/2/2026 • MEC 4/15/2026

Alameda Health System	CPC Executive Summary to AHS and AH Medical Executive Committee(s) – April 2026
Policies and Procedures	Chairs: Kelley Bullard, MD & Salma Adin, MBA, BSN, RN

TOPIC or TITLE OF POLICY	Document Owners	Summary of Changes	Last Approved Date	Next review date after BOT approval	Purpose	History of Review Committee
Anticoagulant Therapy in Patients Undergoing PCI	**Xin Yang, MD**	• Change target ACT • Consent Item – Policy •		04/2029		• System P&T 3/2026 • CPC 4/2/2026 • MEC 4/15/2026
Vaccines for Children Program	**Eric Mahone, PharmD**	• Add language to enrollment and recertification for providers, training and storage units and digital data loggers • Consent Item - Policy		04/2029		• System P&T 3/2026 • Ambulatory Operations Council 3/2026 • CPC 4/2/2026 • MEC 4/15/2026
Adult Medicine Refill Clinics – Clinical Pharmacist Duties and Function	**Eric Mahone, PharmD**	• Remove medication classes • Consent Item - Policy		04/2029		• System P&T 3/2026 • Ambulatory Operations Council 3/2026 • CPC 4/2/2026 • MEC 4/15/2026
Direct Oral Anticoagulation Policy	**Priya Patel, PharmD**	• TJC triennial review, no changes • Consent Item - PolicyTech		04/2029		• System P&T 3/2026 • CPC 4/2/2026 • MEC 4/15/2026
Theft or Impairment of Pharmacy Employees	**Priya Patel, PharmD**	• Minimal changes - Add language for DEA reporting requirements • Consent Item - PolicyTech		04/2029		• System P&T 3/2026 • CPC 4/2/2026 • MEC 4/15/2026

Alameda Health System			CPC Executive Summary to AHS and AH Medical Executive Committee(s) – April 2026			
Policies and Procedures				Chairs: Kelley Bullard, MD & Salma Adin, MBA, BSN, RN		
TOPIC or TITLE OF POLICY	**Document Owners**	**Summary of Changes**	**Last Approved Date**	**Next review date after BOT approval**	**Purpose**	**History of Review Committee**
Intra-Coronary Nitroglycerine	**Xin Yang, MD**	• Revised • Consent Item - Policy		04/2029		• System P&T 3/2026 • CPC 4/2/2026 • MEC 4/15/2026
Intra-Coronary Nitroprusside (Dr. Xin Yang)	**Xin Yang, MD**	• Revisions requested by Cardiology • Expand contraindications to include sildenafil, vardenafil, tadalafil, riociguat. • Consent Item - Policy		04/2029		• System P&T 3/2026 • CPC 4/2/2026 • MEC 4/15/2026
IV Adenosine for Fractional Flow Reserve in Interventional Services	**Xin Yang, MD**	• TJC Triennial review • No changes • Consent Item - Policy		04/2029		• System P&T 3/2026 • CPC 4/2/2026 • MEC 4/15/2026
Pregnant Patients and IV Contrast Administration	**Frederick Lee, EdD**	• TJC triennial review • Revisions to align with best practices • Consent Item - Policy		04/2029		• System P&T 3/2026 • Approved by Radiology 3/2026 • CPC 4/2/2026 • MEC 4/15/2026
Radiopharmaceuticals: Radioactive Kit Preparation	**Frederick Lee, EdD**	• TJC triennial review • Revisions to align with current processes • Consent Item - Policy		04/2029		• System P&T 3/2026 • Approved by Radiology 3/2026 • CPC 4/2/2026 • MEC 4/15/2026

Alameda Health System			CPC Executive Summary to AHS and AH Medical Executive Committee(s) – April 2026			
Policies and Procedures				Chairs: Kelley Bullard, MD & Salma Adin, MBA, BSN, RN		
TOPIC or TITLE OF POLICY	**Document Owners**	**Summary of Changes**	**Last Approved Date**	**Next review date after BOT approval**	**Purpose**	**History of Review Committee**
Highland Outpatient Pharmacy Automatic Quantity Change Policy	**Nataliya Miller, PharmD /Eric Mahone, PharmD**	• Minor language revisions, No content revisions • Consent Item - PolicyTech		04/2029		• System P&T 3/2026 • Approved by Radiology 3/2026 • CPC 4/2/2026 • MEC 4/15/2026



Policy	
FALSE CLAIMS ACT	Reference # tbd
LEVEL X☐ System ☐ Site	EFFECTIVE DATE: 9/2015 NEXT REVIEW DATE: **4/2029**

Purpose
Alameda Health System (AHS) is subject to the possibility of irregularities or misinterpretations concerning the rules which govern our industry related to the False Claims Act (FCA) This is not usual or common but due to the complexity of our business, is a possibility. This policy states AHS' position on enforcement and discipline when irregularities have been identified.

SCOPE
This policy applies to AHS Workforce to ensure compliance with federal and state laws pertaining to the false claims act.

Definitions:

- Abuse – "Abuse" is any incident or practice that is inconsistent with accepted medical or business practice. For example, billing Medicare or Medicaid for services not reimbursable per the claims processing guidelines would be considered "abuse".
- Fraud – "Fraud" is the intentional or deliberate misrepresentation made by an individual that could result in some unauthorized benefit.
- Claim – As set forth in 31 U.S.C. § 3729, "Claim" includes any request or demand, whether under a contract or otherwise, for money or property which is made to a contractor, grantee, or other recipient if the United States Government provides any portion of the money or property which is requested or demanded, or if the Government will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded.
- False Claim– A "false claim" is any bill presented to the government for payment where the individual presenting the bill for payment knows the services were never provided or the goods never delivered. Defective goods or services also constitute a "false claim."
- Qui Tam – The False Claims Act is unique in that it includes a "qui tam" or whistleblower provision. "Qui tam" is the shortened phrase that liberally translated means, "he who brings the action for the king as well as for himself." In other words, an individual citizen with evidence of fraud against the government may sue on behalf of the government to recover the stolen goods or property. To compensate for the risk and effort of filing a qui tam case, the relator (citizen) is awarded a portion of the funds recovered, typically between 15 and 25 percent.
- Whistleblower – A person or entity making the protected disclosure is commonly referred to as a whistleblower. A whistleblower can be an employee, former employee or member of an organization who reports misconduct. Generally, the misconduct is a violation of a law, rule or regulation.

Policy
Alameda Health System (AHS) take health care fraud and abuse very seriously. AHS is committed to following all applicable laws and regulations, in particular those that address health care fraud, waste and abuse and the proper billing of Medicare, Medicaid and other government-funded health care programs. This includes the Federal False Claims Act (FCA) and the Deficit Reduction Act (DRA) as well as other applicable state and federal laws.

Federal False Claims Act (FCA)
What it does:
Allows a civil action to be brought against a health care provider who:

- Knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval to any federal employee;
- Knowingly makes, use or cause to be made or used a false record or statement to get a false or fraudulent claim paid;
- Knowingly makes, uses or causes to be made or used, a false record or statement or to conceal, avoid, or decrease an obligation to pay or transmit property to the government; or
- Conspires to defraud the government by getting a false of fraudulent claim allowed or paid.

Deficit Reduction Act (DRA)
What it does:
Allow States to adopt state false claims acts that substantially mirror the requirements of the Federal False Claims Act (FCA).
Examples of a false claim:

- Billing for procedure not performed
- Violation of another law, such as a claim submitted appropriately, but the service was the result of an illegal relationship between a physician and the hospital (physician received kickbacks for referrals)
- Falsifying information in the medical record
- Billing for medically unnecessary services
- Billing for non-covered services
- Billing for incorrect level of service

What you can do:

Assurances of the following are ways that all AHS employees and its affiliated physician partners can do to help improve billing and coding compliance.

- Maintain honest and accurate records of all our activities.
- Submit claims only for services and supplies ordered by a physician or other authorized person that are actually rendered and medically necessary.
- Do not file a claim for services that were not rendered.
- Ensure that diagnoses are properly coded and that they are supported by medical necessity requirements.
- Do not use diagnostic information provided by a physician or non-physician practitioner from earlier dates of services, unless conforming to approved standing orders.
- Ensure that bills submitted for payment are properly coded, documented and billed in accordance with all applicable laws, regulations, guidelines and policies.
- Research all credit balances and refund any monies received that is not due to AHS in a timely manner.
- Do not submit any claims for payment or reimbursement of any kind that are false, fraudulent, inaccurate, incomplete or fictitious.
- Bill for services using correct coding practices that accurately describe the services that were provided. If inaccuracies are discovered in bills that have already been sent, take immediate steps to alert the payer and correct the bill in accordance with the payer's guidelines and requirements.
- Insufficient documentation to support the services provided is perhaps the most common reason for Medicare to deny or delay reimbursement.
- Physicians, nurses, and other practitioners must complete medical records and other documentation to prove that they provided items or services.
- Take particular care to avoid improper or illegal billing and coding practices such as up-coding and unbundling.

Violations:
Anyone who violates the FCA is liable for civil penalty of between $5,500 and $11,000 per false claim, plus three times the amount of the damages incurred by the government. The government may also exclude violators from participating in Medicare, Medicaid and other government programs. Intentional submission of a false claim ruse are subject to federal criminal enforcement and may also be liable to the United States government for the costs of civil action brought to recover any penalties or damages.
The government relies heavily on the federal and state FCA to prosecute billing fraud.

The FCA's *qui tam* provisions permit private persons to: (1) sue, on behalf of the government, persons or entities who knowingly have presented the government with false or fraudulent claims; and (2) share in any proceeds ultimately recovered as a result of the suit.

The FCA includes provisions to discourage retaliating against employees for initiating *qui tam* law suits. Any employee who is terminated, demoted, suspended or in any way discriminated against because of acts in support of an action under the FCA has a right to sue the organization for reinstatement, back pay and other damages.

The FCA includes a provision that reduces the penalties for providers who promptly self-disclose a suspected FCA violation to the U.S. Justice Department. In addition, the Department of Health and Human Services, Office of Inspector General (OIG) self-disclosure protocol allows providers to conduct their own investigations, take appropriate corrective measures, calculate damages and submit the findings that involve more serious problems than just simple errors to the agency.

California False Claims Act:
In addition to the federal FCA, California has its own False Claim Act, set forth in Sections 12650 through 12655 of the California Government Code. The California False Claims Act is triggered by claims for payment submitted to the state and its agencies. The California False Claims Act is very similar to the FCA in terms of the types of acts that give rise to liability. Like the FCA, the California False Claims Act allows private parties to sue on behalf of the state as *qui tam* plaintiffs.

Protections Under the False Claims Act:
The federal False Claims Act protects anyone who files a lawsuit under the Act from being fired, demoted, threatened, or harassed by their employer as a result of filing a False Claims Act lawsuit.

Procedure
What you should do if you think there may have been a violation of a false claim:
If you see something that is not right, or looks like one of the examples of a false claim indicated in this policy, AHS compliance department encourages you to:

1. Report the problem to your immediate supervisor if something looks suspicious. If you feel you cannot inform your supervisor about the problem;
2. Report it to the Chief Compliance Officer (CCO) at 510-437-4338 for further investigation. If you are not comfortable doing this;

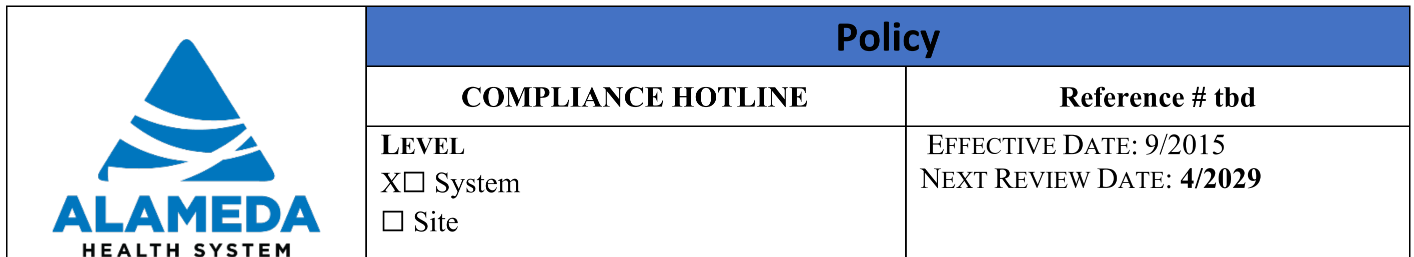
3. Call the AHS Compliance Hotline at 844-310-0005 (English) or 800-216-1288 (Spanish), 24 hours, 7 days a week.

Confirmed fraud, waste, and abuse incidents involving Alameda Alliance patients must be reported to the Alameda Alliance Health Plan within 10 working days from discovery.

AHS does not allow any form of retaliation against employees or its affiliated physician partners who report instances of non-compliance.

References

- Deficit Reduction Act of 2005 (S. 1932) §§ 6031-6034 (DRA)
- 31 U.S.C. Money and Finance Subchapter III – Claims against the United States; 31 U.S.C. §3730 Civil Actions for False Claims, 31 U.S.C. False Claim Procedure, 31 U.S.C. §3732 False Claims Jurisdiction, and 31 U.S.C. §Civil Investigative demands.
- Administrative Remedies 31 U.S.C. §§ 3801, et seq
- The California False Claims Act, Cal. Government code §12650-12655 Article 9 False Claims Action.
- Section 12653 Employer interference with employee disclosures, etc.; liability of employer, remedies of employee of the California False Claims Act.



	Policy	
	COMPLIANCE HOTLINE	Reference # tbd
	LEVEL X☐ System ☐ Site	EFFECTIVE DATE: 9/2015 NEXT REVIEW DATE: **4/2029**

Purpose
This policy is intended to cover concerns that could impact AHS, such as actions that:
• May lead to incorrect financial reporting;
• Are unlawful;
• Are not in line with company policy, including the Code of Conduct; or
• Otherwise amount to improper conduct.
Regular business matters that do not require anonymity should be directed to the employee's supervisor and are not addressed by this policy.
Safeguards:

SCOPE
This policy applies to all AHS employees on utilizing the Compliance Hotline.

Policy
Alameda Health System (AHS) will provide an avenue for AHS workforce members to raise concerns and have assurance that they will be protected from retaliation, reprisals or victimization for reporting (whistleblowing) in good faith.

Harassment or Victimization
Harassment or victimization of individuals submitting hotline reports will not be tolerated. See HR Section 3.00 POLICY 3.25 NON-RETALIATION AND NONRETRIBUTION.

Confidentiality
Every effort will be made to protect the reporter's identity by our hotline vendor. Please note that the information provided in a hotline report may be the basis of an internal and/or external investigation by our company into the issue being reported. It is possible that as a result of the information provided in a report, the reporter's identity may become known to us during the course of our investigation.

Anonymous Allegations
The policy allows employees to remain anonymous, at their option. Concerns expressed anonymously will be investigated, but consideration will be given to:
· The seriousness of the issue raised;
· The credibility of the concern; and
· The likelihood of confirming the allegation.

Malicious Allegations
Malicious allegations could result in disciplinary action.

Procedure

Reporting
The hotline procedure is intended to be used for serious and sensitive issues when a workforce member does not feel comfortable reporting through their chain of command. Concerns should be reported to the compliance hotline, which is hosted by a third-party vendor, in any of the following ways:

- English **844-310-0005**
- Spanish: **800-216-1288**
- Website: www.lighthouse-services.com/alamedahealthsystem
- E-mail: reports@lighthouse-services.com (must include company name with report)
- Fax alternative for written documents: 215-689-3885 (must include company name with report)

Reporters to the hotline will have the ability to remain anonymous if they choose. Please note that the information provided by you may be the basis of an internal and/or external investigation into the issue you are reporting, and your anonymity will be protected to the extent possible by law. However, your identity may become known during the course of the investigation because of the information you have provided. Reports are submitted by Lighthouse to AHS or its designee and may or may not be investigated at the sole discretion of our company.

Employment-related concerns should continue to be reported through your normal channels such as your supervisor, local HR representative, or to the Chief Human Resources Officer.

Timing
The earlier a concern is expressed, the easier it is for us to take action.

Evidence
Although you are not expected to prove the truth of an allegation, the employee submitting a report needs to demonstrate in their hotline report that there are sufficient grounds for concern.

How the Report will be Handled:
The action taken will depend on the nature of the concern. The Audit and Compliance Committee of the AHS Board of Trustees receives a copy of each report and follow-up reports on actions taken by the company.

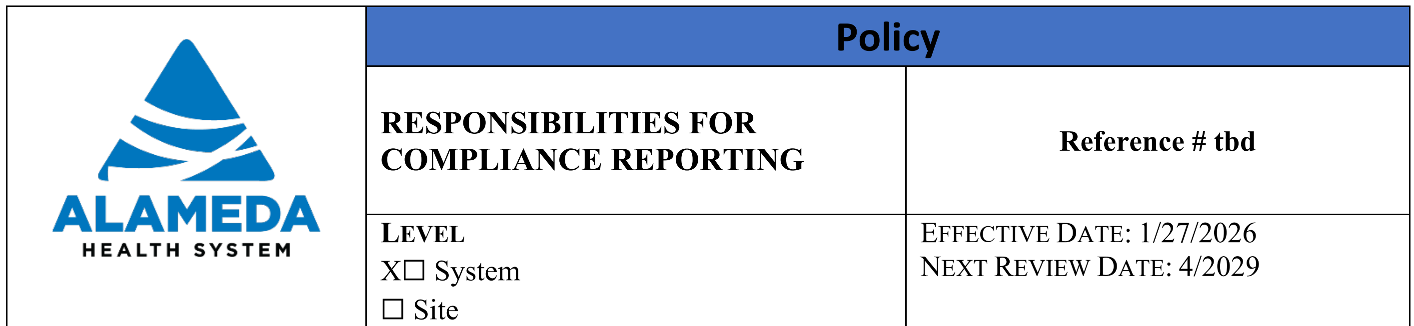
Initial Inquiries
Initial inquiries will be made to determine whether an investigation is appropriate, and

the form that it should take. Some concerns may be resolved by agreed upon action without the need for an investigation.

Feedback to Reporter
Whether reported directly to AHS personnel or through the hotline, the individual submitting a report will be given the opportunity to receive follow-up on their concern:
· Acknowledging that the concern was received;
· Indicating how the matter will be dealt with;
· Giving an estimate of the time that it will take for a final response;
· Telling them whether initial inquiries have been made;
· Telling them whether further investigations will follow, and if not, why not.

Further Information
The amount of contact between the individual submitting a report and the body investigating the concern will depend on the nature of the issue, the clarity of information provided, and whether the employee remains accessible for follow-up. Further information may be sought from the reporter.

Outcome of an Investigation
At the discretion of the company and subject to legal and other constraints, the reporter may be entitled to receive information about the outcome of an investigation.



	Policy	
ALAMEDA HEALTH SYSTEM	**RESPONSIBILITIES FOR COMPLIANCE REPORTING**	**Reference # tbd**
	LEVEL X☐ System ☐ Site	EFFECTIVE DATE: 1/27/2026 NEXT REVIEW DATE: 4/2029

Purpose
To establish a process to encourage reporting by Alameda Health System (AHS) employees of compliance concerns and issues.

Background:
On September 10, 2002, the Alameda Health System ("AHS") established the Compliance Program. The Compliance Program is structured on the guidance provided by the United States Department of Health and Human Services, Office of Inspector General in 63 FR 8987 (February 23, 1998), 63 FR 70138 (December 18, 1998), and 65 FR 59434 (October 5, 2000) (et. al) and is responsible for implementing a Compliance Program to ensure that AHS services are provided in compliance with all applicable federal, state, and local laws and regulations. Employees or other individuals acting on behalf of AHS must know the proper steps to take in the event they should report a perceived or suspected violation of applicable federal, state, and local laws and regulations. Failure on the part of AHS or any employee or individual acting on behalf of AHS to comply with all statutes, regulations, and guidelines applicable to federal programs or to report suspected non-compliance could result in civil and criminal liability, sanctions, and penalties.

Scope
This policy applies to all Alameda Health System (AHS) employees for reporting compliance concerns and issues.

Policy
It is the policy of AHS to report and investigate any suspected actual or potential violation of law, regulation, AHS policy and procedure, or the AHS Code of Conduct.

Procedure

Employee Responsibilities (including management):

1. Immediately report knowledge of suspected actual or potential violations of law, regulation, AHS policy and procedure, or the AHS Code of Conduct to:
   a. A supervisor, manager, or other management staff within the employee's specific chain-of-command. If employees are uncomfortable about raising concerns directly to a supervisor or if a concern has already been raised and not addressed, employees should report their concerns to one of the following options:
      i. The Compliance Office (510-437-7788 or x47788);
      ii. Toll-Free Telephone:
         • **English: 844-310-0005**

- **Spanish: 800-216-1288**

iii. Website: www.lighthouse-services.com/alamedahealthsystem

iv. E-mail: reports@lighthouse-services.com (must include company name with report)

v. Fax: (215) 689-3885 (must include company name with report)

b. Any AHS employee who wishes to remain anonymous may use the Compliance Hotline to report compliance-related issues or concerns. Reports made using any of the above options shall be handled as confidentially as practical and/or as allowed by law.

c. No employee will be subject to retaliation, retribution, or harassment for

d. reports of a suspected violation made in good faith.

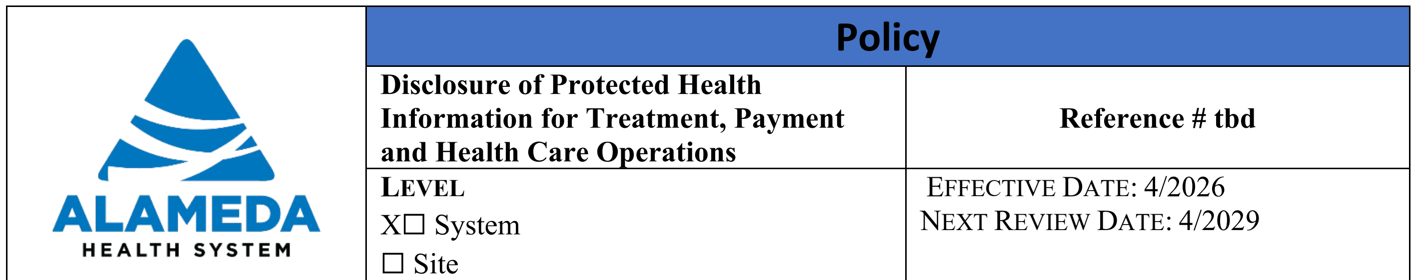
Management Responsibilities (AHS executives, managers and supervisors):

1. Take appropriate measures to ensure support of employee reporting of actual or potential compliance issues. To this end, management will ensure that employees understand that they:
   a. Have an obligation to raise compliance concerns and issues to the appropriate parties;
   b. May seek clarification and guidance on compliance related issues from management or the Compliance Office; and
   c. May report compliance related issues without fear of retaliation.
2. Maintain an "open door" policy to support and encourage employee reporting of compliance-related issues or concerns.
3. Ensure that reports of actual or potential violations are handled as confidentially as possible.
4. Take issues that cannot be resolved to a higher level of management.
5. Place a high priority on Compliance Office referred issues.

Compliance Office Responsibilities:

1. Implement and publicize a reporting process that encourages employees to report compliance related concerns to:
   a. A supervisor, manager, or other management staff within the chain-of-command
   b. The Compliance Program Office (510-437-7788 or x47788)
   c. The confidential, toll-free Compliance Hotline
      i. English: 844-310-0005
      ii. Spanish: 800-216-1288
      iii. Website: www.lighthouse-services.com/alamedahealthsystem
2. Maintain a system to document and track reported compliance issues.
3. Coordinate prompt review and investigation of all reported, known or potential violations.

4. Ensure follow-up on resolution of compliance issues and concerns.
5. Document all actions taken in response to a compliance issue report, including any steps taken to address identified improper conduct, if any.
6. Report directly to the AHS Audit and Compliance Committee on a regular basis regarding compliance issue reporting activities.



	Policy	
ALAMEDA HEALTH SYSTEM	**Disclosure of Protected Health Information for Treatment, Payment and Health Care Operations**	**Reference # tbd**
	LEVEL X☐ System ☐ Site	EFFECTIVE DATE: 4/2026 NEXT REVIEW DATE: 4/2029

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PURPOSE
The purpose of this policy is to establish the conditions under which Alameda Health System (AHS) may access, use, and disclose Protected Health Information (PHI) for Treatment, Payment, and Health Care Operations (TPO), in accordance with the HIPAA Privacy Rule.

SCOPE
This policy applies to all AHS workforce members including employees, medical staff, contractors, volunteers, trainees, and any other person whose conduct is under the direct control of AHS.

DEFINITIONS
Protected Health Information (PHI): Individually identifiable health information maintained or transmitted by AHS in any form or medium, as defined under 45 C.F.R. § 160.103.

Treatment: Provision, coordination, or management of health care and related services among health care providers.

Payment: Activities undertaken to obtain or provide reimbursement for health care services.

Health Care Operations: Activities supporting AHS operations such as quality assessment, credentialing, training, and fraud/abuse detection, as defined under 45 C.F.R. § 164.501.

RESPONSIBILITIES
All AHS workforce members must comply with this policy when accessing, using, or disclosing PHI.

POLICY
AHS accesses, uses, and discloses PHI for Treatment, Payment, and Health Care Operations (TPO) as permitted under the HIPAA Privacy Rule.

1. General Use and Disclosure for TPO
AHS may access, use, or disclose PHI for TPO purposes without patient authorization when permitted under HIPAA.

2. Disclosures to Facilities Involved in Patient Transfers — Treatment and Payment
AHS may disclose PHI required by another health care facility for Treatment and Payment activities when a patient has been transferred.

3. Disclosures for Health Care Operations to Another Facility
AHS may disclose PHI to another health care facility for Health Care Operations where the patient has been transferred and all of the following conditions are met:
   a. Both organizations have or had a relationship with the patient;
   b. The PHI pertains to that relationship; and
   c. The disclosure is either:
      i. For the purpose of health care fraud and abuse detection or compliance; or
      ii. For any of the following purposes:
         - Conducting quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines; population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination; contacting of Health Care Providers and patients

with information about Treatment alternatives; and related functions that do not include Treatment;

- Reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, health plan performance, conducting training programs in which students, trainees, or practitioners in areas of health care learn under supervision to practice or improve their skills as Health Care Providers, training of non-health care professionals, accreditation, certification, licensing, or credentialing activities.

REFERENCES

45 C.F.R. § 164.506

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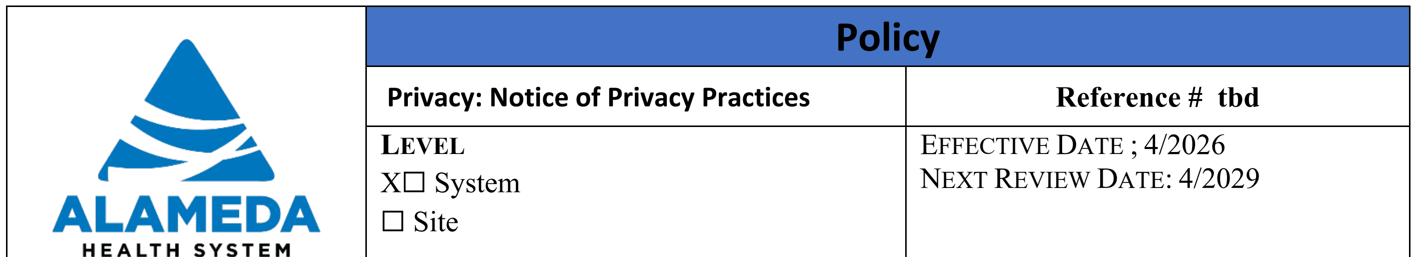

ALAMEDA HEALTH SYSTEM	Policy	
	Privacy: Notice of Privacy Practices	**Reference # tbd**
	LEVEL X☐ System ☐ Site	EFFECTIVE DATE ; 4/2026 NEXT REVIEW DATE: 4/2029

PURPOSE
The purpose of this policy is to ensure Alameda Health System (AHS) provides patients with adequate notice of how AHS may use and disclose Protected Health Information (PHI), the patient's rights regarding PHI, and AHS's legal duties under the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

SCOPE
This policy applies to all AHS workforce members—including employees, medical staff, contractors, volunteers, trainees, and any other person whose conduct is under the direct control of AHS—across all AHS facilities, clinics, programs, and service locations.

DEFINITIONS
Protected Health Information (PHI): Individually identifiable health information maintained or transmitted by AHS in any form or medium, as defined under 45 C.F.R. § 160.103.

Notice of Privacy Practices (NPP or "the Notice"): A document required by 45 C.F.R. § 164.520 that informs individuals about permissible uses and disclosures of PHI, individual rights, and AHS's legal duties.

Good Faith Effort: Reasonable attempt by AHS to obtain acknowledgment of receipt of the Notice from the patient.

RESPONSIBILITIES
All AHS workforce members must comply with this policy and ensure patients receive the NPP as required.

Registration is responsible for providing the Notice, requesting acknowledgment, and documenting receipt or inability to obtain acknowledgment.

POLICY
1. Content of the Notice
AHS provides each patient with a Notice of Privacy Practices written in plain language and containing all elements required under 45 C.F.R. § 164.520. The current version of the Notice is maintained at all AHS work sites and posted on the AHS Internet.

2. Acknowledgment of Receipt
AHS must make a good faith effort to obtain written acknowledgment from the patient that they received the Notice. If acknowledgment is obtained, AHS maintains documentation for the required retention period. If acknowledgment cannot be obtained, AHS documents the good faith efforts and reasons for inability to obtain acknowledgment.

3. Revisions to the Notice
AHS will promptly revise and distribute its Notice whenever there is a material change to uses or disclosures of PHI, individual rights, AHS's legal duties, or privacy practices described in the Notice.

4. Provision of Notice
a. AHS makes the Notice available to any person upon request.
b. AHS provides the Notice electronically or in person no later than the date of first service delivery after April 14, 2003, including for electronic services.
c. Paper copies of the Notice are available at AHS facilities upon request.
d. AHS posts the Notice in a clear and prominent location where it can be easily read by individuals seeking service.

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5. Electronic Notice

a. AHS prominently posts the Notice on its website.

b. AHS may provide the Notice by email if the patient agrees; confirmation of email transmission is retained. If email transmission fails, a paper copy is provided.

c. Patients receiving electronic notice may request a paper copy at any time.

6. Documentation and Retention

AHS retains copies of each version of the Notice for at least seven (7) years from the later of the date of creation or the date last in effect.

REFERENCES

45 C.F.R. § 164.520

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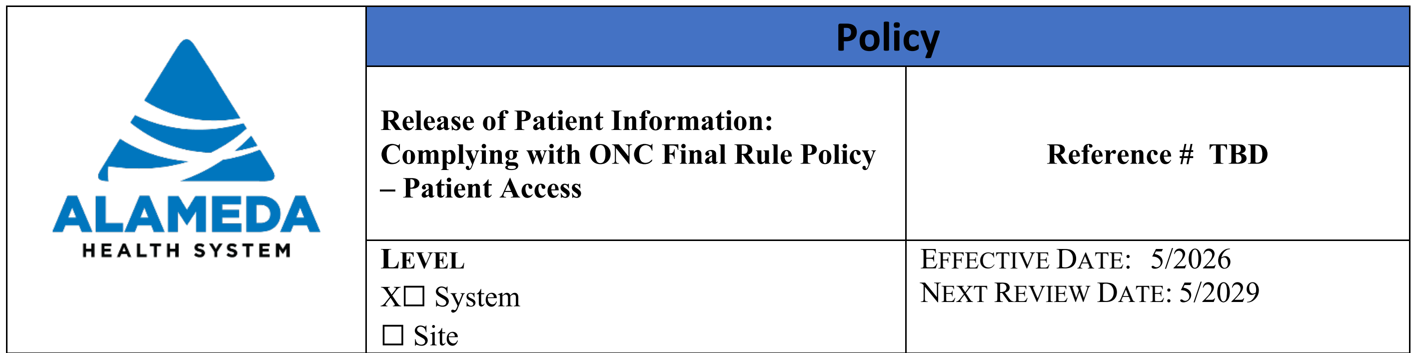

	Policy	
ALAMEDA HEALTH SYSTEM	**Release of Patient Information: Complying with ONC Final Rule Policy – Patient Access**	**Reference # TBD**
	LEVEL X☐ System ☐ Site	EFFECTIVE DATE: 5/2026 NEXT REVIEW DATE: 5/2029

PURPOSE

The purpose of the Release of Patient Information: Complying with Office of the National Coordinator for Health Information Technology (ONC) Final Rule Policy is to provide guidance to Alameda Health System (AHS) workforce members on how requests for patient medical information and test results will be released to patients. The "21st Century Cures Act: Interoperability, Information Blocking, and the ONC Health IT Certification Program Final Rule" (the "ONC Final Rule") prohibits health providers, technology vendors, health information exchanges and health information networks from practices that inhibit the exchange, use, or access of electronic health information (EHI) [1]. There is inherent tension between the promotion of electronic information sharing in the ONC Final Rule and the strict standards under HIPAA and related state laws to safeguard the privacy and security of protected health information (PHI). Prior to the ONC Final Rule, providers could err on the side of caution when disclosing PHI, but now, permitted disclosures of EHI/PHI are required unless an exception applies.

SCOPE

Patients have a broad right to access their own medical information and records under both federal and California laws, subject to narrow exceptions even when it comes to mental health and sensitive test results. AHS require that patients submit requests for medical records (including physician notes and clinical lab results) in writing if they want to receive the records in electronic form. However, the ONC Final Rule establishes eight categories of exceptions that are deemed to not constitute informational blocking. These eight "safe harbors" are available at: https://www.healthit.gov/sites/default/files/cures/2020 03/InformationBlockingExceptions.pdf. One of them is the "Privacy Exception," which includes the circumstances where "if an actor is permitted to provide access, exchange, or use of EHI under a privacy law, then the actor should provide that access, exchange, or use. However, an actor should not be required to use or disclose EHI in a way that is prohibited under state or federal privacy laws."

Both the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA) and California's Confidentiality of Medical Information Act (CMIA), which provides stronger privacy protections for medical information than HIPAA, recognize that a patient has the right to access his or her own medical information. This right of patient access extends to physician notes, HIV, STD, genetic screening and other sensitive test results, and applies regardless of whether a test is positive or negative. However, there are differences in the preconditions that a provider can impose before sharing medical records with a patient, especially when shared in electronic form, and processes that must be followed under California law when sharing certain sensitive test results.

For example, Health and Safety Code § 123148(d) specifically provides that "[t]he electronic disclosure of test results under this section shall be in accordance with any applicable federal law governing privacy and security of electronic personal health records. However, any state statute that governs privacy and security of electronic personal health records, shall apply to test results under this section and shall prevail over federal law if federal law permits." Because the ONC Final Rule allows state law to preempt it, § 123148 remains the governing provision at this time. As such, these additional requirements and preconditions per state statute must be met before certain sensitive lab results can be disclosed electronically.

DEFINITIONS

[1] Per 45 § 171.102, "Electronic health information (EHI) means electronic protected health information as defined in 45 CFR 160.103 to the extent that it would be included in a designated record set as defined in 45 CFR 164.501, regardless of whether the group of records are used or maintained by or for a covered entity as defined in 45 CFR 160.103, but EHI shall not include: (1) Psychotherapy notes as defined in 45 CFR 164.501; or (2) Information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding."

Electronic Health Information (EHI) means electronic protected health information to the extent that it would be included in a designated record set, regardless of whether the group of records are used or maintained by or for a covered entity. EHI shall not include: (1) Psychotherapy notes; or (2) Information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding.

Protected Health Information (PHI) includes but is not limited to any and all individually identifiable information about the physical or mental health condition or treatment of any individual, including but not limited to: any identifying information about a patient, such as a patient's name or a photo or video of the patient; any information about a patient's health condition or medication; and any information about payment for a patient's care and services.

Workforce members include employees, contracted staff, students, volunteers, medical staff and any other individual representing or working at AHS.

RESPONSIBILITIES

All AHS workforce members must comply with this policy when accessing, using, or disclosing PHI.

POLICY

The ONC Final Rule promotes secure and more immediate access to health information for patients and helps ensure that patients can also electronically access their electronic health information at no cost. Thus, AHS will provide patients the right to access their medical information subject to narrow exceptions defined in both federal and state regulations.

1. **Test Results:**
   a. **Health and Safety Code § 123148 and Disclosing Clinical Lab Test Results**: Health and Safety Code § 123148 requires that a health care professional disclose clinical lab test results to a patient who is the subject of the tests if requested by the patient in oral or written form. Disclosure to the patient must also be in oral or written form and cannot be electronic unless electronic disclosure is requested/consented by the patient unless deemed inappropriate by the health care professional who requested the test.
   b. AHS must obtain the consent of the patient in order to provide the patient's lab results through the internet or electronic means. The consent must meet the requirements of Civil Code § 56.10 or 56.11.
   c. The following sensitive test results cannot be disclosed to a patient electronically or via the internet unless (1) the patient requests the disclosure, (2) the health care professional deems this electronic disclosure as an appropriate means, and (3) a healthcare professional has first discussed in person, by telephone, or by any other means of oral communication, the test results with the patient:
      - A positive HIV test result, unless the test subject is anonymously tested and the internet posting follows other requirements that does not link to any patient-identifying information;

  - This does not prevent the disclosure of HIV test results, including viral load and CD4 count test results, to a patient living with HIV by secure internet posting if the patient has previously been informed about the results of a positive HIV test pursuant to the requirements of this section.
- Presence of antigens indicating a hepatitis infection;
- Abusing the use of drugs; and
- Test results related to routinely processed tissues and imaging scans that reveal a new or recurrent malignancy.

d. For HIV test results, California law imposes additional preconditions when disclosing the results to a patient. Per Health and Safety Code § 120990(h), after the HIV test result has been received by the provider, the medical care provider or the person who administers the test shall ensure that the patient receives timely information and counseling, as appropriate, to explain the results and the implications for the patient's health:

- If the patient tests positive for HIV infection, the medical provider or the person who administers the test shall inform the patient that there are numerous treatment options available and identify follow up testing and care that may be recommended, including contact information for medical and psychological services.
- If the patient tests negative for HIV infection and is determined to be at high risk for HIV infection by the medical provider or person administering the test, the medical provider or the person who administers the test shall advise the patient of the need for periodic retesting, explain the limitations of current testing technology and the current window period for verification of results, and provide information about methods that prevent or reduce the risk of contracting HIV, including, but not limited to, pre-exposure prophylaxis and post-exposure prophylaxis, consistent with guidance of the federal Centers for Disease Control and Prevention, and may offer prevention counseling or a referral to prevention counseling.

e. AHS has 2 categories when releasing test results electronically upon a patient's request and consent:

- All test results not restricted by the above guidelines are released.
- The above sensitive test results are restricted unless the requirements/preconditions of Health and Safety Code § 123148 have been met.

2. Patient Right of Access to Medical Information:

a. A patient's right to review, access and obtain copies of his or her medical information is reflected in the following provisions, among others:

45 CFR § 164.524

- (1) *Right of access.* Except as otherwise provided in paragraph (a)(2) or (a)(3) of this section, an individual has a right of access to inspect and obtain a copy of protected

health information about the individual in a designated record set[2], for as long as the protected health information is maintained in the designated record set, except for:

- (i) Psychotherapy notes[3]; and
- (ii) Information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding.

Health & Safety Code § 123100

- The Legislature finds and declares that every person having ultimate responsibility for decisions respecting his or her own health care also possesses a concomitant right of access to complete information respecting his or her condition and care provided. Similarly, persons having responsibility for decisions respecting the health care of others should, in general, have access to information on the patient's condition and care. It is, therefore, the intent of the Legislature in enacting this chapter to establish procedures for providing access to health care records[4] or summaries of those records by patients and by those persons having responsibility for decisions respecting the health care of others.

42 CFR § 2.23

- (a) Patient access not prohibited. These regulations do not prohibit a part 2 program (substance abuse program) from giving a patient access to their own records,

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[2]Per 45 CFR § 164.501, designated record set means:

(1) A group of records maintained by or for a covered entity that is:

(i) The medical records and billing records about individuals maintained by or for a covered health care provider;

(ii) The enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or

(iii) Used, in whole or in part, by or for the covered entity to make decisions about individuals.

(2) For purposes of this paragraph, the term record means any item, collection, or grouping of information that includes protected health information and is maintained, collected, used, or disseminated by or for a covered entity.

[3]Per 45 CFR § 164.501, Psychotherapy notes means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. Psychotherapy notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: Diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

[4]Per HSC § 123105(d), "Patient records" means records in any form or medium maintained by, or in the custody or control of, a health care provider relating to the health history, diagnosis, or condition of a patient, or relating to treatment provided or proposed to be provided to the patient. "Patient records" includes only records pertaining to the patient requesting the records or whose representative requests the records. "Patient records" does not include information given in confidence to a health care provider by a person other than another health care provider or the patient, and that material may be removed from any records prior to inspection or copying under Section 123110 or 123115. "Patient records" does not include information contained in aggregate form, such as indices, registers, or logs.

including the opportunity to inspect and copy any records that the part 2 program maintains about the patient. The part 2 program is not required to obtain a patient's written consent or other authorization under the regulations in this part in order to provide such access to the patient.

b. Under these federal and state regulations, a health care provider must disclose medical information to the patient if the patient requests it in accordance with the above regulations. This right of access is limited only in specific circumstances, such as for temporary research purposes, situations that would endanger the life of self/another[5] or if the PHI makes reference to another person's PHI[6].

3. **Exceptions to the Right of Access**
   a. Both HIPAA and California laws contain exceptions to an individual's right of access to his or her health information. However, the exceptions included in HIPAA are different from those included in California law.
   b. **California Law:** provides a patient greater access to his or her medical records than does HIPAA. Thus, California law prevails over HIPAA's right to access provisions. California law states that a patient has the right to inspect and obtain a copy of all of his or her medical records with only two exceptions:
      i. Mental health records under specified circumstances (i.e. when a license health professional has determined, in the exercise of professional judgement, that the access requested is reasonably likely to endanger the life or physical safety of the patient).
      ii. Copies of X-rays or tracings derived from electrocardiography, electroencephalography, or electromyography need not be provided to the patient or

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[5]Per HSC § 123115(b), When a health care provider determines there is a substantial risk of significant adverse or detrimental consequences to a patient in seeing or receiving a copy of mental health records requested by the patient, the provider may decline to permit inspection or provide copies of the records to the patient, subject to the following conditions:

(1) The health care provider shall make a written record, to be included with the mental health records requested, noting the date of the request and explaining the health care provider's reason for refusing to permit inspection or provide copies of the records, including a description of the specific adverse or detrimental consequences to the patient that the provider anticipates would occur if inspection or copying were permitted.

(2) (A) The health care provider shall permit inspection by, or provide copies of the mental health records to, a licensed physician and surgeon, licensed psychologist, licensed marriage and family therapist, licensed clinical social worker, or licensed professional clinical counselor, designated by request of the patient.

[6]HIPAA permits a denial of access to that portion of any PHI that makes reference to another person (other than the provider) if a licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to cause substantial harm to such person.

patient's representative (although they must be permitted to review them), if the original X-rays or tracings are transmitted to another health care provider upon written request of the patient or patient's representative and within 15 days after receipt of the request.

iii. California law does not permit the withholding of any other medical records from the patient.

c. **HIPAA Exceptions**

i. **Psychotherapy Notes:** HIPAA distinguishes between psychotherapy notes (which must be kept separate from the rest of the medical record) and other mental health records. California law does not treat psychotherapy notes differently from other mental health records.

ii. HIPAA permits the outright denial of access to a patient's separately maintained psychotherapy notes, even if there is no potential harm to the patient from seeing the notes. However, under state law, a health care provider may decline to permit inspection or provide copies of such records only if the provider determines there is a substantial risk of significant adverse or detrimental consequences to a patient in seeing or receiving a copy of mental health records.
   - Lanterman-Petris-Short (LPS) Act [Welfare and Institutions Code § 5328-5328.9] follows HIPAA standards as it relates to disclosure of mental health information to a patient that requests access to his or her information.

iii. Based on federal and state law differences, the **state standard is the one that must be used for denying access by a patient to his or her separately maintained psychotherapy notes.** If a provider refuses to permit inspection by, or to provide copies of the separately-maintained psychotherapy notes to, the patient, this state standard of harm must be met along with the requirements for denying access.

iv. A healthcare provider is not liable to the patient or any other person for any consequences that result from disclosure of patient records to the patient as required by California law (*see HSC § 123110(h)).*

4. **Denial of Right to Access**

a. Federal and state regulations allow providers to deny a patient's request to access his or her information in specified circumstances as indicated above. Since denials are to be narrowly construed, the rule requires that providers give the patient access to any other PHI requested, after excluding PHI to which the provider has *lawful reason to deny access*.

b. When a provider denies a patient access to Mental Health records the patient must be advised of their right to authorize release of those records to a third party (e.g., attorney, another provider).

5. **Process for Requesting Medical Records in General:** Under both HIPAA and California law, a health care provider can require that individuals make requests for access to medical records in writing, provided that the provider informs individuals of such a requirement. California law, which

is stricter than HIPAA[7], requires that the provider allow the patient to inspect his/her medical record within 5 business days of making a written request. If the patient asks for copies of the records, the copies must be provided within 15 business days.

a. **Disclosure of AHS Patient Medical Record:** AHS has a process to intake and respond to patient record requests in accordance with HIPAA, CMIA and related laws.
b. Disclosure of AHS patient medical record, whether paper or electronic, may be given to the patient following the patient's written request and the above guidelines.

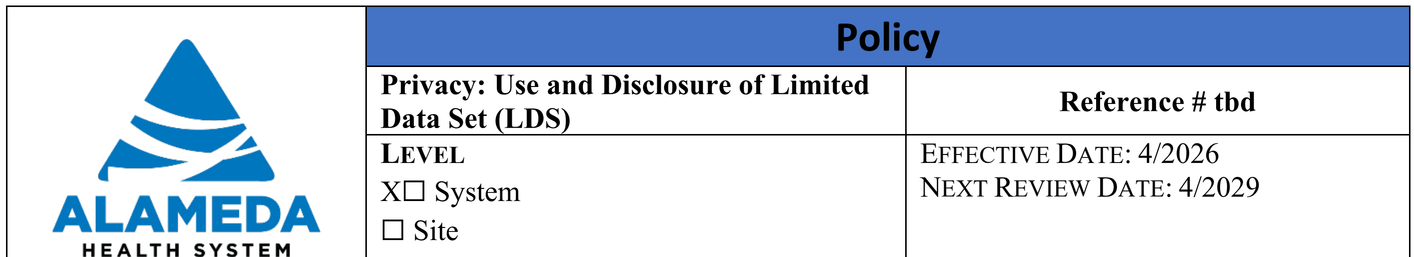
6. **Minor's Medical Information:** A minor[8] patient or their legal representative can access or request copies of their records. Limited exceptions to this right exist. In general, whether the minor or the parent (or other legal representative) has the ability to access the medical record depends on who may legally consent to the treatment that the records relate to.
    a. If the minor has the authority to consent to medical treatment under state law, then the minor is generally the person authorized to have access to the records regarding the treatment, and to decide whether the records may be released to others (including the parent or other legal representative).
    b. Where a parent or other legal representative has the authority to consent to medical treatment for the minor, then the parent or other legal representative is generally the person authorized to have access to the minor's records regarding the treatment, and to decide whether the records may be released to others. However, a provider may deny a parent or other legal representative access to the minor's records, even though the parent or other legal representative had the authority to consent to the treatment, if the provider determines that access to the records would have a detrimental effect on the provider's professional relationship with the minor patient, or the minor's physical safety or psychological well-being.
        i. NOTE: There are several situations in which the minor has the legal authority to consent to medical treatment, but the provider is authorized, or required, to provide specified information to the parents. These situations involve self-sufficient minors, minor victims of sexual assault, minors receiving outpatient mental health treatment or residential shelter services, and minors receiving substance use disorder treatment where the care is *not* provided in a federally-assisted substance abuse program.
            1. However, HIPAA allows a provider to refuse access to a parent or legal representative if the provider makes a good faith determination that the minor's physical safety or psychological well-being would be harmed as a result, the parent(s) or guardian committed the sexual assault on the minor, or the disclosure would be inappropriate.

[7]Under HIPAA, once the covered entity receives the request for access, it must act on it (grant in whole or in part, deny, etc.) no later than 30 days after receipt, subject to one 30-day extension. But California law governs here because it is more stringent in favor of the patient.
[8] Emancipated minor may review his/her own chart and may restrict access to his/her own record by parent or guardian. Sensitive services to a minor allow a minor to restrict access to his/her record by parent or guardian.

c. "Mixed" Medical Record: A minor's medical record may contain information regarding treatment that the minor may consent to, and information regarding treatment that the parent or other legal representative must consent to. In such cases, the health care provider should take extra care to ensure that records are released appropriately.

REFERENCES

42 CFR § 2.23
45 CFR § 164.524
Civil Code § 56.10 and 56.11
Health and Safety Code § 120990(h)
Health & Safety Code § 123100
Health & Safety Code § 123115(b)
Health and Safety Code § 123148(d)
Welfare and Institutions Code § 5328-5328.9



Policy	
Privacy: Use and Disclosure of Limited Data Set (LDS)	**Reference # tbd**
LEVEL X☐ System ☐ Site	EFFECTIVE DATE: 4/2026 NEXT REVIEW DATE: 4/2029

PURPOSE
The purpose of this policy is to ensure Alameda Health System (AHS) accesses, uses, and discloses Protected Health Information (PHI) in the form of a Limited Data Set (LDS) in compliance with the HIPAA Privacy Rule. This policy establishes the requirements for the creation, use, disclosure, and safeguarding of LDS information and outlines when a Data Use Agreement (DUA) is required.

SCOPE
This policy applies to all AHS workforce members including employees, medical staff, contractors, volunteers, trainees, and any other person whose conduct is under the direct control of AHS.

DEFINITIONS
Protected Health Information (PHI): Individually identifiable health information maintained or transmitted by AHS in any form or medium, as defined under 45 C.F.R. § 160.103.

Limited Data Set (LDS): PHI that excludes specific direct identifiers as permitted under 45 C.F.R. § 164.514(e)(2).

Data Use Agreement (DUA): A legally binding agreement between AHS and the Data User that permits the use or disclosure of a Limited Data Set for research, public health, or Health Care Operations.

Data User: The external party or internal individual receiving the Limited Data Set under a DUA.

RESPONSIBILITIES
AHS workforce members must ensure compliance with this policy when creating, accessing, using, or disclosing LDS information.

IRB Program Manager ensures LDS use in research complies with HIPAA and institutional requirements.

POLICY
AHS will access, use, or disclose PHI in the form of a Limited Data Set (LDS) only for research, public health, or Health Care Operations, unless an individual authorization or waiver has been obtained. AHS will only disclose a Limited Data Set pursuant to a valid Data Use Agreement (DUA).

1. Requirements for Use and Disclosure of an LDS
    a. Valid Purpose: The purpose must be research, public health, or Health Care Operations.
    b. Valid Data Use Agreement: A fully executed DUA must be in place before any LDS disclosure.
    c. Minimum Necessary Rule: LDS disclosures must be limited to the minimum necessary to accomplish the permitted purpose.

2. Prohibited Activities
    • The Data User may not attempt to identify or contact individuals.
    • The Data User may not re-identify the LDS or combine it with other datasets for re-identification.

REFERENCES
45 C.F.R. § 164.514(e)

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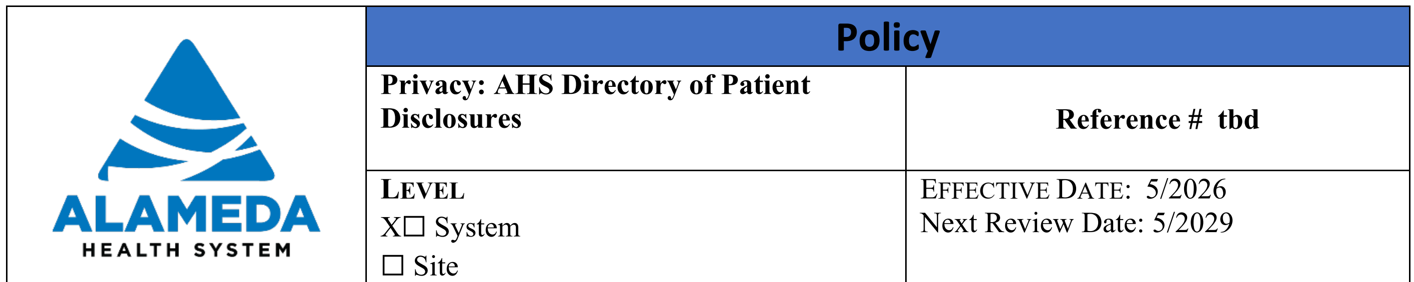


	Policy	
ALAMEDA HEALTH SYSTEM	**Privacy: AHS Directory of Patient Disclosures**	**Reference # tbd**
	LEVEL X☐ System ☐ Site	EFFECTIVE DATE: 5/2026 Next Review Date: 5/2029

PURPOSE
The purpose of this policy is to establish standards and procedures for maintaining a patient registry (facility directory) at Alameda Health System (AHS) in accordance with the HIPAA Privacy Rule. This policy ensures that AHS uses and discloses only limited Protected Health Information (PHI) for directory purposes and provides each patient (or the patient's Personal Representative) with the opportunity to restrict or prohibit such uses and disclosures.

SCOPE
This policy applies to all AHS workforce members, including employees, medical staff, trainees, volunteers, students, contractors, and any other individuals who create, access, or disclose PHI for directory purposes within AHS facilities.

DEFINITIONS
Protected Health Information (PHI): Individually identifiable health information maintained or transmitted by AHS in any form, as defined by HIPAA.

Patient Registry / Directory: A listing of limited patient information maintained for the purpose of allowing AHS staff, visitors, and clergy to obtain basic information about a patient's presence and general condition.

Personal Representative: An individual authorized under applicable law to act on behalf of the patient in making decisions regarding the patient's health information.

Incapacity/Emergency Circumstances: Situations in which a patient is unable to meaningfully express preferences due to medical or mental status, or urgent conditions requiring immediate action.

RESPONSIBILITIES
All AHS workforce members must follow all requirements for obtaining patient notification and preference regarding the patient registry, and to only maintain and disclose directory information permitted under this policy.

POLICY

1. Information to Be Maintained. AHS may only maintain the following pieces of PHI in a patient registry in accordance with this Policy:
   - A. Name;
   - B. Location in the facility (e.g., patient's room number), but may not release information that indicates a patient is being treated in an area of the hospital that is limited to treatment of certain diseases or conditions, such as alcohol or drug rehabilitation, detoxification, psychiatric treatment, or communicable disease treatment;
   - C. General description of the condition of the patient (such as stable, fair, serious), which does not communicate specific medical information about the patient; and
   - D. Religious affiliation (may be disclosed to members of the clergy only).

2. Patient Notification Requirements. AHS may maintain PHI identified above for the purpose of maintaining a patient registry only if it satisfies all of the following conditions:
   - A. The patient is informed of the PHI that may be maintained in the patient registry.
   - B. The patient is informed of the persons to whom AHS may disclose PHI to (including disclosures to clergy of information regarding religious affiliation).
   - C. The patient is provided an opportunity to restrict or prohibit some or all of the uses and disclosures related to the registry, including the right to:

i. refuse to be listed in it;
ii. object to having certain information disclosed; and
iii. object to disclosure of information to certain individuals. A patient who does not object initially can request to have information removed from the registry at any time.

3. Procedures in Case of Incapacity or Emergency

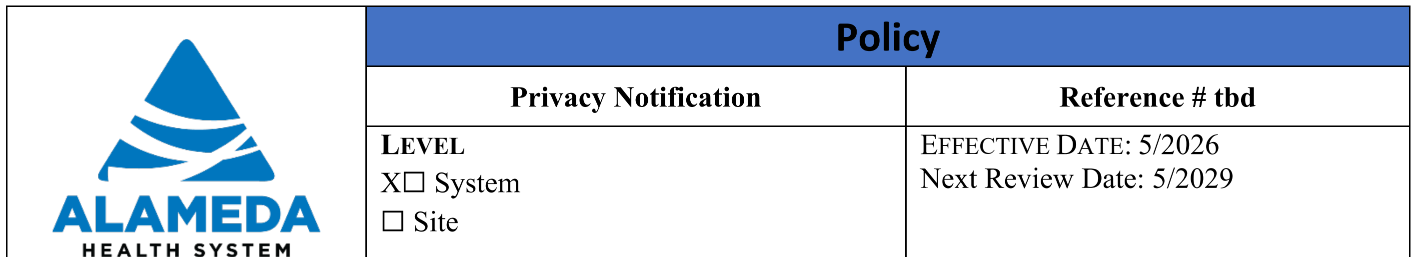
A. When Opportunity to Object Can Be Delayed. In the case of patient's incapacity or an emergency where a patient (or patient's Personal Representative) cannot feasibly be provided an opportunity to restrict or prohibit some or all of the uses and disclosures related to the registry, AHS may make the uses and disclosures that are consistent with the prior expressed preference of the patient that is known by AHS and are in the best interests of the patient as determined by AHS staff in the exercise of professional judgment.
B. Documentation. Where a patient's PHI is used or disclosed for directory purposes pursuant to this Section, staff shall document the basis (i.e., emergency or incapacity) for making the disclosure.
C. Opportunity Given Later. Where PHI is used or disclosed pursuant to this Section, AHS staff shall inform the patient of such use or disclosure and provide the patient with an opportunity to object to such uses and disclosures for directory purposes as soon as practical.

4. Access to Information in the Registry

If the patient has not opted out, AHS may disclose directory information to individuals who ask for the patient by name. Religious affiliation may be disclosed only to clergy.

REFERENCES

45 C.F.R. § 164.510(a)



Policy	
Privacy Notification	**Reference # tbd**
LEVEL X☐ System ☐ Site	EFFECTIVE DATE: 5/2026 Next Review Date: 5/2029

PURPOSE

To establish guidelines for when Alameda Health System (AHS) workforce members may use or disclose a patient's Protected Health Information (PHI) to persons involved in the patient's care or for purposes of notification, and to ensure such disclosures comply with the HIPAA Privacy Rule.

SCOPE

This policy applies to all AHS workforce members—including employees, medical staff, contractors, volunteers, students, residents, and trainees—who access, use, or disclose PHI in the course of performing their duties.

DEFINITIONS

Protected Health Information (PHI): Individually identifiable health information maintained or transmitted by AHS in any form or medium, as defined under 45 C.F.R. § 160.103.

Personal Representative: An individual legally authorized to act on behalf of a patient in making health care decisions, as defined under HIPAA and applicable California law.

Notification: Informing others of the patient's location, general condition, or death.

RESPONSIBILITIES

All AHS workforce members must comply with this policy when accessing, using, or disclosing PHI.

POLICY

AHS may disclose certain portions of a patient's Protected Health Information (PHI) to persons involved in the patient's care, and/or use or disclose the patient's PHI in order to notify (or assist in notifying) such persons of the patient's location, general condition or death. Prior to using or disclosing such PHI except in limited circumstances described below, AHS must provide the patient an opportunity to object or agree to the use or disclosure.

1. General Rule. Absent an objection by the patient (and without having to obtain the patient's Authorization), AHS staff may:

   a. Disclose to a family member, other relative, or close personal friend of the patient, or any other person designated by the patient, PHI which is directly relevant to such person's involvement with the patient's care or payment related to the patient's health care; or

   b. Use or disclose the patient's PHI to notify (or assist in the notification of the patient's family member or Personal Representative or other person responsible for the patient's care) of the patient's location, general condition or death. In connection with this purpose, AHS may disclose the patient's PHI to public or private entities authorized by law or its charter to assist in disaster relief efforts in order to coordinate the notification efforts described in this Section.

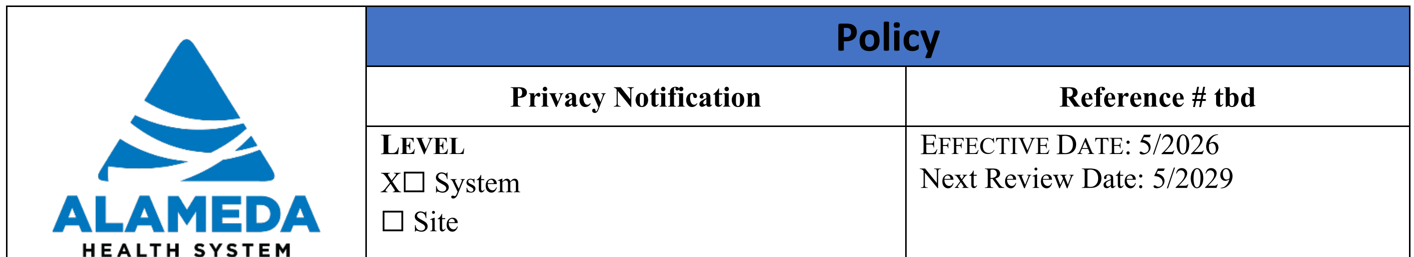
2. Limitations on the PHI Used or Disclosed

   a. AHS staff may not disclose any portion of the PHI that is not relevant to the patient's current condition and that could prove embarrassing to the patient.

   b. AHS staff shall not assume that a patient's agreement or lack of objection pursuant to Section d. below implies agreement to disclose PHI indefinitely in the future.

   c. Disclosure Permitted Where Patient Agrees to Disclosure. Where a patient is present for, or otherwise available prior to a disclosure made pursuant to Section 1. above, and is capable of agreeing to the disclosure, AHS staff may only disclose the patient's PHI (subject to the limitations described above), in any of the following situations:

      i. **Agreement**: The patient agrees to the disclosure; or



Policy	
Privacy Notification	**Reference # tbd**
LEVEL X☐ System ☐ Site	EFFECTIVE DATE: 5/2026 Next Review Date: 5/2029

ii. **No Objection**: The patient does not express an objection to the disclosure when given the opportunity to do so; or

iii. **Reasonable Inference**: Staff reasonably infers from the circumstances, based on the exercise of professional judgment that the patient does not object to the disclosure.

- When possible, staff should formally ask the patient (outside the presence of the family member, close personal friend, etc.) whether the patient objects to such person's presence during a procedure or discussion.
- Reliance on inferences should be as infrequent as practicable.
- Example of reasonable inference: if a patient's family member is in the same room as patient during a procedure, staff can infer that disclosures to the family member are appropriate.

d. **Disclosure Permitted When Patient Is Unable To Agree, But Disclosure is in Patient's Best Interest**. Where a patient is not available or cannot agree or object to a use or disclosure to be made as set forth above because of incapacity or emergency, staff may disclose PHI (subject to the limitations described above) as follows:

i. Staff determines, in the exercise of professional judgment, that the disclosure is in the best interest of the patient. (For example, pharmacy staff may infer that it is in the best interest of the patient to allow another person to pick up a prescription on behalf of the patient.)

ii. The disclosure is limited only to PHI directly relevant to the person's involvement in the patient's health care.

e. Disclosures over the telephone. In general, staff should not give patient status information to a person over the telephone. Staff may release PHI over the telephone only in very limited circumstances.

i. When the staff member recognizes the voice of a person who had previously been identified by a patient.

ii. In order to facilitate immediate treatment or to interpret the health care practitioner's instructions to a person who is assisting the patient, only after the health care practitioner has determined that the patient is unavailable (and therefore cannot give consent) and has determined that it is in the best interest of the patient to disclose the PHI.

The PHI disclosed over the telephone should be limited to information directly relevant to the person's involvement in the patient's care. If more detailed information is requested, the health care practitioner should make an appointment with the patient and the person requesting the information.

f. Verification of Identity. AHS is not required to verify formally the identity of the family members or other individuals involved in the patient's care. The patient's actions involving a person in his or her care serves to verify that person's identity for purposes of this policy.

3. Documentation

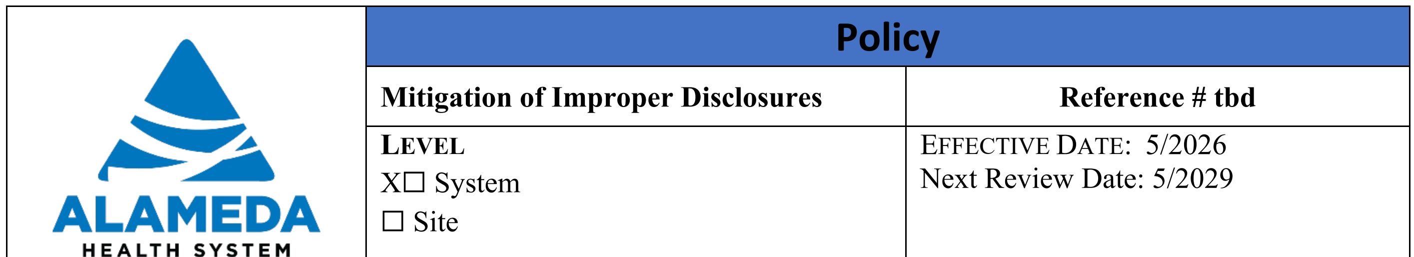
a. To the extent practical, staff should document in the patient's medical record all disclosures made pursuant to this policy.

b. **Accounting**: Disclosures made by AHS in accordance with this policy are not required to be part of an accounting.

c. **Questions About Interpretation**: If any member of AHS staff is concerned about the immediate interpretation of this policy, that staff member is directed to not release information upon an inquiry from a patient's family or friends, and to refer the issue to the Compliance Department for resolution.

REFERENCES

The Joint Commission's Comprehensive Accreditation Manual for Hospitals – IM.02.01.01



ALAMEDA HEALTH SYSTEM	Policy	
	Mitigation of Improper Disclosures	**Reference # tbd**
	LEVEL X☐ System ☐ Site	EFFECTIVE DATE: 5/2026 Next Review Date: 5/2029

PURPOSE
Alameda Health System (AHS) mitigates, to the extent possible, any harmful effect that is known to have occurred as a result of any inappropriate use, access, or disclosure of Protected Health Information (PHI) by AHS workforce members or its Business Associates.

SCOPE
This policy applies to all AHS workforce members, including employees, medical staff, volunteers, trainees, temporary staff, contracted personnel, and all Business Associates that create, receive, maintain, or transmit PHI on behalf of AHS.

DEFINITIONS
Protected Health Information (PHI): Individually identifiable health information maintained or transmitted by AHS in any form or medium, as defined under 45 C.F.R. § 160.103.

Unauthorized Use, Access, or Disclosure: Any use, viewing, acquisition, or transmission of PHI that is not permitted under HIPAA, CMIA, or AHS policies.

Business Associate: An individual or entity performing functions on behalf of AHS involving PHI and not part of the workforce.

Mitigation Plan: A response plan to reduce or eliminate harmful effects of unauthorized PHI disclosures.

RESPONSIBILITIES
All workforce members and business associates must promptly report and mitigate any known or suspected unauthorized use, access, or disclosure of PHI.

POLICY
1. Reporting to Compliance Department. Any AHS workforce member or Business Associate who becomes aware of an unauthorized use, access, or disclosure of PHI must promptly report the incident.

2. Mitigation Plan. The Compliance Department, in response to any report of or information about any unauthorized use, access or disclosure by AHS workforce members or any of its Business Associates, including self-disclosures made by Business Associates pursuant to the terms of each Business Associate's contract or other agreement with AHS, shall develop and implement a plan as soon as possible to mitigate any known or reasonably anticipated harmful effects from such disclosure (the "Mitigation Plan"). The Mitigation Plan shall be tailored to the circumstances of each case, but may include as appropriate, the following elements:

   a) Identifying the source(s) of the unauthorized disclosure and taking appropriate corrective action.
   b) Contacting the recipient to request destruction or return of PHI.
   c) Instructing the recipient to refrain from further disclosures.
   d) Notifying the patient whose PHI was the subject of the unauthorized use, access or disclosure.

e) Reporting applicable events to appropriate regulatory entities (i.e. California Department of Public Health (CDPH), Office of Civil Rights (OCR), etc.)

f) Notifying Human Resources / Labor Relations.

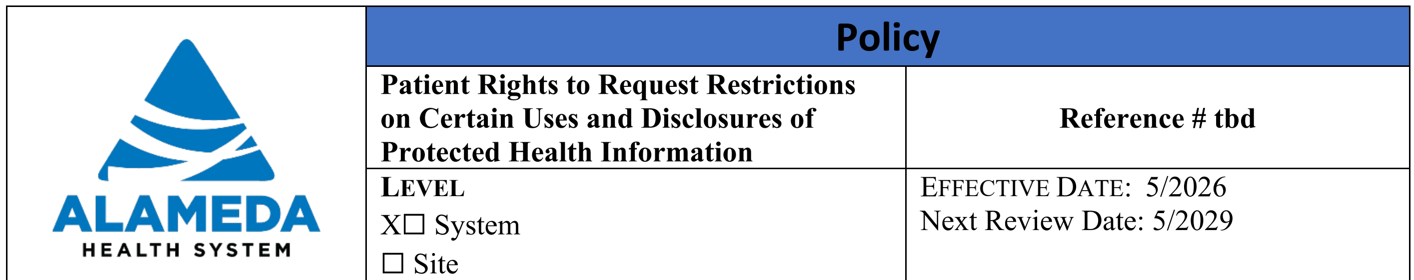
g) Reviewing, and updating where appropriate, contributing policies or procedures.

h) Instruct affected department leaders to provide HIPAA Privacy re-training to department staff and submit sign-in sheets to Compliance Department.

i) In the event the unauthorized use, access or disclosure was made by a Business Associate, review whether such actions warrant possible contract termination.

REFERENCES

45 C.F.R. § 164.530(f)



	Policy	
ALAMEDA HEALTH SYSTEM	**Patient Rights to Request Restrictions on Certain Uses and Disclosures of Protected Health Information**	**Reference # tbd**
	LEVEL X☐ System ☐ Site	EFFECTIVE DATE: 5/2026 Next Review Date: 5/2029

PURPOSE

To establish a standardized process for evaluating and responding to patient requests to restrict the access, use, or disclosure of their Protected Health Information (PHI) in accordance with the HIPAA Privacy Rule (45 C.F.R. § 164.522(a)).

SCOPE

This policy applies to all Alameda Health System (AHS) workforce members, including employees, medical staff, volunteers, trainees, and contractors who create, access, use, or disclose PHI on behalf of AHS.

DEFINITIONS

Protected Health Information (PHI): Individually identifiable health information maintained or transmitted by AHS in any form or medium, as defined under 45 C.F.R. § 160.103.

Personal Representative: An individual legally authorized to act on behalf of a patient in making health care decisions, as defined under HIPAA and applicable California law.

Restriction: A limitation requested by a patient that prevents or limits AHS's access, use, or disclosure of PHI for treatment, payment, or healthcare operations or certain notifications.

RESPONSIBILITIES

All AHS workforce members must comply with any restriction approved and documented in the patient's medical record.

POLICY

AHS recognizes a patient's right under 45 C.F.R. § 164.522(a) to request restrictions on certain uses and disclosures of their Protected Health Information (PHI). Except where HIPAA requires acceptance of a restriction, AHS is not obligated to agree to a patient's request. All requests will be evaluated based on clinical, operational, and safety considerations.

1. **Patient Right to Request Restrictions (45 C.F.R. § 164.522(a)(1))**
Patients may request that AHS restrict:
- Uses or disclosures for treatment, payment, or healthcare operations; and/or
- Disclosures to persons involved in the patient's care or payment, including family members, friends, or other identified individuals, and disclosures for notification purposes.

AHS may, but is not required to, agree to these requested restrictions.

2. **Required Acceptance of Self-Pay Restrictions (45 C.F.R. § 164.522(a)(1)(vi))**
AHS must accept a restriction if the following conditions are met:
- The patient requests that AHS not disclose PHI to a health plan,
- The disclosure would otherwise be made for payment or healthcare operations, and
- The PHI pertains solely to an item or service paid for in full out-of-pocket.

AHS must ensure such PHI is segregated or flagged so it is not disclosed to a health plan.

3. **AHS Review and Discretionary Approval of Other Restrictions**
For all other requested restrictions, AHS will evaluate the request case-by-case. Approval requires:
- Consultation with the attending physician,
- Consultation with the floor nurse supervisor,
- Assessment of patient safety, operational feasibility, and legal obligations.

AHS may decline a request if acceptance would impede treatment, compromise safety, or conflict with law.

4. **Emergency Exception (45 C.F.R. § 164.522(a)(1)(iii))**
If AHS has agreed to a restriction, AHS may use or disclose restricted PHI when the patient requires emergency treatment and the restricted PHI is necessary. AHS must request that the provider receiving the information not further use or disclose it except as permitted by law.

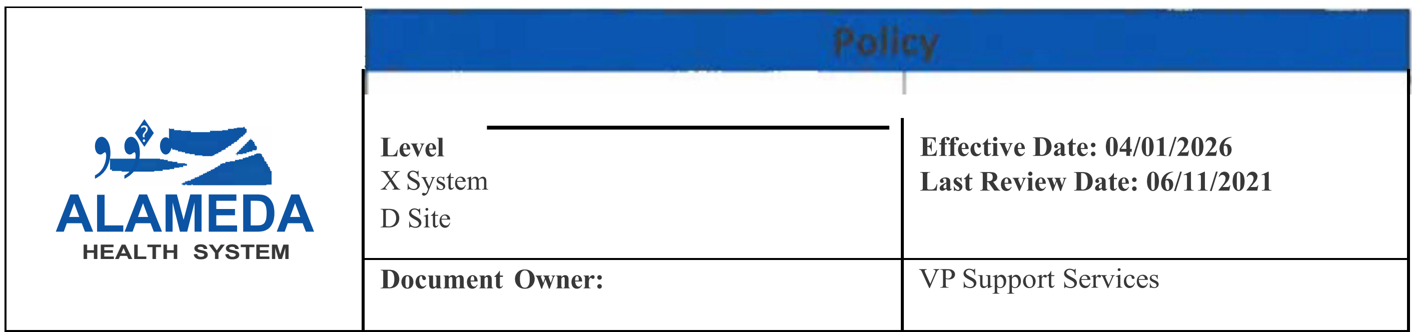
5. **Termination of a Restriction (45 C.F.R. § 164.522(a)(2))**
AHS may terminate a restriction if:
- The patient agrees or requests termination in writing;
- The patient orally agrees to the termination and AHS documents the oral agreement;
- AHS informs the patient of termination, which applies only to PHI created or received after notification.

AHS may not retroactively revoke restrictions.

6. **Documentation Requirements (45 C.F.R. § 164.522(a)(3))**
AHS must document all approved restrictions and flag the patient's record. AHS must maintain records of any modification or termination.

REFERENCES

45 C.F.R. § 164.522(a)



Level X System D Site	Effective Date: 04/01/2026 Last Review Date: 06/11/2021
Document Owner:	VP Support Services

POLICY STATEMENT:
The parking of any motor vehicle at Alameda Health System (AHS) premises is a privilege granted by AHS, not a right. Vehicle owners and operators must be familiar with and adhere to all AHS parking regulations to maintain a safe and clear means for vehicle movement and parking. AHS and the Parking Vendor are not responsible for damage to vehicles that may occur in the parking lots. Violations of this policy may result in citations, revocation of parking privileges, and/or disciplinary action up to and including termination.

PURPOSE:
The purpose of the Alameda Health System (AHS) Parking Policy is to outline the rules and regulations for the utilization of AHS parking lots, obtaining parking privileges, allocation of parking spaces, and the regulations for parking at AHS premises for employees and visitors.

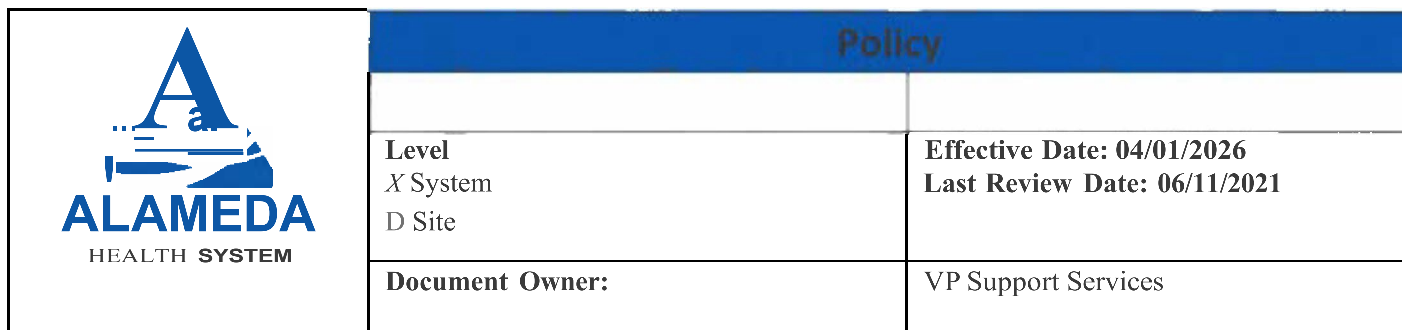
SCOPE:
This policy applies to all Alameda Health System (AHS) campuses and facilities, including all AHS and General Services Agency (GSA) owned or managed parking lots, paths, driveways, and grounds.
It governs the use of parking facilities and the regulations for all individuals operating a motor vehicle on AHS premises, including, but not limited to: permanent, temporary, and contract employees; interns; volunteers; physicians; patients; visitors; vendors; and contractors

DEFINITIONS
AHS Premises - All land, buildings, parking lots, paths, driveways, and grounds owned, leased, or managed by Alameda Health System (AHS) or the General Services Agency (GSA) on AHS's behalf.

RESPONSIBILITIES
AHS Security Team, Alameda County Sheriffs Office, GSA, and Local Law Enforcement: Authorized to enforce all parking regulations and issue citations.
Vehicle Owner/Operator (All Users): Responsible for being familiar with and complying with all AHS parking regulations.

POLICY:

The parking of any motor vehicle at AHS premises is a privilege granted by AHS. To maintain a safe and clear means for the movement and parking of vehicles, AHS has adopted and enforced regulations contained herein. AHS will perform due diligence to provide suitable parking opportunities at all AHS campuses in a manner that recognizes the balance of needs between employees and customers (patients and visitors). Each vehicle owner/operator is responsible for



being familiar with these regulations and will be held responsible for violations thereof. The regulations contained herein are subject to revision, addition, and/or amendment. AHS and the Parking Vendor are not responsible for damage to vehicles which may occur in the parking lots. Further, any individual or entity operating a vehicle on AHS premises is responsible for any damage caused to hospital property, including but not limited to buildings, equipment, landscaping, or other infrastructure. The party responsible will be liable for the full cost of repairs or replacement, as determined by the hospital administration.

PARKING LOT UTILIZATION

This section provides general information and outlines the policy and procedures for parking at Alameda Health System campuses:

Parking Locations - Each AHS campus has designated areas for parking:

1. To fulfill AHS Mission, the AHS Parking Department assesses and assigns parking based on availability, parking type, and operational need based on services provided at the respective campus.
2. Employees may only park in designated employee parking areas as identified by the Parking Department.
3. For campuses with daily/hourly parking provided by AHS, currently only at the KO floor of the K-Garage at the Wilma Chan Highland Hospital Campus (WCHHC), employees will be charged the applicable rates attributed to the entry ticket. This also includes adhering to any maximum time limit for postings.
4. At the Fairmont (FMT) and John George Psychiatric Hospital (JGPH) campus, metered daily/hourly parking stalls are available to all visitors; however, the rules for parking in these stalls and enforcement of parking in these stalls are under the purview of Alameda County General Services Agency (GSA). At the request of Administration and GSA, AHS Security will support GSA parking enforcement on an operationally needed basis.

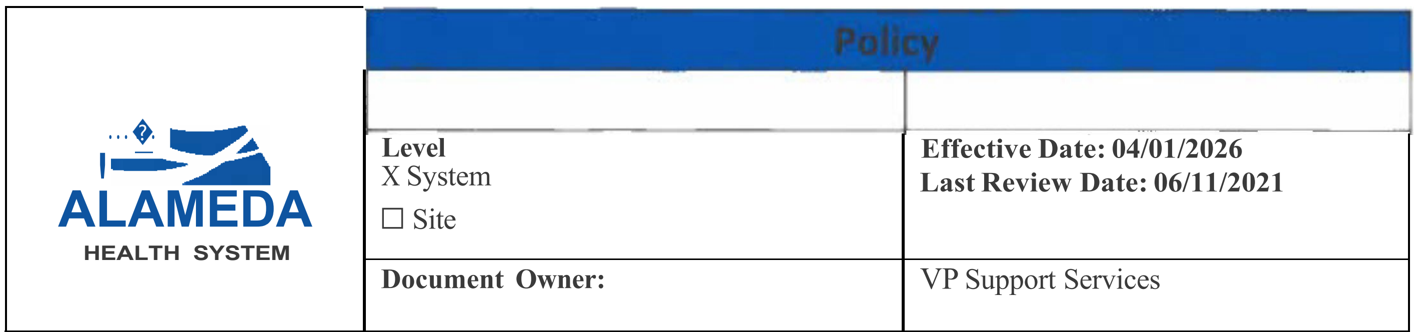
Patient & Visitor Parking

I. All patients and visitors must park in the appropriate AHS patient/visitor parking locations and within appropriate parking stalls, or they will be subject to parking violation citations.

2. Where applicable, Individuals parking in visitor parking lots requiring payment shall be issued a time and date-stamped entry ticket upon entry to the paid parking garage.
    1. All individuals must provide their entry ticket when exiting the lot and pay the hourly visitor rate, if applicable, or the maximum rate for any 24-hour period or lost entry tickets.

2. <u>Parking Validations (Wilma Chan Highland Hospital Campus)</u> In alignment with AHS' mission, vision, and values, patients/visitors with an inability to pay for parking may receive a parking validation from their host department or the Parking Department.
    1. Validations may also be issued for customer service recovery, regulators and inspectors, and VIP guests invited by AHS.
    2. Future considerations may require validation of expense allocations to the host department's cost center.

3. <u>Parking Time-limit Restrictions</u> - AHS parking lots are not approved for vehicular storage or long-term parking.
    1. Parking on AHS grounds is for daily parking for a timeframe of 8 to 16 hours. These hours are determined by the staff members' work schedule and any overtime tasked by the department. Employees working shifts for longer than 16 hours must notify their manager and the [Parking Department] of how long their shift is, the license plate number, and the make and model of the vehicle.
    2. Vehicles left in the parking lot for an extended period - which is determined as 24 or more consecutive hours - may be towed. Should any damage occur as a result of the vehicle being towed, AHS and AHS Parking Vendor are not responsible for said damage. Employees who work 16 hours but fail to notify their manager and the Parking Department may be towed under this section.



3. Under no circumstances are vehicles allowed to be stored at any AHS facility, including FMT and JGPH.
4. Any special accommodations or requests must be made in writing to the Vice President of Support Services or designee.

4. Americans with Disabilities Act (ADA) Parking Employees, patients, or visitors who have a California Department of Motor Vehicles, or another state's Department of Motor Vehicles, issued ADA parking placard or ADA designated license plates issued for ADA parking, may park in ADA approved parking stalls on a first come first serve basis.
   1. Employees who request ADA parking priority access must provide documentation documenting the ADA designation assigned to said employee. This means the documentation identifying the employee is assigned to the ADA placard/license plate.

5. Reserved Parking - AHS reserves the right to designate any portion of any AHS/GSA parking lot as a designated reserved parking area based on operational needs.
   1. WCHHC-
      1. Currently, but subject to change based on operational need, reserved parking spaces are only available for on-call staff whose duties require them to respond to campus on short notice. The reserved spaces are intended for staff who do not have access to on-campus parking. The reserved parking spaces are located on KO of the K-Garage, where employee daily/hourly parking is permitted. Staff authorized to park in the reserved parking spaces are on-call staff with a valid "Reserved" parking placard. The reserved parking stalls are restricted and only useable by on-call employees.
      2. There is a reserved parking space for on-call trauma surgeons located at WCHHC's horseshoe main entrance.
   2. Alameda Hospital and San Leandro Hospital

1. There are reserved and restricted parking areas exclusively for Physician parking.

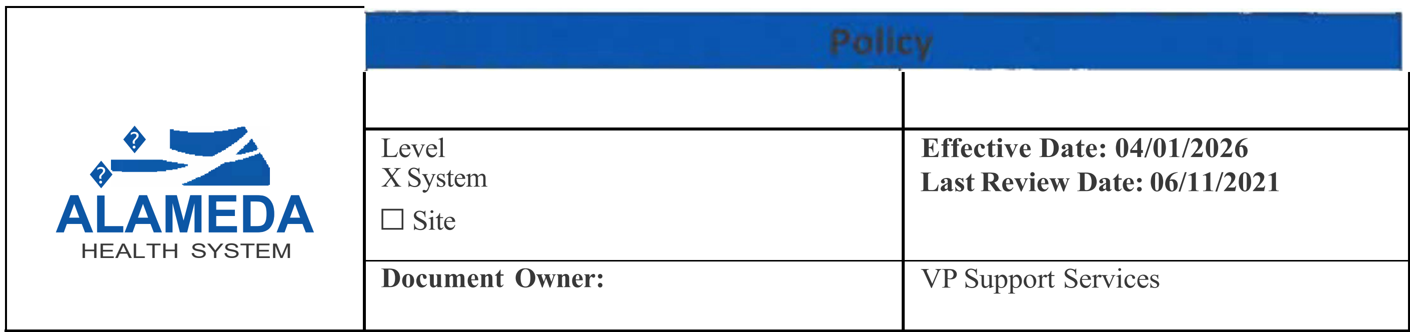
3. At Fairmont Hospital and John George Psychiatric Hospital
   1. There are designated Reserved Parking spaces for Administration due to their professional responsibilities regularly requiring parking at the facility in response to operational emergencies.

6. Vendors and Contractors Parking at all AHS campuses is prioritized for AHS patients and staff. Vendors and Contractors are required to pay for parking while conducting business at AHS campuses. When visiting campuses to conduct business, vendors must park at one of the visitor parking locations:

   1. At the Wilma Chan Highland Hospital Campus (WCHHC), vendors and contractors seeking monthly parking must park at an off-site parking lot.
   2. In special circumstances a contractor's employees may request onsite parking with the Parking Department through the submission of a valid parking application in collaboration with the department hosting the contractor.
   3. If there is on-campus parking availability, they may be allowed to park in employee designated parking areas at the contractor parking rate, with a valid parking placard, depending on space availability.
   4. All Contractor/Vendor Placards must be obtained from the Parking Department via credit cards.

If a construction project makes it necessary to take parking spaces out of service for trenching, material storage, etc., arrangements must be made with the Parking Department via the Facilities department. Appropriate fees will be assessed.

   5. Facilities/Engineering/Delivery Vendors -At the WCHHC, vendors may request parking at the loading dock for short-term parking to provide services. The vendor must request a short-term parking placard from the Receiving department.



Policy	
Level X System ☐ Site	**Effective Date: 04/01/2026** **Last Review Date: 06/11/2021**
Document Owner:	VP Support Services

EMPLOYEE MONTHLY PARKING PROGRAM (APPLICABLE CAMPUSES)

This section provides general information and outlines the policy and procedure for all employee parking at Alameda Health System. The employee parking policy outlines parking provisions for employees utilizing AHS parking lots, clarifies criteria for allocating parking spaces, and outlines the rules for parking on AHS premises. This policy applies to all employees who operate company or personal vehicles during business, including permanent, temporary, contract employees, interns, and volunteers. Parking spaces are on a "first-come, first serve" basis and do not guarantee the placard holder a parking space. It provides the opportunity to legally park where space is available.

1. Obtaining Parking Privileges and a Placard Parking at Fairmont, John George, and WCHHC hospitals require the submission of a parking application and the assignment of a parking placard to authorize parking.
    1. Alameda & San Leandro Hospitals - At Alameda and San Leandro Hospital, parking is on a first come first serve basis, except for the physician parking lots which require a physician parking placard or gate remote to access. Physicians requiring access to the physician's parking lot must submit a parking application for issuance of a parking placard and the remote gate.
    2. Fairmont and John George Hospital- Parking at the Fairmont and John George campuses is managed by Alameda County General Services Agency (GSA). For monthly parking, staff must contact their department supervisor or manager to obtain a parking placard from GSA. GSA manages all aspects of parking at the FMT/JGPH campus with occasional support for parking enforcement by AHS Security.
    3. Wilma Chan Highland Hospital Campus Parking demand for Day Shift on-campus parking at the WCHHC exceeds available space. As a result, there is a waitlist for on-campus parking with an average wait time of 2 years. To be added to the waitlist, please apply via the AHS Intranet, under Divisions select Support Services, and the application can be found under the Parking and Transportation

tab. Employees who do not have access to the intranet, can contact the parking manager for the link to submit a parking application.

2. Parking assignments are based on availability. If a wait list occurs, parking will be assigned on a first come first serve basis. During peak hours, Monday through Friday from 7:00 a.m. to 7:00 p.m., equal priority will be given to people/roles listed below. AHS will do its diligence to ensure those meeting the criteria below are approved for parking first. Specific inquiries will need to be approved by the Chief Administrative Officer, V.P. of Support Services, or designee.
   - Director level and above Executive leaders
   - Disabled persons
   - Individuals whose professional responsibilities **regularly** require parking at the facility in response to life-safety emergencies.

3. Proper Use of Parking Facilities
   1. Patients, Staff, and Visitors must adhere to the protocols and procedures set forth in this policy. Under no circumstances can employees park in patients' or visitors' parking locations.

   Employees who deliberately avoid or manipulate the parking system, park in restricted areas, e.g., red zones, loading docks, patient parking locations, may have parking privileges revoked, and may be subject to a parking citation from the Alameda County Sheriffs Office, Alameda County General Services Agency, the AHS Security team, and/or local law enforcement. Furthermore, staff who intentionally violate the parking policy will be reported to the AHS Human Resources department for violation of the AHS Code of Conduct Policy.

Additional reasons for potential revocation of parking privileges include, but are not limited to, breaking gate arms, hit-and-run incidents, damaging AHS parking facilities or employee vehicles, repeatedly failing to leave keys with valet attendants causing delays due to vehicles

being blocked, and any other issues deemed grounds for revocation by the parking team and the campus Chief Administrative Officer.

Suggestions for the improvement of Parking Services may be made in writing and directed to the Parking Department.

4. Parking Citation Process and Accountability:
   Compliance with parking regulations is mandatory. Violation of the Parking Policy may result in discipline up to and including termination.

   Parking Rates - This section outlines the policy and procedures for parking.

1. Currently, the only campus which requires collection of parking dues for on-campus parking is WCHHC.
2. Parking at all other AHS facilities is free for AHS employees.
3. At the Fairmont and John George campuses, metered parking stalls are available for use by patients, visitors, and employees. The meters are managed by Alameda County General Services Agency.

5. Parking Rate Approval and Review This section outlines procedures pertaining to Parking Rate revisions, review, approval, and proposals to fee increases. Annually, the AHS Parking Services Vendor conducts a parking rate analysis. The parking rate analysis is an assessment conducted by the Parking Vendor reviewing parking rates at like health systems and corporations in the local area. The vendor will provide recommendations for market-competitive parking rates for applicable AHS campuses. The parking rates will be reviewed by the Director of Parking services. In aligning with AHS' mission, vision, and values, changes to parking rates will be considered under the following circumstances:
   1. Request for rate review by the AHS Executive Leadership team (ELT). At a request from the ELT, a rate of analysis and recommendations will be presented for approval.

2. In consideration of annual parking expenditures, every effort is made to streamline and reduce expenses to avoid rate increases; however, rates are subject to change based on operational demands.
3. Parking expenditure exceeding budget.
4. Considering the patient and employee population paying for parking services.
5. When rates warrant adjusting, the Parking Director will present the business need with the proposed new rates to the Executive Leadership Team, Chief Operating Officer, or designer for approval.

6. Payroll Deduction Plan (WCHHC) - At WCHHC, employees with on-campus monthly parking privileges must pay for monthly parking via payroll deduction. To commence parking, employees must submit a Payroll Deduction Authorization form along with their parking application to the Parking Department. The parking department will submit the Payroll Deduction Authorization & Cancellation form to the AHS Payroll department once parking is assigned.
   1. The payroll deduction schedule is used to determine the first payroll deduction date.
   2. To cancel payroll deductions, the employee must return their parking placard along with a completed Payroll Deduction Authorization & Cancellation form to the Parking Department. If the placard is not available at the time of cancellation, an additional payroll deduction may be processed to recoup the cost of the placard.
   3. For missing placards, the placard number and type will be documented on the list of invalid placards. Any further usage of the placard will be subject to citation from the Parking Department, Alameda County Sheriffs Office, General Services Agency, local law enforcement, and reported to the Human Resources department for violation of employee code of conduct.
   4. It is the responsibility of the employee to submit a Payroll Deduction Authorization & Cancellation during leave of absence, when parking is cancelled, or when leaving employment with the Hospital. Payment of fees will continue to

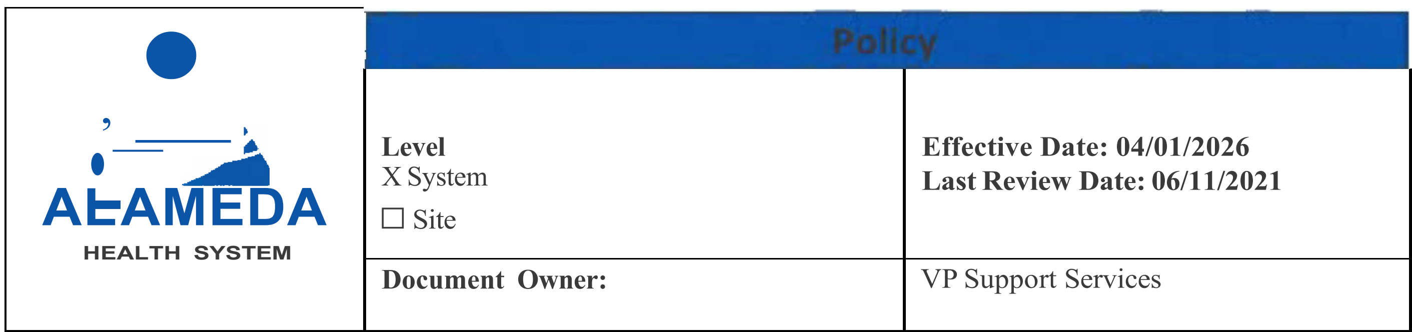
accrue until a cancellation form is submitted, and the placard is returned to the Parking Department.

7. Parking Refunds - The parking department in collaboration with the AHS Payroll department or AHS cashier, may issue refunds to patrons upon receipt of the AHS Parking Refund request form under the following circumstances:
    1. Parking department errors in processing parking applications or cancellations.
    2. Errors in patients paying for parking, e.g., double payments for one service, or for service recovery.
    3. Refunds will not be issued when parking privileges are revoked for disciplinary reasons, and refunds will not be issued for the month privileges are revoked.

PARKING PLACARDS

This section outlines the policy and procedures for placard utilization while parking at the Fairmont, John George, WCHHC garages, WCHHC offsite parking lot, and Alameda and San Leandro Hospital physician parking locations. While parked on the campus, a valid AHS or General Services Agency (GSA) parking placard must always be visible and properly displayed. It is the employee's responsibility to ensure their vehicle is parked in the correct campus parking lot at the appropriate time.

1. Placard Utilization - All parking areas at Fairmont, John George, WCHCC, WCHHC off-site parking lot, and the Alameda and San Leandro physician parking lots require display of appropriate parking placards. This is required for all faculty, staff, visitors, or vendor/service vehicles.
    1. When parking at the AHS campuses, all vehicles must display a valid placard.
        1. Fairmont & John George Hospitals - For monthly parking privileges, staff must obtain and display a valid GSA issued placard.
        2. WCHHC - Only placards authorized and issued by the AHS Parking Dep�rtment are acceptable at these locations.



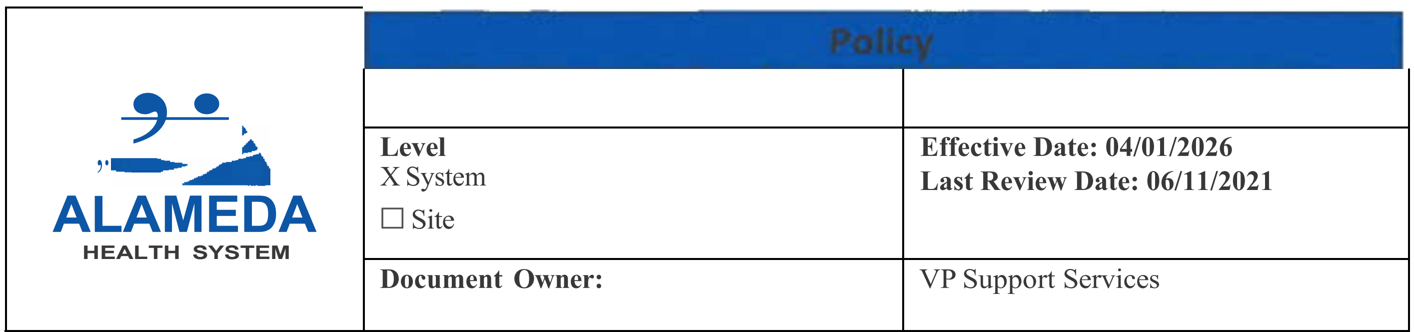
3. Alameda and San Leandro Hospitals have dedicated parking lots for physicians. For the physician parking lots, only physicians, or those designated by physician leadership are authorized to park in the physician parking lots. Physicians parking in these spaces must display an appropriate AHS parking placard.

2. Displaying Placards - Vehicles not displaying valid placards and/or license plates on file are subject to parking violation citations whether payroll deductions are active or not.
   I. Active payroll deduction is not a substitute for having a valid placard displayed or providing vehicle/license plate information.

3. Placard transferability - Placards are not for resale, sharing, or transferable to other persons.
   1. Placards are for use by the employees the placard was assigned to. Only one active parking placard may be assigned per person at one time.

4. Offsite Parking at Highland - Employees, volunteers, and contractors registered to park in the offsite parking lot can move their vehicles and park in the Upper Vallecitos lot after 5:00 P.M., Monday-Friday and all-day Saturday and Sunday. This is a benefit for staff registered for off-site parking.

5. Placard Replacements & Refunds - When parking privileges are revoked for disciplinary reasons, refunds will not be issued for the month's privileges are revoked.
   I. The replacement fees for lost or stolen placards are based on the cost of placards from the vendor.
      I. Fairmont and John George Hospitals - Replacement placards for the John George and Fairmont campuses can be purchased from GSA. Please contact your supervisor to request a replacement placard from GSA.
      2. WCHHC Campus & Alameda (ALH) /San Leandro (SLH) Physician Parking- Replacement placards for the WCHHC campus and ALH/SLH



physician parking lots can be purchased at the Cashier's office. The current fee for replacement placards is $20 by cash or credit card.

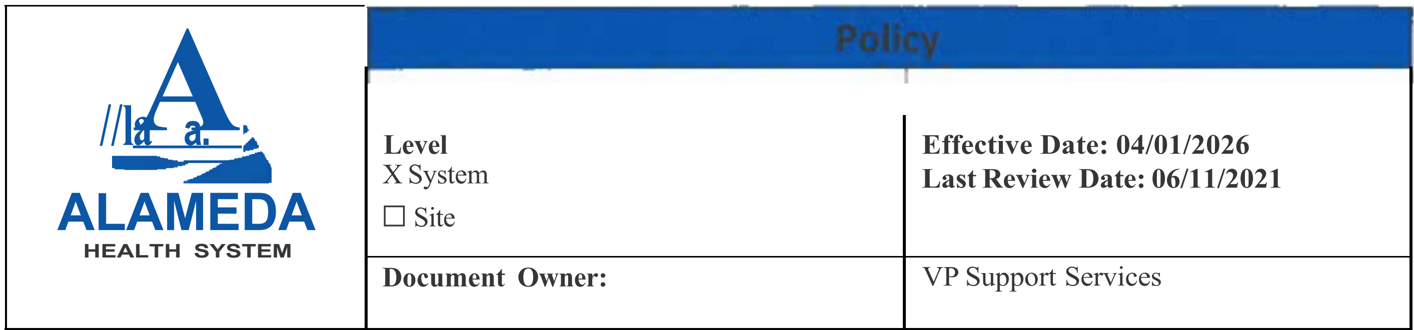
3. If an employee/vendor/contractor refuses to pay for a replacement placard due to any of the following reasons: departing the organization without returning their placard, losing their placard, or their placard was stolen, then the expense for the replacement placard may be charged to the individual's host department cost center.

VISITOR PARKING

When parking at visitor parking garages, all visitors, including vendors, contractors, patients, and people transporting patients to and from the Fairmont, John George, or WCHCC campus must pay the current visitor rate and fees associated to the visitor parking at the respective campus.

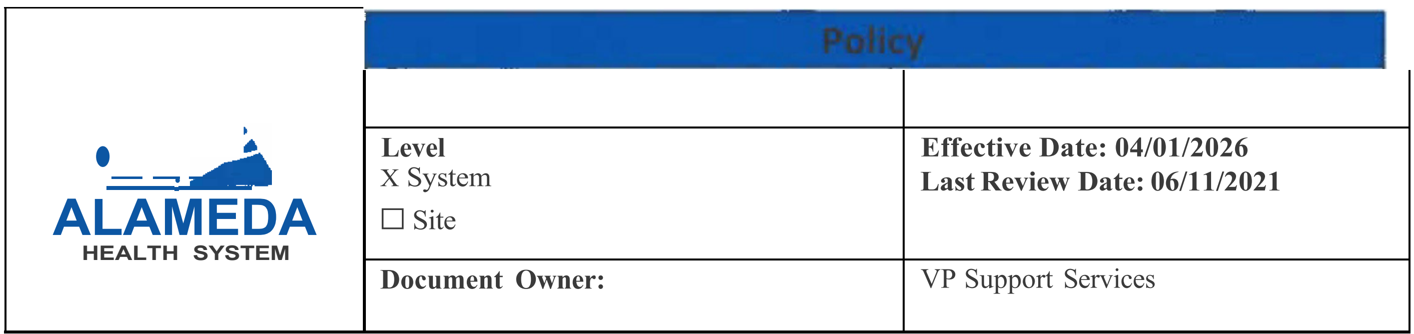
1. Parking Priority Order - Visitor parking is prioritized for patient care and availability is on a first come first served basis. AHS will do its diligence to ensure patients receiving care are given precedence. Parking is prioritized in the following order:
    1. Disabled persons and emergency vehicles.
    2. Patients and visitors.
    3. Individuals whose professional responsibilities regularly require parking at the facility in response to life-safety emergencies. AHS will do its best to determine that those meeting qualifications are approved for parking first. Specific inquiries will need to be approved by the Department Leader, Chief Administrative Officer, or a designee.

2. Fairmont and John George Hospitals - All visitors must pay the visitor parking fees at the metered parking spaces on the respective campuses. Validations are not available on these campuses.



3. WCHHC campus - All visitors must surrender their entry ticket when exiting the visitor parking garage by paying the hourly visitor rate if applicable or the maximum rate for any 24-hour period.
    1. ValidatiQ!!§_- Validated parking is available to patients who have an inability to pay. The hosting department, or the Parking Department, may provide a parking validation to the patient or visitor. Future considerations may require validation to be charged to the respective department's cost center.
        1. Visitors using gated parking lots at WCHHC for business purposes may be entitled to a parking validation at the discretion of the hosting department.
        2. Outpatient clinics funded research studies, and inpatient units may validate patient parking. Validations are issued only with the approval of the department chair or manager.
        3. It is the visitor's/patient's responsibility to request that their entry ticket be validated. Those who do not have their entry ticket validated shall be required to pay the current hourly or max daily rate, based on time of entry and departure.
        4. Under no circumstances are any AHS staff to obtain a validation for patient parking, unless they visit WCHHC as a patient and the validation is approved by the department chair.
        5. Employees who abuse validations by using them for personal use are subject to repaying AHS for all unapproved validations. Department leaders, in collaboration with the Parking Department, are responsible for monitoring validation of utilization and procedures to mitigate abuse. Department leaders are responsible for initiating appropriate action when abuse is detected.

TRAFFIC AND PARKING VIOLATIONS



Level X System ☐ Site	**Effective Date: 04/01/2026** **Last Review Date: 06/11/2021**
Document Owner:	VP Support Services

Alameda Health System hereby gives notice the following regulations will be enforced on all AHS and GSA parking areas.

1. No person shall be allowed to stop, park, or leave any vehicle or animal standing, whether attended or unattended upon the paths, driveways or grounds of AHS which are marked clearly and legibly with the words "NO PARKING".
2. Pursuant to Section 21 I 13a of the California Vehicle Code, the Alameda County Sheriffs Office, General Services Agency, and local law enforcement have been provided the authority to develop and enforce parking regulations as needed to conform with State law.
    1. Parking is enforced 24 hours a day, 7 days a week. Failure to display a valid placard will result in the issuance of parking citations. Individuals parking placards require parking lots with altered, lost, stolen, or unauthorized placards are subject to a parking citation set forth in the applicable sections of the California Penal and Vehicle Codes. It is the responsibility of the placard holder to display a valid placard on his/her vehicle, park in areas posted for such placards only and renew illegible or expired placards on or before the expiration date.
    2. In extenuating circumstances and on a case-by-case basis, some citations may be eligible for dismissal. If the same employee requests a citation to be dismissed three times in one year, the Parking Office may, in lieu of collecting a parking fine, apply for an administrative fee not to exceed five dollars ($5.00) Proposing this per violation. Violation will have 21 days to pay administrative fees or original citations. Concomitantly, if the same employee receives multiple citations, their parking privileges may be revoked.
    3. Motorized vehicles with 5 or more outstanding citations issued on 5 or more days may be subject to tow at the owner's expense.
    4. Anyone cited for possession and use of an altered, stolen, or invalid placard or for improper use may be fined and have their parking privileges permanently revoked. People who feel they have received an unjustified parking citation must contact the Parking Department within 24 hours of the citation date to contest the Citation. The violator will be asked to provide a written explanation of why the

citation was issued in error or why the citation should be dismissed. If it is established that the citation was issued in error or the violator was involved in an extreme emergency, the citation may be considered for dismissal.

5. The AHS Security team is authorized to enforce parking at all AHS campuses, including those managed by GSA, on an as needed basis.

PARKING BY FACILITY & CAMPUS SPECIFIC INFO

1. **Alameda Hospital** (ALH)- Free parking is available to patients and staff in the Hospital parking lot.
    - Staffing: The AHS parking manager will coordinate valet stacked parking with the demand generated by this lot Monday through Friday. There will be no valet attendant services on the weekends.
    - The hours of operation for Valet Parking are from 8:00 a.m. to 4:30 p.m. Monday through Friday.
    - There is a dedicated ALH Physician Parking lot which requires display of a valid AHS Parking Placard and a gate remote to enter the restricted parking area.

2. **Creedon Advanced Wound Care** - Free parking is available to patients and staff in the front and rear parking lots.

3. **Eastmont Wellness Center -** Free parking is available to patients and staff in the parking lot.

4. **Fairmont Rehabilitation and Wellness** -The Fairmont campus parking lot is managed by Alameda County's General Services Agency (GSA). Patients and/or staff may park in

the paid metered parking stalls. Staff must obtain a county parking placard from GSA. To obtain a county parking placard, AHS staff must contact their supervisor who will contact GSA directly. Once the placard is obtained, it must always be displayed for staff to park in the permitted parking lots. Staff must abide by the AHS parking rules and regulations, the California Vehicle Code and all County Ordinances enforced by GSA and local law enforcement. Overnight storage of vehicles, trailers, or RVs is not permitted.

5. **Hayward Wellness Center -** Free parking is available to patients and staff in the mall parking lot.

6. **Wilma Chan Highland Hospital Campus (WCHHC) Parking** - As mentioned in this policy, there is a limited number of on-campus parking spaces at the WCHHC. On-campus parking is prioritized for staff who work at WCHH. All on-campus parking spaces at the WCHHC require payment. There is paid daily/hourly parking for patients and dedicated parking areas for employees. Most of the employee parking is monthly paid parking.
    - **Koret Garage (K-Garage) Patient Parking Garage:** Five (5) story, 362 space parking garage with access for patients on 31st Street and access to AHS staff via 14th Avenue.
        - The AHS parking manager will coordinate valet stacked parking for patients per demand generated at this lot Monday through Friday. Valet attendant services are not provided on the weekends.
        - The parking attendant booth at the visitor entrance will be staffed Monday through Sunday, from 6:00am - 10:30pm.
        - Hours of operation are 24 hours a day, 7 days a week.
        - Floors 3 through 5 are exclusively paid for daily/hourly parking for patients and visitors only. There are no exceptions to this rule,
        - Floors 0-2, also referred to as KO, are the dedicated employee at daily paid hourly rates and houses the reserved on-call employee parking

area. The exit and entrance to the employee parking area (KO) is separate from the patient parking entrance and location.

- Motorcycle parking is available in the secured Bike Cage located on K3. Motorcyclists should drive by the gate to enter the K-Garage and park in the employee bike cage.

- **Vallecitos St. Upper and Lower Employee Parking Lot:** Two (2) story employee parking lot with access via Vallecitos Street.
    - The AHS parking manager will coordinate valet stacked parking at the upper Vallecitos parking garage per the demand generated by this lot Monday through Friday, from 6:00 a.m. to 8:00 p.m. Valet attendant services are not provided on the weekends.
    - Hours of operation: 24 hours a day, 7 days a week.

- **HCP Garage:** Four (4) story employee monthly parking garage with access via East 31st Street.
    - The HCP parking garage is a fully automated parking garage using kiosks for parking entry and exit. Based on need, the AHS parking manager will coordinate a parking attendant to staff at the parking booth to assist with patient transactions from 7:00 a.m. to 6:30 p.m., Monday through Friday - staffing hours determined by the AHS parking manager.

- **Offsite Employee Parking Lot:** Offsite employee parking lot located at East 17th Street.
    - Staffing: The AHS parking manager will coordinate valet stacked parking with the demand generated by this lot Monday through Friday. Valet attendant services are not provided on the weekends or AHS observed holidays.

- Hours of operation: Monday through Friday from 5:00 a.m. to 8:30 p.m.

- **Wings Employee Parking Lots:** Employee parking lots with an entrance on the comer of 14th and Vallecitos St.
    - Staffing: None provided.
    - Hours of operation: 24 hours a day, 7 days a week.

7. **John George Psychiatric Hospital (JGPH)**- The JGPH campus parking lot is managed by Alameda County's General Services Agency (GSA). Patients can park in metered parking stalls. Staff must obtain a county parking placard from GSA. To obtain a county parking placard, AHS staff must contact the JGPH security manager. Once the placard is obtained, it must always be displayed for staff to park in the permitted parking lots. Staff must abide by the AHS parking rules and regulations, the California Vehicle Code and all County Ordinances enforced by GSA and local law enforcement.

8. **Newark Wellness Center-** Free parking is available to patients and staff in the wellness center's parking lot.

9. **Park Bridge Rehabilitation and Wellness Center** Free parking is available to patients and staff in the wellness center parking lot; however, parking spaces are limited.

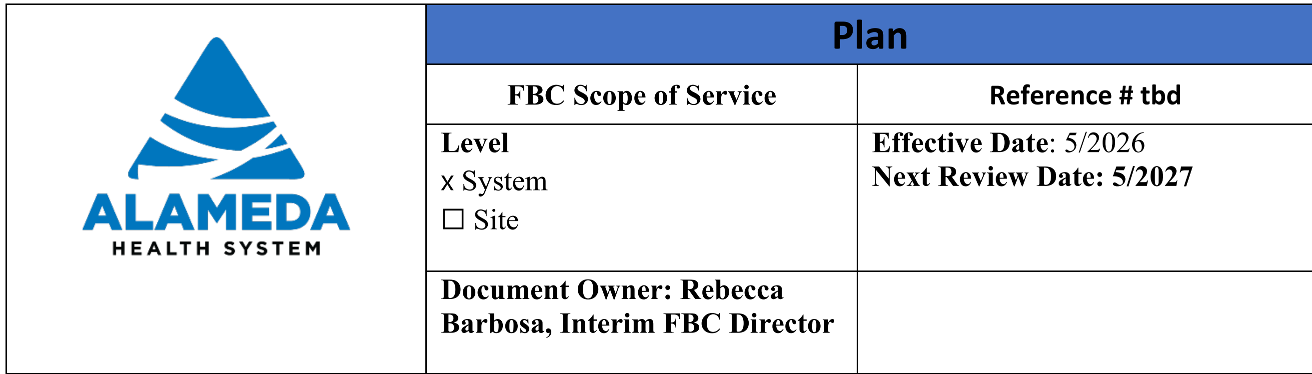
10. **San Leandro Hospital** - Free parking is available to patients and staff in the Hospital parking lot.

11. **South Shore Rehabilitation and Wellness** - Free parking is available for patients and staff in the wellness center parking lot; however, parking spaces are limited.

Support Services Center - Free parking is available to staff in the center's parking lot.

REFERENCES:

California Vehicle Code (CVC), Section 21113a * Applicable Alameda County Ordinances* Alameda Health System (AHS) Code of Conduct Policy* Other Relevant Federal, State, and Local Laws and Regulations (as applicable



ALAMEDA HEALTH SYSTEM	Plan	
	FBC Scope of Service	Reference # tbd
	Level x System ☐ Site	**Effective Date**: 5/2026 **Next Review Date: 5/2027**
	Document Owner: Rebecca Barbosa, Interim FBC Director	

PURPOSE / OBJECTIVE

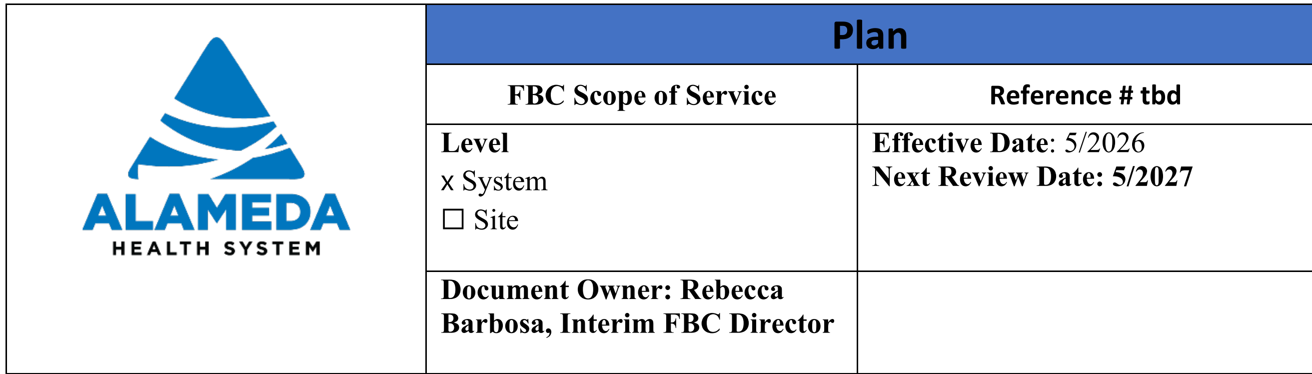
To provide an overall review of the resources, services, and operations of the Family Birthing Center (FBC) at Highland Hospital and to ensure compliance with local, state, and federal operations and licensing requirements.

SCOPE

1. **FBC Providers and Staffing**
   a. Registered Nurses (RNs) licensed to practice in California, minimum per shift
      i. L&D-9
      ii. PP-3
      iii. NICU-3
   b. Obstetrician (OBGYN) 1-minimum per shift with inpatient privileges
   c. Certified Nurse Midwife (CNM) 1- minimum per shift with inpatient privileges
   d. Pediatrician (hospitalist) 1-minimum per shift with inpatient privileges
   e. Clinical Educator or Clinical Nurse Specialist
   f. Ancillary staff
      i. Unit clerks
      ii. OB technicians
      iii. Lactation specialists
      iv. Social workers
2. **Highland Hospital Staff/Resources available 24/7 to support FBC**
   a. Anesthesia
   b. Laboratory
   c. Blood Bank
   d. Pharmacist
   e. Radiology

PROCEDURE

1. **Practice Standards**
   The unit will maintain practice guidelines that will be updated utilizing input from Midwifery, Obstetric (OB), Nursing, Pediatrics, and other relevant organizations.
2. **Service Availability**-24 hours per day, 7 days per week (24/7)
3. **Care Setting**
   a. OB service on the FBC includes:
      i. 8 labor, delivery, recovery (LDR) rooms
      ii. 4 triage beds
      iii. 2 surgical suites
      iv. 3 post-anesthesia beds
      v. 17 rooms for antepartum and postpartum (PP), 4 of which have fetal monitoring capabilities.
      vi. 8 Level II Nursery beds (NICU)



4. **Clinical Services**
   a. OB Triage:
      i. Evaluation of labor
      ii. Medical assessment
      iii. Evaluation of OB patients 20 weeks' gestation through 6 weeks postpartum. (Exceptions may be made by the provider for patients outside of this range.)
      iv. Medication Administration
      v. Fetal evaluation – NST/DVP/BPP
      vi. Determination for admission, observation, discharge or transfer of care to higher level facility.
   b. Labor & Delivery (L&D): medical, midwifery, and nursing care of patient experiencing vaginal or cesarean birth.
   c. Surgeries and Procedures:
      i. Cesarean - ability to begin cesarean delivery within 30 minutes of decision.
      ii. Tubal ligation
      iii. Dilation and curettage
      iv. External cephalic version
      v. Hysterectomy
      vi. Other OB procedures as determined by OB provider
   d. Postpartum Care: evaluation, assessment, and care of the postpartum couplet.
   e. Newborn Care: neonatal, pediatric, and nursing care of the well or ill newborn, including resuscitation and stabilization when indicated
   f. Lactation Support: intervention and education.
   g. Consultation for patients admitted to other units of the hospital.
   h. Patients with the following conditions will not be admitted to FBC or will be transferred if the conditions are identified including but not limited to:
      i. Undergoing radium or radiation therapy, isotope therapy
      ii. GYN conditions or other medical/surgical conditions that are not within the scope of service of FBC.
      iii. Requiring admission to in-patient psychiatric services
5. **Indications for Transfer to higher level of care:**
   a. Preterm labor with delivery anticipated before 32 weeks' gestation
   b. Requiring telemetry in labor.
   c. Anticipated placenta acreta spectrum complications
   d. Anticipated fetal anomalies
   e. Neonates with the following conditions are stabilized and transferred to a higher level of care:
      i. Prematurity < 32 weeks' gestation.
      ii. Birth weight <1500g.
      iii. Respiratory compromise requiring long term mechanical ventilation.
      iv. Hematological disease.
      v. Major congenital anomalies.
      vi. Requiring therapeutic hypothermia for treatment of hypoxic ischemic encephalopathy (HIE).
      vii. Requiring imaging studies not available at AHS.

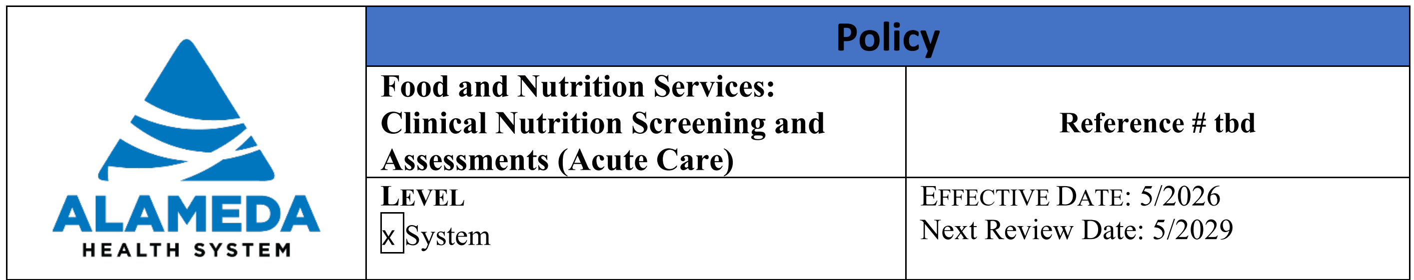
6. **Data Collection and Reporting**
   a. Unit leadership will ensure data collection and tracking of maternal and newborn morbidity and mortality and report to state agency when indicated (CMQCC) for conditions including but not limited to:
      i. NTSV cesarean section rate
      ii. PPH requiring transfusion
      iii. Readmission for infection
      iv. Maternal or fetal death
      v.

ATTACHMENTS

None

APPROVAL(S):

Approving Committee / Executive	Date of Approval
Dr. Stephanie Ho, Obstetrics Chair/ Rebecca Barbosa, FBC Interim Director	March 31, 2026
CPC	April, 2026
MEC	April, 2026



	Policy	
ALAMEDA HEALTH SYSTEM	**Food and Nutrition Services: Clinical Nutrition Screening and Assessments (Acute Care)**	**Reference # tbd**
	LEVEL x System	EFFECTIVE DATE: 5/2026 Next Review Date: 5/2029

POLICY STATEMENT
The Clinical Nutrition Screening and Assessments (Acute Care) policy is utilized by Registered Dietitian Nutritionists (RDNs) to identify patients who may require medical nutrition therapy. Patients identified at nutrition risk during the initial nutrition screening will be further evaluated with comprehensive nutrition assessment and receive nutrition intervention when applicable.

SCOPE:
Alameda Hospital, San Leandro Hospital, Wilma Chan Highland Hospital, and John George Psychiatric Hospital

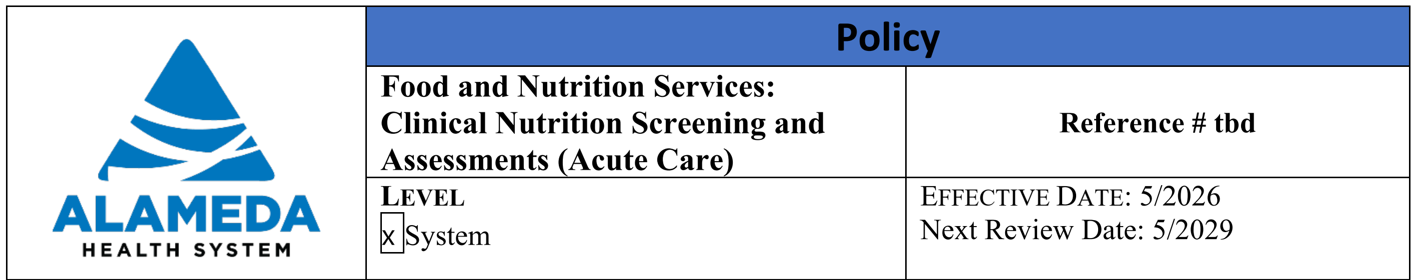
DEFINITIONS
RDN - Registered Dietitian Nutritionist
RN - Registered Nurse
EHR - Electronic Health Record
TPN - Total Parenteral Nutrition
PPN - Peripheral Parenteral Nutrition
NPO - Nil Per Os (nothing by mouth)
BMI - Body Mass Index
DM - Diabetes Mellitus
ICU - Intensive Care Unit
ED - Emergency Department
LOS - Length of Stay
NFPE - Nutrition Focused Physical Exam

RESPONSIBILITIES

Nursing
1. Initial nutrition screening will be performed by a Registered Nurse during the patient admission process. All patients will be assessed for nutrition risk based on pre-determined validated nutrition criteria within 24 hours of admission. The RN will document the initial nutrition screen in the Nutrition Screen Flow-Sheet in the EHR including the following malnutrition criteria:
   a. Unplanned weight loss in the last 3 months
   b. Poor oral intake for 4 or more days
2. When any of the above indicators are chosen, a nutrition consult will be generated.

Registered Dietitian Nutritionist
1. Patients will be assessed by a Registered Dietitian Nutritionist according to the following prioritization table:

Criteria	High Priority	Moderate Priority	Low Priority	No Nutrition Risk
Diet Order	• New TPN/PPN • New Tube Feeding	• Existing tube feeding or TPN Regimen		



	• Non-ICU patients NPO/Clear Liquids/Full Liquids x 4 days			
Anthropometrics		• BMI <18.5		
Positive Nutrition Risk Screen in EPIC		• Unplanned weight loss within 3 months • Poor oral intake for 4 or more days	• Other (consult needed) • Stage 1 pressure injury, vascular wounds, DM wounds	
Type of Consult	• Initiate calorie count • Sedation/ analgesia order set • Enteral support recommendations • Parenteral support recommendations	• Provider consult • Diet Education • Diet Evaluation • See patient for nourishments or supplements • Nutrition Recommendations/ requirements • Nutrition Screen Consult		
Other	• Severe malnutrition	• Moderate malnutrition • Stage 2-4 pressure injury present	• Stage 1 pressure injury present	
Assessment*	• Within 1 day	• Within 2 days	• Within 3 days	
Reassessment*	• 3 days • 5 days**	• 5 days • 7 days**	• 7 days • 10 days**	• 10 days • 14 days**

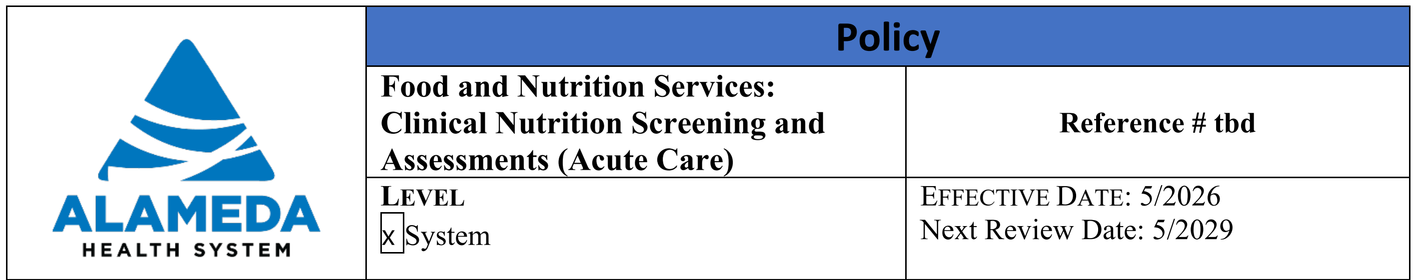
* Criteria for nutrition priority are not comprehensive, and dietitians have the ultimate clinical discretion to place patients at the appropriate priority level based on clinical judgement. Priority levels may also change throughout a patient's length of stay.
** For John George and San Leandro Rehabilitation patients.

a. Any patient that is not currently followed by nutrition must be seen for an assessment by:
   1. Wilma Chan Highland, Alameda, and San Leandro Hospitals: LOS of 6 days
   2. San Leandro Rehabilitation Unit/John George Psychiatric Hospital: LOS of 7 days
b. Patients on Hospice and/or Comfort Care: RDN will discuss and document patient's goals of care with physician to determine if nutrition intervention is indicated. If no nutrition

intervention indicated, no nutrition assessment is warranted at that time. Physician nutrition consult to follow if needed.

    c. Patients in Observation or the ED: RDNs will practice clinical judgment to determine the appropriate timeline of care. Consults placed for these patients may be deprioritized until the patient is admitted to inpatient status. These patients will be addressed by the RDN if nutrition intervention is indicated.

2. Nutrition assessments will utilize the Nutrition Care Process model. The nutrition assessment will include evaluation of information including:
    a. Food/nutrition history
    b. Biochemical data, medical tests, and procedures
    c. Anthropometric measurements
    d. Nutrition Focused Physical Exam (NFPE) findings
    e. Patient history
3. Based on the assessment findings, the RDN will identify a nutrition diagnosis and determine, in collaboration with the patient when able, an appropriate nutrition intervention that will follow.
    a. If recommendations made require a physician order and no physician order is placed or physician response is documented in the EHR, the RDN will follow up with the physician to verify a response to the recommendation. The RDN will document the results of this discussion in the EHR.
4. Nutrition Monitoring and Evaluation: The RDN monitors and evaluates the patient's response to care. Monitoring and evaluation may include, but is not limited to nutrition reassessment, meal rounds, or medical rounds. Monitoring and evaluation may result in new nutrition intervention/goals.
5. The dietitian may enter a brief note in the following situations if the patient is not at nutrition risk:
    a. Assessment with no nutrition diagnosis
    b. Lifestyle / BMI >24 consults
    c. LOS day 6/7 assessment
    d. Repeat consults, nutrition already following
    e. Education consult
    f. Renal consults
    g. Food preference consults
6. When completing a nutrition reassessment documentation may include, but will not be limited to:
    a. Patient response to established intervention and status of goal achievement
    b. Identification of additional nutrition diagnoses, followed by interventions and goals to support the new nutrition diagnosis.
    c. When nutrition goals are met or are no longer applicable and no further nutrition diagnosis is found, a dietitian may document "No nutrition diagnosis at this time". The dietitian may then re-screen according to the Nutrition Risk Screen, prioritization table, and/or interdisciplinary rounds. The results are documented as appropriate.
7. Hand-off Communication
    a. When the care of a patient transfers from one dietitian to another, there is a "hand off" of information about the patient. While the information may be written or verbal, there must always be the opportunity to ask and respond to questions in a timely fashion.

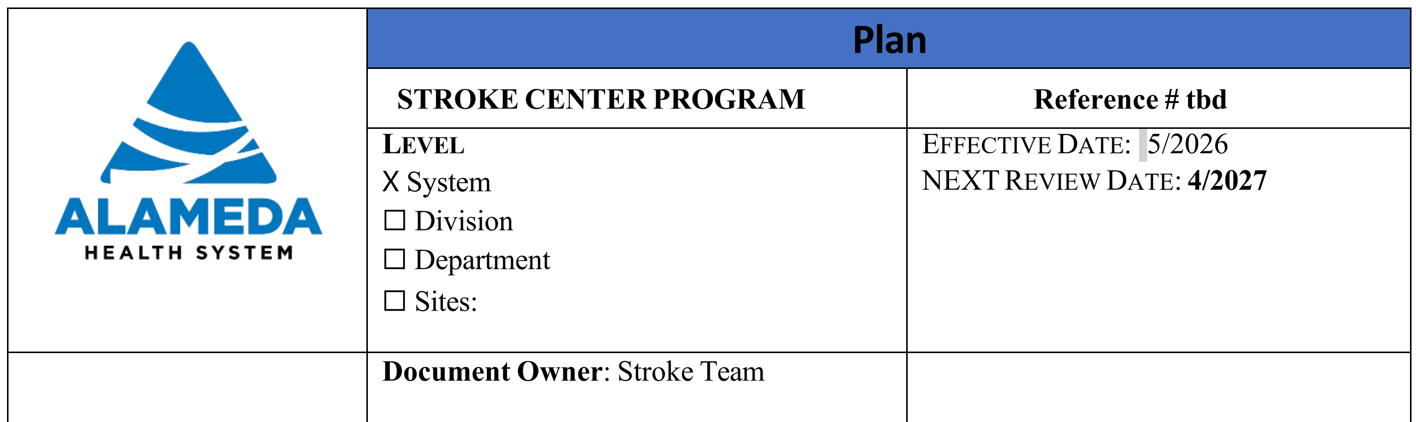


Information communicated during the "hand-off" includes the patient's current condition, nutrition interventions implemented and the patient's response to the intervention.

8. Documentation in the medical record shall only include hospital approved abbreviations.

REFERENCES

1. Academy of Nutrition & Dietetics. eNCPT, 2023 2. https://www.jointcommission.org/facts_about_do_not_use_list/ (accessed 6/6/2023)
2. https://www.jointcommission.org/facts_about_do_not_use_list/ (accessed 10/7/2019)
3. Joint Commission's National Patient Safety Goal #2: Improve the effectiveness of communication among caregivers.



ALAMEDA HEALTH SYSTEM	**Plan**	
	STROKE CENTER PROGRAM	**Reference # tbd**
	LEVEL X System ☐ Division ☐ Department ☐ Sites:	EFFECTIVE DATE: 5/2026 NEXT REVIEW DATE: **4/2027**
	Document Owner: Stroke Team	

PURPOSE/ OBJECTIVE

To provide acute stroke care and enhance stroke recognition to the community. Recognizing that effective stroke treatment requires an integrated and coordinated approach, hospital leadership provides hospital-wide Stroke Center Programs that include activities within the organization which contribute to the maintenance and improvement of acute stroke care and prevention.

Mission Statement: Alameda Health System is an integrated public health carsystem of hospitals and multiple wellness centers dedicated to providing effective and efficient acute stroke care for the people of our community. This includes increasing public awareness about stroke recognition, stroke prevention and providing appropriate treatment quickly to enhance the quality of life for our patients.

Recitals

Alameda Health System recognizes that a patient with an acute stroke must be treated in a timely fashion for optimal results. The System strives to offer the best care possible to the citizens of Alameda County. The System will initiate actions to implement these protocols and plans with emphasis on processes and systems as outlined by the Brain Attack Coalition and American Heart Association/American Stroke Association statements.

Alameda Health System also recognizes the need for community education in stroke prevention and awareness and commits the resources necessary to provide such education.

The System will communicate clearly with other facilities also providing stroke care and will formulate formal written agreements with appropriate facilities for the emergent transfer of critical stroke patients requiring a higher level of care.

The System recognizes the importance of excellence in patient care upon arrival in the Emergency Department and commits the resources necessary for training of personnel to ensure all involved parties have the proper education needed to provide optimal stroke care for patients.

The System recognizes that maintenance of certification requires an ongoing

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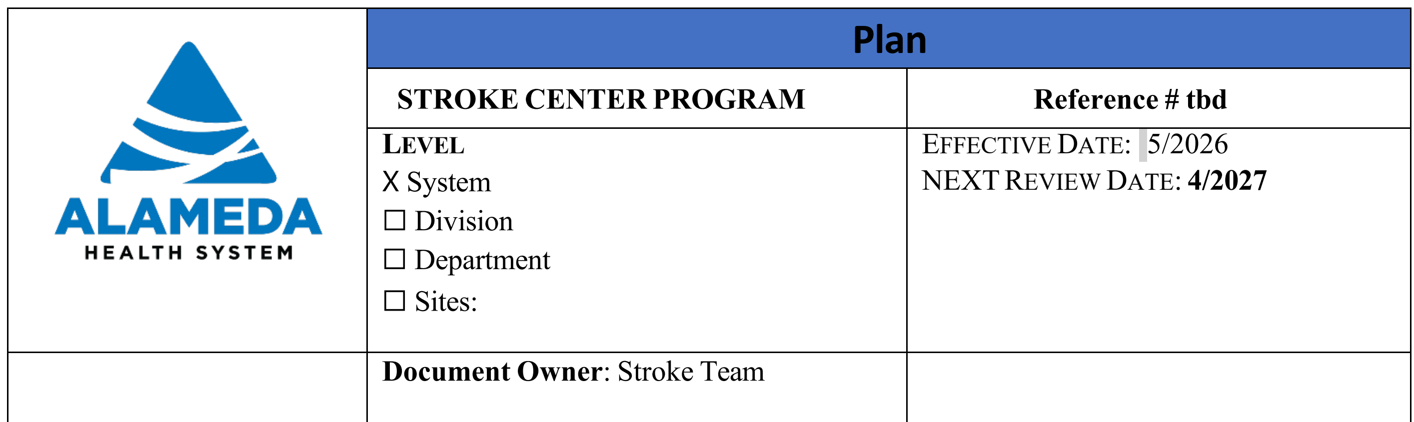

effort directed at data collection, continuing education, and awareness of advances in stroke treatment, and commits the necessary resources to providing the above to maintain certification.

Alameda Health System and its Medical Staff commit to providing current treatments available to the community and will maintain educational requirements as necessary. Patients who receive acute stroke treatment will be reviewed in the Medical Staff performance improvement process as is deemed necessary and appropriate to ensure quality care is given.

SCOPE

- Provide care for patients with ischemic strokes**,** hemorrhagic strokes and transient ischemic attacks (TIAs).
- Deliver patient care within a defined continuum of care.
- Provide education to our patients, families, health care providers, and the community on an ongoing basis.
- Collaborate with existing community agencies to align efforts and services toward primary and secondary stroke prevention.

DEFINITIONS

Primary Stroke Center is a hospital certified by the Joint Commission to provide high-quality, specialized care for acute stroke patients, offering rapid evaluation, advanced imaging, and essential treatments like clot busting drugs (thrombolytics) with a dedicated stroke team and unit.

RESPONSIBILITIES

Board of Trustees of Alameda Health System, through the approval of this document, authorizes the establishment of a planned and systematic approach to the stroke certification process, including the adequate allocation of resources. The Board delegates the oversight of the Stroke Center Program to the Medical Staff and Chief Administrative Officer.

Medical Staff: The Medical Staff collaborate with hospital departments and other services or disciplines in an organization-wide approach to

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improving acute stroke care.

Administration and Management Staff: The Chief Administrative Officer (CAO) along with the management staff actively fosters an effective approach to acute stroke care and program certification. They are authorized to assist with the implementation of the Stroke Program and are responsible for the day-to-day implementation and evaluation of the processes and activities noted in this program, including allocation of adequate resources for employees to participate in stroke care improvement activities.

A. Core Stroke Team

1. Stroke Medical Director

   The Stroke Medical Director is a board-certified physician in Neurology, Internal Medicine, or Emergency Medicine. They are responsible for overall organization and monitoring of the stroke program. The Stroke Medical Director duties include oversight of the program, including response times and general management of the stroke patient, as well as evaluation and management of the stroke units. The Stroke Medical Director is also responsible for clinical oversight of the stroke nurse coordinator and general administrative duties related to the Stroke program (See Stroke Medical Director Contract for specifics). The Stroke Director also provides education for physicians, the stroke team, participates in clinical interdisciplinary rounds as needed and has oversight for quality improvement.

2. Stroke Nurse Coordinator/Program Manager

   The Stroke Nurse Coordinator/Program Manager is responsible for improving clinical care through the application of evidence-based practice. Provides educational programs in conjunction with the nursing education department, leads quality improvement activities, develops, directs, and monitors, along with the Stroke Medical Director, clinical nursing practices related

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to stroke care.

The Stroke Nurse Coordinator/Program Manager will assist with or provide the following:

a. Acute stroke response
b. Monitor proper medical and nursing management of stroke patients
c. Standards of care and practice guidelines for acute stroke patients
d. Clinical activities related to stroke
e. Education to families, patients, staff and to the community
f. Data collection for *Get with the Guidelines*
g. Performance improvement activities

B. Stroke Management Team Members

1. Medical Director of Emergency Department (or designee)

The ED medical director serves on the Stroke Committee. This role is vital to the team in serving as a resource to the ED physicians and members of the Core Stroke Team, providing clinical oversight for the emergency medical care of stroke patients, and reviewing performance indicators for adherence to standards. The ED Medical Director also presents and reviews clinical cases identifying areas of strength and areas for improvement, as well as maintaining ongoing communication with the Stroke Nurse Coordinator/Program Manager.

2. Emergency Department Nurse Director/Manager (or designee)

The ED Nurse Director/Manager serves on the Stroke Committee. The leader serves as a resource to the ED physicians and nurses, reviews performance indicators for adherence to standards and maintains ongoing communication with the Stroke Nurse Coordinator/Program Manager.

3. Director of Nursing Services (or designee)

   The Director of Nursing Services serves on the Stroke Committee. The manager provides clinical direction and leadership for stroke patients. Serves as a resource for Nursing Administration as well as back-up administrative support.

4. RN Vice President of Patient Care Services (or designee)

   The Vice President of Patient Care Services serves on the Stroke Committee The leader provides administrative support, clinical direction and leadership for the stroke program.

5. Director of Pharmacy (or designee)

6. Director of Imaging (or designee)

7. Director of Laboratory Services (or designee)

8. Quality Improvement Manager (or designee)

9. Other Stroke Committee members may include:

   a. Inpatient Physician Leaders
   b. Staff Neurologists
   c. Acute Care Nursing Leaders
   d. Administrative Leaders
   e. Clinical Education Specialists
   f. Director of Community Relations (or designee)
   g. Director of Respiratory (or designee)
   h. Director of Rehabilitation Services (or designee)
   i. Director of Nutrition Services (or designee)
   j. Director of Care Coordination/Social Services (or designee)
   k. EMS representatives as available

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C. Interdisciplinary Departments: The Stroke Program services are provided by several departments and specialized personnel who function collaboratively as part of an interdisciplinary team to achieve positive patient outcomes. The departments who have direct contact with patients are outlined below.

1. Emergency Department

   The Emergency Department personnel are fully integrated with the Emergency Medical System (EMS). Both local EMS and ED personnel are familiar with the diagnosis and treatment of patients with cerebrovascular disease. This includes the importance of rapid identification of patients with suspected stroke and initiation of therapy.

2. Critical Care/Telemetry/Step Down Unit

   Stroke patients are routinely admitted to Critical Care, the Telemetry Unit and Step Down Unit for specialized monitoring and close neurological observation.

3. Radiology/Computerized Tomography (CT)/Diagnostic Imaging
   a. Radiologists are available to evaluate imaging studies 24 hours/day seven days a week.
   b. The CT scanner is available 24 hours/daily, seven days/week. Magnetic Resonance Imaging (MRI) and related techniques are available on a scheduled basis.
   c. General Radiology: available 24 hours, seven days a week.

4. Laboratory Services

   Laboratory services: available 24 hours, seven days a week.

5. Cardiology Services
   a. EKGs are available 24 hours/day seven days a week.
   b. Transthoracic Echocardiography is available during normal business hours and as on-call basis on weekends.
   c. Transesophageal Echocardiography (TEE) is available on a scheduled basis.

6. Pharmacy Services

   a. Pharmacy services: available 24 hours/day seven days a week.
   b. All medications on the Stroke Order Sets are available 24 hours/day seven days a week.

7. Rehabilitation Services

   Physical, occupational and speech therapy is available for patient assessment and therapy during hospitalization.

8. Case Management and Social Services

   Case managers and social workers with experience dealing with stroke patients and their families are a part of our interdisciplinary stroke care. They have knowledge regarding inpatient rehabilitation facilities and community resources in the geographic regions represented by our patient population.

9. Patient and Family

   The Hospital recognizes that patients and their families are an integral part of healthcare and therefore will be educated about their role and responsibility in recognizing acute strokes, calling the EMS system and stroke prevention practices. To facilitate the best delivery of care, the patients or their designees are responsible to:

   - Provide, to the best of their knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to their health. The onset of symptoms and the last time the patient was seen 'normal' are particularly important.
   - To report perceived risks to their care and unexpected changes in their condition to the

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practitioner responsible for the patient's care.

- Ask questions when they do not understand what they have been told about their care or what they are expected to do.
- Communicate any concerns they may have.

PROCEDURES:

1. **Patient Education**

An effective approach to acute stroke care requires an environment in which patients, their families, and organization staff and leaders can identify an acute stroke event. This can be accomplished through:

- Recognition and acknowledgement of stroke signs and symptoms
- Initiation of community and individualized patient education to reduce the risk of stroke
- Internal reporting of what has been found and the actions taken
- Focus on processes and systems
- Emphasizing cooperation and communication among health care providers to treat acute stroke care
- Staff education regarding medical care of acute strokes which supports the sharing of knowledge to affect behavioral changes.

2. Community Education

Periodic community education services, such as Stroke Risk Assessments and health fairs provide additional education to promote stroke prevention and awareness

3. Staff Education and Training:

Staff receive education and training during the initial orientation process and on an ongoing basis regarding job-related aspects of acute stroke management, including recognition of an acute stroke, thrombolytics treatment and time-sensitive treatment. Because the optimal provision of healthcare is provided in an interdisciplinary manner,

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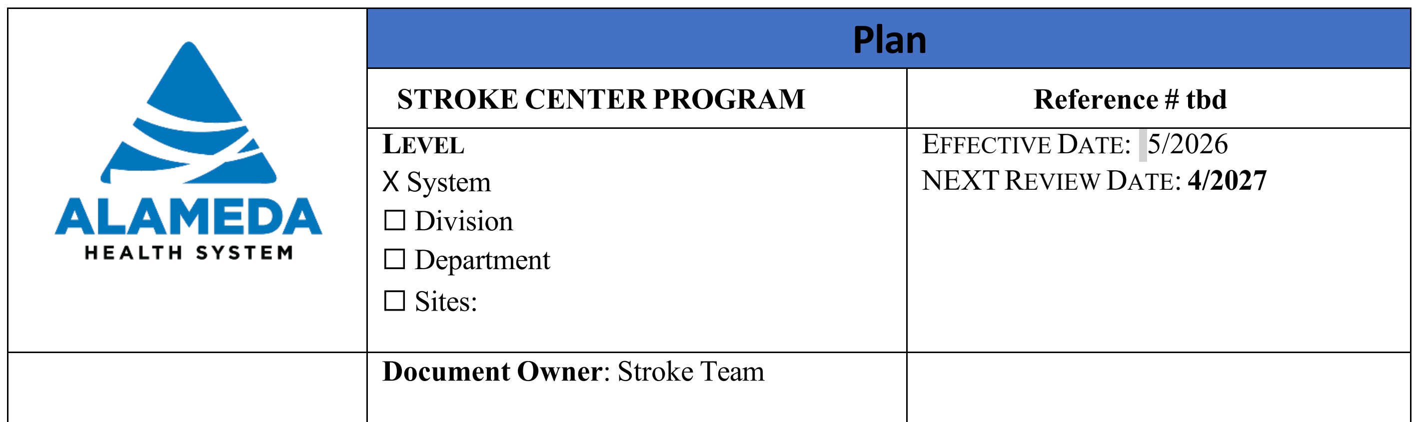

staff members are educated and trained on the provision of an interdisciplinary and team approach to patient care.

1. Nursing Education

   Nursing works collaboratively with the Stroke Team to provide ongoing stroke education. Education may be provided in one or more of the following ways:

   - Continuing education classes
   - On unit in-service
   - Unit specific skills day
   - Standard of care, protocols, discharge home instruction
   - Self-learning modules
   - Computer education

2. Medical Education

   The Stroke Team provides ongoing education to the medical staff in the form of

   - Stroke lecture series
   - CME classes
   - Stroke clinical reviews
   - Medical Department Meetings/ Grand Rounds

3. Ancillary Departments

   Stroke education is available to ancillary departments through

   - In-services
   - CEU classes
   - Stroke committee meetings

4. **Code Stroke notification system** the Code Stroke notification system is activated (5-5555) to notify appropriate personnel for urgent treatment of stroke patients.

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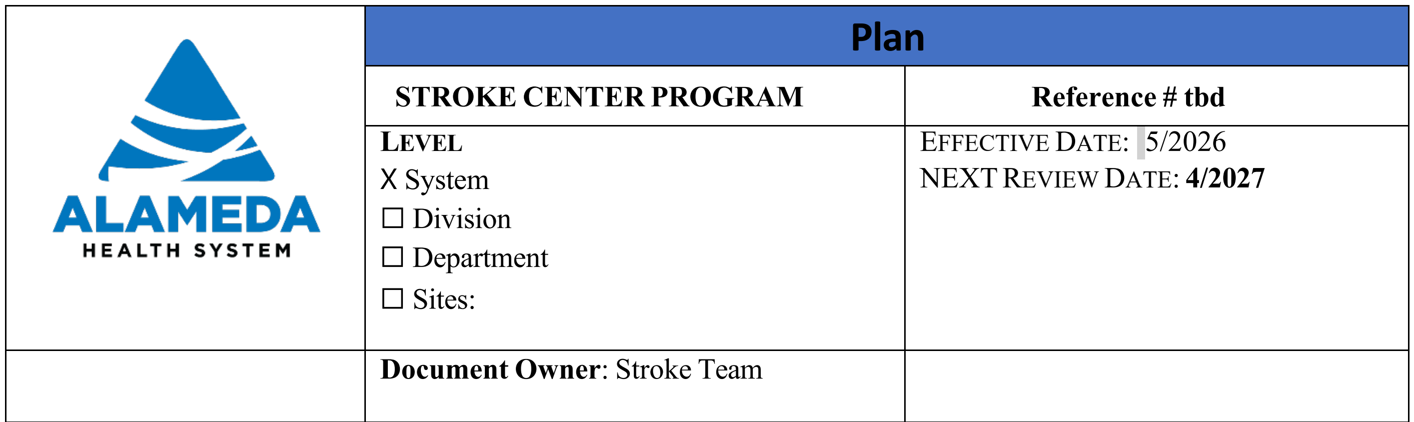

5. Stroke Protocols and Order Sets

All order sets and protocols are developed from evidence-based practices, and clinical practice guidelines as recommended by The Brain Attack Coalition and American Heart Association/American Stroke Association statements.

The Stroke Committee will follow a systematic, multi-step process for all stroke-related policies, protocols, Clinical Practice Guidelines (CPG's) and order sets.

6. Stroke Registry

Stroke patient data is entered into the hospital-based program *Get with the Guidelines* (GWTG). The stroke module of GWTG focuses on the acute treatment and the secondary prevention regimen for stroke patients and is based on the American Stroke Association/American Heart Association guidelines and is consistent with the Brain Attack Coalition recommendations.

7. Stroke Committee meeting times

The Stroke Committee meets at least four times per year, and more often as indicated

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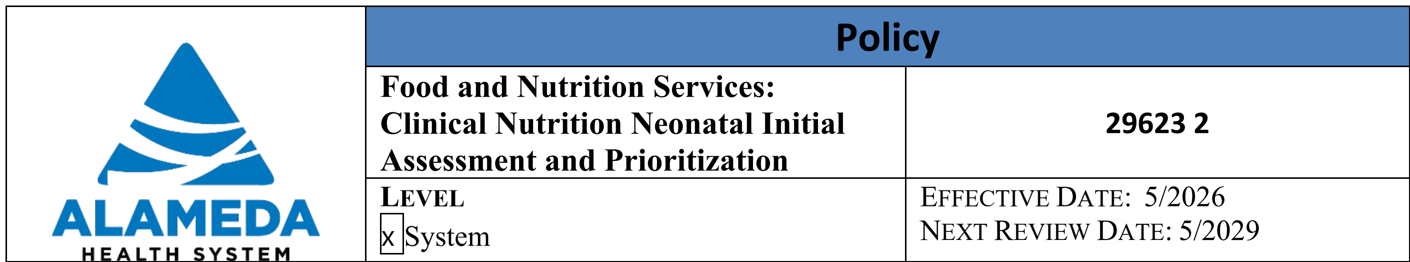
APPROVALS

Approving Committee / Executive	Date of Approval
Stroke Subcommittee Task Force	November, 2025
Alameda Hospital Stroke Committee	March 17, 2026
Highland Hospital Interdisciplinary Stroke Committee	March 24, 2026
Clinical Practice Council	April 2, 2026



	Policy	
ALAMEDA HEALTH SYSTEM	**Food and Nutrition Services: Clinical Nutrition Neonatal Initial Assessment and Prioritization**	**29623 2**
	LEVEL ☒ System	EFFECTIVE DATE: 5/2026 NEXT REVIEW DATE: 5/2029

POLICY STATEMENT

There shall be a clinical Registered Dietitian Nutritionist (RDN) who is registered by the Commission on Dietetic Registration, American Dietetic Association, available to the service providing care for all neonatal patients. RDN to use the nutrition data collected by nursing to perform the initial screening assessment and prioritization process to identify neonatal patients who may require medical nutrition therapy. All patients (including pediatric patients) identified at nutrition risk during the initial screening will be further evaluated with comprehensive assessment and receive nutrition intervention(s) when applicable.

SCOPE:

Wilma Chan Highland Hospital Family Birthing Center (FBC) and Neonatal Intensive Care Unit (NICU).

Ambulatory Care (Wellness Clinics and Highland Outpatient clinics

DEFINITIONS

RDN - Registered Dietitian Nutritionist
TPN - Total Parental Nutrition
PPN - Partial Parenteral Nutrition
NPO - Nil Per Os (nothing by mouth)
ICU - Intensive Care Unit.
NICU - Neonatal Intensive Care Unit
DM - Diabetes Mellitus
RN - Registered Nurse
SD - Standard Deviation
DOL - Day of Life

RESPONSIBILITIES

Initial Screening

Nursing

1. Obtains anthropometrics including height, weight, and head circumference within 24 hours of admission
2. The goal of a nutritional screen is to identify infants with nutrition-related problems so that those at most risk can receive adequate and appropriate nutrition support. Nutrition risk screening is completed by the registered nurse (RN) within 24 hours of admission.
3. A positive nutrition screen is triggered if the patient meets any of the following criteria:
    a. ≤1500 gm birthweight
    b. < 32 weeks gestational age at birth
    c. Small for gestational age
    d. Intrauterine growth restriction
    e. Abnormal gastrointestinal, cardiorespiratory, or renal function
    f. Inherited or acquired metabolic disease
    g. Feeding intolerance or problems
    h. Failure to grow or gain weight
    i. Parenteral nutrition >5 day
    j. Z Score comparison – decline of ≥0.8 SD (This Parameter should not be used in first 2 weeks of life)
4. Nursing then chooses 1 of 3 options regarding a nutrition referral if any of those triggers are present:

a. Yes, referral to RD triggered
b. Yes, no referral needed
c. No, not needed

Prioritization

Registered Dietitian Nutritionist

1. LEVEL 1 High Risk:
   a. Infants who trigger positively on the nutrition screen as listed above will be considered high nutrition risk (Level 1) infants regardless of whether nutrition referral is entered. These are infants who have diagnoses indicating risk of malnutrition or inability to receive adequate enteral nutrition. Additional criteria may classify the infant as high risk as indicated on page 2 of this policy. High risk infants are assessed by the RD by day of life (DOL) 4 or by day 4 of admission to the NICU. Assessment are comprehensive and address the infant's birthweight, gestational age, adequate of nutrition, nutritional problems, and a plan of care. Patients are reassessed (follow-up) on a weekly basis by the RD. When risk level increases to level 1 after the initial screening the dietitian then assesses or reassesses within 72 hours of notification of the change. The RD participates in bedside rounds, which is usually the method for notification of the change in risk level.
   b. Reassessments will be documented every 5-7 days until the nutrition risk decreases or nutrition issues are resolved.
2. LEVEL 2 Moderate to Low Risk:
   a. All other infants receive a complete nutritional assessment by DOL 8 or admission day 8. The RD will document any nutrition problems and the plan of care. The dietitian will reassess the infant every 7-10 days to assess adequacy of the plan of care and re-evaluate risk level.
   b. Nutrition Reassessment (Follow-Up): Weight changes, pertinent labs, mode of nutrient delivery, and estimated calorie and specific nutrient needs are monitored and adjusted based on gestational age and medical condition. Feeding issues are discussed with the parents as necessary. The infant's growth charts are updated weekly.

Nutrition Screening and Assessment Guidelines Overview

Assessment Parameter	High Risk Criteria (Level 1)	Moderate – Low Risk Criteria (2)
Birth weight	≤1500 grams	>1500 grams
Gestational Age	≤31 weeks	>31 weeks

Diagnosis	• Small for gestational age • Intrauterine growth retardation • Sepsis • Necrotizing Enterocolitis • Inborn Errors of Metabolism • Cardiac anomalies or Congenital Malformations with Nutrition Implications • Protracted emesis	• Neonatal seizures • Poor feeding skills • Apnea • Prematurity (if none of the high risk conditions exist) • Recurrent hypoglycemia • Large for gestational age
	• Chronic Lung Disease/Bronchopulmonary dysplasia • Failure to thrive • Nutritional rickets • Short bowel disease • Cystic fibrosis • Inflammatory bowel disease	
Other Factors	• Prolonged mechanical ventilation • Inadequate weight gain	Parenteral nutrition > 5 days
Assessment Guidelines	Initial assessment by DOL 4 or day 4 of admission to NICU Or Within 72 hours of notification of increase to high risk status from moderate or low risk	Initial assessment of DOL 8 or day 8 of admission to NICU
Z Score Comparison (should not be used in first 2 weeks of life)	• ≥ 1.2 SD	• 0.8-1.2 SD
Follow-Up	• RD will attend patient care rounds weekly to learn about infant's condition and make recommendations as needed • Reassessments will be documented every 5-7 days until risk decrease or issues are resolved	• RD will attend patient care rounds weekly to learn about infant's condition and make recommendations as needed • RD to document follow-up note every 7-10 days

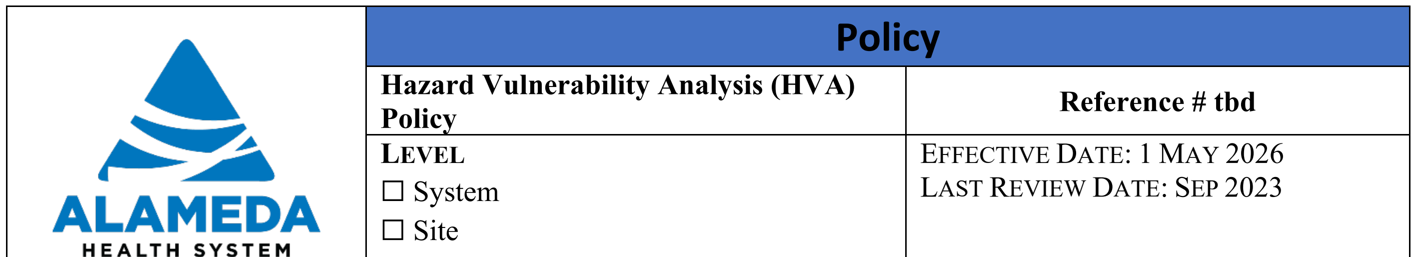
   i. One time per week (Initial assessment date is day one of the week)

b. Low Nutrition Risk: Previously high or moderate risk patients whose current nutrition care goals require minimal/infrequent re-assessment.
   i. One time per two weeks (Initial assessment date is day one of the week) or as indicated by the clinical team

c. No Nutrition Risk: When nutrition goals are met/are no longer applicable, no further nutrition diagnosis/problem is found, or when patient is on comfort care/hospice with no nutrition related interventions indicated.
   i. RDN may "sign-off" on patient and will document in EHR that future follow-up/assessment will only be provided when consulted by physician or other medical staff.

REFERENCES

1) Academy of Nutrition & Dietetics. eNCPT, 2023
2) https://www.jointcommission.org/facts_about_do_not_use_list/ (accessed 6/6/2023)
3) Joint Commission's National Patient Safety Goal #2: Improve the effectiveness of communication among caregivers.
4) Policy: Nutrition Assessment, Diagnosis, Intervention, Monitoring and Evaluation
5) 2017 Guidelines for the Provision and Assessment of Nutrition Support Therapy in the Pediatric Critically Ill Patient. JPEN J Parenteral Enteral 2017 Vol 41, Issue 5, pp. 706 – 742, Summary of 2017 Pediatric Guidelines



ALAMEDA HEALTH SYSTEM	Policy	
	Hazard Vulnerability Analysis (HVA) Policy	**Reference # tbd**
	LEVEL ☐ System ☐ Site	EFFECTIVE DATE: 1 MAY 2026 LAST REVIEW DATE: SEP 2023

POLICY STATEMENT

Alameda Health System (AHS) is committed to maintaining a safe, resilient healthcare environment by preparing for and mitigating the impact of natural and human-caused disasters. To ensure readiness, AHS will conduct an annual Hazard Vulnerability Analysis (HVA) to identify risks, determine operational impacts, and guide emergency preparedness planning across all system facilities.

PURPOSE

AHS must be prepared for a wide range of disasters and emergency situations. This policy establishes the framework for:

- Identifying and analyzing hazards that may affect AHS
- Prioritizing risks based on probability and potential impact
- Ensuring AHS can effectively prepare, respond, and recover
- Supporting the Emergency Operations Plan (EOP) and business continuity activities

The expected outcome is a data-driven assessment that informs emergency planning, drills, training, resource allocation, and mitigation strategies.

SCOPE

This policy applies to:

- All Alameda Health System hospitals, clinics, and leased facilities
- The Environment of Care (EOC) Committee
- The Emergency Management Committee
- Environmental Health & Safety (EHS)
- All departments with responsibilities in disaster response, continuity of operations, and emergency management

DEFINITIONS

Hazard Vulnerability Analysis (HVA) – A systematic method used to identify potential hazards, assess their probability of occurrence, and evaluate potential human, business, and property impacts.

Emergency Operations Plan (EOP) – The system-wide plan that outlines AHS procedures for preparing, responding, and recovering from emergencies.

Environment of Care / Emergency Management Committees – AHS committees responsible for reviewing organizational safety, regulatory requirements, and the emergency management program.

Probability of Occurrence – The likelihood that a hazard will occur within AHS's service area.

Impact Assessment – Evaluation of how a hazard affects human safety, business operations, property, and recovery capacity.

RESPONSIBILITIES

Environment of Care (EOC) / Emergency Management Committees

- Conduct the annual Hazard Vulnerability Analysis.
- Review new hazards that arise throughout the year.
- Recommend mitigation strategies and preparedness activities based on HVA results.

Environmental Health & Safety (EHS) Manager

- Facilitate completion of the HVA.
- Distribute the completed HVA to the emergency management community for review and feedback.
- Maintain documentation of all analyses and scores.

Department Leaders

- Review HVA results relevant to their operational areas.
- Implement preparedness actions or mitigation strategies as directed.

Emergency Management Community

- Review HVA results and provide input on emerging hazards, threats, or vulnerabilities.

PROCEDURES

1. Annual Hazard Vulnerability Analysis

- The EOC/Emergency Management Committees will conduct the HVA once per year.
- The analysis will identify hazards likely to impact AHS facilities, operations, staff, and patients.

2. Review of New Hazards

- The Committees may reconvene at any time during the year to reassess hazards when new information emerges, such as:
  - Environmental changes
  - Local/regional threats
  - New technology or equipment
  - Infrastructure vulnerabilities

3. Use of the Hazard Vulnerability Analysis Tool

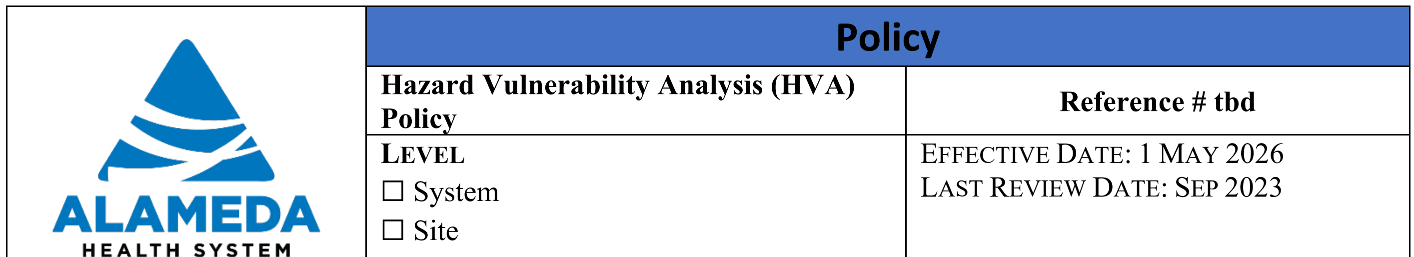
- All hazards will be listed and scored using the approved HVA tool.
- Scores will reflect:
  - Probability of occurrence
  - Potential human impact
  - Business operations impact
  - Property damage risk
  - Internal and external resource requirements
  - Recovery time and complexity

4. Documentation

- The completed HVA will be fully documented using the HVA Tool.
- The numerical scoring will inform:
  - Emergency preparedness priorities
  - Mitigation projects
  - Training needs
  - Drill and exercise scenarios

5. Distribution and Review

- The EHS Manager will share the completed HVA with:



Policy	
Hazard Vulnerability Analysis (HVA) Policy	**Reference # tbd**
LEVEL ☐ System ☐ Site	EFFECTIVE DATE: 1 MAY 2026 LAST REVIEW DATE: SEP 2023

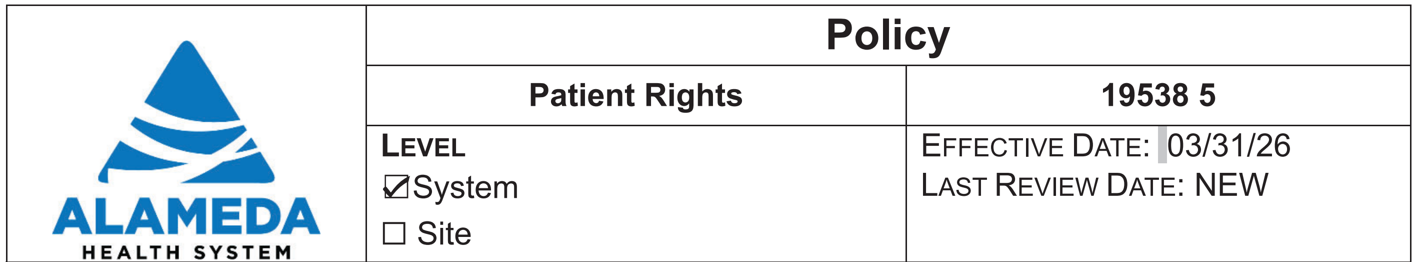
- Emergency management community partners
- Relevant internal committees
- Leadership as required

6. Integration with Emergency Management Program

- HVA results will directly inform:
  - Annual Emergency Operations Plan updates
  - Hazard-specific annex development
  - Resource planning and capital requests
  - Safety and infrastructure improvement recommendations

REFERENCES

- The Joint Commission Comprehensive Accreditation Manual for Hospitals
- Hospital Incident Command System (HICS) Guidance
- CMS Emergency Preparedness Rule
- Alameda Health System Emergency Operations Plan



ALAMEDA HEALTH SYSTEM	Policy	
	Patient Rights	19538 5
	LEVEL ☑ System ☐ Site	EFFECTIVE DATE: 03/31/26 LAST REVIEW DATE: NEW

Purpose

To educate patients about their rights and responsibilities in relation to their health care to engage them in the process and better meet their needs.

Policy

It is the policy of Alameda Health System (AHS) that all workforce members are responsible for recognizing the rights and responsibilities of patients. Alameda Health System (AHS) provides all patients or their delegate/ legal representative, as applicable, with information about patient rights and responsibilities of the patient, consistent with applicable state/federal laws.

Scope

Applies to all patients receiving care, treatment, and services from Alameda Health System. Applies to all workforce members who provide patient care, treatment, and services on behalf of the hospital.

Definitions

Patient responsibilities – Consistent with state law, the patient (and/or legal representative, as appropriate) has the following responsibilities:

- To provide information that facilitates care, treatment, and services
- To ask questions or acknowledge when the patient does not understand the treatment course or care decisions
- To follow instructions, policies, rules, and regulations that support quality care and a safe environment
- To be considerate and respectful when interacting with staff members
- To maintain civil language and conduct
- To meet financial commitments to the hospital
- To provide accurate and complete information about health-related matters
- To take an active role in making decisions about care, treatment, and services by doing the following:
  - Discussing condition and treatment with the practitioner
  - Reporting any changes to condition
  - Providing advance directive and/or expressing wishes regarding use of life support
- To cooperate with hospital staff who provide care
- To ask questions if plans or direction of care are not clearly understood
- To follow and respect the hospital's rules and regulations about patient care and conduct

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- To be considerate of the rights of other patients and staff members
- To follow guidelines about use of cameras
- To accept responsibility for actions if treatment is refused or practitioner instructions are not followed
- To provide the hospital with complete information to process insurance claims
- To arrange to pay bills within an acceptable time period
- To be responsible for belongings and not bring unnecessary items or valuables to the hospital
- To inform staff members of all information that may affect care and safety

Patient rights – Consistent with state law, the patient (and/or legal representative, as appropriate) has the following rights:

- To be informed of visitation rights, including:
  - Right to receive visitors, according to the patient's wishes and consent
  - Right to withdraw or deny consent for visitors
- To be treated with dignity and respect
- To effective communication
- To have cultural and personal values, beliefs, and preferences respected
- To personal privacy and privacy of heath information
- To pain management
- To religious or other spiritual services
- To access, request amendments to, and obtain information on disclosures of health information
- To have a family member, a friend, or another individual present for emotional support during the patient's stay
- To be free from discrimination based on age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, and gender identity or expression
- To receive information in a manner that is understandable and tailored to the patient's age, language, and ability to understand
- To receive information in a manner that meets the patient's needs when they are impaired by vision, speech, hearing, or cognitive impairments
- To be involved in making decisions about care, treatment, and services
- To have the patient's physician promptly notified of the patient's hospital admission
- To refuse care, treatment, and services and to receive information about this in writing
- To have a surrogate decision maker if the patient is unable to make decisions on their own. The surrogate decision maker has the right to refuse care, treatment, and services on the patient's behalf
- To have family involved in decision making about care, treatment, and services
- To receive information about the outcomes of the patient's care, treatment, and services that is needed to participate in current and future health care decisions
- To be informed about anticipated outcomes of care, treatment, and services that relate

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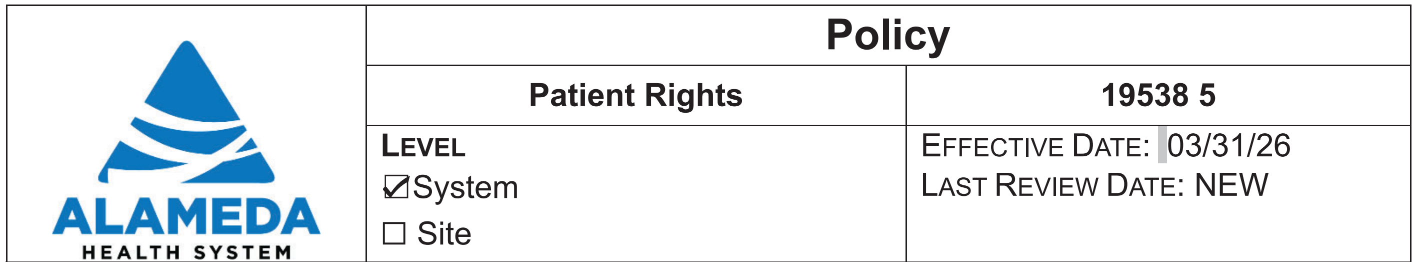

to sentinel events

- To give or withhold informed consent
- To give or withhold informed consent to produce or use recordings, films, or other images for purposes other than the patient's care
- To receive relevant information when deciding whether to participate in research, investigation, or trials, including the following:
    - Explanation of the purpose of the research
    - Expected duration of participation
    - Clear description of the procedures involved in the research
    - Statement of the potential benefits, risks, discomforts, and side effects
    - Alternative care, treatment, and services available to the patient that might prove advantageous
- To receive information about the individual(s) responsible for and providing the patient's care, treatment, and services
- To be free from neglect, exploitation, and verbal, mental, physical, and sexual abuse
- To have an environment that preserves dignity and contributes to positive self-image
- To have complaints reviewed by the hospital without being subject to coercion, discrimination, reprisal, or unreasonable interruption of care
- To access protective and advocacy services
- To discuss with a physician any ethical issues that arise during the course of care
- To request access to the hospital's Ethics Committee
- To receive information about advance directives
- To have advance directives respected and followed
- To have issues addressing autopsy and organ donation conducted in a sensitive manner
- To request and receive pastoral counseling
- To request and expect the hospital to arrange for the prompt and orderly transfer of the patient's care to others when the hospital cannot meet the patient's request or needs for care, treatment, and services

Responsibilities

Compliance with this policy and its related procedures is the responsibility of all AHS members who provide patient care, treatment, and services.

Procedures

1. Display signage explaining patient rights and responsibilities in all-access areas of the facility.
2. Provide copy of the Patient Rights information/ form to all inpatients on admission and to all outpatients on admission or registration.
3. Answer any questions about patient rights and responsibilities or provide

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information/referrals upon request.

4. Include information regarding patient's rights and responsibilities in the Patient and Family Handbook.
5. Encourage the patient and/or legal representative, as appropriate, to read the patient rights and responsibilities section of the Patient and Family Handbook. See AHS webpage for electronic copy at the following link: http://www.alamedahealthsystem.org/wp-content/uploads/2021/03/AHS-Patient-Family-Handbook-2022.pdf
6. There are individual AHS policies/protocols on the following patient rights, including but not limited to:

   a. Withholding/Withdrawing Life Sustaining Treatments
   b. Ethical Issues
   c. End of Life
   d. Advance Directives
   e. Emotional, Spiritual, and Attitudinal Support
   f. Restraints/ Seclusion
   g. Pain Management
   h. Patient Education
   i. Patient Complaints/Patient Affairs
   j. Patient Informed Consent
   k. Interpreter/ Language Service
   l. Visitors

Reference

Joint Commission Standard RI.01.01.01, EP 1. "The [hospital] has written policies on patient rights."

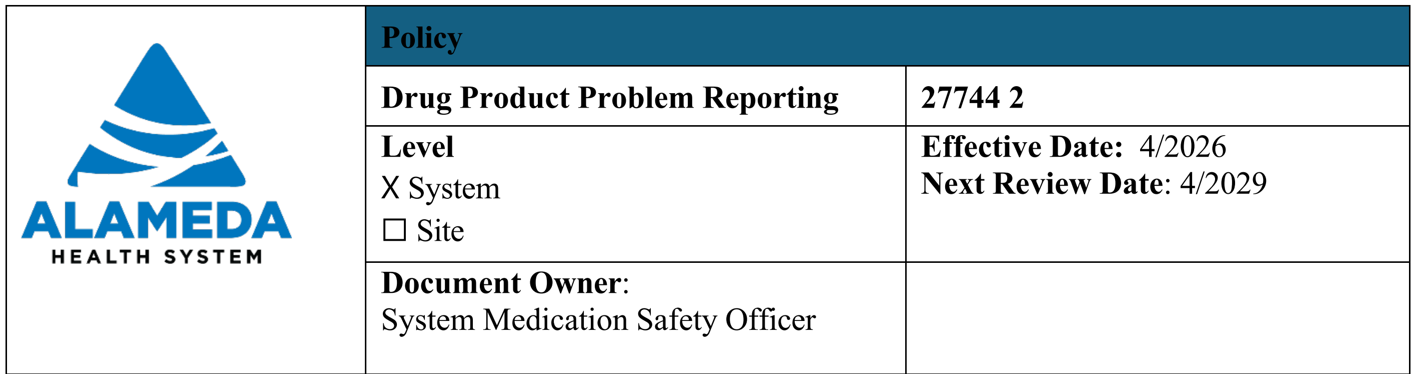
Attachment

Patient Rights Form
Patient and Family Handbook

Approvals

Clinical Practice Committee	Date:
Medical Executive Committee	Date:
Board of Trustees	Date:

approval



	Policy	
ALAMEDA HEALTH SYSTEM	**Drug Product Problem Reporting**	**27744 2**
	Level X System ☐ Site	**Effective Date:** 4/2026 **Next Review Date**: 4/2029
	Document Owner: System Medication Safety Officer	

Purpose

All drug defects or suspected counterfeit drugs should be reported to the drug product problem reporting program using one of the following procedures.

Policy

All drug defects identified, including concerns about quality, authenticity, performance, or safety, will be reported to the FDA through MedWatch Field Reports. If the drug defect is associated with a Compounded Sterile Product (CSP), an additional report will be made to the CA Board of Pharmacy within 12 hours of defect discovery.

Procedure

A. Defective Drug Prodcuts:
   1. Drug product problem reporting forms are available online through the FDA website
      a. https://www.accessdata.fda.gov/scripts/medwatch/
      b. Begin Online Report: Health Professionals (FDA Form 3500)

   2. Notify the manufacturer of the defective drug product. Indicate clearly on the product that it is not to be used and take it out of the normal storage area.
      a. Give defective drug to pharmacy buyer to hold for follow-up with the rep/manufacturer.
      b. It is also important that the department administrative assistant be notified so that credit can be pursued.

   3. After FDA has been notified about the problem, they will follow-up with a written response to the report.

   4. For quality or safety events related to CSPs, the details provided in the FDA Medwatch report should be sent to the Board of Pharmacy through email: compounding.pharmacy@dca.ca.gov

B. Counterfeit Drug Product:
   1. An illegitimate/counterfeit product for which credible evidence shows the product:
      a. Is counterfeit, diverted or stolen

approval

b. is intentionally adulterated and would result in serious adverse health consequences or death;
c. is the subject of a fraudulent transaction; or
d. appears otherwise unfit for distribution and would be reasonably likely to result in serious adverse health consequences or death.

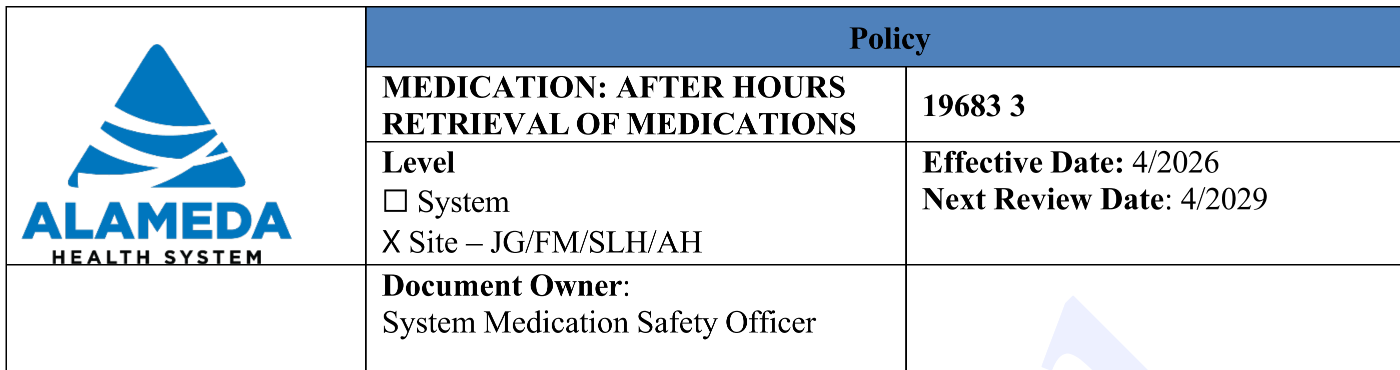
2. If a pharmacy has reasonable cause to believe that a dangerous drug or dangerous device in, or having been in, its possession is counterfeit or the subject of a fraudulent transaction, pharmacy shall notify the CA Board of Pharmacy within **72 hours** of obtaining that knowledge.
   This must be completed using the complaint form provided at the CA board of pharmacy website

3. The Drug Supply Chain Security Act (DSCSA) requires dispensing pharmacies to notify FDA and all appropriate immediate trading partners within **24 hours** after determining a product is illegitimate.
   a. https://www.accessdata.fda.gov/scripts/medwatch/
   b. Begin Online Report: Health Professionals (FDA Form 3500)

Approvals

		System	**AHS Core**	**Alameda Hospital**
Departmental	**Date:**	**3/2026**		
System Pharmacy and Therapeutics Committee	**Date:**	**3/2026**		
Clinical Practice Committee	**Date:**	**4/2026**		
Medical Executive Committee	**Date:**	**4/2026**		
Board of Trustees	**Date:**	**5/2026**		

approval



ALAMEDA HEALTH SYSTEM	Policy	
	MEDICATION: AFTER HOURS RETRIEVAL OF MEDICATIONS	**19683 3**
	Level ☐ System X Site – JG/FM/SLH/AH	**Effective Date:** 4/2026 **Next Review Date**: 4/2029
	Document Owner: System Medication Safety Officer	

Purpose

To outline the process for availability and proper retrieval of medications by the House Nursing Supervisor(s) when the pharmacy is closed.

Policy

When the pharmacy is closed, medications may be retrieved from the designated Automated Dispensing Units (Pyxis Med Stations). In the event that the medication is unavailable in the Automatic Dispensing Units, the Nursing Supervisors must follow the outlined procedure to obtain medication.

Procedure

1. It is the responsibility of the Pharmacy Management and Nursing Administrator to ensure compliance with this policy.

2. The Nursing Supervisor will assist the charge nurse of the unit to help procure the medication if it is not available in their designated Pyxis Med Station.

3. The Nursing Supervisor will use the Global Find feature in the Pyxis Med Station to locate an alternate location of the medication in the hospital

4. The Supervisor will deliver the medication to the floor, where the patient's nurse will verify the medication against the physician order prior to administration.
    a. The Nurse Supervisor may NOT perform the following functions:
        i. Fill take-home prescriptions for hospital patients or emergency room patients.
        ii. Give prescription information to an outside pharmacy.
    b. For intravenous admixtures, see policy "Intravenous Admixture Program Policy" and policy "Immediate- Use compounding Policy for Nursing Personnel."

5. If the order calls for a drug not available in any of the Pyxis Med Stations and is deemed emergent to be administered before the pharmacy is open, the supervisor is to call the remote services pharmacist for consultation and recommendation for therapeutic alternative if appropriate.

6. If the facility has an on- call Pharmacist, they may be asked to come into the hospital to dispense the medication if necessary, or to arrange for medication to be provided from another facility if appropriate.

7. If the Facility does not have an on- call Pharmacist, the Nursing Supervisor may arrange for delivery of medication from the hospital that provides order verification for the facility.

8. House Nursing Supervisor Orientation and Competency
    a. The House Nursing Supervisor will be oriented to the proper pharmacy procedures to retrieve medications after the pharmacy is closed.
    b. Each House Resource Supervisor will demonstrate competencies annually of the procedures to retrieve medications after pharmacy is closed. A Pharmacist will document the competencies on the Nursing Competency Assessment Form.
    c. Based on need, Pharmacy shall coordinate with the Department of Nursing to provide nursing education on new technology, processes, and information that impact nursing role in the medication use process.

Approvals

		System	AH	AHS Core
Pharmacy Departmental	**Date:**	**3/2026**		
Pharmacy and Therapeutics Committee	**Date:**	**3/2026**		
Quality and Safety Committee	**Date:**	**4/2026**		
Medical Executive Committee	**Date:**	**4/2026**		
Board of Trustees	**Date:**	**5/2026**		

approval

SAN LEANDRO PHARMACY DEPARTMENT
House Resource Supervisor Competency Assessment

NAME: ____

COMPLETION OF THIS CHECK LIST IS MANDATORY. IT WILL BE PLACED IN YOUR PERSONNEL FILE.

This check list is designed to:

1. Help you and your preceptors keep track of your progress during orientation as either a new employee or annual competency assessment.
2. Document your competency in skills required to assure your functioning as a safe and qualified employee.
3. How competencies are met: **Direct Observation/ Demonstration**

COMPETENCY STANDARD	MET	NOT MET	N/A
A. Review Policy and Procedure for Entry			
B. Ability to Locate Reference Materials			
C. Ability to locate PO medications			
D. Ability to locate Injectable Meds			
E. Ability to locate EENT Meds			
F. Ability to locate Bulk (PO and External)			
G. Ability to follow P&P on First Dose			
H. Proper Sign-Out Procedure			
I. Ability to locate On-Call Pharmacist Schedule			
J. Use of the Night Locker			
K. Ability to locate and use Night Locker and Automated Dispensing Machine (ADM) Binder to find the meds			
L. Proper recording of data for Night Locker			
M. Procuring Medication from Outside Source			

House Resource Supervisor signature:____________________________ Date:_____________

Reviewing Pharmacist signature: ___ Date: _

approval

Title: ANTICOAGULANT THERAPY IN PATIENTS UNDERGOING PCI

Department	Cardiology Services	*Effective Date*	2/2016
Campus	Highland Hospital	*Date Revised*	10/2015, 2/2019, 3/2026
Category	Clinical	*Next Scheduled Review*	04/2029
Document Owner	Cardiology Division Chief	*Executive Responsible*	Chief Administrative Officer/ Chief Nurse Executive

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

Purpose

To provide guidelines for periprocedural anticoagulation for patients undergoing Percutaneous Coronary Intervention (PCI).

Policy

An anticoagulant will be administered to patients undergoing PCI to reduce the risk of intracoronary and catheter thrombus formation. The choice of anticoagulant will be upon discretion of the Interventional Cardiologist, and may include unfractionated heparin (UFH), enoxaparin or bivalirudin.

Procedure

1. Patients who have not received therapeutic anticoagulation in the 12 hours prior to the procedure, will receive either:
   a. Bivalirudin at 0.75 mg/kg loading dose , followed by 1.75 mg/kg/h IV infusion, or
   b. UFH at 70-100 U/kg loading dose for target ACT of 250-300 s, if no IV glycoprotein IIb/IIIa inhibitor (GPI) is planned, or
   c. UFH at 50-70 U/kg loading dose for target ACT of 200-250 s, if IV GPI is planned.

2. Patients who have received prior UFH will receive either:
   a. Additional UFH as needed to maintain ACT of 250-300 s, if no IV GPI planned, or
   b. Additional UFH as needed to maintain ACT of 200-250 s, if IV GPI is planned, or
   c. Bivalirudin at the usual loading dose followed by the drip, 30 minutes after UFH has been discontinued.

3. Patients who have received prior enoxaparin within the prior 12 hours will receive either:
   a. Bivalirudin at the usual loading dose followed by the drip, or
   b. An IV dose of enoxaparin at 0.3 mg/kg, if the last SC enoxaparin dose was administered 8-12 h earlier.

4. Bivalirudin and enoxaparin doses will be adjusted, as appropriate for patients with reduced kidney function.

References

1. Rao SV, et al. 2025 ACC/AHA/ACEP/NAEMSP/SCAI Guideline for the Management of Patients With Acute Coronary Syndromes: A Report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines. *Circulation*. 2025;151:e771–e862.
2. Sunil V. Rao et al. Anticoagulant Therapy for Percutaneous Coronary Intervention. Circulation: Cardiovascular Interventions. 2010; 3: 80-88

Approvals

		System	**Alameda Hospital**	**AHS Core**
Cardiology Department	**Date:**	**3/2026**		
Pharmacy	**Date:**	**3/2026**		
System Pharmacy & Therapeutics Committee	**Date:**	**3/2026**		
Clinical Practice Council	**Date:**	**4/2026**		
Medical Executive Committee	**Date:**	**4/2026**		
Board of Trustees	**Date:**	**5/2026**		

Alameda Health System

VACCINE FOR CHILDREN PROGRAM

Department	AMBULATORY SVCS ADMINISTRATION	Effective Date	5/05
Campus	All	Date Revised	4/05, 7/06, 1/07, 4/2010, 1/2014, 1/2017, 5/2022, 2/2026
Unit	All	Next Scheduled Review	3/2029
Manual	Pharmacy	Author	System Ambulatory Pharmacy Operations Manager
Replaces the following Policies: Medication and Vaccine Receiving and Storage (Ambulatory Policy)		Responsible Person	ACMO - Ambulatory

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

Purpose

To provide guidelines for the safe handling of vaccines provided by the California Department of Public Health- Vaccine for Children (VFC) program and meet program requirements.

Policy

Ambulatory Clinic management in coordination with the pharmacy will meet the VFC program requirements as required by the California Department of Public Health (CDPH). AHS policy will correspond to the yearly updates for the VFC Program Participation Requirements. Categories of this policy include:

VFC Requirements at a Glance 2026

1) Enrollment and Recertification
   a. Provider Profile
   b. Training
2) Vaccine Management
   a. Vaccine Management Plan
   b. Vaccine Storage Units
   c. Storage Unit Configuration
   d. Digital Data Loggers (DDLs)
   e. Digital Data Logger Configuration and Maintenance
   f. Vaccine Orders & Accountability
   g. Receiving Vaccine Deliveries
   h. Vaccine Storage
   i. Monitoring Storage Unit Temperatures
   j. Taking Action for Temperature Excursions
   k. Vaccine Inventory Management
   l. Reporting Waste and Returns
   m. Vaccine Transfers & Transports
3) Vaccine Administration
   a. Eligibility Screening & Documentation, Vaccine Administration, Reporting Doses

Administered

b. Billing for Vaccine Administration

4) Program Integrity

a. Site Visits

b. Fraud and Abuse

c. Record Retention

d. Enrollment, Recertification & Termination

VFC providers are required to agree to order and provide all age-appropriate ACIP-recommended vaccines to VFC eligible patients. VFC providers agree to follow all immunization recommendations from the American Academy of Pediatrics (AAP), recognizing that VFC supply of vaccine should **not** be used for recommendations that fall outside of ACIP-recommended vaccines and age ranges.

Vaccinations are to be administered in a manner that is consistent with the AHS Medication Administration Policy.

Background

The Vaccine for Children Program originates from the US. Centers for Disease Control and Prevention (CDC) through the National Center for Immunization and Respiratory Diseases and is administered through the California Department of Public Health (CDPH). Alameda Health System (AHS) clinics are eligible to participate in the VFC program as AHS clinics are Federally Qualified Health Centers. Vaccine is supplied to the clinics at no cost for VFC eligible children (0-18 years old).

Procedure

Enrollment and Recertification

1. Provider Profile

a. AHS will annually submit a provider profile representing the VFC-eligible populations served by my practice/facility and the privately insured (i.e., non-VFC eligible) population we plan to vaccinate. AHS will submit more frequently if a) the number of children served changes or b) the status of the facility changes during the calendar year. (VFC "Provider Agreement" #1)

b. Designate the on-site Provider of Record Designee, who is authorized to sign VFC Program documents and assume responsibility for VFC-related matters in the absence of the Provider of Record. (California VFC Program "Provider Agreement Addendum" #1A)

c. Designate the on-site Vaccine Coordinator and Backup Vaccine Coordinator (PDF), who are responsible for updating and implementing the practice's vaccine management plan (Word). (P.A.A. #1B)

d. Immediately report in myCAvax any changes to key practice staff roles (Vaccine Coordinator or Backup, Provider of Record or Designee); any changes to the Provider of Record or Designee require an electronic signature by the Provider of Record. (P.A.A.

#1C)

e. Immediately report to the VFC Program changes to the practice address or account ownership, which may require additional follow-up. (P.A.A. #1D)

f. Definitions:

    i. Provider of Record (POR): The on-site physician-in-chief, medical director, or equivalent, who signs the VFC “Provider Agreement” and the California VFC Program “Provider Agreement Addendum” and is ultimately accountable for the practice’s compliance. Must be a licensed MD, DO, NP, PA, pharmacist, or a Certified Nurse Midwife with prescription-writing privileges in California.

    ii. Provider of Record Designee: On-site staff designated by the Provider of Record with sufficient authority to assume responsibility for VFC-related matters in their absence.

    iii. Vaccine Coordinator: An on-site employee who is fully trained and responsible for implementing and overseeing the practices vaccine management plan. The Vaccine Coordinator (PDF) might be responsible for all vaccine management activities, including training other (especially new) staff. This role might be filled by medical assistants, LVN, RN, office manager, or other trained staff.

    iv. Backup Vaccine Coordinator: On-site staff who is fully trained in and fulfills the responsibilities of the Vaccine Coordinator in their absence.

g. Optional Roles

    i. Organization Vaccine Coordinator: Large organizations may assign this role to coordinate communications across locations and ensure staff are properly trained to implement their vaccine management plan. This role must complete all required training for the Vaccine Coordinator role.

    ii. Additional Vaccine Coordinator: Add an additional vaccine coordinator to share vaccine management responsibilities if needed. This role must complete all required training for the Vaccine Coordinator role and should be on-site when feasible.

    iii. Immunization Champion: A staff member who goes above and beyond their normal duties to promote immunizations to patients and in the community.

2. Training

a. Providers may take the required EZIZ lessons that satisfy educational requirements for enrollment and annual recertification once the California VFC Program has launched recertification, typically around mid-December. For recertification, look for annual program communications that announce available training test-out options.

b. Anyone acting in VFC roles (Provider of Record and Designee, Vaccine Coordinator and Backup, or the optional Organization Vaccine Coordinator and Additional Vaccine Coordinator roles) must complete the required EZIZ lessons when hired and annually thereafter; staff must demonstrate competency in their assigned VFC roles. (California VFC Program “Provider Agreement Addendum” #3A)

c. Any clinician who administers VFC-supplied vaccines must be knowledgeable of and familiar with all American Academy of Pediatrics (AAP) immunization recommondations, all ACIP-recommended immunizations, including schedules, indications, dosages, and new products. (P.A.A. #3B)

d. All staff who conduct VFC Program eligibility screening, documentation, and billing (e.g., front- or back-office staff) must be knowledgeable of all VFC eligibility categories, documentation, and billing for administration and general billing guidelines. Ensure proper training of personnel, including admitting and billing personnel, on processes for screening and billing for administration fees. (P.A.A. #3C)

e. All staff and supervisors who monitor storage unit temperatures or sign off on temperature logs must complete the related EZIZ lesson when hired and annually thereafter; they must be fully trained on use of the practice's data loggers and actions required after a temperature excursion is discovered. (P.A.A. #3D)

f. Train staff who are authorized to accept packages to immediately notify the Vaccine Coordinator when VFC-supplied vaccines are delivered. (P.A.A. #3E)

g. Conduct vaccine transport and temperature excursion response drills annually or more frequently as needed (e.g., when hiring new staff or staff errors are discovered) to maintain competency and readiness for emergencies. (P.A.A. #3F)

Vaccine Management

1. Vaccine Management Plan

a. VMP - http://eziz.org/assets/docs/IMM-1122.docx
b. Each site will maintain a current and completed Vaccine Management Plan (VMP) for routine and emergency use that includes practice-specific guidelines and protocols, with names of staff who have temperature monitoring responsibilities, and completion dates of required EZIZ lessons. (California VFC Program "Provider Agreement Addendum" #2A)
c. Staff with assigned vaccine-management responsibilities must review, sign, and date the vaccine management plan annually and each time it is updated, when VFC Program requirements change, and when staff with designated vaccine-management responsibilities change. (P.A.A. #2B)
d. Follow emergency guidelines to prepare for, respond to, and recover from any vaccine-related emergencies. (P.A.A. #2C)
e. Store or post the vaccine management plan in a location easily accessible by staff ideally near the vaccine storage units; and ensure relevant staff are trained to follow guidance when needed. (P.A.A. #2D).

2. Vaccine Storage Units

a. Providers agree to store all publicly supplied vaccines in vaccine refrigerators and freezers that meet California VFC Program requirements. Adherence to storage and handing requirements is certified as part of annual provider recertification and during both routine and unannounced site visits conducted by CDPH Field Representatives.
   i. Do not store vaccine in dormitory-style units or in the freezer compartment of household combination units at any time. (VFC "Provider Agreement" #9B)
   ii. Store vaccine under proper storage conditions at all times. Refrigerator and freezer vaccine storage units and temperature monitoring equipment and practices must meet California Department of Health Vaccines for Children

Program storage and handling recommendations and requirements. (P.A. #9C)

iii. Have refrigerators and freezers that comply with CA VFC Program's storage unit requirements: Very high-volume provider locations must use purpose-built (pharmacy-grade, biologic-, or laboratory-grade) refrigerators. Other provider locations may use refrigerators and freezers that are purpose-built (preferred) or commercial-grade (acceptable). Household-grade, stand-alone refrigerators are discouraged. Purpose-built combination units, including auto-dispensing units without doors, are allowed. Notes: (1) Exception for specialty provider locations such as birthing hospitals: Freezer units are not required. (2) Ultra-low temperature freezers are allowed for storage of Pfizer COVID19 vaccines but are not required. (California VFC Program "Provider Agreement Addendum" #4A)

iv. Manual-defrost freezers are allowed for use if the practice has access to an alternate storage unit when defrosting the freezer. (Note: Defrost manual-defrost freezers only when frost exceeds 1cm or the manufacturer's suggested limit.) The alternate storage unit must have appropriate freezer temperatures and be monitored using a CA VFC-compliant digital data logger. Never store VFC-supplied vaccines in a cooler while defrosting manual defrost freezers. (P.A.A. #4B)

v. Never use any of the following for routine vaccine storage: household-grade, combination refrigerator-freezers; compact, household-grade, stand-alone refrigerators with capacity 11 cubic feet or less; dormitory-style or bar-style combination refrigerator/freezers; manual-defrost refrigerators; convertible units; cryogenic (ultra-low) freezers; or any vaccine transport unit (including coolers and battery-operated units). (P.A.A. #4C)

vi. Purchase new refrigerators (purpose-built) or freezers (any grade) if existing storage units malfunction frequently or experience frequent temperature excursions; update new storage unit information in myCAvax and the provider's vaccine management plan. (P.A.A. #4D)

3. Vaccine Storage Unit Configuration

a. Prepare vaccine refrigerators and vaccine freezers following VFC Program requirements. (California VFC Program "Provider Agreement Addendum" #5A)

b. Place water bottles (in refrigerators) and ice packs (in freezers only) to stabilize temperatures. (Exception for pharmaceutical grade and purpose-built, auto-dispensing units without doors. Follow manufacturer's guidance.) (P.A.A. #5B)

c. Place data logger buffered probes vertically in the center of refrigerators and freezers near vaccines. (Exception for purpose-built, auto-dispensing units without doors. Follow manufacturer's guidance.) (P.A.A. #5C)

d. Place data logger digital displays outside vaccine storage units to allow temperature monitoring without opening vaccine storage unit doors. (Exception for purpose-built, auto-dispensing units without doors.) (P.A.A. #5D)

e. Plug in only one storage unit per electrical outlet that does not have built-in GFI circuit switches and is not controlled by light switches; never plug vaccine storage units into extension cords, or power strips or surge protectors with an on/off switch. (P.A.A. #5E)

f. Post Do Not Unplug (PDF) signs on electrical outlets and circuit breakers to prevent interruption of power. (P.A.A. #5F)

g. Set up vaccine refrigerators and freezers (PDF) following CA VFC Program requirements. (P.A.A. #5G)

h. Clearly identify unit space or containers that will store VFC-supplied and privately

purchased vaccines. (P.A.A. #5H)

i. Group vaccines by pediatric, adolescent, and adult types. (P.A.A. #5I)

j. Allocate enough space to position vaccines or baskets 2-3 inches away from walls, storage unit floor, and other baskets to allow space for air circulation. (Exception for purpose-built, auto-dispensing units without doors.) (P.A.A. #5J)

k. Post the CDPH universal temperature log (PDF) on vaccine storage unit doors or in an easily accessible location. (P.A.A. #5K)

4. Digital Data Loggers (DDLs)

a. Continuous temperature monitoring is an essential component of each provider's vaccine management plan. All staff and supervisors who monitor storage unit temperatures or sign off on temperature logs must be properly trained in the use of the practice's digital data loggers.

b. Store vaccine under proper storage conditions at all times. Refrigerator and freezer vaccine storage units and temperature monitoring equipment and practices must meet California Department of Health Vaccines for Children Program storage and handling recommendations and requirements. (VFC "Provider Agreement" #9C)

c. Equip all refrigerators and freezers (primary, backup, overflow, or any other temporary unit) storing VFC-supplied vaccines with CA VFC-compliant digital data loggers. (For purpose-built, auto-dispensing units without doors: Built-in, internal data loggers must meet VFC Program requirements—except for buffered probes, which are not required.) (California VFC Program "Provider Agreement Addendum" #6A)

d. Only use data loggers that include the following minimum features: a digital display of current, minimum, and maximum temperatures; minimum accuracy of ±1.0°F (0.5°C); a buffered temperature probe (only use the probe that comes with the device) immersed in a vial filled with up to 60mL liquid (e.g., glycol, ethanol, glycerin), loose media (e.g., sand, glass beads), or a solid block of material (e.g., Teflon®, aluminum); an audible or visual out-of-range temperature alarm; logging interval of 30 minutes; a low-battery indicator; and memory storage of 4,000 readings or more. A battery source is required for backup devices used during vaccine transport. Note: Ultra-low temperature freezers are not required but must be equipped with an air-probe or a probe designed specifically for ultra-cold temperatures. (P.A.A. #6B)

e. Digital data loggers, including backup digital data loggers, must be able to generate a summary report of recorded temperature data since the device was last reset; summary reports must include minimum and maximum temperatures, total time out of range (if any), and alarm settings. Devices that only generate CSV data files or Excel spreadsheets are not acceptable. (P.A.A. #6C)Keep on hand at least one backup, battery-operated, digital data logger for use during recalibration, when primary device breaks, when primary device does not meet calibration requirements, or during emergency vaccine transport. Depending on size of the practice, additional devices might be needed. (P.A.A. #6D)

f. Digital data loggers must have a current and valid certificate of calibration (PDF), including backup digital data loggers. (P.A.A. #6E)

5. Digital Data Logger Configuration and Maintenance

a. Configure key settings (PDF) for primary and backup digital data loggers, including device name, low and high temperature alarm limits, immediate notification of out-

of-range temperatures, and a maximum logging interval of 30 minutes. (California VFC Program "Provider Agreement Addendum" #7A)

b. Store the backup data logger's buffered probe in the vaccine refrigerator and keep its digital display separately in a cabinet; document the device's location on the practice's vaccine management plan (Word). (Exception for purpose-built, auto-dispensing units without doors: Store the entire device in a cabinet.) (P.A.A. #7B)
c. Calibrate primary and backup devices (both device and probe together) every two to three years or according to the manufacturer's suggested timeline—ideally by a laboratory with accreditation from an International Laboratory Accreditation Cooperation (ILAC) Mutual Recognition Arrangement (MRA) signatory body. Notes: If the manufacturer supplies a pre-calibrated replacement probe upon device calibration expiration, the device and probe do not need to be calibrated together. (P.A.A. #7C)
d. Certificates issued by non-accredited laboratories must meet CA VFC Program requirements for certificates of calibration (PDF). (P.A.A. #7D)
e. Calibrate primary and backup devices on different schedules to ensure all refrigerators and freezers storing VFCsupplied vaccines are equipped with data loggers at all times. (P.A.A. #7E)
f. Keep certificates of calibration on file and make available to the VFC Program upon request. (P.A.A. #7F)
g. Purchase a new data logger if existing device or probe malfunctions, is damaged, or if device provides repeated, inaccurate temperature readings. (Exception for replacement probes recommended and replaced by the device manufacturer.) Update new device information in myCAvax and the provider's vaccine management plan. (P.A.A. #7G)

6. Vaccine Orders & Accountability

a. Providers submit vaccine order requests in myCAvax for all available vaccines including flu, RSV and COVID-19. Product offering may be impacted by vaccine supply. Vaccine orders should be carefully timed to minimize under-ordering (insufficient inventory to meet demand) and over-stocking (preventable loss if doses expire before use).
b. Order vaccine and maintain appropriate vaccine inventories. (VFC "Provider Agreement" #9A)
c. For providers that plan to vaccinate any non-VFC eligible population according to their provider profile, I agree to purchase and maintain a separate vaccine inventory to vaccinate my non-VFC-eligible population. Non-VFC-eligible populations include a) Fully insured children, b) Other underinsured children (served by a provider/facility that is not a FQHC/RHC or a deputized provider), c) Enrolled in CHIP. (P.A. #15)
d. Order in myCAvax all ACIP-recommended vaccines (including flu, RSV, and special-order vaccines), and non-routine vaccines when indicated or requested, to meet the needs of the total VFC-eligible patient populations reported for the provider PIN. (California VFC "Provider Agreement Addendum" #8A)
e. Order only one brand and formulation for each vaccine to avoid administration errors. Notes: Under limited circumstances, providers may be allowed to order more than one brand or formulation with VFC Program approval. (2) Any changes to vaccine brand ordering require a Vaccine Brand Change Request Form (PDF). (P.A.A. #8B)
f. Order all vaccine doses in sufficient quantities to last until the next order period; order

quantities must factor in VFC vaccine doses administered (since the previous order) as reported to the California Immunization Registry (CAIR or CAIR/Healthy Futures) and the VFC doses on hand (at the time of the order). (P.A.A. #8C)

g. Order vaccines according to the provider location's assigned order frequency or as guided by the CA VFC Program; provider locations who have not ordered and administered all ACIP-recommended vaccines for their patient population in the past 12 months will be terminated from the VFC Program. Notes: (1) Vaccines ordered solely to prevent account termination and are lost due to expiry will be considered a negligent loss. (2) Newly enrolled providers must order within 3 months to maintain their active enrollment in the VFC Program. (P.A.A. #8D)
h. Order vaccines using the approved practice address for the provider PIN. (P.A.A. #8E)
i. Account for every dose of VFC-supplied vaccine ordered and received by the provider location. (P.A.A. #8F)
j. Report all VFC vaccine doses administered (since the previous order) and doses on hand (at the time of the order) on each vaccine order. Vaccine doses administered must be based on actual vaccine administration logs or registry/EMR administration summary reports. (P.A.A. #8G)
k. Maintain accurate and separate stock vaccine records (e.g., purchase invoices, receiving packing slips) for privately purchased vaccines if vaccinating non-VFC patients with ACIP-recommended vaccines and make records available to the VFC Program upon request. (P.A.A. #8H)

7. Receiving Vaccine Deliveries

a. Never reject vaccine shipments. (California VFC Program "Provider Agreement Addendum" #9A)
b. Receive, inspect, and store vaccines and diluents within manufacturer-recommended ranges immediately upon delivery. (P.A.A. #9B)
c. Immediately report any shipment incidents in myCAvax; providers are encouraged to use the Vaccine Receiving Checklist (PDF) to gather the necessary reporting data. (P.A.A. #9C)
d. Keep packing slips for all vaccine shipments received, including publicly funded and private vaccine shipments. (P.A.A. #9D)
e. The provider location must be open with staff available to receive vaccines at least one day a week (other than Monday) and for at least four consecutive hours. (P.A.A. #9E)

8. Vaccine Storage

a. Always store vaccine under proper storage conditions. Refrigerator and freezer vaccine storage units and temperature monitoring equipment and practices must meet California Department of Health Vaccines for Children Program storage and handling recommendations and requirements. (VFC "Provider Agreement" #9C)
b. Dedicate vaccine refrigerators and freezers to the storage of vaccines only; if storage of medications or biologics is necessary, store below vaccines on a different shelf. (California VFC Program "Provider Agreement Addendum" #10A)
c. Store all frozen vaccines (Merck MMR, MMRV, Varicella, and Moderna COVID-19) between -58.0°F and 5.0°F (-50.0°C and -15.0°C) according to manufacturer recommendations. (P.A.A. #10B)
d. Store all other refrigerated vaccines between 36.0°F and 46.0°F (2.0°C and 8.0°C) according to manufacturer recommendations. (P.A.A. #10C)
e. Store vaccines in original packaging and allow space for air circulation. (P.A.A. #10D)
f. Store VFC-supplied and privately purchased vaccines separately and grouped by vaccine

type. (P.A.A. #10E)

g. Do not store vaccines in doors, vegetable bins, floor, or near/under cooling vents. (P.A.A. #10F)
h. Place vaccines with the earliest expiration dates toward the front of vaccine storage units and use first. (P.A.A. #10G)
i. Always store VFC-supplied vaccines at the approved location for the provider PIN. (P.A.A. #10H)

9. Monitoring Storage Unit Temperatures

a. Monitoring storage unit temperatures consistently and accurately plays an important role in protecting the vaccines that protect your patients. Twice daily temperature monitoring helps to prevent loss of expensive vaccines and potential need for revaccination of patients by identifying out-of-range temperatures quickly and allowing for immediate corrective action.
b. AHS agrees to replace vaccine purchased with federal funds that are deemed non-viable due to provider negligence on a dose-for-dose basis. (VFC "Provider Agreement" #13)
c. Record vaccine storage unit temperatures on the CDPH universal temperature log (PDF). (California VFC Program "Provider Agreement Addendum" #11A)
d. Monitor and record (PDF) current, minimum, and maximum temperatures twice each day: at the beginning and end of each business day. (P.A.A. #11B)
e. Temperature logs must be legible and completed accurately and in ink. (P.A.A. #11C)
f. Neatly cross out, correct, initial, and date any inadvertent documentation error immediately. (P.A.A. #11D)
g. Download temperature data files, review, and respond to any unreported out-of-range temperatures at the end of every two-week reporting period. (P.A.A. #11E)
h. The supervisor must certify and sign that temperatures were recorded twice daily, staff printed names and initials, and any temperatures excursions were documented with corrective actions taken for each completed temperature log sheet. (P.A.A. #11F)
i. Replace vaccines (on a dose-for-dose basis) as instructed by the CA VFC Program if storage unit temperatures are not monitored and documented, if temperature logs or temperature data files are falsified, or if temperature logs or temperature data files are missing during a site visit. (P.A.A. #11G)
j. Retain temperature logs and temperature data files for three years—even if the provider is no longer participating in the CA VFC Program due to provider-initiated withdrawal or VFC-initiated termination. (P.A.A. #11H)

10. Taking Action for Temperature Excursions

a. Vaccines stored out of range might be deemed non-viable and considered a negligent vaccine loss. A temperature excursion does not automatically mean that exposed vaccines are non-viable or unusable. Staff must immediately prevent use of vaccines exposed to out-of-range temperatures and notify relevant staff. The data collected when reporting temperature excursions is used to determine whether a vaccine is likely to be viable and can be administered to patients.
b. Take immediate action to prevent vaccine spoilage and correct any improper storage condition for all out-of-range storage unit temperatures. (California VFC Program "Provider Agreement Addendum" #12A)
c. Respond to all data logger alarms and temperature excursions. Quarantine and do not administer vaccines exposed to out-of-range temperatures until vaccine viability has been determined. (P.A.A. #12B)
d. Identify and report in myCAvax every temperature excursion from any data logger that is

recording temperatures for a unit storing VFC-supplied vaccines and comply with any instructions provided. Communicate temperature excursions to vaccine manufacturers if instructed by myCAvax. (P.A.A. #12C)

e. Never discard affected vaccines unless advised by vaccine manufacturers, the CA VFC Program, or Field Representatives. (P.A.A. #12D)
f. Transport vaccines in the event of extended power outages or unit malfunctions following the guidelines for proper refrigerated (PDF) and frozen vaccine transport (PDF). (P.A.A. #12E)

11. Vaccine Inventory Management

a. Careful inventory management ensures providers maintain an adequate vaccine supply for all patients represented in their profile. A physical count of vaccines might be required if the number of VFC doses on hand doesn't match the quantities reported on previous vaccine orders. Remove spoiled or expired vaccine immediately to minimize administration errors.
b. Conduct a physical vaccine inventory at least monthly, and before ordering vaccines, using the Vaccine Inventory Form (PDF) or equivalent electronic or paper form. (California VFC Program "Provider Agreement Addendum" #13A)
c. Never borrow VFC-supplied vaccines to supplement private or other publicly funded vaccine stock, or vice versa. (P.A.A. #13B)
d. For vaccines that will expire within 6 months and cannot be used, follow VFC Program requirements to notify and transfer short-dated doses to another active VFC provider to prevent a negligent vaccine loss. Note: For providers with expired vaccines who ordered the minimum quantity or ordered seasonal vaccines (e.g., COVID-19, flu, and RSV), vaccines will not be considered a negligent loss. (P.A.A. #13C)
e. Remove spoiled, expired, deauthorized, and wasted vaccines from storage units to prevent inadvertent use. (P.A.A. #13D)
f. Monitor vaccine storage units regularly and purchase additional storage units if capacity cannot accommodate the inventory in a manner consistent with CA VFC Program requirements. (P.A.A. #13G)

12. Reporting Waste & Returns

a. Return all spoiled/expired public vaccines to CDC's centralized vaccine distributor within six months of spoilage/expiration. (VFC "Provider Agreement" #9D)
b. Report in myCAvax all spoiled, expired, or wasted doses of VFC-supplied vaccines prior to submitting a new vaccine order. (California VFC Program "Provider Agreement Addendum" #13E)
c. Confirm with vaccine manufacturers and/or the CA VFC Program before reporting any VFC-supplied vaccine as spoiled. (P.A.A. #13F)
d. Reporting & Return of Nonviable Vaccines – California Vaccines for Children (VFC)

13. Vaccine Transfers & Transports

a. Vaccine transfer can be minimized by consistent inventory management, but providers might need to transfer vaccines to another active VFC providers if vaccines will expire within six months and are likely expire before administration or in the event of an emergency.
b. Contact the VFC Call Center to obtain approval to transfer VFC-supplied vaccines; only transfer VFC vaccines to another active VFC provider. (California VFC Program "Provider Agreement Addendum" #14A)
c. Transfer VFC supplied vaccines only when necessary. Vaccines should never be

routinely transferred to and from an existing location. (P.A.A. #14B)

d. Report in myCAvax all transfers in and out of inventory. (P.A.A. #14C)
e. Transport vaccines only when necessary and follow the guidelines for proper refrigerated (PDF) and frozen vaccine transport (PDF) each time vaccines are transported. (P.A.A. #14D)
f. Complete a vaccine transport log (PDF) each time vaccines are transported. (P.A.A. #14E)
g. In case of an emergency, only transport VFC-supplied vaccines to alternate storage locations equipped with vaccine storage units and digital data loggers that meet CA VFC Program requirements. Temporary storage of vaccines in a cooler is unacceptable. (P.A.A. #14F)
h. Never transport VFC-supplied vaccines to personal residences. (P.A.A. #14G)
i. Use backup, battery-operated, digital data loggers to monitor temperatures during vaccine transport. (P.A.A. #14H)
j. If instructed by the CA VFC Program, agree to replace any vaccines that were transported without proper temperature monitoring documentation on a dose-for-dose basis. (P.A.A. #14I)

Vaccine Administration

1. **Eligibility Screening & Documentation**
    a. Children must meet federal VFC eligibility criteria to receive publicly funded vaccines. Providers must document screenings to prove compliance and ensure vaccines are going to the intended populations. Document screening date, VFC eligibility (Y/N), and any eligibility criterion if met. If multiple eligibility criteria apply, select the criterion that requires the least amount of out-of-pocket expenses for the parent or guardian.
    b. AHS will screen patients and document eligibility status at each immunization encounter for VFC eligibility (i.e., federally or state vaccine-eligible) and administer VFC-purchased vaccine by such category only to children who are 18 years of age or younger who meet one or more of the following categories: Federally Vaccine-Eligible Children (VFC eligible): a) Are an American Indian or Alaska Native; b) Are enrolled in Medicaid; c) Have no health insurance; d) Are underinsured: A child who has health insurance, but the coverage does not include vaccines; a child whose insurance covers only selected vaccines (VFC-eligible for non-covered vaccines only); a child whose insurance does not include first-dollar coverage for a vaccine. Underinsured children are eligible to receive VFC vaccine only through a Federally Qualified Health Center (FQHC), or Rural Health Clinic (RHC) or under an approved deputization agreement. State Vaccine-Eligible Children: a) In addition, to the extent that my state designates additional categories of children as "state vaccine-eligible," I will screen for such eligibility as listed in the addendum to this agreement and will administer state-funded doses to such children. Children aged 0 through 18 years that do not meet one or more of the federal vaccine eligibility categories (VFCeligible), are not eligible to receive VFC-purchased vaccine. (VFC "Provider Agreement" #2)

2. **Vaccine Administration**
    a. Providers are required to ensure that VFC-eligible children have access to ACIP-recommended vaccines not routinely administered, such as Meningococcal Group B (MenB) and Pneumococcal polysaccharide (PPSV23) vaccines and make them available when indicated or requested.
        i. For the vaccines identified and agreed upon in the provider profile, I will comply with immunization schedules, dosages, and contraindications that are established

by the Advisory Committee on Immunization Practices (ACIP) and included in the VFC Program unless: a) In the provider's medical judgment, and in accordance with accepted medical practice, the provider deems such compliance to be medically inappropriate for the child according to the immunization recommendations put forth by the American Academy of Pediatrics (AAP-Immunization-Schedule.pdf); and b) The particular requirements contradict state law, including laws pertaining to religious and other exemptions. (VFC "Provider Agreement" #3).

b. AHS will not deny administration of a publicly purchased vaccine to an established patient because the child's parent/guardian/individual of record is unable to pay the administration fee. (P.A. #7)
c. AHS will distribute the current Vaccine Information Statement (VIS) or Immunization Information Statement (IIS) each time a vaccine is administered and maintain records in accordance with the National Vaccine Injury Compensation Program (VICP), which includes reporting clinically significant adverse events to the Vaccine Adverse Event Reporting System (VAERS). Note: For any ACIP recommended vaccine or immunization product that does not yet have a Vaccine (or Immunization) Information Statement available, a provider may use the manufacturer's package insert, written FAQs, or any other document – or produce their own information materials – to inform patients about the benefits and risks of that vaccine. Once a VIS is available it should be used; but providers should not delay use of a vaccine because of the absence of a VIS. If the vaccine is under an Emergency Use Authorization (EUA), the EUA Fact Sheet for Recipients should be made available. For VFC monoclonal antibody immunizing products (e.g., nirsevimab), when not co-administered with other vaccines, report all suspected adverse reactions to MedWatch. Report suspected adverse reactions following co-administration of a VFC monoclonal antibody immunizing products (e.g., nirsevimab) with any vaccine to the Vaccine Adverse Event Reporting System (VAERS). (P.A. #8)
d. Administer all VFC-supplied vaccines at the approved practice address for the provider PIN; do not refer patients to other facilities where they might be charged for vaccine administration. (California VFC Program "Provider Agreement Addendum" #15A)
e. Recommend non-routine, ACIP-recommended vaccines when indicated or when requested. (P.A.A. #15B)
f. Acknowledge and follow VFC Program and manufacturer guidance, including revaccination, if non-viable vaccines have been administered to patients. (P.A.A. #15C)
g. Record information about each immunization given, including: (1) the name of the vaccine, (2) the date it was given, (3) the route and administration site, (4) the lot number and manufacturer, (5) the name and title of the person who administered it, (6) the practice's name and address and (7) the VIS publication date and date VIS was provided. (National Vaccine Injury Compensation Program)

3. **Reporting Doses Administered**
   a. Providers should have a backup system when conducting off-site clinics or any time the reporting system is not accessible. Providers may use the vaccine usage logs (PDF) to collect administration data for later entry into CAIR.
      i. I will enter all vaccines doses administered in my practice, regardless of patient's age or eligibility status, into the California Immunization Registry (CAIR), or an approved Immunization Information system, in accordance with all specified elements of AB 1797. Vaccine administration submission shall include specifics about the vaccine (including manufacturer, lot number, and NDC), funding source, patient's eligibility category by dose, and should occur within the same

day of administration, but no later than 14 days, and prior to submission of vaccine orders. Doses administered reported as part of vaccine ordering should match quantities reported to the immunization registry. (VFC "Provider Agreement" #14)

ii. Report all VFC-supplied vaccine doses administered to the California Immunization Registry (CAIR or CAIR/Healthy Futures) under the Registry ID for the corresponding provider PIN receiving vaccines; data must include all required VFC screening and administration elements. (California VFC Program "Provider Agreement Addendum" #15D)

4. **Billing for Vaccine Administration**
   a. AHS will immunize eligible children with publicly supplied vaccine at no charge to the patient for the vaccine. (VFC "Provider Agreement" #5)
   b. AHS will not charge a vaccine administration fee to non-Medicaid federally-vaccine eligible children that exceeds the administration fee cap of $26.03 per vaccine dose. For Medicaid children, AHS will accept the reimbursement for immunization administration set by the state Medicaid agency or the contracted Medicaid health plans. (P.A. #6)
   c. AHS will not deny administration of a publicly purchased vaccine to an established patient because the child's parent/guardian/individual of record is unable to pay the administration fee. (P.A. #7)
   d. For non-Medi-Cal, VFC-eligible children: Waive the administration fee if the parent/guardian is unable to pay. Never bill parents who are unable to pay the waived administration fees. (California VFC Program "Provider Agreement Addendum" #15E)
   e. For Medi-Cal children: Never bill the difference between Medi-Cal's administration fee and the administration fee cap to the parent/guardian. (P.A.A. #15F)

Program Integrity

1. **Site Visits**
   a. AHS will participate in VFC Program compliance site visits, including unannounced visits and other educational opportunities associated with VFC Program requirements. (VFC "Provider Agreement" #11)
   b. Clinic staff must conduct themselves in an ethical, professional, and respectful manner in all interactions with VFC Program staff. (California VFC Program "Provider Agreement Addendum" #16A)
   c. Providers agree to allow CDPH Field Representatives to conduct visits without requiring personal information about CDPH staff. (P.A.A. #16B)
   d. Make all vaccine administration records (privately and publicly funded) available to representatives from the California Department of Public Health Immunization Branch and VFC Program. (P.A.A. #16D)
   e. Comply with all mandatory corrective actions and the timeline provided by the VFC Program. Unresolved mandatory corrective actions may result in prevention of completion of recertification and/or placement on a conditional enrollment. Failure to complete required annual recertification may lead to program termination. (P.A.A. #16E)
   f. Acknowledge that failure to meet conditional enrollment conditions may lead to permanent termination from the VFC Program. (P.A.A. #16F)

2. **Fraud and Abuse**
   a. AHS agrees to operate within the VFC Program in a manner intended to avoid fraud and abuse. Consistent with "fraud" and "abuse" as defined in the Medicaid regulations at 42

CFR § 455.2, and for the purposes of the VFC Program: Fraud: an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law. Abuse: provider practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to the Medicaid program, (and/or including actions that result in an unnecessary cost to the immunization program, a health insurance company, or a patient); or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for healthcare. It also includes recipient practices that result in unnecessary cost to the Medicaid program. (VFC "Provider Agreement" #10)

3. **Record Retention**
    a. AHS will maintain all records related to the VFC Program for a minimum of three years, and upon request, make these records available for review. VFC records include, but are not limited to, VFC screening and eligibility documentation, billing records, medical records that verify receipt of vaccine, vaccine ordering records, and vaccine purchase and accountability records. (VFC "Provider Agreement" #4)
    b. Retain temperature logs and temperature data files for three years—even if the provider is no longer participating in the CA VFC Program due to provider-initiated withdrawal or VFC-initiated termination. (California VFC Program "Provider Agreement Addendum" #11H)
    c. Never destroy, alter, or falsify immunization or VFC Program-related records. (P.A.A #16B)

4. **Enrollment, Recertification & Termination**
    a. Prospective providers must assign key practice staff to VFC roles, complete all required training, enroll in the California Immunization Registry, and comply with storage equipment requirements before enrolling in myCAvax. Enrolled providers are responsible for all VFC-supplied vaccines received in their practice.
    b. Recertification: Providers must recertify their participation in the VFC Program each year by updating their information, completing or testing out of required EZIZ training, and signing new provider agreements. Failure to recertify will lead to termination from the VFC Program. A waiting period to request re-enrollment may apply
    c. Termination: Providers may voluntarily withdraw from the VFC Program, which may also terminate a provider's VFC "Provider Agreement" for failure to comply with program requirements. In both cases, the Provider of Record must return spoiled/expired vaccine or transfer all unused VFC-supplied vaccines to another active VFC provider.
        i. 'I understand this facility, or the California Department of Health Vaccines for Children Program, may terminate this agreement at any time. If I choose to terminate this agreement, I will properly return any unused federal vaccine as directed by the California Department of Health Vaccines for Children Program.' (VFC "Provider Agreement" #16)

    a.

References

1. VFC Requirements at a Glance
2. AAP-Immunization-Schedule.pdf

Approvals

Ambulatory Operations Council	Date: 3/9/26
Pharmacy and Therapeutics	Date: 3/2026
Clinical Practice Committee	Date: 4/2026
Medical Executive Committee	Date: 4/2026

<u>Alameda Health System</u>

Adult Medicine Refill Clinics – Clinical Pharmacist Duties and Function

Department	**Ambulatory Care Services**	**Effective Date**	**7/2018**
Campus	**All**	**Date Revised**	**3/2026**
Unit	**Adult Medicine – Eastmont Wellness, Hayward Wellness, Highland Wellness, Newark Wellness**	**Next Scheduled Review**	**3//2029**
Manual	**Clinical Practice**	**Author**	**System Ambulatory Pharmacy Operations Manager**
Replaces the following Policies:		**Responsible Person**	**ACMO**

SCOPE OF SERVICES

PURPOSE: To provide guidelines for authorizing refill requests in the Adult Medicine/Family Medicine Clinics across the AHS Wellness Centers by the Clinical Pharmacist Specialist – Ambulatory Care.

OBJECTIVES:

- To expedite patient services by authorizing refills on maintenance medications
- Reduce provider refill prescription load and time spent on record review
- Increase provider time for clinical duties
- Provide medication reconciliation,
- Ensure that patients have follow up appointments with the PCP in order to provide continuity of care.

GENERAL INFORMATION:

<u>Refill Clinic Supervisor</u>: **Medical Director – Highland Adult Medicine Clinic**
Medical Director – Eastmont Wellness Center
Medical Director - Hayward Wellness Center
Medical Director – Newark Wellness Center

Primary Staff: Clinical Pharmacist Specialist – Ambulatory Care
Pharmacy Technician – Ambulatory Care

Eligibility criteria:

1. Patient should have had an appointment within the last 12 months or have a pending new or return appointment. Refills will be given up to the next PCP appointment or up to 12 months if the patient has a record of being assigned and seen in the clinic previously
2. Patient must be on chronic medications for chronic disease management
3. Refills **will not** be completed for the following:
    a. All DEA scheduled medications
    b. All acute medications
        i. Exception: Antibiotics or non-controlled pain medications can be refilled only if the medical record clearly states that therapy is to be continued for longer than the standard course of therapy.

c. Warfarin will only be refilled if the patient has a therapeutic INR within the last 12 weeks and has a follow up appointment in the Anticoagulation Clinic or PCP. Patients will be referred to the Anticoagulation Clinic for next available appointment if criteria are not met.

REFILL REVIEW DUTIES AND RESPONSIBILITIES:

- Document in the electronic health record all refill requests via phone message, fax, or in person
- Review the medical record for documentation of prescribed medication
- Refill medications according to protocol guidelines
- Coordinate the scheduling of appointments for patients as needed.
- All medications will be reviewed for appropriateness (e.g. indication, dosage, contraindications etc.) Pharmacist may either consult UpToDate or Micromedex, or other appropriate drug reference.
- All drugs will be substituted with the generic equivalent for any brand name drugs unless originally prescribed as dispense as written
- The refill pharmacist may change formulation of oral and topical medications (i.e tablet to capsule or cream to ointment) based on patient or insurance request.
- The refill pharmacist may change the dosage form of the medication (i.e 15mg daily to 30mg ½ tablet) as needed based on patient or insurance request.
- The refill pharmacist may change the quantity of a prescription for chronic medications from <90 days to a 90 day supply as required by insurance as needed.
- The refill pharmacist may change the pharmacy to which an eRx is sent based on patient and insurance request as needed.
- If a patient has been seen within 1 year, provide refills until next scheduled appointment or up to one year as appropriate.
- If a patient has not been seen by PCP in >12 months, an in-basket message to the appropriate registration/front desk pool to schedule an appointment and refill drug until next scheduled appointment if appropriate laboratory tests are normal
    - Consult with PCP for disposition
- Request PCP/clinic attending authorization if necessary (i.e. abnormal lab values, reported adverse events, contraindications, drug-drug interactions etc…)
- Complete prior authorizations as needed. May substitute with drug class as needed. Consult with PCP if necessary.
- If medication does not appear in the medical record or if there is a dose discrepancy:
    - call patient and/or pharmacy and determine dose
    - call patient and/or pharmacy and determine duration of treatment at this dose
    - call patient and/or pharmacy and determine name of prescribing physician
    - Contact PCP or clinic attending for refill authorization
- Order laboratory tests based on medication monitoring parameters as allowed by Collaborative Practice Agreement between physicians and pharmacists
- Document all activities in the electronic health record as Telephone or Refill encounters as appropriate

REFILL PROCESS:

- Preferred method of refill request is through electronic refill requests directly from the patient's pharmacy. Patients should be instructed to always request medications directly from their pharmacy first, but also may request refills either by phone or drop-in.
- Pharmacies will request refills on the behalf of patients by electronic requests through SureScripts. When SureScripts cannot match patient records, back-up communication will be via e-fax.
- Prescriptions will be electronically prescribed to patient's preferred pharmacy
- PCP authorization or review of refills will be requested via in-basket message through the EHR if necessary
- Patients will be contacted by pharmacy staff if refills are not authorized or if an appointment must be made.

LABORATORY TESTS:

- Clinical Pharmacist will order laboratory tests per Collaborative Practice Agreement between the physician and pharmacist.
    - Tests will be ordered if existing labs are not up to date.
    - Results automatically route to provider in-basket, but will be tracked by Clinical Pharmacist if ordered through the Collaborative Practice Agreement.

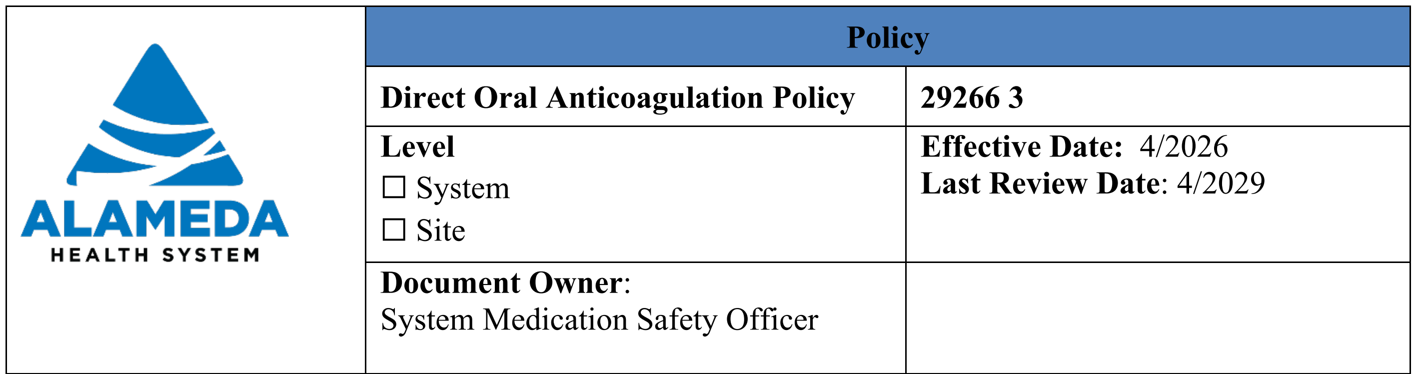
If laboratory tests return normal:

- Refills will be given until next scheduled PCP visit.

If laboratory tests are abnormal:

- Refills will be authorized per PCP's discretion.

Ambulatory Operations Council	3/9/26
Pharmacy and Therapeutics Committee	3/2026
Clinical Practice Committee	4/2026
Medical Executive Committee	4/2026



Policy	
Direct Oral Anticoagulation Policy	**29266 3**
Level ☐ System ☐ Site	**Effective Date:** 4/2026 **Last Review Date**: 4/2029
Document Owner: System Medication Safety Officer	

PURPOSE:
To provide a guideline for the safe and effective use of direct oral anticoagulants and to provide guidance to Pharmacists who will order labs for monitoring and dose adjustments.

POLICY:
The pharmacist will monitor oral anticoagulants to minimize anticoagulant toxicity, and maximize the use for each hospital stay to achieve the therapeutic goals.

The guideline that follows is not a substitute for good clinical judgment.

Procedure

1. Initiation:
    a. Upon receipt of an order for direct oral anticoagulation in the hospital, the pharmacist will assess for appropriate indication, baseline CBC, renal function (e.g., CrCl), and hepatic function (e.g.,Child-Pugh) as needed.
    b. Before dose adjustment, if indication for oral anticoagulants are for off-label use, please clarify with MD.
    c. Drug-drug interactions will be assessed throughout duration of therapy / hospital stay (Table 3).
2. Medication Selection by Physicians
    a. The initiation and maintenance of anticoagulation therapy will be based on guidelines appropriate to the medication used, to the condition being treated, and to potential drug interactions.
        i. Please refer to the AHS Clinical Standard: Anticoagulation Guide for patient specific factors to consider when choosing VKA vs. DOACs (2019 AHA/ACC/HRS Focused Update of the 2014 AHA/ACC/HRS Guideline for the Management of Patients With Atrial Fibrillation: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines and the Heart Rhythm Society. J Am Coll Cardiol 2019).

3. Ordering Labs

review

a. Patients receiving anticoagulants for therapeutic use will have baseline and current laboratory values available for monitoring and adjusting anticoagulant therapy.
b. Pharmacists will have the ability to order lab work as related to the initiation or continuation of anticoagulation for therapeutic use including but not limited to:

Anticoagulant	**Baseline Lab Tests (if not done within last 24 hours)**	**Ongoing Lab Tests**	**Recommended Frequency of Current Lab**
Dabigatran	CBC, SCr	CBC, SCr	CBC: Every 3 days for the first week, then weekly if stable or as needed Scr: Every 3 days or as needed
Edoxaban	CBC, SCr, AST/ALT		
Apixaban	CBC, SCr		
Rivaroxaban	CBC, SCr, AST/ALT		

4. Reversal of DOACs
   a. Refer to the AHS Clinical Standard: Anticoagulation Guide

5. Perioperative Management of Anticoagulation
   a. Many surgical procedures can be safely performed without interrupting systemic anticoagulation. Please review most current guideline recommendations, assess thromboembolic and bleeding risk before interrupting systemic anticoagulation for procedures.
   b. Bridging preoperatively is generally reserved for individuals considered at high risk of thromboembolism (e.g., recent embolic stroke or systemic embolic event in the last 3 months, mechanical mitral valve, mechanical aortic valve and additional stroke risk factors, atrial fibrillation and very high stroke risk (CHADS2 score of 5 or 6), venous thromboembolism (VTE) within the previous 3 months, coronary stenting within the previous 12 weeks, previous thromboembolism during interruption of chronic anticoagulation). [5,6]

c. Refer to the AHS Clinical Standard: Anticoagulation Guide for specific recommendations on perioperative management of DOACs

REFERENCES

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2) Raval AN, Cigarroa JE, Chung MK, Diaz-Sandoval LJ, Diercks D, et al. Management of Patients on Non-Vitamin K Antagonist Oral Anticoagulants in the Acute Care and Periprocedural Setting: A Scientific Statement From the American Heart Association. Circulation. 2017;135(10):e604-e633. doi: 10.1161/CIR.0000000000000477.
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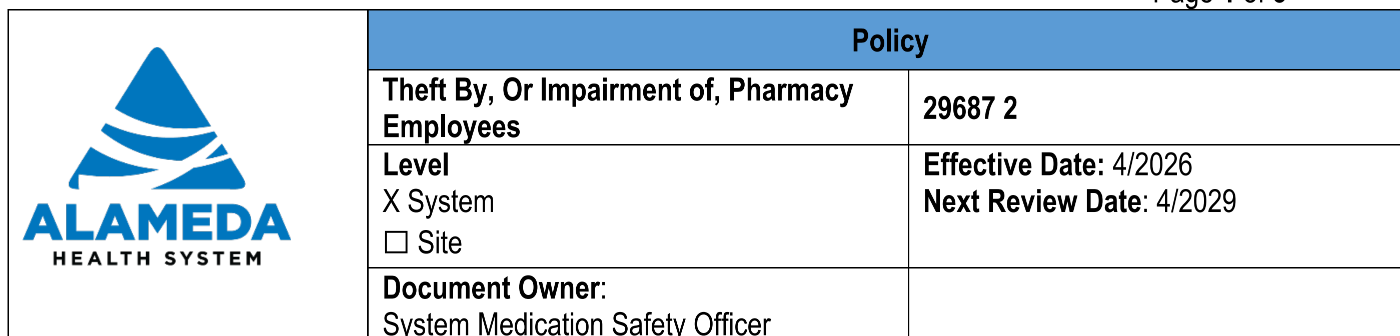
APPROVALS

		System	Alameda Hospital
Pharmacy Department	**Date:**	**3/2026**	
System Pharmacy and Therapeutics	**Date:**	**3/2026**	
Clinical Practice Council	**Date:**	**4/2026**	
Medical Executive Committee	**Date:**	**4/2026**	
Board of Trustees	**Date:**	**5/2026**	



ALAMEDA HEALTH SYSTEM	Policy	
	Theft By, Or Impairment of, Pharmacy Employees	**29687 2**
	Level X System ☐ Site	**Effective Date:** 4/2026 **Next Review Date**: 4/2029
	Document Owner: System Medication Safety Officer	

review

Purpose

To ensure safe and effective delivery of pharmaceutical care and protection of the public. The pharmacy must take actions to protect the public when a licensed individual employed by or with the pharmacy is discovered or known to be chemically, mentally, or physically impaired to the extent it affects his or her ability to practice the profession or occupation authorized by his or her license.

Policy

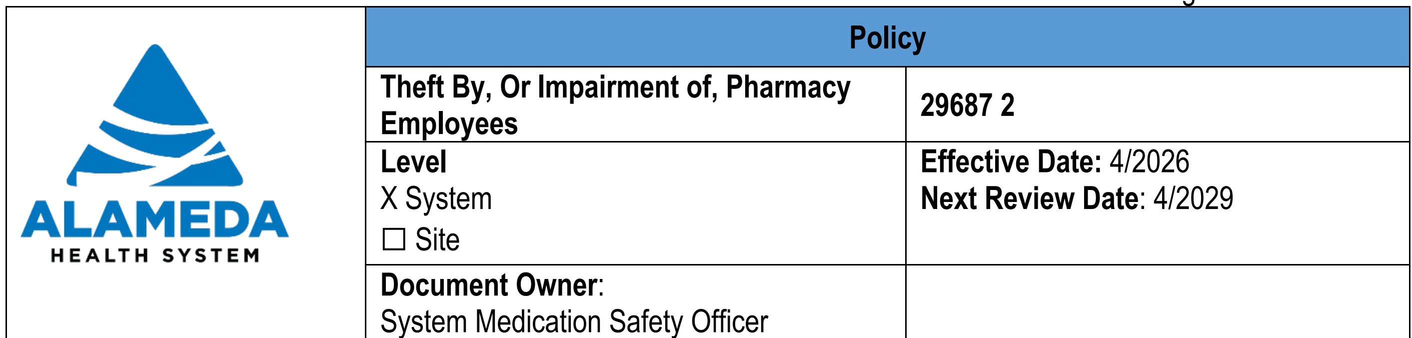
The department of pharmacy must report to the California State Board of Pharmacy within 14 days of the receipt or development of information with regard to any licensed employee who is discovered or known to be mentally, chemically, or physically impaired to the extent that it affects their ability to practice their profession or occupation as authorized by their license, or is discovered or known to have engaged in theft, diversion, or self-use of dangerous drugs. In such an event, the individual must be immediately removed from the schedule pending investigation. Depending on the outcome of investigation, the employee may be subject to discipline, up to and including termination.

Federal regulations require that registrants notify the DEA Field Division Office of the Administration in the area, in writing, of the theft or significant loss of any controlled substance, disposal receptacles or listed chemicals within 1 business day of discovery of such loss or theft.

Procedure

In the event that reasonable suspicion exists for a pharmacy employee regarding theft or impairment, the information will be provided to the employee's immediate supervisor and the Director of Pharmacy Services. Such as the following:

- Any admission by a licensee of a chemical, mental, or physical impairment affecting his/her ability to practice
- Any admission by a licensee of theft, diversion, or self-use of dangerous drugs
- Any video or documentary evidence demonstrating any chemical, mental, or physical impairment of a licensee to the extent it affects his/her ability to practice
- Any video or documentary evidence demonstrating theft, diversion, or self-use of dangerous drugs by a licensee



Policy	
Theft By, Or Impairment of, Pharmacy Employees	**29687 2**
Level X System ☐ Site	**Effective Date:** 4/2026 **Next Review Date**: 4/2029
Document Owner: System Medication Safety Officer	

- Any termination based on chemical, mental, or physical impairment of a licensee to the extent it affects his/her ability to practice
- Any termination of a licensee based on theft, diversion, or self-use of dangerous drugs

The Pharmacist-in-Charge will immediately report any of the above to the Pharmacy Operation Manger.

Appropriate Alameda Health System procedures will be followed regarding theft and substance abuse policies including all investigative resources available under HR personnel policies.

The department of pharmacy services shall report to the California State Board of Pharmacy, within 14 days should a theft or impairment be determined.

The department of pharmacy services shall report to the Field Division office of the DEA in writing of theft or significant loss of any controlled substances within one business day of discovery of such loss or theft.

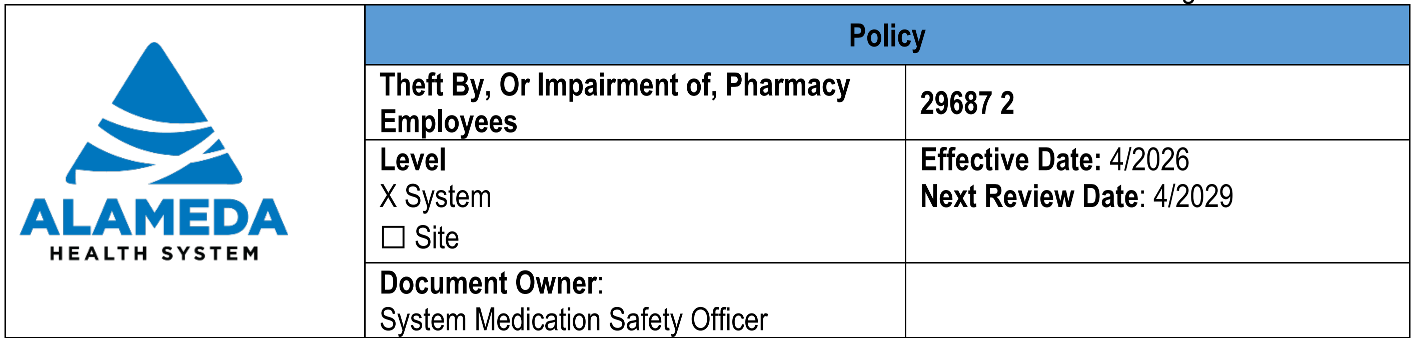
The department of pharmacy services must also file a completed and accurate DEA Form 106 with the DEA through the DEA's Diversion Control Division secure network application within 45 days after discovery of the theft or loss.

The report shall include sufficient detail to inform the board of the facts upon which the report is based, including an estimate of the type and quantity of all dangerous drugs involved, the timeframe over which the losses are suspected, and the date of the last controlled substances inventory.

Upon request of the board, the pharmacy shall prepare and submit an audit involving the dangerous drugs suspected to be missing.

Anyone making a report authorized or required by the Business and Professions Code 4104, shall have immunity from any liability, civil or criminal, that might otherwise arise from the making of the report. Any participant shall have the same immunity with respect to participation in any administrative or judicial proceeding resulting from the report.

review



	Policy	
ALAMEDA HEALTH SYSTEM	**Theft By, Or Impairment of, Pharmacy Employees**	**29687 2**
	Level X System ☐ Site	**Effective Date:** 4/2026 **Next Review Date**: 4/2029
	Document Owner: System Medication Safety Officer	

References
Business and Professions Code 4104
21 C.F.R. §1301.76

Approvals

		System	AHS Core	Alameda Hospital
Departmental: Pharmacy	**Date:**	**3/2026**		
System Pharmacy and Therapeutics	**Date:**	**3/2026**		
Clinical Practice Committee	**Date:**	**4/2026**		
Medical Executive	**Date:**	**4/2026**		
BOT	**Date:**	**5/2026**		

review

INTRA-CORONARY NITROGLYCERINE

Department	Interventional Services	*Effective Date*	5/2011
Campus	Highland Hospital	*Date Revised*	4/2011, 2/2016, 3/2026
Category	Clinical	*Next Scheduled Review*	3/2029
Document Owner	Cardiology Division Chief	*Executive Responsible*	Chief Administrative Officer /Chief Nurse Executive

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

Purpose

To provide additional guidance to the Interventional Services Suite for the safe handling and administration of medications designated as High Risk / High Alert and to prevent patient injury from medication errors by establishing additional safeguards for High Risk/High Alert medications.

Policy

Background

1. High Risk/High Alert Medications are medications that bear a heightened risk of causing patient harm when they are used in error. Protocols and precautions are necessary for the safe and efficient procuring, storing, ordering, transcribing, preparing, dispensing, administering, and/or monitoring of each high risk/ high alert medication.

2. Nitroglycerine may be used per the physician's discretion via the intracoronary route of administration.

3. Indications: Acute no re-flow of coronary or saphenous vein/arterial graft to coronary artery, treatment of coronary spasm, routine dilatation for coronary angiography, chest pain in the setting of coronary intervention.

4. Contraindications:

    a) Known allergies to drug
    b) Use of sildenafil or vardenafil (within 24 hours)
    c) Use of tadalafil (within 48 hours) or
    d) Use of riociguat.

5. This medication requires a high alert double check when passing it off to the scrub and physician.

Procedure

1. Pharmacy will prepare Nitroglycerine 100mcg/ml (10ml vials) and place in the pyxis refrigerator of the cardiac cath lab on an ongoing basis.

2. The drug will be removed from the pyxis by the RN under the patient's name.

3. The scrub personnel will verify with the physician and RN the drug name, and concentration, and label the syringe it is placed in per hospital protocol- withdrawing the medication from the vial using sterile technique.

4. Only the physician will administer the Nitroglycerine via the intra-coronary route.

<u>References</u>

Kloner RA, Hutter AM, Emmick JT, et al. Time course of the interaction between tadalafil and nitrates. J Am Coll Cardiol. 2003;42:1855–1860. 24.

Parker JD, Bart BA, Webb DJ, et al. Safety of intravenous nitroglycerin after administration of sildenafil citrate to men with coronary artery disease: a double-blind, placebo-controlled, randomized, crossover trial. Crit Care Med. 2007;35:1863–1868. 25.

Swearingen D, Nehra A, Morelos S, et al. Hemodynamic effect of avanafil and glyceryl trinitrate coadministration. Drugs Context. 2013;2013:212248.

Approval

		System	Alameda Hospital	AHS Core
Cardiology Department	**Date:**	**3/2026**		
Pharmacy	**Date:**	**3/2026**		
System Pharmacy & Therapeutics Committee	**Date:**	**3/2026**		
Clinical Practice Council	**Date:**	**4/2026**		
Medical Executive Committee	**Date:**	**4/2026**		
Board of Trustees	**Date:**	**5/2026**		

INTRA-CORONARY NITROPRUSSIDE

Department	Interventional Services	***Effective Date***	5/2011
Campus	Highland Hospital	***Date Revised***	4/2011, 2/2016, 3/2026
Category	Clinical	***Next Scheduled Review***	3/2029
Document Owner	Cardiology Division Chief	***Executive Responsible***	Chief Administrative Officer /Chief Nurse Executive

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

Purpose

To provide additional guidance to the Interventional Services Suite for the safe handling and administration of medications designated as High Risk/High Alert and to prevent patient injury from medication `errors by establishing additional safeguards for High Risk/High Alert medications.

Policy

Background

1. High Risk/High Alert Medications are medications that bear a heightened risk of causing patient harm when they are used in error. Protocols and precautions are necessary for the safe and efficient procuring, storing, ordering, transcribing, preparing, dispensing, administering, and/or monitoring of each high risk/ high alert medication.

2. Nitroprusside may be used per the physicians' discretion via the intracoronary route of administration.

3. Indications: Acute no re-flow of coronary or saphenous vein/arterial graft to coronary artery.

4. Contraindications:
    a) Known allergy to medication
    b) concomitant use with sildenafil, tadalafil, vardenifil, or riociguat.

5. This medication requires a high alert double check both while mixing the medication and passing it off to the scrub and physician.

Procedure

1. Required:
    a. Nitroprusside 50mg/2ml vial
    b. 1000ml D5%W for diluents

2. Using aseptic technique, the RN-Invasive Specialist will prepare the standard intracoronary nitroprusside mixture by placing 50mg Nitroprusside in 1000 ml D5%W to yield a final concentration of 50mcg/ml. This will be verified by an additional RN or MD in the room.

3. Sterile tubing will be placed on the scrub field and IV bag with drug properly identified and labeled will be spiked by the RN. The scrub personnel will verify with the physician and RN the drug name, and concentration, and label both the tubing and syringe it is placed in per hospital protocol.

4. Only the physician will administer the nitroprusside via the intra-coronary route.

References

1. Barcin C, Denktas AE, Lennon RJ, et al. Comparison of combination therapy of adenosine and nitroprusside with adenosine alone in the treatment of angiographic no-reflow phenomenon.Catheter Cardiovasc Interv 2004;61:484-91.
2. Parham WA, Bouhasin A, Ciaramita JP, Khoukaz S, Herrmann SC, Kern MJ. Coronary hyperemic dose responses of intracoronary sodium nitroprusside. Circulation 2004;109:1236- 43.
3. Hillegass WB, Dean NA, Liao L, Rhinehart RG, Myers PR. Treatment of no-reflow and impaired flow with the nitric oxide donor nitroprusside following percutaneous coronary interventions: initial human clinical experience. J Am Coll Cardiol 2001;37:1335-43.

Approvals

		System	Alameda Hospital	AHS Core
Cardiology Department	**Date:**	**3/2026**		
Pharmacy	**Date:**	**3/2026**		
System Pharmacy & Therapeutics Committee	**Date:**	**3/2026**		
Clinical Practice Council	**Date:**	**4/2026**		
Medical Executive Committee	**Date:**	**4/2026**		
Board of Trustees	**Date:**	**5/2026**		

IV ADENOSINE FOR FRACTIONAL FLOW RESERVE IN INTERVENTIONAL SERVICES

Department	Interventional Services	*Effective Date*	5/2011
Campus	Highland Hospital	*Date Revised*	4/2011, 2/2016, 3/2026
Unit	Clinical	*Next Scheduled Review*	3/2029
Document Owner	Cardiology Division Chief	*Executive Responsible*	Chief Administrative Officer/Chief Nurse Executive

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

Purpose

Keywords: FFR, Adenosine, Fractional, Flow, Reserve

1. To provide additional guidance to the Interventional Services Suite for the safe handling and administration of medications designated as High Risk / High Alert and to prevent patient injury from medication errors by establishing additional safeguards for High Risk / High Alert medications.

Policy

Background:

High Risk/High Alert Medications are medications that bear a heightened risk of causing patient harm when they are used in error. Protocols and precautions are necessary for the safe and efficient procuring, storing, ordering, transcribing, preparing, dispensing, administering, and/or monitoring of each high risk/ high alert medication.

1. Indications: IV adenosine is indicated for use in a Fractional Flow Reserve Study of coronary arteries. (FFR)

2. Contraindications: Known allergy to Adenosine, advanced heart block, or significant bronchoconstrictive lung disease such as Asthma and C.O.P.D.

Procedure

Adenosine- Intravenous Infusion for FFR (Fractional Flow Reserve Study)

Required: 0.9% Normal Saline (100ml) and Adenosine (90mg/30ml vial)
With aseptic technique: Remove 40 ml of Normal Saline from bag and discard.
Replace with 30 ml Adenosine in the 100 ml bag. This yields a final concentration of 90mg/90ml or 1mg/ml.
Infusion should be started at 140mcg/kg/min unless otherwise directed by physician. For an intermediate FFR measurement of 0.75 to 0.80, the dose may be safely increased to 180mcg/kg/min

Side effects: Could potentially cause transient AV block. Pt may also experience angina like sensation in chest and throat.
Reassure patient that this is a normal expected sensation and will subside in a short time. AV block is much less common with IV Adenosine than with IC adenosine and is rarely seen in clinical practice.
Aminophylline should be kept in the Interventional Services Suite for the reversal of Adenosine during FFR if necessary. The dose is 50mg IV over 30-60 seconds undiluted. This may be repeated up to 250 mg.
See Table below for dosing information

IVAdenosineDosageTable

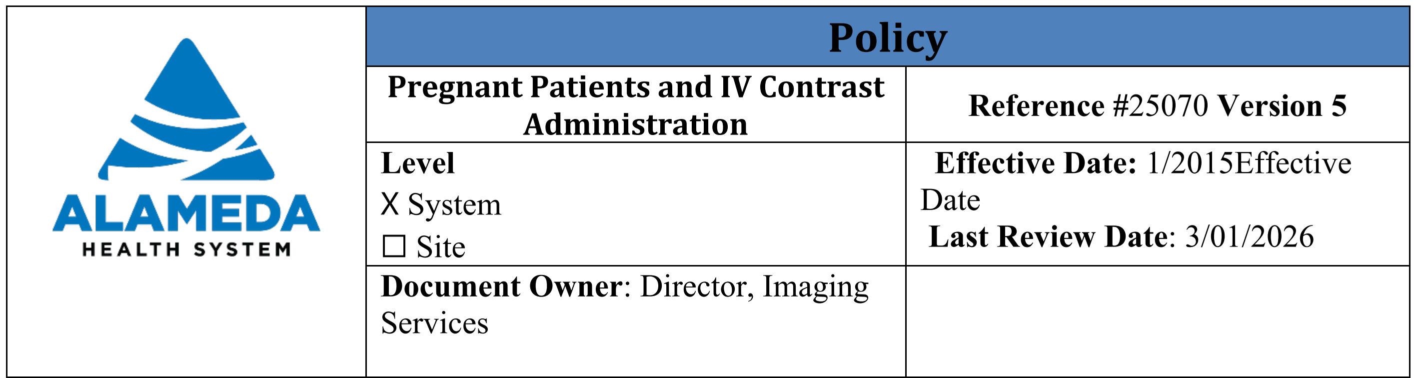
Weight		140mcg/kg/min	180mcg/kg/min*
lbs	kg	DripRate (ml/hr)	DripRate (ml/hr)
99	45	378	486
110	50	420	540
121	55	462	594
132	60	504	648
143	65	546	702
154	70	588	756
165	75	630	810
176	80	672	864
187	85	714	918
198	90	756	972
209	95	798	1026
220	100	840	1080
231	105	882	1134
243	110	924	1188
254	115	966	1242
265	120	1008	1296

References

Catheterization and Cardiovascular Interventions 71:198–204 (2008)

Approvals

		System	Alameda Hospital	AHS Core
Cardiology Department	**Date:**	**3/2026**		
Pharmacy	**Date:**	**3/2026**		
System Pharmacy & Therapeutics Committee	**Date:**	**3/2026**		
Clinical Practice Council	**Date:**	**4/2026**		
Medical Executive Committee	**Date:**	**4/2026**		
Board of Trustees	**Date:**	**5/2026**		



	Policy	
ALAMEDA HEALTH SYSTEM	**Pregnant Patients and IV Contrast Administration**	**Reference** #25070 **Version 5**
	Level X System ☐ Site	**Effective Date:** 1/2015Effective Date **Last Review Date**: 3/01/2026
	Document Owner: Director, Imaging Services	

POLICY STATEMENT

Alameda Health System (AHS) shall administer intravenous (IV) iodinated contrast (CT) and gadolinium-based contrast agents (MRI) to pregnant or potentially pregnant patients only when medically necessary and when the anticipated diagnostic benefit outweighs potential fetal risk, in accordance with current American College of Radiology (ACR) guidance.

PURPOSE

To establish standardized procedural requirements governing the administration of IV contrast media in pregnant or potentially pregnant patients to ensure maternal and fetal safety while supporting appropriate diagnostic imaging.

SCOPE

This policy applies to all Radiologists, Ordering Providers, Radiology Technologists, Nursing staff, and Imaging Leadership involved in CT and MRI contrast administration at all Alameda Health System facilities.

DEFINITIONS

Iodinated Contrast Media (CT Contrast) – Water-soluble intravenous contrast agents used primarily for CT imaging.

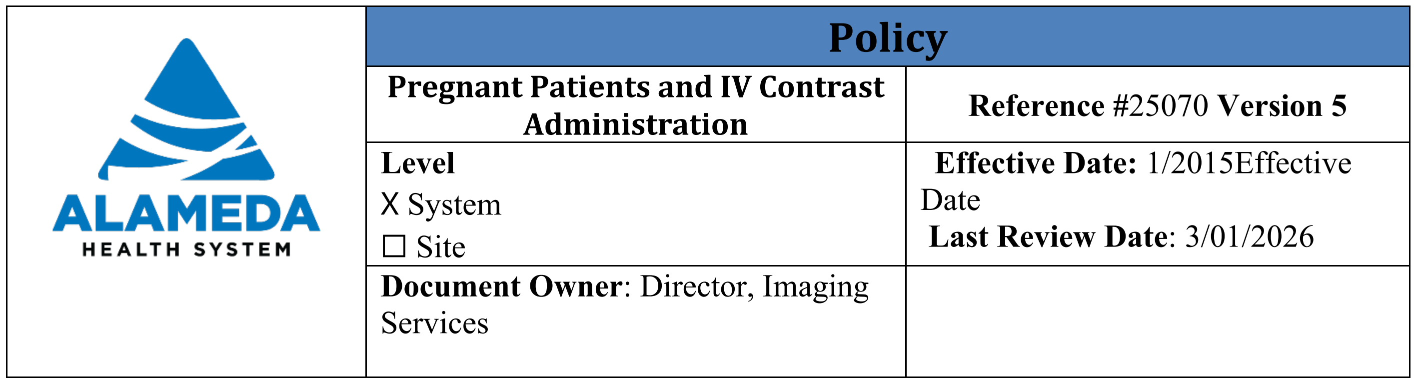
Gadolinium-Based Contrast Agents (GBCA) – Intravenous contrast agents used for MRI imaging.

Potentially Pregnant Patient – A patient of childbearing age whose pregnancy status has not been definitively excluded.

Informed Consent – Documented patient authorization acknowledging understanding of risks, benefits, and alternatives.

RESPONSIBILITIES

1. Radiologists – Ensure MRI contrast administration in pregnancy meets policy criteria and complete required documentation.
2. Ordering Providers – Confirm clinical necessity of imaging during pregnancy.
3. Radiology Technologists – Verify pregnancy status per AHS screening protocol and verify required consent documentation prior to contrast administration.
4. Imaging Leadership – Maintain oversight of policy compliance.



ALAMEDA HEALTH SYSTEM	**Policy**	
	Pregnant Patients and IV Contrast Administration	**Reference** #25070 **Version 5**
	Level X System ☐ Site	**Effective Date:** 1/2015Effective Date **Last Review Date**: 3/01/2026
	Document Owner: Director, Imaging Services	

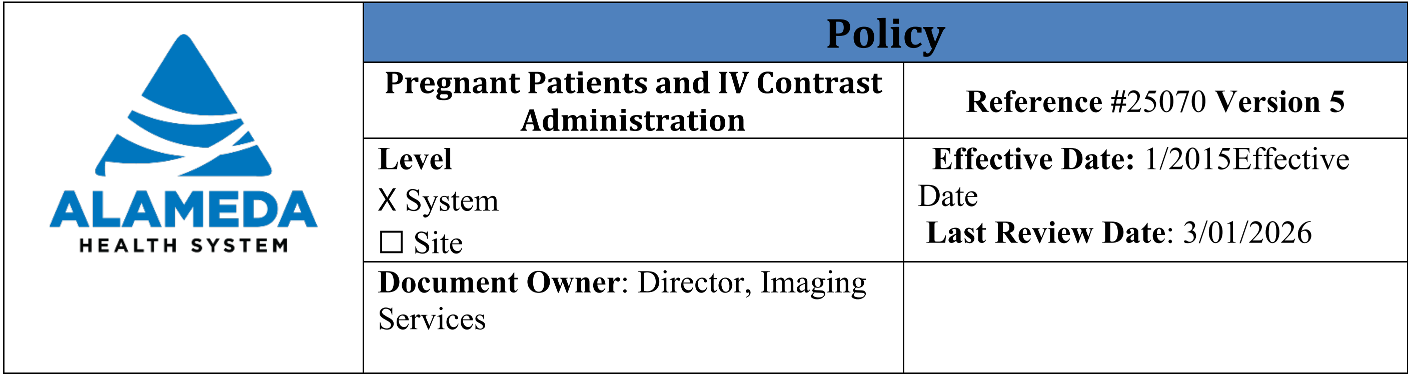
POLICY TEXT

I. CT Imaging – Iodinated Contrast

1. Confirm or assess pregnancy status prior to contrast administration per AHS pregnancy screening protocol.
2. Iodinated contrast may be administered to a pregnant or potentially pregnant patient when the ordered examination is clinically indicated.
3. Iodinated contrast shall not be withheld solely due to pregnancy when the imaging study is medically necessary.
4. Inform the patient that iodinated contrast crosses the placenta and that no established harm has been demonstrated from maternal intravascular administration.
5. Obtain and document verbal consent in the electronic health record prior to contrast administration.
6. In emergent or life-threatening situations, contrast may be administered without prior consent when delays endanger the patient or fetus. The emergent indication shall be documented.

II. MRI Imaging – Gadolinium-Based Contrast Agents (GBCA)

1. Confirm or assess pregnancy status prior to contrast administration.
2. Gadolinium-based contrast agents shall be administered during pregnancy only when:
    a. The information cannot be obtained without contrast enhancement;
    b. Alternative imaging modalities are insufficient;
    c. The results will directly affect patient and/or fetal care during pregnancy; and
    d. Delay until after pregnancy is not clinically appropriate.
3. The radiologist shall confer with the referring physician prior to GBCA administration.
4. The radiologist shall document in the radiology report or medical record:
    a. That the information requested from the MRI study cannot be acquired without the use of IV contrast or by using other imaging modalities;
    b. That the information needed affects the care of the patient and/or fetus during the pregnancy; and
    c. That the referring physician is of the opinion that it is not prudent to wait to obtain this information until after the patient is no longer pregnant.
5. Obtain written informed consent prior to GBCA administration.
6. Use the lowest effective GBCA dose necessary to achieve diagnostic results.
7. In emergent situations, GBCA may be administered if the diagnostic information is critical to immediate management and delay would pose greater risk.



	Policy	
ALAMEDA HEALTH SYSTEM	**Pregnant Patients and IV Contrast Administration**	**Reference** #25070 **Version 5**
	Level X System ☐ Site	**Effective Date:** 1/2015Effective Date **Last Review Date**: 3/01/2026
	Document Owner: Director, Imaging Services	

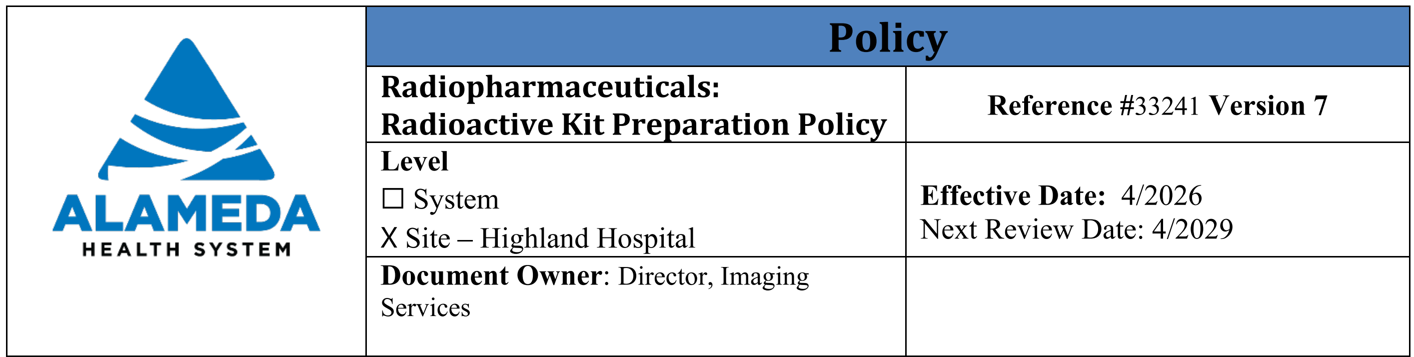
REFERENCES

American College of Radiology (ACR) Manual on Contrast Media – Current Edition
ACR–SPR Practice Parameter for Imaging Pregnant or Potentially Pregnant Patients
FDA Pregnancy Category Classifications

Printed copies are for reference only. Please refer to the electronic version for the most current policy.

Approvals:

		System	AHS Core	Alameda Hospital
Departmental	**Date:**	**3/2026**		
System Pharmacy & Therapeutics	**Date:**	**3/2026**		
Clinical Practice Committee	**Date:**	**4/2026**		
Medical Executive Committee	**Date:**	**4/2026**		
Board of Trustees	**Date:**	**5/2026**		



	Policy	
ALAMEDA HEALTH SYSTEM	**Radiopharmaceuticals: Radioactive Kit Preparation Policy**	**Reference** #33241 **Version 7**
	Level ☐ System X Site – Highland Hospital	**Effective Date:** 4/2026 Next Review Date: 4/2029
	Document Owner: Director, Imaging Services	

POLICY STATEMENT

Alameda Health System (AHS) shall maintain standardized, safe, and compliant procedures for the preparation of radiopharmaceutical kits containing radioactive materials to ensure patient safety, staff safety, radiation protection, and regulatory compliance.

PURPOSE

To establish clear procedural and safety standards for the preparation, labeling, handling, documentation, and disposal of radioactive kits used in Nuclear Medicine procedures.

This policy ensures:

- Safe handling of radioactive materials
- Proper dose tracking and documentation
- Compliance with radiation safety regulations
- Adherence to aseptic technique standards
- Minimization of radiation exposure to staff and patients

SCOPE

This policy applies to all Nuclear Medicine Technologists, Radiology/Nuclear Medicine Departments, radiopharmacy coordination processes, dose tracking systems, and all AHS facilities where radioactive kit preparation occurs.

DEFINITIONS

Radiopharmaceutical Kit – A commercially prepared pharmaceutical kit requiring reconstitution with a radioactive isotope prior to administration.

Unit Dose – A patient-specific radiopharmaceutical dose prepared for a single scheduled examination.

Aseptic Technique – Infection prevention practices used to maintain sterility during medication preparation.

Dose Tracking System – The electronic or manual system used to record radiopharmaceutical lot numbers, expiration dates, activity, and administration data.

Vial Shield – Radiation shielding device used to reduce technologist exposure during handling.

RESPONSIBILITIES

Nuclear Medicine Technologists – Prepare kits in accordance with policy; ensure labeling, documentation, aseptic technique, and radiation safety compliance.

Director, Imaging Services – Maintain policy oversight, ensure annual review, and validate staff competency.

Radiation Safety Office – Provide regulatory guidance and oversight.

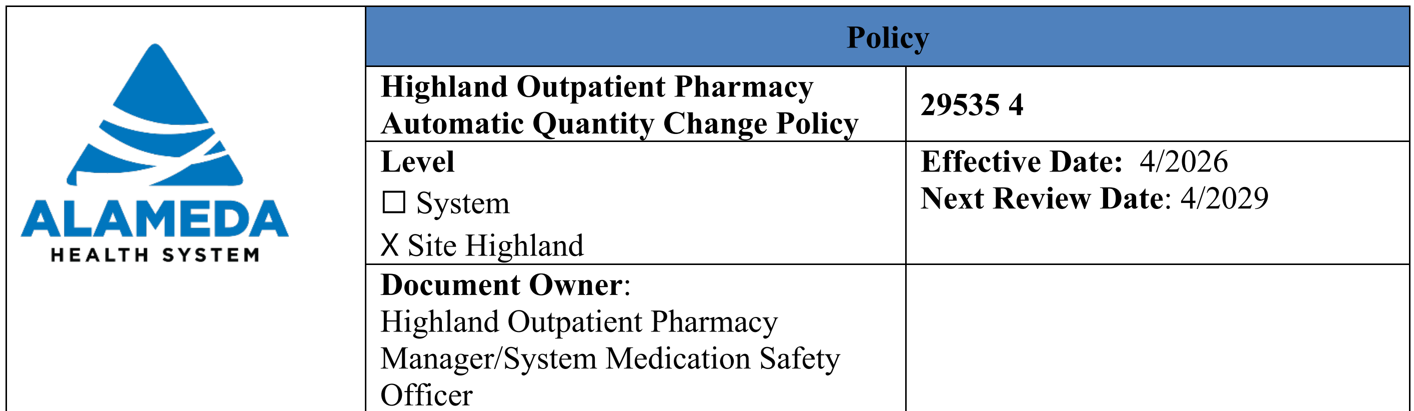
Pharmacy Leadership – Support radiopharmacy coordination and regulatory compliance.

POLICY TEXT

1. All scheduled patients shall have unit doses ordered for their examinations.
2. Radiopharmaceutical kits shall be purchased from a licensed radiopharmacy.
3. All kits must be entered into the dose tracking system with expiration dates and lot numbers recorded.
4. Aseptic technique shall be used throughout preparation. Radiation exposure must be minimized using shielding and protective measures. Disposable gloves must be worn.
5. Prior to reconstitution, verify expiration date and vial integrity.
6. Label each vial with the patient's name and the technologist's initials.
7. Follow manufacturer instructions provided with the kit.
8. Disinfect rubber vial stoppers with 70% Isopropyl Alcohol and allow at least 10 seconds drying time.
9. Dispose of syringes, needles, and supplies in accordance with the Radiopharmaceuticals: Waste Disposal Policy.
10. Affix a label to the vial shield including compound name, date, time, volume, and activity.
11. Prepare kits for single use only and no more than one (1) hour prior to use.
12. Review this procedure annually with all technologists.

REFERENCES

Alameda Health System Radiation Safety Manuals
42 CFR §482.12(e)
42 CFR §482.21
Title 22 California Code of Regulations (CCR) §70713



	Policy	
ALAMEDA HEALTH SYSTEM	**Highland Outpatient Pharmacy Automatic Quantity Change Policy**	**29535 4**
	Level ☐ System X Site Highland	**Effective Date:** 4/2026 **Next Review Date**: 4/2029
	Document Owner: Highland Outpatient Pharmacy Manager/System Medication Safety Officer	

PURPOSE

Decrease calls to clinics, emergency department, and discharging providers for routinely prescribed medications that are not dispensable in repackaged containers or amber vials. This will in turn improve compliance related to medication storage.

POLICY STATEMENT

The Outpatient Pharmacy at the Highland campus will follow quantity substitution policy for prescriptions from Highland Clinics, Highland Emergency Department, and Highland discharge providers for medications that must be dispensed in manufacturer containers or at a certain quantity/size as approved by the P&T committee.

PROCEDURE

1. Upon receiving a prescription order for a partial quantity of a medication which cannot be broken or repackaged from the original container (must be dispensed in the original container), pharmacy will change the prescribed quantity to ensure that the full packaged bottle or container is dispensed. (see Attachment A for list of medications)

2. A call to the clinic, emergency department, or discharging provider is not required for all approved drugs on this protocol list or when the quantity ordered is not manufactured in the corresponding size (ex/ insulin vials-packages of 10ml only)

3. For a drug not on the pre-approved list in Attachment A, a provider will be contacted to authorize a quantity change. If quantity change is authorized, pharmacist will update the prescribed quantity.

4. The corresponding quantity change will be reflected in Epic in the medication order.

5. The pharmacist will note the automatic quantity substitution and date on the prescription in the software system [Epic- Willow Ambulatory (WAMB)]. The prescription order will inlcude drug name, strength, sig., and quantity. If provider approval is needed for medications not on the pre-approved list, the provider's name will be documented on the prescription.

6. Patient will be notified if medication changes are made based on this quantity change policy.

approval

APPROVALS

		System	Alameda
Pharmacy Department	**Date:**	3/2026	
Ambulatory Care Operations Council	**Date:**	3/2026	
System Pharmacy and Therapeutics (P&T)	**Date:**	3/2026	
Clinical Practice Council (CPC)	**Date:**	4/2026	
Medical Executive Committee	**Date:**	4/2026	
Board of Trustees	**Date:**	5/2026	

approval

ATTACHMENT A **Prescription Medication**	**Repackaged**	**Order Set Request**
Darunavir/cobicistat/emtricitabine /tenofovir alafenamide (**Symtuza**)	DO NOT REPACKAGE	quantities of #30 (1 bottle)
Prasugrel (**Effient**) **10** mg tabs		quantities of #30 (1 bottle)
Bictegravir/emtricitabine/tenofovir **(Biktarvy)**		quantities of #30 (1 bottle)
Dabigatran etexilate mesylate (**Pradaxa)**		quantities of #60 (1 bottle)
Emtricitabine /Rilpivirin /Tenofovir Disoproxil Fumarate (**Complera**)		quantities of #30 (1 bottle)
Tofacitinib **(Xeljanz oral solution)**		quantities of 240ml (1 bottle)
Etravirine (**Intelence**)		quantities of #60 (1 bottle)
Linaclotide (**Linzess)**		quantities of #30 (1 bottle)
Pancrelipase (**Pancreaze**) Pancrelipase (Viokace); Pancrelipase (Zenzep); Pancrelipase (Creon)		quantities of #100 (1 bottle)
Tofacitinib (**Xeljanz/Xeljanz XR)**		quantities of #30 (1 bottle)
Efavirenz/lamivudine/and tenofovir disoproxil fumarate (**Symfi)**		quantities of #30 (1 bottle)
Dolutegravir (**Tivicay)** 10 mg/ Dolutegravir PD **5mg tab** for solution		quantities of #30 (1 bottle)
Dolutegravir/rilpivirine (**Juluca**)		quantities of #30 (1 bottle)
Nitroglycerin 0.4mg (**Nitrostat**)		quantities of #25 (1 vial)
Nelfinavir (**Viracept**) 250mg		quantities of #300 (1 bottle)

Doravirine (**Pifeltro**)		quantities of #30 (1 bottle)
Doravirine/lamivudine and tenofovir disoproxil fumarate (**Delstrigo)**		quantities of #30 (1 bottle)
Rilpivirine (**Edurant**)		quantities of #30 (1 bottle)
Alecensa 150mg (**Alectinib**)		quantities of #240 (1 bottle)
Aspirin/extended-release dipyridamole 25mg/200mg (**Aggrenox**)		quantities of #60 (1 bottle)
Atazanavir/cobicistat (**Evotaz**)	**30 days**	quantities of #30 (1 bottle)

Note: these medications should be dispensed in original container per manufacturer specifications

OTC Medications		**Do Not Repackage Reason**	**ORDER SET REQUEST**
Acetaminophen 120mg suppository 650mg suppository		Special wrapping/packaging	12 each box
Condoms		Box contains instructions for use	3 or 12 per box-based on manufacturer availability
Dextromethorphan 10mg/Guaifenesin 100mg/5ml (Robitussin DM)		Bottle contains measuring cup	118 ml each
Famotidine 10mg tablets		Package as unit	30 per box
Ferrous sulfate 15mg/drop		Bottle contains special dropper	50 ml each
Guaifenesin	600mg ER tablets	Package as unit	20 per box
	100mg/5ml solution	Bottle contains measuring cup	118 ml each
Hydrocortisone Acetate 25mg suppository		Special wrapping/packaging	12 each box
Loratadine 5mg/5ml Solution		Bottle contains measuring cup	120 ml each
Miralax 17 grams	Packets		14 packets per box
	Bottle	Bottle contains powder and special dosing cup	238gm or 510gm

Nicotine gum	2mg	Individual pieces- waste	50 pieces
	4mg	Individual pieces- waste	100 piece
Nicotine lozenge	2mg	Individual pieces- waste	81 piece
	4mg mini lozenge	Individual pieces- waste	72 piece
Nicotine patch (7mg, 14mg, and 21mg)		Individual pieces- waste	14 patches per box
Pepto Bismol	525mg bottle	Bottle contains powder and special dosing cup	237 ml
	262mg chewable tablet	Package as unit	30 per box
Diabetes Supplies	Insulin pen needles	Package as unit	100 per box
	Lancets	Package as unit	100 per box
	Test strips	Package as unit	50 or 100 per box
Maalox/Mylanta (Aluminum-Magnesium Hydroxide-Simethicone)	Liquid	Package as unit	355ml
Milk of Magnesia 400mg/5ml	Liquid	Package as unit	473ml
Tri-Vi-Sol Multivitamin drops		Package as unit	50 ml each

Medications not manufactured in the prescribed package quantity (ex/ insulin vials- available only as 10ml).

approval

ALAMEDA
HEALTH SYSTEM

April 22, 2026

TO: Quality Professional Services Committee

FROM: Bhrett Lash, M.D., Alameda Health System Vice Chief of Staff
Manasa Kalluri, M.D., Alameda Hospital Chief of Staff

SUBJECT: **Agenda Item:** B3

Meeting Date: April 22, 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.

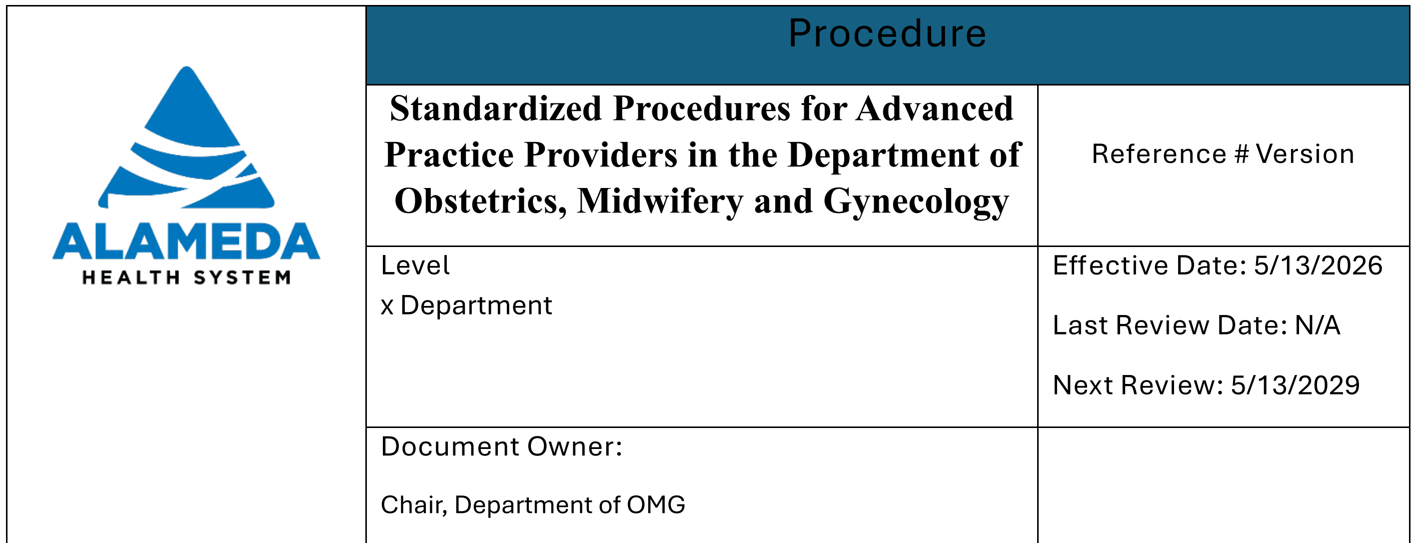
Board Action Requested: Approval of Medical Staff policies and procedures.

New Polices for AHS Medical Staff:

- Standardized Procedures for Advanced Practice Providers in the Department of Obstetrics, Midwifery and Gynecology
- FBC Nurse Standardized Procedures for Newborn Admission Order Entry

Revised Polices for AHS & AH Medical Staff:

- Medical Staff Credentialing and Privileging of Providers
- Medical Staff Credentialing Information Integrity and Data Security



ALAMEDA HEALTH SYSTEM	Procedure	
	Standardized Procedures for Advanced Practice Providers in the Department of Obstetrics, Midwifery and Gynecology	Reference # Version
	Level x Department	Effective Date: 5/13/2026 Last Review Date: N/A Next Review: 5/13/2029
	Document Owner: Chair, Department of OMG	

PROCEDURE STATEMENT

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

PURPOSE

It is the intent of this document to authorize the Advanced Practice Providers (APP) within Alameda Health System in the Department of Obstetrics, Midwifery and Gynecology to implement the Standardized Procedures without the immediate supervision or approval of a physician. The Standardized Procedures, including all the policies and protocols, are defined in this document, and will be referred to generally as the "Standardized Procedures".

Standardized procedures will be maintained in Policy Tech and reviewed every three (3) years.

DEFINITIONS

1. Advanced Practice Provider refers to either Nurse Practitioner or Physician Assistant
   a. **Nurse Practitioner** by definition shall be:
      i. Master's or Doctoral Degree in Nursing
      ii. Current license as a Registered Nurse in California
      iii. Current certification by the State of California, Board of Registered Nursing as a Nurse Practitioner
      iv. California-issued BRN Furnishing Number
      v. Current National Certification
      vi. Active DEA registration number
      vii. National Provider Identification Number
   b. **Physician Assistant** by definition shall be:
      i. Successful completion of a Physician Assistant program of instruction in primary health care approved by the Physician Assisting Examining Committee; OR NCCPA for Physician's Assistant

ii. Possession of a valid Certificate as a Physician Assistant issued by the California Board of Medical Quality Assurance
iii. A valid Drug Enforcement Agency (DEA) Number AND Certification by the National Commission on Certification of Physician Assistants (NCCPA)
iv. National Provider Identifier Number.

All requirements, applications, procedures and duties are the same for both APP provider classifications, with the exception of issuing drug orders and furnishing, as discussed herein.

2. **Supervising Physician** shall be an attending physician who is a current member in good standing of the Medical Staff, and who holds privileges in the Department of Obstetrics, Midwifery and Gynecology.

PROCEDURE

Application

1. In addition to general requirements set forth and described in the Medical Staff Bylaws, Rules and Regulations, policies and privileges forms, the following criteria shall specifically apply to any APPs applying for privileges in the department of Obstetrics, Midwifery and Gynecology:
   a. Recent clinical experience as an Obstetrics, Midwifery and Gynecology APP.
   b. Current Basic Life Support (BLS) Certification

Conditions and Standards of Practice

1. **General Conditions**
   a. The Advanced Practice Provider (APP) shall render all care within the standards provided in this document.
   b. The APP shall provide all care in accordance with the laws and regulations of the State of California, and with the Bylaws and Regulations of the Medical Staff and the Department of Obstetrics, Midwifery and Gynecology.
   c. At no time shall the care rendered by the APP exceed the scope of the licensure. All cases beyond the scope of practice of the APP, and those with which the APP has questions will be referred to the consulting physician
   d. The APP agrees to work cooperatively with the consulting physician, nursing staff and other health professionals
   e. The APP shall immediately notify their Division Chief in the event that the practitioner's license to practice is revoked, limited or otherwise affected by action of the Federal or State Health Care Agency, or in the event that they receive any notification or investigation of their license.

2. **Focus Professional Practice Evaluation (FPPE)/Proctoring**

The routine FPPE/Proctoring plan is outlined on the NP or PA privilege form. Once all elements of the FPPE/Proctoring are complete, the outcome of the FPPE will be recorded in the confidential Quality section of the credentials file (maintained by the Medical Staff Office).

During the initial proctoring period the charts of each patient seen by the PA/NP will be reviewed by the Supervising Physician.

Formal review will be made in writing by the Department Chair or designee initially, and annually, thereafter. The content of such formal evaluation will be discussed with the PA/NP as part of their annual review and kept on file.

3. **Patient Records**

The APP will be responsible for the preparation of a complete medical record for each patient contact per

existing Alameda Health System policies and Medical Staff Bylaws, Rules & Regulations and policies.

4. **Supervision**

The APP is authorized to implement the Standardized Procedures in this document without the direct or immediate observation, supervision or approval of a physician, except as may be specified in the Scope of Practice. In accordance with Medical Staff Bylaws, Rules & Regulations and policies, the supervising physician is ultimately responsible for adherence to this protocol and for the quality of care provided by APP in their respective areas. Physician consultation is available at all times, either on-site, telephone, or by electronic means.

Scope of Practice

1. **Policy**

APPs are authorized to diagnose and treat obstetrical and gynecological medical problems according to accepted criteria and management including, but not limited to:

a. Obtain medical history and perform physical examinations;
b. Manage care for normal antepartum and/or postpartum and gynecology patients;
c. Conduct initial and ongoing assessments;
d. Order, conduct and interpret labs and other diagnostic studies as appropriate;
e. Counsel patients and their families on goals of care, diagnosis and management
f. Facilitate referrals and arrange community resources;
g. Administer, provide and transmit drug orders or devices in compliance with institutional and regulatory guidelines;
h. Complete consultation notes for every patient encounter in the patient's health record;
i. Collaborate with interdisciplinary team members;
j. Participation in quality improvement initiatives, clinical documentation, and activities as required by the department or institution; and
k. Perform procedures, for which privileges have been granted.

2. **Authorized Duties and Practice**

The APP is authorized to do the following patient-related activities within the scope of practice defined by Title 16:

a. Take the patient's medical history and perform a physical examination for any presenting problem;
b. Order specific laboratory studies and x-rays, and other studies as appropriate for that patient;
c. Collect specimens as indicated for additional tests;
d. Perform pertinent laboratory tests in compliance with Clinical Laboratory regulations;
e. Perform any other procedure for which they have been granted privileges;
f. Counsel patients and their families on health promotion, diagnosis and management options;
g. Diagnose and treat conditions listed above;
h. Complete medical records for every patient encounter in the department of Obstetrics, Midwifery and Gynecology computer based format followed by all providers in the Department of Obstetrics, Midwifery and Gynecology.

3. **Emergency Care**

The APP may perform life sustaining measures, whenever necessary.

4. **Procedures and Minor Surgeries**

a. APP at time of hire will need to demonstrate competency in each of the basic Obstetrics, Midwifery and Gynecology skills. Specialized and advanced procedures require proctoring and approval before procedure may be performed without direct or immediate observation in the Obstetrics, Midwifery and Gynecology patient. The APP will follow existing Obstetrics,

Midwifery and Gynecology department protocols for each procedure done in the Obstetrics, Midwifery and Gynecology patient, including sterile procedure, sedation, observation and confirmatory testing.

b. For procedures that require consent APP will be responsible for obtaining informed consent from the patient
c. At the completion of the procedure the APP will write a procedure note that includes any complications.
d. The list of procedures an APP can do for Obstetrics, Midwifery and Gynecology patients once granted privileges and demonstrated competency by direct observation or documented prior work experience is defined on the privilege form.

5. **Protocols**
   a. The APP has been granted privileges within the Alameda Health System to perform the requested procedures.
   b. The APP has been trained to perform the procedure(s), has been observed satisfactorily performing the procedure(s) by another provider competent in that skill, and continued competency is assessed per AHS policy.
   c. The APP is following standard medical technique for the procedures described in the Resources listed in this document.
   d. Appropriate patient consent is obtained, if necessary, before the procedure.
   e. Unless otherwise exempt, all biopsied tissue is sent for a pathology report.
   f. All other applicable Standardized Procedures in this document are followed during health care management.
   g. All General Policies regarding Review, Approval, Setting, Education, Evaluation, Patient Records, Supervision and Consultation in these Standardized Procedures are in force.

Drug Orders and Furnishing

POLICY

The APP is authorized to furnish or order drugs and devices under the following protocols:

PROTOCOLS

1. The APP has a current Furnishing (for NP), NPI, and DEA number.
2. The drugs and devices ordered or furnished are consistent with the APP's educational preparation or for which clinical competency has been established and maintained and listed in the AHS formulary, the patient's insurance formulary, non-formulary medications for which there are no substitutes, or practice recommendations listed in the Resources in this document. Examples are listed in the "Formulary" document at the end of this Standardized Procedure.
3. The drug or device furnished or ordered is appropriate to the condition being treated.
4. APPs may order or prescribe those medications that are FDA approved unless it is used in a clinical investigation, such as a clinical trial, which must be approved by AHS IRB. Additionally, expanded access, sometimes called "compassionate use," may be used when it is outside of a clinical trial of an investigational medical product. Prior IRB review and approval is required, even if only one patient is to be treated under this procedure. Prior approval by the FDA is also required for these cases.
5. "Off label" use, or prescription of FDA-approved medications for uses other than that indicated by the FDA, is permitted when such practices are within the current standard of care for treatment of the disease or condition.
6. Patient education is given regarding the drug or device.

7. The Statement of Approval and Agreement signed by the nurse practitioners/physician assistants will act as the record of APPs authorized to Furnish.
8. All other applicable Standardized Procedures in this document are followed during health care management.
9. All General Policies regarding Review, Approval, Setting, Education, Evaluation, Patient Records, Supervision and Consultation in these Standardized Procedures are in force.

Ordering scheduled Controlled Substances

POLICY
The APP is authorized to furnish or order scheduled controlled substances per the following protocols:

PROTOCOLS
1. The APP follows the provisions of the Standardized Procedure for Furnishing.
2. The controlled substances that may be ordered are included in the formulary(s) or references listed in this document.
3. Relevant scheduled drug contracts, DEA requirements, and all State and Federal regulations are adhered to.
4. Schedule II & III controlled substances are furnished or ordered following the Patient Specific Protocol, in addition to these General Protocols for Scheduled Controlled Substances.
5. The APP may furnish, prescribe or order any medications on the patient's insurance formulary or non-formulary medications for which there is no substitute, within the scope of the provider's license and within the scope of AHS ordering policies.
6. All other applicable Standardized Procedures in this document are followed during health care management.
7. All General Policies regarding Review, Approval, Setting, Education, Evaluation, Patient Records, Supervision and Consultation in these Standardized Procedures are in force.

SCHEDULE III PATIENT SPECIFIC PROTOCOL
1. Schedule III substances may be furnished or ordered when the patient is in one of the following categories, including but not limited to the following conditions:
    a. Acute Illness, Injury or Infection: such as cough, fractures
    b. Acute intermittent but recurrent pain: such as headache
    c. Chronic continuous pain
    d. Hormone replacement

2. Limit order for acute illness, injury or infection to a maximum of 30 days & no refills without reevaluation.

3. For chronic conditions:
    a. Pain management protocol or department guidelines is/are adhered to, if appropriate.
    b. Amount given, including all refills (maximum of 5 in 6 months per DEA regulations, is not to exceed a 120-day supply as appropriate for the condition.
    c. No further refills without reevaluation.

4. Education and follow-up is provided.

SCHEDULE II PATIENT SPECIFIC PROTOCOL

1. Schedule II controlled substances may be ordered when the patient has one of the following diagnoses and under the following conditions.
   a. Pain from cancer, post-operative pain, and trauma.
   b. Pain unresponsive to, or inappropriately treated by CS III-V substances
   c. Attention Deficit Hyperactivity Disorder (ADHD)
   d. Neuropsychiatric Conditions

2. Limit order for acute and chronic conditions as specified above in Schedule III Protocol.
3. No refills for CS II medications are authorized except where authorized by the DEA.
4. Pain Management Protocol or Department guidelines is/are adhered to if appropriate.

Medication Management

POLICY
The advance practice provider is authorized to manage drugs and devices under the following protocols:

PROTOCOLS
1. The management of drugs or devices includes evaluating, initiating, altering, discontinuing, furnishing and ordering of prescriptive and over-the-counter medications.
2. Medication evaluation includes assessment of:
   - Other medications being taken.
   - Prior medications used for current condition.
   - Medication allergies and contraindications, including appropriate labs and exams.
3. The drug or device is appropriate to the condition being treated, and:
   - Accepted dosages per references.
   - Generic medications are ordered if appropriate.
4. A plan for follow-up and refills is written in the patient's chart.
5. The prescription must be written in patient's chart including name of drug, strength, instructions and quantity, and signature of the advance practice provider.
6. All other applicable Standardized Procedures in this document are followed during health care management.
7. All General Policies regarding Review, Approval, Setting, Education, Evaluation, Patient Records, Supervision and Consultation in these Standardized Procedures are in force

Authorizations

POLICY
The APP is authorized, under the following protocols, to:
- Assess Worker's Compensation injuries and illnesses
- Certify Disability
- Manage Home Health and Personal Care Services
- Order Restraint and Seclusion

PROTOCOLS
1. Workers' Compensation: The Doctor's First Report of Occupational Injury or Illness for a workers' compensation claim can be for a period of time off in relation to injury. The treating physician is required to sign the report and to make any determination of any temporary disability.
2. Certify Disability: The APP has performed a physical exam and collaborated with a physician and surgeon.

3. Home Health and Personal Care Services: Approval, signing, modifying, or adding to a plan of treatment or plan of care
4. Restraint and Seclusion: The APP must be knowledgeable and competent in the Hospital Conditions of Participation for Patients' Rights including the Interpretive Guidelines. Ordering physical or chemical restraint, and/or seclusion, is in strict accordance with the protocols adopted in the Resources section of this document which include the extent of implementation and which meets the intent of the acute medical and surgical hospitals Conditions of Participation for Rights.
5. All other applicable Standardized Procedures in this document are followed during health care management.
6. All general policies regarding review, approval, setting, education, evaluation, patient records, supervision and consultation in these standardized procedures are in force.

6. **Standard of Care**

Standards for adequacy of diagnosis, management and treatment shall be in accordance with hospital Policy and Procedure, clinic protocols, current community standards of care, Obstetrics, Midwifery and Gynecology Department protocols or current texts/articles on care found in the Department of Obstetrics, Midwifery and Gynecology.

7. **Consultation and Referral**

The APP will be providing health care as outlined in this document. In general, communication with a physician who is a current member in good standing of the Medical Staff, and who holds privileges in the Department of Obstetrics, Midwifery and Gynecology will be sought for all the following situations, and any others deemed appropriate. Whenever a physician is consulted, a notation to that effect, including the physician's name, must be made in the chart.

a. Conditions that do not follow clinical protocols, procedures, classic diagnostic patterns, or that have failed to respond to standardized treatments and/or management.
b. Any significant unexplained physical or historical findings.
c. Emergency situations after initial care.
d. When the patient expresses a desire to see a physician.

The following situations are examples (not exhaustive) of those that will likely require physician advice or consultation:

a. Surgical consultations
b. Complex gynecology care
c. Complex cervical dysplasia management

8. **Other duties**

The patient must be informed that the provider is an APP and be given the opportunity to request care by a physician should the patient desire it.

9. **APP - Nursing Staff Relationship**

The APP is authorized to give nursing personnel orders for all laboratory and x-ray studies, treatment and medication for those patients for whom the APP is providing medical care. Orders given by the APP are orders generated in agreement with the Consulting Physician. Any questions regarding these orders that are not satisfactorily resolved through discussion with the APP should be brought to the Consulting Physician before being carried out.

10. **Agreement Review**

The signature on the Attestation by the APP acknowledges agreement to practice within the limits of the foregoing standardized procedures/practice guidelines. Upon its review, if changes are made, new

signatures will be necessary.

REFERENCES/RESOURCES

- AHS/AH Medical Staff Bylaws
- Medical Staff Advanced Practice Provider policy and procedure manual
- Medical Staff Privilege forms
- Nurse Practice Act in the California Business and Professions Code
- Physician Assistant Practice Act
- ASCCP Cervical Dysplasia Guideline
- References that define Standard of care for the include, but are not limited to:
  o UpToDate
  o Roberts and Hedges Procedural Book
  o AHS Formulary for drug use and current antibiogram

APPROVALS

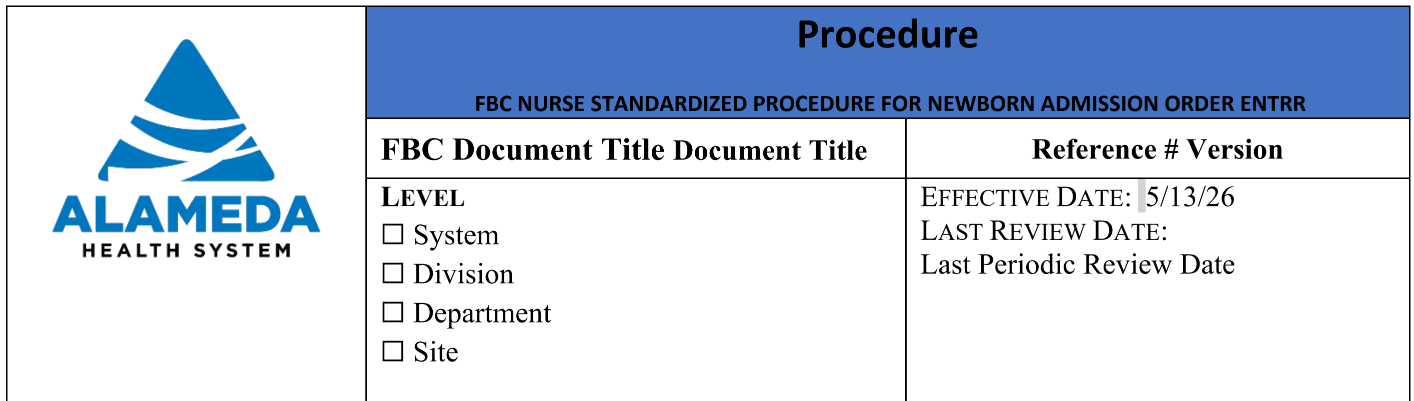
Approving Committee/Executive	Date of Approval	
	AH	**AHS**
Interdisciplinary Practice Committee	3/25/26	
Credentials Committee	4/9/26	
CPC		
Medical Executive Committee	n/a	4/15/26
QPSC	4/22/26	
Board of Trustees	5/13/26	

Signature:

Signature implies the following: approval of all the policies and protocols in this document, the intent to abide by the Standardized Procedures, the willingness to maintain a collegial and collaborative relationship with all the parties, and agreement of all collaborating/supervising physicians within the department.

Nurse Practitioner/Physician Assistant (Printed Name): ____

Signature:____ Date: _________________________



ALAMEDA HEALTH SYSTEM	**Procedure** FBC NURSE STANDARDIZED PROCEDURE FOR NEWBORN ADMISSION ORDER ENTRR	
	FBC Document Title Document Title	**Reference # Version**
	LEVEL ☐ System ☐ Division ☐ Department ☐ Site	EFFECTIVE DATE: 5/13/26 LAST REVIEW DATE: Last Periodic Review Date

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

PROCEDURE STATEMENT

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

Purpose

It is the intent of this document to authorize the Advanced Practice Providers (APP) within Wilma Chan Highland Hospital in the Department of Family Birth Center (FBC) to implement the Standardized Procedures without the immediate supervision or approval of a physician. The Standardized Procedures, including all the policies and protocols, are defined in this document, and will be referred to generally as the "Standardized Procedures".

SCOPE

1. **Role**
   Registered Nurse
2. **Population**
   Well babies at or more than 35 weeks' gestational age who are admitted to the newborn nursery
3. **Setting**
   Family Birthing Center
4. **Limitations**

   a. Standardized Procedure for Newborn Admission Order Entry (SP-NAOE) does not apply to any newborns who are less than 35 weeks' gestation at birth.

   b. SP-NAOE does not apply to newborns who are admitted to Intensive Care Nursery (ICN).

      1. Infants born at less than 35 weeks gestation or birth weight less than 2000 grams

Development

Standardized procedures for nursing on the FBC are developed jointly by unit nursing leadership (e.g., manager, director, and/or clinical educator) and departmental leadership (e.g., division chief and/or department chair) in accordance with the requirements set forth in Section 2715 of the California Business and Professions Code and the California Nursing Practice Act.

PROCEDURE

1. Initiation of this standardized procedure is done by RNs within the Family Birthing Center (FBC) who have been authorized through evaluation and approved in writing to perform nursing functions addressed in this procedure.

2. **Standardized Procedure Functions**

   a. This standardized procedure will be utilized in conjunction with the Newborn Nursery Admission order set.

   b. RN may implement the SP-NAOE for any newborn admitted to the FBC, except those who meets exclusion criteria above.

   c. RN enters Newborn Nursery Admission order set, per protocol, in the newborn's medical record.

      i. RN is not required to obtain a verbal order or telephone order from the newborn's attending pediatrician.

   d. FBC attending pediatrician will be notified of infant's birth via Epic chat.

   e. SP functions are described in **Appendix A**

4. **RN Requirements/Education**
   Registered Nurses who may practice under this SP are graduates of an accredited educational program in registered nursing and hold an active license to practice Registered Nursing in the State of California. Additionally, RNs practicing under this SP possess the following attributes:
   a. Current BLS or ACLS certification from the American Heart Association
   b. Current NRP certification from the American Academy of Pediatrics
   c. Employment on the Family Birthing Center at Highland Hospital
   d. Initial and annual education on Standardized Procedure for Newborn Admission Order Entry (SP-NAOE)

5. **RN Evaluation and Record-Keeping**
   a. Initial Competency Evaluation is based on the following:
      i. Completion of FBC SP-NAOE Procedure Competency

ii. Review SP-NAOE and all additional affiliate specific policies related to SP-NAOE

iii. Competency will be assessed by an experienced FBC RN

b. Ongoing Competency Evaluation
   i. Review SP-NAOE and all additional affiliate specific policies related to SP-NAOE
   ii. Yearly competency evaluation during FBC Annual Unit-Based Competencies

c. Maintenance of Records
   Written records of initial and ongoing annual competency evaluations will be kept on file and maintained by the nurse manager or designee.

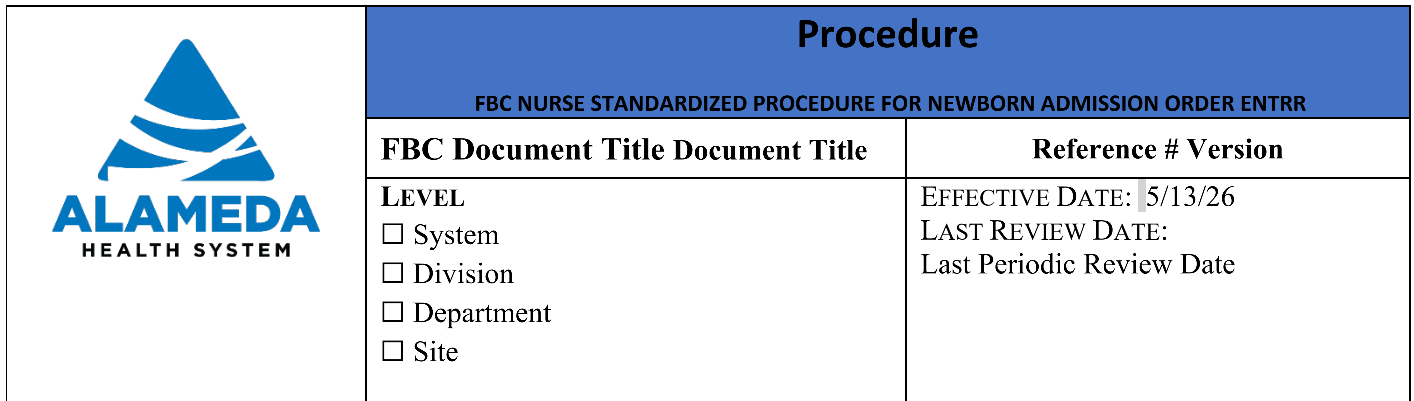
6. **Supervision**
   a. No direct supervision is required of RNs with documented approval/competence to practice under SP-NAOE.
   b. The attending pediatrician is available to the RN at all for consultation either in person, by telephone, or by other electronic means.

7. **Physician Notification**
   The following circumstances will be communicated to the patient's attending physician immediately: Appendix F.

8. FBC attending pediatrician will be notified of infant's birth via Epic chat.

9. **Documentation**
   All functions performed under SP-NAOE by the FBC RN will be documented in the patient's medical record (MR).

10. **Periodic Review**
    The FBC Nurse /Physician Leadership Team will review SP-NAOE tri-annually to ensure practices are current. Revision according to evidence-based practice changes may occur at any time and may be initiated by any member of the FBC Nurse /Physician Leadership Team.



FBC Document Title Document Title	Reference # Version
LEVEL ☐ System ☐ Division ☐ Department ☐ Site	EFFECTIVE DATE: 5/13/26 LAST REVIEW DATE: Last Periodic Review Date

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

REFERENCES

1. California Board of Registered Nursing. *Standardized Procedure Guidelines*. 1993; rev. 2011. Department of Consumer Affairs, Sacramento, CA. Retrieved January 20, 2021, from https://www.rn.ca.gov/pdfs/regulations/npr-i-19.pdf

2. California Code of Regulations, Title 16, Division 14, Article 7. Standardized Procedure Guidelines § 1474. Register 2021, No. 2. Retrieved January 20, 2021, from https://govt.westlaw.com/calregs/Document/IB5F41390D48E11DEBC02831C6D6C108E?transitionType=Default&contextData=%28sc.Default%29#co_anchor_I1E60F87D97B74833B1896ACB25FFBCD9 Business and Professions Code 2725

APPROVALS

		System	AH	AHS
Department	Date:	1/23/2026		
Pharmacy and Therapeutics (P&T)	Date:	2/23/2026		
Interdisciplinary Practice Committee	Date:	3/25/26		
Credentials Committee	Date:	4/9/26		
Clinical Practice Council (CPC)	Date:			
Medical Executive Committee	Date:		N/A	4/15/26
QPSC	Date:	4/22/26		
Board of Trustees	Date:	5/13/26		

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

ATTACHMENTS

APPENDIX A

Standardized Procedure Functions Under SP-NAOE

1. **Administration of Vitamin K (Phytonadione)**
   a. Vitamin K (Phytonadione) 1 mg IM within 2 hours of birth
   b. If parent(s) refuses Vitamin K (Phytonadione) the RN will
      i. Provide the parent(s) with Parental Declination of Vitamin K Administration form (**Appendix C**) to read.
      ii. Notify physician within 2 hours of birth
         1) Physician will discuss with the parent the risks, benefits and alternatives with the parent(s).
         2) If family decides to decline vitamin K, physician will have family sign Parental Declination of Vitamin K form
      iii. Signed form will be scanned into the MR.
      iv. Document **"not given/refused"** in the newborn medication administration record (MAR).
      v. Communicate the parent(s) refusal to Vitamin K (Phytonadione) administration at nursing hand off
2. **Administration of Erythromycin Ophthalmic Ointment**
   a. Place 0.5-inch (1 cm) ribbon of Erythromycin ophthalmic ointment 0.5% or equivalent in each conjunctival sac within 2 hours of life
   b. Note: Erythromycin ophthalmic ointment 0.5% may be substituted per Pharmacy therapeutic interchange
   c. If the parent(s) refuses Erythromycin the RN will:
      i. Notify physician within 18 hours of birth

ii. Physician notification may wait until the next morning if within the 18-hour period, unless mother is positive for gonorrhea.

iii. If mother is positive for gonorrhea, contact physician within 2 hours of birth.

1) Physician will discuss with the family the risks, benefits and alternatives.

2) If family decides to decline erythromycin ophthalmic ointment, physician will have family sign Parental Declination of Erythromycin Ophthalmic Ointment form (**Appendix D**)

iv. Signed form will be scanned into MR.

v. Document "**not given/refused"** in the newborn MAR.

3. **Administration of Hepatitis B Vaccine and/or Hepatitis B Immune Globulin (HBIG):**

a. Provide current Hepatitis B Vaccination Information Statements (VIS) to the parent(s)

b. Maternal Hepatitis Status NEGATIVE

i. Administer Pediatric Hepatitis B vaccine 0.5 ml IM within 24 hours after birth.

ii. If the parent(s) refuse Hepatitis B vaccine the RN will:

1) Notify Physician within 18 hours of birth. (Notification may wait until the next morning if within the 18-hour period.)

a) Physician will discuss risks, benefits and alternatives with the parent(s)

2) Document "**not given/ refused"** in the newborn MAR

c. Maternal Hepatitis Status POSITIVE/UNKNOWN

i. If Mother is HBsAg POSITIVE

1) Change Hepatitis B medication orders to match mothers surface antigen POSITIVE status

2) Administer Pediatric Hepatitis B vaccine 0.5 ml IM within 12 hours of birth; and

3) Hepatitis B Immune Globulin (HBIG) 0.5 ml IM within 12 hours of birth.

ii. If Mothers is HBsAg is UNKNOWN and baby is greater than or equal to 2000g

1) Change Hepatitis B medication orders to match mothers surface antigen UNKNOWN status

2) Administer Pediatric Hepatitis B vaccine 0.5 ml IM within 12 hours of birth; and

3) Notify OB provider to obtain Mother's HBsAg result prior to discharge

iii. If Mother is HBsAg is POSITIVE/UNKNOWN AND Parent(s) Refuse Hepatitis B vaccine and/or HBIG:

1) Notify physician within 12 hours of birth.

a) Physician will discuss the risks, benefits and alternatives with the parent(s).

2) Signed Parental Declination of Hepatitis B Vaccine and Hepatitis B Immune Globulin form (**Appendix E**) will be scanned into the MR

3) Document **"not given/ refused"** in the newborn the MR

4. **Newborn Feeding**

a. **Breastfed newborns**

i. Initiate a breastfeeding opportunity as soon as medically possible, within the first hour after delivery. Exception:

1) If mother is HIV positive, breastfeeding may be allowed, but notify physician to have discussion with family

2) If mothers toxicology screen is positive, contact physician per policy prior to feeding

a) Refer to guideline: FBC BREAST MILK COLLECTION, STORAGE, SCANNING AND PREPARATION

ii. For the late pre-term infant encourage feeding every 2-3 hours at a minimum

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b. **Formula fed newborns**

i. If mother's feeding plan is only formula, ensure mother signs consent for formula if it is not medically indicated.

ii. Include term infant formula option in feeding order

5. **Lab Tests and Screenings**

a. If mother is Rh Negative and/or blood Type O:

i. Order and sent newborn workup

ii. If the cord blood is not obtained, notify physician

b. All newborns will have cord arterial blood gas and cord venous blood gas sent

i. Notify physician if infant has Apgar less than 7 at 5 minutes of life

ii. Notify physician if pH is less than 7.01 or if base deficit is -10 or more

c. Newborn Metabolic Screen (PKU)

i. All babies will have a newborn screen obtained at 24 hours of age.

ii. Refer to Policy: FAMILY BIRTHING CENTER NEWBORN SCREENING TEST

iii. If parent(s) refuses Metabolic Screening, document refusal in medical record

1) Parent(s) signs *California Newborn Screening Test Request Form*, refusal

2) Send original copy to laboratory, scan golden copy into newborn medical record, and give pink/blue copies to parent(s)

3) Notify physician

b. Transcutaneous Bilirubin (TcB)/Bilirubin

i. Refer to guideline, FBC TRANSCUTANEOUS (TcB) BILIRUBIN MEASUREMENT IN THE NEWBORN. Performed for the following newborns:

1) Newborns with a positive Coombs result at 12 hours of age and again every 12 hours until discharge.

2) Newborns noted to be jaundiced within the first 24 hours.

3) All other newborns will have TcB obtained around 24 hours of life with routine newborn screenings, and subsequently every morning for duration of hospitalization.

ii. Document Bilimeter (JM-105) results in the MR.

iii. TcB result:

1) If TcB result appears as a flashing >20, which indicates a critical high of greater than 20 mg/dL, nurse obtains stat serum bilirubin (TsB) and notifies physician if critical value.

2) Refer to CRITICAL RESULTS AND COMMUNICATION OF CRITICAL RESULTS procedure.

3) If TcB result falls under Category A or B, nurse obtains TsB.

a) Category A: If the TcB is within 3 mg/dL of phototherapy threshold per AAP

b) Category B: If the TcB is 13 mg/dL or higher

iv. TsB result:

1) If serum bilirubin result is:

a) Above the threshold for treatment, or if the nurse has any concerns, the infant's physician should be notified immediately

b) If the TSB result is within 1-2 mg/dL below the AAP phototherapy threshold, the physician should be notified

c) If the serum direct bilirubin is greater than 1 mg/dL, the physician is notified

d) Document physician notification in MR

c. Hearing Screening

i. Hearing screens will be performed on all newborns prior to discharge.

ii. Refer to guideline: FBC NEWBORN HEARING SCREEN

iii. If parent(s) refuses Hearing Screening, document refusal in medical record

1) Parent(s) signs *Consent/Refusal To Newborn Hearing Screening* and is given the CA NHSP Waiver Brochure

2) Scan refusal into medical record

3) Notify physician

d. Congenital Heart Screening

i. Congenital heart screening will be performed on all babies after 24 hours of life or prior to discharge if leaving prior to 24 hours.

ii. Refer to Policy: FAMILY BIRTHING CENTER CRITICAL CONGENITAL HEART DEFECT SCREENING WITH PULSE OXIMETRY

iii. If parent(s) refuses Congenital Heart Screening, document refusal in medical record and notify physician

e. Car Seat Study

i. Perform car seat evaluation after 24 hours of age and prior to discharge if gestational age a birth is less than 37 weeks.

ii. Refer to guideline: FBC INFANT CAR SEAT TOLERANCE SCREEN (ICSTS)

f. Blood Glucose and Screening/Management

i. Obtain blood glucose for the following newborns:

1) Symptomatic

2) Late preterm

3) Small for gestational age

4) Large for gestational age

5) Born to mothers with diabetes

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ii. Refer to procedure: FBC NEONATAL BLOOD GLUCOSE MONITORING

6. Output

a. Physician will be notified for:

i. No stool by 24 hours of life
ii. No urine by 24 hours of life

7. Vital Signs

a. Refer to Policy: SCOPE OF SERVICE: FAMILY BIRTHING CENTER INPATIENT UNITS (LABOR AND DELIVERY, OB EMERGENCY, MOTHER BABY UNIT, INTERMEDIATE CARE NURSERY)

8. Hypoglycemia Management

a. Refer to procedure: FBC NEONATAL BLOOD GLUCOSE MONITORING

b. Administer 0.4g – 1g Glucose (GLUTOSE 15) 40% oral gel to buccal mucosa PRN up to 3 doses within first 24 hours of life for POC glucose less than 40 mg/dL in first 4 hours of life or less than 45 mg/dL between 4 and 24 hours of life (Recommended dose 200mg/kg/dose and round to nearest 0.5 mL)

c. Weight/dose/volume table:

Wt	Dose	Volume
2 kg	0.4 g	1 mL
3 kg	0.6 g	1.5 mL
4 kg	0.8 g	2 mL
5 kg	1 g	2.5 mL

9. Newborn Toxicology Testing

a. Urine Toxicology testing is not routinely recommended. If concerns, call the physician to discuss and obtain an order if neonatal toxicology screen is indicated

10. Screen for Sepsis

a. Refer to guideline: Early Onset Sepsis Calculator Guidelines, can be found on Department of Pediatrics intranet

b. If EOS risk is less than 0.4 cases per 1000 live births and a well appearing infant, then proceed with routine care.

c. If EOS risk is greater than or equal to 0.4 cases per 1000 live births, but less than 1 case per 1000 live births, in a well appearing infant, then proceed with vital sign checks every 4 hours for first 24 hours.

d. If EOS risk is greater than or equal to 1 case per 1000 live births but less than 3 cases per 1000 live births, in a well appearing infant:

1. Nurse to order and draw blood culture.

2. Please do vital signs every 4 hours for first 24 hours

e. If EOS risk is greater than 3 per 1000 OR an infant who has abnormal vital signs (equivocal exam or clinically ill appearing), notify physician.

11. Reportable Conditions to Physician:

a. Axillary temperature of less than 36.5° C (97.7° F) or greater than 37.8°C (100° F) after 1 hour of life. (Initiate the FAMILY BIRTHING CENTER WELL BABY HYPOTHERMIA POLICY AND PROCEDURE).

b. Cardiac Parameters:

i. Heart rate consistently less than 80, greater than or equal to 180 in the absence of abnormal temperature.

ii. Irregular heart rate rhythm.

iii. Heart murmur.

iv. Signs of poor perfusion: Capillary refill greater than 3 seconds, pale or mottled skin.

c. Respiratory Parameters:

i. Resting respiratory rate less than 20 or consistently, greater than 60 in the absence of abnormal temperature.

ii. Persistent signs of respiratory distress such as: Tachypnea, labored or shallow respirations, grunting, nasal flaring, retractions, or duskiness.

iii. Oxygen therapy required.

d. Apnea episode.

e. Jaundice present at birth or within 24 hours.

f. No urine output by 24 hours

g. Abdominal distention, vomiting and/or no stool by 24 hours.

h. Lethargy or excessive irritability (inconsolability).

i. Seizure-like activity.

j. Yellow or green eye drainage.

k. Abnormal lab values.

l. Maternal HIV.

m. Mothers with current substance abuse

n. Mothers with active herpes lesions at delivery

12. Patient /Family Education

a. Provide relevant information and handouts, and vaccine information sheet.

13. Documentation

a. Ensure that required information has been obtained to admit patient to the unit.

b. Document all required patient information in the medical record.

c. Document all medications given.

d. Document all physician notifications

REFERENCES

A. American Academy of Pediatrics /American College of Obstetricians and Gynecologists (2012). Guidelines for Perinatal Care, 7th Edition.

B. Red Book (2012), Report of the Committee on Infectious Diseases. 29th ed. Elk Grove Village, IL: American Academy of Pediatrics.

C. California Board of Registered Nursing (2014) website: STANDARDIZED PROCEDURE GUIDELINES www.rn.ca.gov/pdfs/regulations/npr-i-19.pdf

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APPENDIX B

FAMILY BIRTHING CENTER
UNIT BASED COMPETENCIES

SP NAOE Procedure Competency

Employee Name ______ Date ______

Competency statement: Utilizing age-appropriate strategies, able to demonstrate skills and verbalize knowledge of role and job behaviors Performance criteria: Utilizing age-appropriate strategies, able to locate, describe, perform and/or demonstrate item Indicate method of validation for each item: OB – observed; VR – verbal review; RD – return demonstration.	Evaluator to Complete		
	Method	Initials	Date
UNIT PROCESSES			
☐ **Items required for SP NAOE:** • RN can access SP NAOE Order Set • RN can release orders.			
☐ **Able to state:** • RN aware of when clinically indicated to contact pediatrician. **Indications:** • Emergent Neonatal Resuscitation • Blood loss • Abruption			
☐ **RN will gather Supplies required for blood transfusion:** • Neonatal Syringe Set with 150-micron filter and 60 mL Syringe • 3-way stopcock • 2 x 10 mL Normal Saline Flush Syringes • Med Pump • Extension Tubing • Blood Product ordered by MD (10mL/kg)			
☐ **Procedure Set-up:** • RN will Don proper PPE- • RN will verify with 2nd RN or MD blood product, per policy. Clamp then attach IV spike from neonatal syringe set with 150-Micron filter to blood product. • Attach 3-way stopcock to luer lock adapter of syringe-set; closed to blood-product. • Attach 60 mL syringe to 3-way stopcock, open clamp and stopcock, pull back ordered amount of blood into syringe. • To remaining unit of blood product, attach 5 mL syringe and close 3-way stopcock to prevent blood product from leaking. Clamp neonatal syringe set. • Attach 60 ml syringe to PIV/UVC and prime tubing, ensuring all air is removed. • Administer over 5-10 min, if to be administered via pump program it to correct volume and time as ordered by MD.			

Page 1 of 2

FAMILY BIRTHING CENTER
UNIT BASED COMPETENCIES

Competency statement: Utilizing age-appropriate strategies, able to demonstrate skills and verbalize knowledge of role and job behaviors **Performance criteria:** Utilizing age-appropriate strategies, able to locate, describe, perform and/or demonstrate item Indicate method of validation for each item: OB – observed; VR – verbal review; RD – return demonstration.	**Evaluator to Complete**		
	Method	**Initials**	**Date**
• Attach tubing to IV site (peripheral or umbilical) • Attach 10 mL syringe of Normal Saline and Flush line at completion of blood product transfusion. • Complete documentation in HER.			
☐ **Demonstrates technique/skill:** • Set up transfusion • Verifies Consent (unless emergent) • Take vital signs, during and after transfusion • Document findings in EHR			
☐ Able to state **Transfusion Reaction:** • Able to recognize acute reaction to transfusion therapy. • **Stop the transfusion immediately and notify the physician and blood bank if signs or symptoms of reaction occur.** Signs and symptoms: o Tachycardia (>180 or 10% greater than baseline) o Hypotension/Shock o Rise in temperature >38 C (100.4F) and a change of >1C (2F) from pre-transfusion temperature taken within 30 minutes before start of the transfusion. o Diffuse bleeding o Hematuria o Oliguria/Anuria o Rash			

Acknowledgement: I received training and education on the above performance criteria, and I assume responsibility for my practice by maintaining ongoing education and communicating any skills and/or practice needs to my manager/supervisor.

Signature of employee: ____________________ Date:

Signature of evaluator ____________________ Date

APPENDIX C

ALAMEDA HEALTH SYSTEM

Highland Hospital

Parental Declination of Vitamin K Administration

Date____________
Time____________

We/I _______________________________________, the parent(s) of ______________________, born at Highland Hospital on __________ have decided to decline the administration of Vitamin K to my/our newborn. The pediatrician ____________________ has discussed with me/us that the reason that this injection is routinely given is to prevent Hemolytic Disease of the Newborn, a rare but serious disorder that involves uncontrollable and spontaneous bleeding in babies in the first days/weeks of life. Complications include, but are not limited to, brain damage and death. I/we understand these risks and will not hold Highland Hospital (member of Alameda Health System) or any of its employees responsible should this problem affect my/our child.

Signed: ______________________ __________
Mother Time/Date

______________________ __________
Partner Time/Date

______________________ __________
Witness Time/Date

1411 East 31st Street, Oakland, CA 94602 AlamedaHealthSystem.org

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APPENDIX D

ALAMEDA HEALTH SYSTEM

Highland Hospital

Parental Declination of Erythromycin Eye Ointment

Date____________
Time____________

We/I ____, the parent(s) of _______________________, born at Highland Hospital (member of Alameda Health System) on _____________ have decided to decline the administration of Erythromycin Eye Ointment to my/our newborn. The pediatrician, ____________________, has discussed with me/us that the reason that this ointment is routinely given is to prevent Ophthalmia Neonatorum, an inflammation of the lining of the eyes caused by Gonorrhea, Chlamydia, and/or other bacteria or viruses. This process can be severe and lead to permanent loss of vision (blindness) or become disseminated (spread throughout the body) and lead to damage of other organ systems or even death. I/we understand these risks and will not hold Highland Hospital (member of Alameda Health System) or any of its employees responsible should this problem affect my/our child.

Signed ______________________ __________
Mother Time/Date

______________________ __________
Partner Time/Date

______________________ __________
Witness Time/Date

1411 East 31st Street, Oakland, CA 94602 AlamedaHealthSystem.org

APPENDIX E

ALAMEDA HEALTH SYSTEM

Highland Hospital

Parental Declination of Hepatitis B Vaccine and Hepatitis B Immune Globulin

Date____________
Time____________

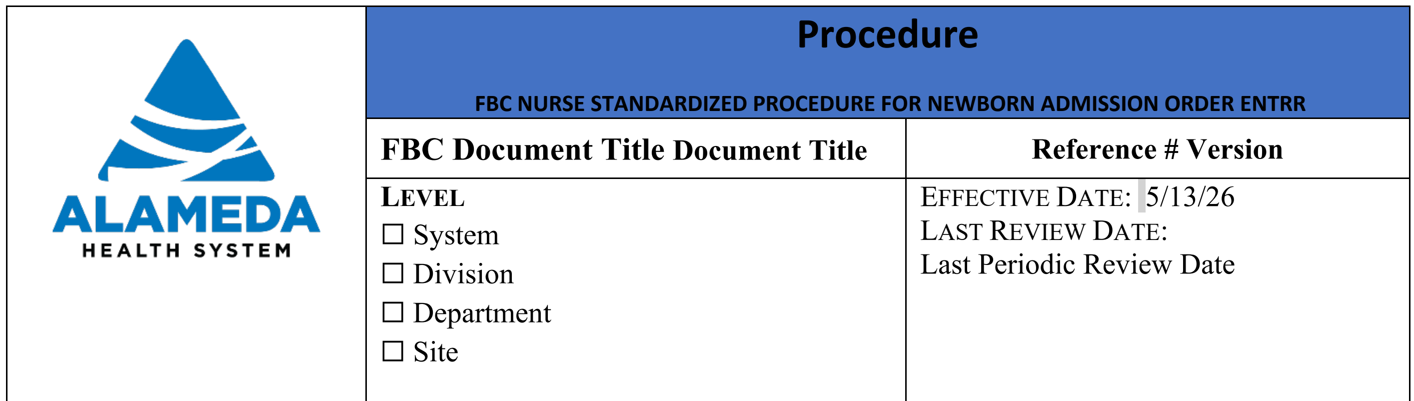
We/I _____________________________________, the parent(s) of ____________________, born at Highland Hospital on __________ have decided to decline the administration of Hepatitis B vaccine and/or Hepatitis B Immune Globulin (HBIG) to my/our newborn. The pediatrician ____________________ has discussed with me/us that the reason these treatments are indicated are due to maternal Hepatitis B status being unknown or positive. These injections are recommended to prevent my newborn from acquiring hepatitis B virus infection in infancy. Complications include, but are not limited to, acute hepatitis B, chronic hepatitis B, cirrhosis, fulminant fatal hepatitis B, and death. I/we understand that if I/we later decide to obtain the above recommended medications for my/our newborn, post exposure prophylaxis efficacy is significantly reduced the longer vaccine and HBIG administration is delayed. I/we understand these risks and will not hold Highland Hospital (member of Alameda Health System) or any of its employees responsible should this problem affect my/our child.

Signed: ______________________ __________
Mother Time/Date

______________________ __________
Partner Time/Date

______________________ __________
Witness Time/Date

1411 East 31st Street, Oakland, CA 94602 AlamedaHealthSystem.org



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Appendix F

Reportable Conditions to Physician:

a. EOS sepsis score for those requiring blood culture, or calculator suggests antibiotics, or are equivocal on exam as per EOS policy (not just maternal fever 102ºF or higher)

b. Babies born to mothers with active herpes lesions

c. Mothers who are HIV + to get medications and testing ordered

d. Difficult extraction either in LDR or operating room

e. Greater than 3 failures at instrument delivery

f. Second stage of labor longer than 4 hours

g. Preterm birth less than 35 weeks gestation

h. Axillary temperature of less than 36.5° C (97.7° F) or greater than 37.8°C (100° F) after 1 hour of life.

i. Cardiac Parameters:

   a. Heart rate consistently is less than 80, greater than or equal to 180 in the absence of abnormal temperature.

   b. Irregular heart rate rhythm.

   c. Heart murmur.

   d. Signs of poor perfusion: Capillary refill greater than 3 seconds, pale, or mottled skin.

j. Respiratory Parameters:

   a. Resting respiratory rate less than 20 or consistently, greater than 60 in the absence of abnormal temperature.

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b. Persistent signs of respiratory distress such as: Tachypnea, labored or shallow respirations, grunting, nasal flaring, retractions, or duskiness.

c. Oxygen therapy required.

k. Apnea episode

l. Jaundice present at birth or within 24 hours

m. No urine output by 24 hours

n. Abdominal distention, vomiting and/or no stool by 24 hours

o. Lethargy or excessive irritability (inconsolability)

p. Seizure-like activity.

q. Yellow or green eye drainage.

r. Abnormal lab values.

s. Maternal HIV.

t. Mothers with current substance abuse

u. Mothers with active herpes lesions at delivery

Alameda Health System

MEDICAL STAFF CREDENTIALING AND PRIVILEGING OF PROVIDERS

Department	Medical Staff	***Effective Date***	5/2011
Campus	AHS, AH	***Date Revised***	5/2011, 6/2014, 6/2017, 6/2019, 2/2020, 1/2022, 4/2022; 4/2023; 5/2023; 10/2023; 11/2023; 2/2024; 3/2024; 3/2025; 4/2025; 8/2025; 11/2025; 3/2026; 4/2026; 5/2026
Unit	Medical Staff	***Next Scheduled Review***	5/13/2029
Manual	Medical Staff	***Author***	Manager, Medical Staff Services
Replaces the following Policies:		***Responsible Person***	Chief of Staff

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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.

The criterion outlined herein is reviewed and approved by the Credentials Committee.

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 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) and saved in the provider’s credentials file. When oral verification is conducted, a documented record entry will include the name and contact information of the individual who provided the verification. Primary source documentation is dated and labeled with the name/user identification of the individual who performed the validation.

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 and Exclusions
    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. <u>Continuing Medical Education</u>
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. <u>Provider Enrollment</u>
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. <u>Ongoing Professional Practice Evaluation (OPPE)</u>
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. <u>Additional Information</u>
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. <u>Timeliness of Information</u>
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 ONLYof $100.00.
   b. AHS application fee of $300.00 and reappointment fee of $500.00.
   c. AH application fee of $300.00 and reappointment 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 Medial Staff Office and the Department Chair. Failure to communicate any changes in dates will result in the resignation being effective as of the date on the Voluntary Resignation Form and all systems access will cease as outlined in the deactivation process.

PROVIDER RIGHTS TO AMEND APPLICATION AND REVIEW CREDENTIALS FILE

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

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

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

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

<u>Approvals:</u>

<table>
<tr><th></th><th></th><th>AHS</th><th>AH</th></tr>
<tr><td>Credentials Committee</td><td>Date:</td><td colspan="2">4/9/26</td></tr>
<tr><td>Medical Executive Committee</td><td>Date:</td><td>4/15/26</td><td>4/17/26</td></tr>
<tr><td>QPSC</td><td>Date:</td><td colspan="2">4/22/26</td></tr>
<tr><td>Board of Trustees</td><td>Date:</td><td colspan="2">5/13/26</td></tr>
</table>

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.

The invitation to the online application portal was sent on *[enter month/date/year]*, and the application remains at *[enter %]* 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.

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

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

Please contact your Department Chair regarding the above.

Alameda Health System

MEDICAL STAFF CREDENTIALING INFORMATION INTEGRITY AND DATA SECURITY

Department	Medical Staff Services	*Effective Date*	11/19/2025
Campus	AHS, AH	*Date Revised*	5/2026
Unit	All	*Next Scheduled Review*	5/13/26
Manual	Medical Staff	*Author*	Manager, Medical Staff Services
Replaces the following Policies: Medical Staff Credentialing System Controls		*Responsible Person*	Vice President, Physician Services

Purpose

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

Policy Statement

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

Procedure

A. Scope of Credentialing Information

Credentialing information protected under this integrity policy will include:

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

B. Staff Responsibilities/Access

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

identifies that credentialing information changes and/or updates are appropriate.

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

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

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

C. Documenting Updates to Credentialing Information

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

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

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

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

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

Type of updates to existing credentialing that are appropriate:

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

D. Inappropriate Documentation and Updates

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

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

E. Auditing, Documenting and Reporting Information Integrity

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

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

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

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

The audit tool includes the following information:

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

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

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

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

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

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

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

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

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

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

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

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

G. Information Integrity Training

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

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

H. Confidentiality and Information Security

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

Medical Staff services personnel are granted access to the credentialing database in accordance with their assigned user role defined in this policy. Electronic files are primarily maintained within the credentialing database; however, supporting materials may also be electronically stored in a network folder, accessible to all medical staff personnel. Personnel shall secure all confidential information when not in use.

Workstations shall be in physically secure areas and computer screens should be positioned to prevent viewing form unauthorized individuals.

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

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

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

References:

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

		AHS	**AH**
Credentials Committee	**Date:**	**4/9/26**	
Medical Executive Committee	**Date:**	**4/15/26**	**4/1/726**
QPSC	**Date:**	**4/22/26**	
Board of Trustees	**Date:**	**5/13/26**	

ALAMEDA HEALTH SYSTEM

April 22, 2026

TO: Quality Professional Services Committee

FROM: Bhrett Lash, M.D., Alameda Health System Vice Chief of Staff
Manasa Kalluri, M.D., Alameda Hospital Chief of Staff

SUBJECT: **Agenda Item:** B4

Meeting Date: April 22, 2026

Item Description: Medical Staff Application Demographic Grid/Application Request Form & Specialty Privilege Forms

COMMITTEE ACTION: Approval of revised Medical Staff Privilege Forms

Background:
The application demographic grid/application request and specialty privilege form(s) listed in the analysis section are revised privileges forms, designed to offer a systematic approach for care across our facilities (AHS, SLH, AH) as applicable.

Analysis:
The Medical Staff demographic grid/application form provides a way to collect key information to support release of credentialing applications to start the credentialing process.

Privilege forms—new or revised—are updated through a standardized, evidence-based process.

Board Action Requested:
Approval of revised demographic grid/application request form and privilege forms for system-wide credentialing and privileging to support patient care at AHS.

Medical Staff Application Form for AHS & AH:
- Demographic Grid/Application Request

Revised Privilege Forms for AHS & AH:
- Gastroenterology

Privilege Forms for AHS:
- Obstetrics and Gynecology APP

Revised Privilege Form for AH:
- Wound Care

ALAMEDA HEALTH SYSTEM   ALAMEDA HEALTH SYSTEM Alameda Hospital

Alameda Health System Medical Staff Services
Medical Staff Application Request/Demographic Grid

Thank you for your interest in applying for membership and/or privileges at Alameda Health System and/or Alameda Hospital Medical Staff(s). Please complete and return the Demographic Grid below along with a current CV/Resume to start the application process. ***Incomplete forms will be returned.***

The credentialing process takes a minimum of 60-90 days following receipt of a completed application.

Provider Demographic Information	
Name: *(Full legal name as listed on Government/State-Issued ID; this will be used as name of record)*	Credentials: *Medical Staff:* ☐MD ☐DO ☐DPM ☐PsyD ☐DDS *Advanced Practice Provider (APP):* ☐PA ☐NP ☐CRNA ☐CNM ☐OD
CA State License Number:	NPI:
Specialty:	Board Certification Specialty(s): *Certification date (or anticipated date, if in the examination process):*
Mailing Address:	Phone Number:
E-mail:	cc email *(if applicable)*:
Medical Staff and Organizational Affiliation Information	
Medical Staff Department:	Division *(if applicable)*:

Please select which Medical Staff(s) and Staff Category(ies) for which you are seeking affiliation.

Alameda Health System (AHS) Medical Staff ☐ Yes or ☐ No / ☐Primary or ☐Secondary

Locations: ☐Highland ☐San Leandro ☐Fairmont ☐John George ☐Ambulatory Wellness Centers (*please check all Wellness Centers that apply*): *☐Highland Urgent Care ☐Mobile Van ☐Highland Wellness ☐San Leandro Rehab ☐Eastmont Wellness ☐Hayward Wellness ☐Newark Wellness*

Anticipated Staff Category (APPs excluded):* ☐Active Staff ☐Courtesy Staff ☐Consulting Staff

Alameda Hospital (AH) Medical Staff ☐ Yes or ☐ No / ☐Primary or ☐Secondary

Locations: ☐Alameda Hospital ☐South Shore ☐Creedon ☐Marina Wellness ☐Park Bridge

Anticipated Staff Category (APPs excluded):* ☐Active Staff ☐Courtesy Staff ☐Consulting Staff

**Category Descriptions (activity threshold every two years):*

Active Staff*: involved in at least forty (40) patient care activities at the respective facility.*

Courtesy Staff*: provide services for at least six (6) patients but engage in no more than forty (40) patient care activities at respective facility* ***AND*** *Active at another California hospital, with eight (8) patient care activities.*

Consulting Staff: *involved in at least one (1) patient care activity at the respective facility* ***AND*** *Active at another California hospital.*

Last updated 3/2026

ALAMEDA HEALTH SYSTEM   ALAMEDA HEALTH SYSTEM Alameda Hospital

Alameda Health System Medical Staff Services
Medical Staff Application Request/Demographic Grid

<table>
<tr><th colspan="2">Medical Staff and Organizational Affiliation Information (cont.)</th></tr>
<tr><td colspan="2">Please provide your Employment, Contract or Group Practice information.

☐ AHS Employed. FTE Status: ______________ ☐ Full-time ☐ Part-time ☐ Services as Needed
Cost Center Number:

☐ AHS Contracted. Name of contracted group/individual:
Anticipated number of hours to be provided: ☐ Full-time ☐ Part-time ☐ Other:
Will billing be assigned to AHS: ☐ Yes ☐ No

☐ Community Provider (No AHS Employment/Contract). Practice/Group Name:
Practice Administrator name and email:</td></tr>
<tr><td>Hiring Manager/Contact Name:</td><td>Supervising Physician(s) (APPs only):</td></tr>
<tr><td>Tentative start date, if provided:
Note: Start dates MUST be contingent upon appointment of Medical Staff privileges.</td><td>Form completed by:</td></tr>
</table>

The Medical Staff has a two-step application process. Upon receipt of a completed pre-application request, Medical Staff Services will send the link to the online portal, username, password, and informational email.

1. **Pre-Application**: The processing timeline to review the pre-application will be approximately 5 days following the receipt of the pre-application. Once qualifying criteria is confirmed, the initial application will be sent.

2. **Initial Application:** The timeline to process an initial application is generally 60-90 days following the receipt of a completed initial application; this may vary based on application complexity.

Email completed form, along with CV, to:
ksalinas@alamedahealthsystem.org;medicalstaff@alamedahealthsystem.org

Medical Staff Office (internal use only) Date received/Notes:

Last updated 3/2026

Gastroenterology

Delineation of Privileges

Applicant's Name:

Instructions:

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

Required Qualifications	
Membership	Meet all requirements for Medical Staff membership.
Education/Training	Completion of an ACGME or AOA accredited Residency training program in Internal Medicine. **AND** Completion of an ACGME or AOA accredited Fellowship training program in Gastroenterology.
Certification	Current certification or board eligible for initial certification in Gastroenterology by the American Board of Internal Medicine or subspecialty certification in Gastroenterology by the American Osteopathic Board of Internal Medicine. **OR** Applicants requesting subspecialty privileges only in Transplant Hepatology must meet the required qualifications indicated for those privileges.
Clinical Experience (Initial)	Applicant must provide documentation of provision of gastroenterology services (100 cases) representative of the scope and complexity of the privileges requested during the previous year (waived for applicants who completed Gastroenterology fellowship training during the previous year). **OR** Applicants requesting subspecialty privileges only in Transplant Hepatology must meet the required qualifications indicated for those privileges.
Clinical Experience (Reappointment)	Applicant must provide documentation of provision of clinical services (50 cases) representative of the scope and complexity of privileges requested during the previous 24 months. **OR** Applicants requesting subspecialty privileges only in Transplant Hepatology must meet the required qualifications indicated for those privileges.

Primary Privileges in Gastroenterology

Description: Gastroenterology is the subspecialty of internal medicine that focuses on the evaluation and treatment of disorders of the gastrointestinal tract. Gastroenterology requires an extensive understanding of the entire gastrointestinal tract, including the esophagus, stomach, small intestine, liver, gall bladder, pancreas, colon, and rectum.

Request		***Request all privileges listed below.***
AHS Core	AH	Click **shaded blue check box** to Request all privileges. Uncheck any privileges you do not want to request.
		- Currently granted privileges
		Attending and Ordering privileges
		Evaluate, diagnose, medically manage and provide treatment to patients presenting with diseases, disorders, or conditions of the gastrointestinal tract, including the esophagus, stomach, small intestine, liver, gall bladder, pancreas, colon, and rectum. Privileges include medical management of general medical conditions which are encountered in the course of care for gastroenterology patients

Focused Professional Practice Evaluation (FPPE)/Routine Initial Proctoring		
AHS Core	AH	
		Two (2) concurrent medical consultation or outpatient visit case reviews.

Gastroenterology Procedures

Request		***Request all privileges listed below.***
AHS Core	AH	Click **shaded blue check box** to Request all privileges. Uncheck any privileges you do not want to request.
		- Currently granted privileges
		Proctoscopy and/or flexible sigmoidoscopy
		Colonoscopy with and without biopsy or polypectomy including hemostasis (injection, electrosurgical, clipping or ligation) and dilatation
		Colonoscopy device placement including stent
		Upper gastrointestinal endoscopy and enteroscopy with or without biopsy or polypectomy including hemostasis (injection, electrosurgical, clipping or ligation) and sclerotherapy or banding of esophageal varices and dilation of the esophagus or pylorus or duodenum
		Upper gastrointestinal endoscopy device placement including stent and Bravo
		Use of energy sources during an endoscopic procedure

		Percutaneous endoscopic gastrostomy (PEG)
		Capsule endoscopy
		Transient elastography
		Abdominal paracentesis

Focused Professional Practice Evaluation (FPPE)/Routine Initial Proctoring		
AHS Core	AH	
		Two (2) concurrent case evaluations.
		Five (5) retrospective chart reviews reflective of the scope and complexity of privileges requested.

Transplant Hepatology Privileges

Description: Care and treatment of patients with liver disease.

Qualifications	
Education/Training	Completion of an ACGME accredited Fellowship training program in Transplant Hepatology.
Certification	Current certification or board eligible for initial certification in Transplant Hepatology by the American Board of Internal Medicine.
Clinical Experience (Initial/Reappointment)	Applicant must provide documentation of provision of clinical services representative of the scope and complexity of privileges requested during the previous 24 months (waived for applicants who completed Transplant Hepatology fellowship training during the previous year).

Request		***Request all privileges listed below.***
AHS Core	AH	Click **shaded blue check box** to Request all privileges. Uncheck any privileges you do not want to request.
		- Currently granted privileges
		Attending and Ordering privileges
		Perform history and physical examination
		Evaluate, diagnose, medically manage, and provide treatment to hepatology patients. Privileges include medical management of general medical conditions which are encountered in the course of care for the hepatology patient

Focused Professional Practice Evaluation (FPPE)/Routine Initial Proctoring		
AHS Core	AH	
		Two (2) concurrent outpatient visit case reviews.

Moderate (Procedural) Sedation

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

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

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

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

ERCP Procedures (HIGHLAND HOSPITAL ONLY)

Description: An endoscopic retrograde cholangiopancreatogram (ERCP) is a procedure that combines the use of a flexible, lighted scope (endoscope) with X-ray pictures to examine the tubes that drain the liver, gallbladder and pancreas.

Qualifications	
Education/Training	Completion of an ACGME or AOA accredited Fellowship training program in Gastroenterology.
Clinical Experience (Initial)	Applicant must provide documentation of provision of clinical services (25 cases) representative of the scope and complexity of the privileges requested during the previous year (waived for applicants who completed training during the previous year).
Clinical Experience (Reappointment)	Applicant must provide documentation of provision of clinical services (20 cases) representative of the scope and complexity of privileges requested during the previous 24 months.
Additional Qualifications	Applicants must qualify for and be granted primary privileges in Gastroenterology. **AND** Current California Fluoroscopy Certificate/Permit, in accordance with Title 17, Article 1, section 30463, required for fluoroscopy use any time in or outside of operating area; radiology technologist cannot be used in lieu of individual licensed provider.

Request		***Request all privileges listed below.***
AHS Core	**AH**	Click **shaded blue check box** to Request all privileges. Uncheck any privileges you do not want to request.
		- Currently granted privileges
		Procedures
		ERCP (Current California Fluoroscopy certificate/permit required).

Focused Professional Practice Evaluation (FPPE)/Routine Initial Proctoring		
AHS Core	**AH**	
		Five (5) ERCP case reviews.

Telemedicine Privileges Inpatient or Outpatient Care

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

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

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

Acknowledgment of Applicant

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

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

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

Practitioner's Signature

Date

Department Chair Recommendation - Privileges

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

Privilege	Condition/Modification/Deletion/Explanation

Department Chair Recommendation - FPPE Requirements

Signature of Chief/Designee ______________________ Date ______________________

Signature of Department Chair/Designee ______________________ Date ______________________

Obstetrics and Gynecology- APP - AHS

Delineation of Privileges

Applicant's Name:

Instructions:

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

Required Qualifications

Education/Training	Physician Assistant: Successful completion of an accredited Physician Assistant Education program which meets the requirements required for licensure and Physician Assistant certification. **OR** Nurse Practitioner: Master's or Doctoral Degree in Nursing and successful completion of a graduate program for the education and preparation of nurse practitioners or meet the training/education requirements according to Title 16, Article 8, Section 1482; BPC Section 2834-2837.
Licensure	Physician Assistant: Licensed as a Physician Assistant by the Physician Assistant Board of California. **OR** Nurse Practitioner: Licensed as a registered nurse by the California Board of Registered Nursing AND license certification as a Nurse Practitioner by the California Board of Registered Nursing.
Certification	Physician Assistant: Certification by the National Commission on Certification of Physician Assistants (NCCPA). Nurse Practitioner: Certification by the American Nurses Credentialing Center (ANCC), American Academy of Nurse Practitioners Certification Board (AANP), American Association of Critical-Care Nurses (AACN), or National Certification Corporation (NCC) in Women’s Health Care.
Clinical Experience (Initial/Reappointment)	Physician Assistant/Nurse Practitioner: Recent training and/or clinical experience is required for all applicants for appointment and reappointment. Recent clinical experience is defined as having performed at least 200 patient care activities relevant to the practice prerogatives requested in the preceding two (2) years.
Additional Qualifications	Physician Assistant: Practice Agreement Nurse Practitioner: California Nurse Practitioner Furnishing Number. **AND** Signed Standardized Procedure Supervising Physician Agreement Current DEA registration Current BLS

COGNITIVE PRACTICE PREROGATIVES

Description: Privileges available to the Advanced Practice Provider (PA and NP) working with Obstetrics and Gynecology physicians with the same privileges.

Request ☐	***Request all privileges listed below.*** *Uncheck any privileges that you do not want to request.*	Div Chief Rec ☐	Dept Chair Rec ☐
☐	Obtain the patient's medical history and perform a physical examination.	☐	☐
☐	Manage the normal antepartum and/or postpartum patient	☐	☐
☐	Manage the Gynecology patient	☐	☐
☐	Conduct an initial and ongoing assessment of the patient's medical and physical status	☐	☐
☐	Order, conduct, and interpret labs and other diagnostic studies	☐	☐
☐	Counsel patients and their families on health promotion, diagnosis, and management options	☐	☐
☐	Facilitate and initiate referrals to appropriate health care agencies and arrange for community resources	☐	☐
☐	Administer, provide, or transmit drug orders or devices according to protocols and the requirements in the Advanced Practice Provider policy manual	☐	☐

Focused Professional Performance Evaluation (FPPE)/Initial Proctoring Requirements

Five (5) Cognitive Practice Prerogatives clinical activities, including first three (3) H&Ps.

PROCEDURAL PRACTICE PREROGATIVES

Surgical Assistant Qualifications: Nurse Practitioners only: Documentation of completion of a RN First Assistant education program that meets AORN Standards (standalone program or a portion of a graduate or postgraduate program).

OR

Certification as an RNFA (CRNFA) by National Assistant at Surgery Certification or predecessor organization, Assistant at Surgery – Certified (AS-C).

Request ☐	***Request all privileges listed below.*** *Uncheck any privileges that you do not want to request.*	Div Chief Rec ☐	Dept Chair Rec ☐
	MEDICAL/PROCEDURAL		
☐	Pelvic Exam, including Pap Smear	☐	☐
☐	Diaphragm Fitting	☐	☐
☐	Wet Prep Exam for Vaginitis	☐	☐
☐	Insertion and Removal of Contraceptive Implant	☐	☐
☐	Endometrial Biopsy	☐	☐
☐	Laminaria Insertion	☐	☐
☐	Pessary Fitting	☐	☐
☐	Word Catheter Placement	☐	☐
☐	Foley catheter management	☐	☐
☐	Desiccation or biopsy of skin lesions	☐	☐

☐	Foreign Body Removal	☐	☐
☐	I & D of Simple Lesion	☐	☐
☐	Removal of Sutures and Staples	☐	☐
☐	Simple Laceration Repair including Suturing	☐	☐
☐	Wound Care	☐	☐
☐	Needle Aspiration	☐	☐
	SURGICAL		
☐	Surgical Assist: Cesarean Section(RNFA training/certification required for NPs)	☐	☐
☐	Surgical Assist: Gynecology(RNFA training/certification required for NPs)	☐	☐
	Specialized Procedures		
☐	Loop Electrosurgical Excision Procedure (LEEP)	☐	☐
☐	Colposcopy	☐	☐
☐	Laminaria Insertion	☐	☐
	Advanced Procedures		
☐	Limited Obstetrical Ultrasound Examination	☐	☐
☐	Limited Gynecology Ultrasound Examination	☐	☐

Focused Professional Performance Evaluation (FPPE)/Initial Proctoring Requirements	
☐	Five (5) case reviews that are representative of the scope and complexity of privileges requested.
☐	Five (5) concurrent Endometrial Biopsy case reviews.
☐	Three (3) concurrent Laminaria Insertion case reviews.
☐	Three (3) concurrent Colposcopy case reviews.
☐	Three (3) concurrent Loop Electrosurgical Excision Procedure (LEEP) case reviews.
☐	One (1) concurrent limited OB ultrasound case review.
☐	One (1) concurrent limited GYN ultrasound case review.

Telemedicine Privileges Inpatient or Outpatient Care

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

Qualifications

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

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

Acknowledgment of Applicant

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

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

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

Practitioner's Signature ______________________ Date ______________

Department Chair Recommendation - Privileges

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

Privilege	Condition/Modification/Deletion/Explanation

Division Chief Recommendation - FPPE Requirements

Signature of Division Chief/Designee | Date

Signature of Department Chair/Designee | Date

Submit

Alameda Hospital

Wound Care - Alameda Hospital

Delineation of Privileges

Applicant's Name:

Instructions:

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

Required Qualifications	
Membership	Meet all requirements for Medical Staff membership.
Education/Training	Completion of an ACGME or AOA accredited Residency training program.

Clinical Experience (Initial/Reappointment) Applicant must provide documentation of provision of care (25 cases) representative of the scope and complexity of the privileges requested during the previous 24 months (waived for applicants who completed training during the previous year).

WOUND CARE PROCEDURES

Description: Privileges available to physicians providing care, treatment, and services in Wound Care.

Request ☐	***Request all privileges listed below.*** *Uncheck any privileges that you do not want to request.*	Svc Chair Rec ☐
	Evaluation and Management	
☐	Evaluate, diagnose, and provide therapeutic treatment and management for wound care	☐
	Wound Debridement	
☐	Partial thickness	☐
☐	Full thickness	☐
☐	Subcutaneous Tissue	☐
☐	Subcutaneous Tissue and Muscle	☐
☐	Subcutaneous Tissue, Muscle and Bone	☐
	Other Procedures	
☐	I&D, Abscess, simple	☐
☐	I&D, Abscess, complex	☐
☐	Cauterization	☐
☐	Biopsy, skin	☐
☐	Biopsy, bone	☐
☐	Suture removal	☐
☐	Removal of foreign body	☐
☐	Pare hyperkeratotic lesion	☐
☐	Total Contact Cast (TCC) application	☐
☐	Preparation and application of skin substitutes	☐
☐	Vacuum assisted closure devices	☐

Focused Professional Practice Evaluation (FPPE)/Routine Proctoring Requirements		
☐	Two (2) case reviews representative of the scope and complexity of privileges requested.	

HYPERBARIC OXYGEN THERAPY PRIVILEGES

Description: Medical use of oxygen at a level higher than atmospheric pressure for treating conditions such as gas gangrene, neurological injury, and carbon monoxide poisoning.

Qualifications

Education/Training

Completion of an ACGME or AOA accredited fellowship training in Undersea and Hyperbaric Medicine.

OR

Documentation of completion of other substantive advanced training that would qualify the applicant for the UHMS sponsored Certificate of Added Qualifications.

Clinical Experience (Initial/Reappointment)	Applicant must provide documentation of provision of hyperbaric medicine services (50 cases) representative of the scope and complexity of the privileges requested during the previous 12 months (waived for applicants who completed Undersea and Hyperbaric Medicine training during the previous year).

Request ☐	***Request all privileges listed below.*** *Uncheck any privileges that you do not want to request.*	Dept Chair Rec ☐
☐	Hyperbaric Oxygen Therapy	☐

Focused Professional Practice Evaluation (FPPE)/Routine Proctoring Requirements		
☐	Two (2) case reviews representative of the scope and complexity of privileges requested.	

Telemedicine Privileges Inpatient or Outpatient Care

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

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

Request ☐	***Request all privileges listed below.*** *Uncheck any privileges that you do not want to request.*	Dept Chair Rec ☐
☐	Telehealth initial and follow up consultations	☐
☐	Virtual Check-ins	☐
☐	E-Visits	☐

Acknowledgment of Applicant

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

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

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

Practitioner's Signature ______________________ Date ______________

Department Chair Recommendation - Privileges

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

Privilege	Condition/Modification/Deletion/Explanation

Signature of Department Chair/Designee ______________________ Date ______________

Submit

REPORT/DISCUSSION: Medical Staff Reports

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

April 22, 2026

Manasa Kalluri, MD, AH Chief of Staff

Bhrett Lash, MD, AHS Vice Chief of Staff

ALAMEDA HEALTH SYSTEM

REPORT/DISCUSSION: Quality Reports

BOT Executive Summary: Quality Report
Ana Torres, Vice President of Quality
April 22, 2026

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

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

HARMS

While the system-wide Total Harms metric will not meet the goal, Alameda Hospital and Highland Hospital remain on track to meet their FY2026 harm reduction goals. The majority of harms occurred in following categories: Hospital Acquired Pressure Injury (HAPI), Behavior Events with Injury, and Falls with Injury.

HAPI events are measured at Alameda Hospital, Highland Hospitals and San Leandro Hospital only. Behavior Events with Injury and Falls with Injury are tracked across the system and include Post Acute, John George and Ambulatory settings.

- HAPI (19 events)
  Mitigation efforts are focused on implementing and sustaining best practices includes conducting skin assessments on admission and turning patients every two hours.
- Behavior Events with Injury (88 events)
  These events are being addressed through the Workplace Violence (WPV) Team which is transitioning under the leadership of Regulatory Affairs. The team is currently evaluating and aligning initiatives from The Joint Commission, Cal/OSHA, and BETA Healthcare Group to identify gaps, standardize reporting and ensure consistent implementation across the organization.
- Falls with Injury (80 events)
  Interventions include proactive toileting during hourly rounding, managing patient expectations regarding call-light usage, and training falls champions on the Bedside Mobility Assessment Tool to support safe patient mobility.

SEPSIS BUNDLE COMPLIANCE

Sepsis bundle compliance has steadily improved and FYTD performance met goal.
Alameda Hospital met the goal. Highland and San Leandro Hospitals have not met the goal, but the performance is exceeding baseline performance.

SEPSIS MORTALITY

The sepsis mortality ratio is currently performing at baseline. All sepsis-related deaths are reviewed to determine whether the patient died *from* sepsis or *with* sepsis, and to assess potential preventability. Reviews have identified that incomplete documentation of patient comorbidities may be contributing to a mortality ratio that appears higher than expected.

READMISSIONS

The 30-day All Cause Readmission rate goal was not met. Readmissions is an opportunity for all three acute care hospitals. Readmission reduction efforts focus on improving discharge teaching and addressing the site-specific drivers of readmission.

The Readmission Team is working with Business Intelligence to track timely placement of post discharge orders and follow up completion rates. This work is complementary to the REACH program and Enhanced Care Management's efforts to provide a telehealth visit within 72 hours of discharge.

WAIT TIME FOR NEW APPOINTMENT – Specialty and Primary

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

ED BOARDING FOR ADMITTED PATIENTS

The ED Boarding times did not meet the goal although performance is exceeding baseline.
ED Boarding is being addressed by the systemwide Throughput Steering Committee. The committee has established five task forces focused on the key drivers of patient throughput: Access, Readmissions, Surge Red, System Bed Capacity, and Length of Stay reduction.
While improvement has been observed, it has been noted that the metric does not capture patients in observation status. As a result, this metric will be adjusted or replaced as part of the FY2027 OKR process.

HEALTH-RELATED SOCIAL NEEDS (HRSN)

The HRSN Screening metric met the goal. Patients that screen positive for one of HRSNs are connected with community services via FindHelp.

LIKELIHOOD TO RECOMMEND:

The Likelihood to Recommend metric met the established goal. This metric measures the Likelihood to Recommend in Acute Care, Emergency Department and Ambulatory Surgery.

The improvement plan focuses on addressing responsiveness of staff, leader rounding, the discharge communication process which addresses several patient satisfaction domains. Additional efforts include reinforcing GIFT and standards of behavior with accompanying customer service training.

Key Point 2: CMS Star Ratings and Leapfrog Safety Grades upcoming releases.
The CMS Star Ratings are scheduled for release in April 2026, followed by the Leapfrog Safety Grades in May 2026.

CMS Star Rating
For the April 2026 release:

- Alameda is projected to improve from 3 Stars to 4 Stars.
- Highland Hospital and San Leandro Hospital are projected to remain at 1 Star. While both hospitals have demonstrated significant improvement in performance, the CMS measurement period (7/2021 – 12/2024) does not fully capture these gains, which limits the impact on this release.

Leapfrog Safety Score
For the Spring 2026 Leapfrog Safety Score release, current projections indicate:

- Alameda Hospital will improve from a B to an A.
- Highland Hospital is expected to remain at a C.
- San Leandro Hospital is projected to improve from a C to a B.

Key Point 3: There were no onsite regulatory surveys in March 2026.
There were no regulatory surveys in March. The Regulatory Team has been focused on licensing projects and survey readiness activities. The Joint Commission survey is expected to occur by April 22, 2026.

Key Point 4: The Culture of Safety Survey has concluded.
The annual culture of safety survey was conducted in March 2026 with a 51% response rate. This year the Pulse Survey, a shorter version of the SCORE survey, was administered. The Pulse survey measures five domains: Safety Climate, Teamwork, Local Leadership, Burnout, and Improvement Readiness. The results are being reviewed and will be presented at a future meeting.

April
2026

Regulatory Affairs QPSC Report

- OPEN Session

Nilda Perez – System Director of Regulatory Affairs
ALAMEDA HEALTH SYSTEM

I. Regulatory Events Summary – OPEN Session

A. Site Visits and Complaints

1. No site visits or complaints in March 2026.

B. AHS Licensing Projects

1. Fairmont Hospital – Outpatient Rehabilitation Services Space Program Flex application submitted to CDPH for approval. If granted, this will increase patient treatment space and expand access to services.
2. Alameda Hospital – Outpatient Occupational Therapy Services Program Flex application submitted to CDPH for approval. If granted, this will increase patient treatment space and expand access to services.
3. Marina Wellness Outpatient Clinic – Licensing application approved by Central Applications Branch in January 2026. Licensing survey will be performed (date to be scheduled) by CDPH Licensing and Certification office for approval of outpatient services addition to the Alameda Hospital license.

C. Joint Commission Activity

1. No Joint Commission activity.

D. Continuous Survey Readiness Activities

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

Public Reporting Updates

CMS April 2026 Star Rating

Leapfrog Health Care Grades Release

Public Reporting Ratings and Projections

CMS	Alameda Hospital	Highland/San Leandro Hospitals	
CMS Star Rating July 2025 (1/20-12/23	3 Stars	1 Star	
CMS Star Rating April 2026 (7/21-12/24)	4 Stars	1 Star	
	Alameda Hospital	Highland Hospital	San Leandro Hospital
Leapfrog Fall 2025	**B**	**C**	**C**
Leapfrog Spring 2026 Preview Projection	***A**	***C**	***B**
Leapfrog Fall 2026 Projection	***A**	***B**	***A or B**

- * Indicates projected/estimated values
- 2026 Spring grades are still in the preview period
- Final grades are subject to change

Top Areas of Opportunity: How are we doing now? Change between CMS April 2026 and Calendar Year 2025

Success

- Significant Reduction in Hospital Acquired Infections:
- CLABSI performance in Best decile
- MRSA and CAUTI rates slightly better than national average
- 54% reduction in Surgical Site Infections
- Patient Experience
  - Highland and San Leandro all domains better than 50th Percentile
  - Alameda 84% improvement

Opportunities

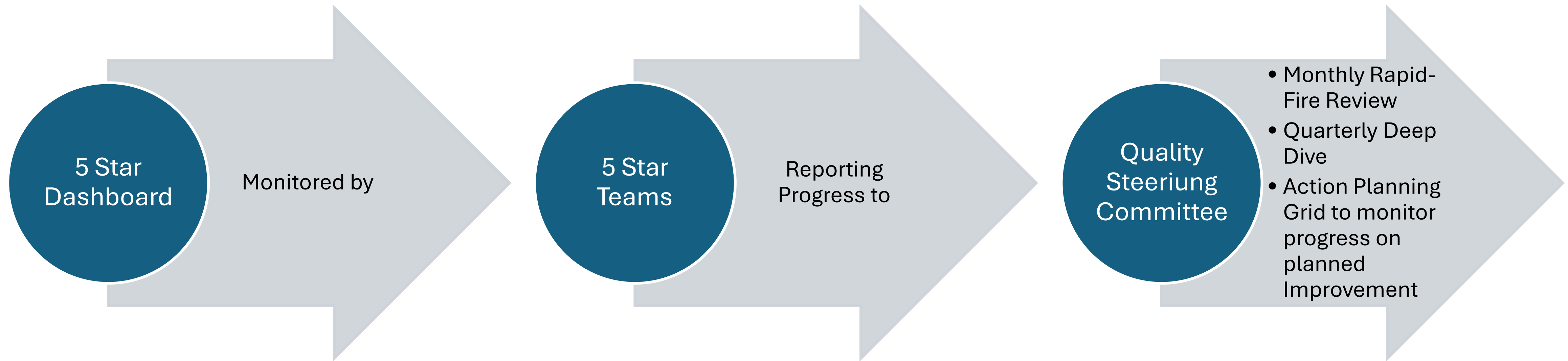
- Readmission domain expanded to track returns :
  - Admissions, Emergency Visits and Observation
  - Actions:
    - Reach Program: Telehealth visit within 72 hours of discharge
    - Home Health/DME Order Standardization

CMS 5 Star Steering and Workgroups

Team	Executive Sponsor	Provider/ Physician Team Sponsor	Operations/ Nursing Team Sponsor	Performance Improvement Facilitator
CMS 5 Star Steering	**Terrance Fitzgerald-Shaw** **Dr. Lisa Laurent**	**Andrea Wu, MD**	Chris Adams & Salma Adin	**Annette Johnson**
Timely Effective Care	Chris Adams or Salma Adin CMO Team	Caitlin Bailey, MD Sammy Hodroge, MD	Salma Adin	Allie Lowry
Readmissions/ Mortality	Dana Littlepage, DNP CMO Team	Scott Lynch, MD Evan Rusoja, MD	Care Coordination System Director Yenny Johnson	Nina Salman
Safety- Surgery Focus	Chris Adams or Salma Adin CMO Team	Gregory Victorino, MD Laura Lang, MD	Janet David Lustina/ Jovita Okorie	Michael Au
Safety – Infection Control Focus	Chris Adams or Salma Adin CMO Team	Robert McCabe, MD Benson Chen, MD Ty Elliott, MD	Salma Adin\Jessa Nelson	Michael Au
Patient Experience	Chris Adams or Salma Adin CMO Team	Indhu Subramanian, MD	Salma Adin\Jessa Nelson	Dr. Angela Ng
Timely Effective Care - Imaging Focus	Harold Glenn CMO Team	Albert Roh, MD Marina Trilesskaya, MD Christina Chou, MD	Fredrick Lee, Ed.D Lucy Walker Jerome Carpenter	Annette Johnson

Updated: 1.12.26

Monitoring and Driving Improvement



Current Projected Rolling 12-Month Star Rating

★ ★ ★

Measure	Measure Group	Direction for Improvement	Goal for 2028 (4 Star)	CY2025	Jan 2026 Score	Prelim Feb 2026 Score
Mortality	30-day death rate for heart attack patients	↓		8.83	12.12	16.67
Mortality	Death rate for CABG surgery patients	↓		-	-	-
Mortality	Death rate for COPD patients	↓		1.47	3.03	4.62
Mortality	30-day death rate for heart failure patients	↓		0.00	0.00	0.00
Mortality	30-day death rate for pneumonia patients	↓		2.03	4.00	5.41

Pocket Slides

Assumptions Used in Fall 2026 Projection

- HAI performance updated to reflect the Fall 2026 reporting period (CY2025 data)
- Patient experience scores updated to reflect the Fall 2026 reporting period (10/01/24 – 09/30/25)
- National mean assumed based on Spring 2026 values (national mean possibly increase in the next reporting cycle)
- PSI-4 and PSI-90 held at current CMS data
- CPOE, BCMA, ICU staffing, Nursing hours, and Safe Practice assumed unchanged

Alameda Hospital FY 2026 Detailed Quality OKR and KPI Dashboard

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

Safe Care - Caring, Healing, Teaching All			Performance			FY26 Goals	
OBJECTIVES	KEY RESULTS	Detailed KPIs	Feb 2026	FY26 YTD	FY25 Actual	Improvement	Benchmark
Provide safe care	Eliminate Patient Harms	Total Patient Harms	4	17	27	24	14
		CLABSI # Events/SIR	0/0	0/0	0/0	0/0.317	0/0
		CAUTI # Events/SIR	0/0	0/0	1/0.56	0/.55	0/.264
		MRSA # Events/SIR	0/0	0/0	0/0	0/0.658	0/0.335
		C. Difficile # Events/SIR	0/0	0/0	5/0.75	3/.58	2/.346
		SSI # Events/SIR	0/0	0/0	1/1.23	1/1.324	0/.849
		Falls with Injury/% Per 1000 Days	2/1.92	5/0.61	10/0.53	9/0.477	3/0.24
		Reportable HAPI #/% per 1000 Discharges	0/0	2/1.1	0/0	0/0	0/0
		Behavior Events with Physical Injury	2/1.92	10/1.23	10/0.76	9/0.684	8/0.608
		HAPI all Stages #/% per 1000 Discharges	3/13.825	29/15.96	50/18.22	45/16.398	40/14.576
		Serious Safety Events (F or Greater)	1	2	0		
	Reduce Mortality from Sepsis	Sepsis Mortality Observed:Expected & Total Deaths	NA	0.81	1.04	1	0.93
		Bundle Compliance Sepsis Early Management	90.00%	84.72%	77.00%	75%	88%
	Embed Critical Behaviors	Hand Hygiene Compliance	85.70%	88.87%	82.62%		95%

Fiscal Year Starts in July 1 and Ends June 30

FY26 YTD is results from July 2025 to Feb 2026

Timely, Effective, and Efficient Care			Performance			FY26 Goals	
OBJECTIVES	KEY RESULTS	Detailed KPIs	Feb 2026	FY26 YTD	FY25 Actual	Improvement	Benchmark
Promote wellbeing	Provide the right care at the right time	All Cause 30-Day Readmission Rate	13.07%	14.62%	14.82%	11.69%	11.12%
Provide accessible care	Minimize Time Spent Waiting for our Patients	ED Boarding Time for Admitted Patients	3:02	2:30	2:24	2:12	1:30
Equitable Care			**Performance**			**FY26 Goals**	
OBJECTIVES	KEY RESULTS	Detailed KPIs	Feb 2026	FY26 YTD	FY25 Actual	Improvement	Benchmark
Serving all: Deliver equitable care	Health-related social needs recognized and addressed	Health-related social needs assessment completed on inpatients	81.00%	76.00%	49.50%	82%	89%
		% of patients that screened positive for at least 1 Health-related social needs	21.00%	24.00%	NA		
Patient-Centered Care			**Performance**			**FY26 Goals**	
OBJECTIVES	KEY RESULTS	Detailed KPIs	Feb 2026	FY26 YTD	FY25 Actual	Improvement	Benchmark
Be the most welcoming system to receive care	Optimize performance regarding patient experience	Likelihood to recommend Acute	80.25%	74.30%	62.99%	63.89%	71.10%
		Likelihood to recommend ED	64.86%	67.03%	64.40%	65.40%	71.60%
		Communication with Nurses	81.41%	75.57%	69.60%	70.60%	79.90%
		Communication with Providers	93.15%	79.71%	75.91%	76.91%	79.20%

Fiscal Year Starts in July 1 and Ends June 30

FY26 YTD is results from July 2025 to Feb 2026

Fiscal Year 2025

OKR Metric Definitions for QPSC

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

Fiscal Year 2025

OKR Metric Definitions for QPSC

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

Fiscal Year 2025

OKR Metric Definitions for QPSC

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

Ambulatory FY 2026 Detailed Quality OKR and KPI Dashboard

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

Safe Care - Caring, Healing, Teaching All			Performance			FY26 Goals	
OBJECTIVES	KEY RESULTS	Detailed KPIs	Feb 2026	FY26 YTD	FY25 Actual	Improvement	Benchmark
Provide safe care	Eliminate Patient Harms	Total Patient Harms	0	0	1	1	0
		Behavior Events with Physical Injury	0	0	1	1	0
		Serious Safety Events (F or Greater)	0	0	0	1	0
	Embed Critical Behaviors	Hand Hygiene Compliance	93.60%	93.11%	82.84%		95%

Timely, Effective, and Efficient Care			Performance			FY26 Goals	
OBJECTIVES	KEY RESULTS	Detailed KPIs	Feb 2026	FY26 YTD	FY25 Actual	Improvement	Benchmark
Promote wellbeing	Provide the right care at the right time	All Cause 30-Day Readmission Rate	10.12%	12.73%	12.26%	11.56%	11.12%
		MyChart Activation Rate	39.00%	39.00%	27.00%		
	Find and treat conditions early	Breast Cancer Screening	62.18%		59.48%	60.27%	63.48%
		Cervical Cancer Screening	50.58%		46.44%	49.64%	67.46%
		Colorectal Cancer Screening	62.20%		61.68%	57.98%	57.98%
	Achieve the best health outcomes	Glycemic status assessment of patients with diabetes	29.09%		31.16%	29.94%	27.01%
		Controlling High Blood Pressure	63.71%		63.82%	63.86%	72.75%
		Child and Adolescent Well-Care Visits	53.76%		49.99%	49.85%	64.74%

Fiscal Year Starts in July 1 and Ends June 30

FY26 YTD is results from July 2025 to Feb 2026

Timely, Effective, and Efficient Care (continued)			Performance			FY26 Goals	
OBJECTIVES	KEY RESULTS	Detailed KPIs	Feb 2026	FY26 YTD	FY25 Actual	Improvement	Benchmark
	Minimize Time Spent Waiting for our Patients	TNAA Primary Care - Return	14	14	10	10	2
		TNAA Specialty Care -Return	2	2	7	15	2
		% of Specialty Clinics with an average of less than or equal to 15 days for New Patients Appointments*	17.00%		11.76%		80%
		% of Adult Primary Care Clinics with an average of less than or equal to 10 days for New Patients Appointments *	0.00%		0.00%		100%

Patient-Centered Care			Performance			FY26 Goals	
OBJECTIVES	KEY RESULTS	Detailed KPIs	Feb 2026	FY26 YTD	FY25 Actual	Improvement	Benchmark
Be the most welcoming system to receive care	Optimize performance regarding patient experience	Likelihood to recommend (Dental)	76.06%	66.62%	62.51%	63.51%	79.10%
		Likelihood to recommend (Primary/Specialty)	76.84%	77.56%	73.18%	74.18%	80.00%
		Communication with Care Provider (Primary/Specialty)	76.78%	76.85%	76.48%	77.48%	83.20%

Fiscal Year Starts in July 1 and Ends June 30

*Preliminary Data

FY26 YTD is results from July 2025 to Feb 2026

Fiscal Year 2025

OKR Metric Definitions for QPSC

Metric	Definition	GOAL	
		Improvement	Benchmark
Total Patient Harms	The number of potential health-care acquired patient harms Includes: , Behavior Events that result in Injury	10% reduction compared to FY25 overall	20% reduction compared to FY25 overall
Behavior Events with Physical Injury	Behavior events that resulted in physicial injury via Midas Safety Alerts # of Events/Rate: Number of events divided by number of patient days times 1000	10% reduction compared to FY25 overall	20% reduction compared to FY25 overall
Serious Safety Events (F or Greater)	Risk Events that are given a significance of F or Greater	10% reduction compared to FY25 overall	20% reduction compared to FY25 overall
Hand Hygiene Compliance	Hand hygiene is a leading way to reduce the spread of pathogens in healthcare settings. It includes: Washing hands with soap and water and Using an antiseptic handrub. Hand hygiene compliance is the percentage of times that a person performs hand hygiene when an opportunity arises. It's calculated by dividing the number of hand hygiene actions performed by the total number of opportunities.		The level of adherence crucial for patient safety and preventing healthcare-associated infections.
All Cause 30-Day Readmission Rate	Percentage of inpatient acute med-surg encounters, regardless of payer type, with an unplanned readmission to any AHS facility within 30 days for any cause among encounters for acute care inpatients with a principal discharge diagnosis/procedure for a clinical classification category in the Cardiorespiratory, Cardiovascular, Medicine, Neurology, or Surgery/Gynecology cohort. *Note:* This measure approximates, but likely does not match, the value of the corresponding CMS readmission measure.	11.56% 50% gap reduction to the 50th Percentile CMS Hospital Compare	11.12% 50th Percentile CMS Hospital Compare
MyChart Activation Rate	% of patients who have activated MyChart		
Breast Cancer Screening	The percentage of individuals 50–74 years of age who were recommended for routine breast cancer screening and had a mammogram to screen for breast cancer	60.27%	63.48% 90th %tile
Cervical Cancer Screening	The percentage of individuals 21–64 years of age who were recommended for routine cervical cancer screening who were screened for cervical cancer using any of the following criteria: • Individuals 21–64 years of age who were recommended for routine cervical cancer screening and had cervical cytology performed within the last 3 years. • Individuals 30–64 years of age who were recommended for routine cervical cancer screening and had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years. • Individuals 30–64 years of age who were recommended for routine cervical cancer screening and had cervical QIP PY8 Reporting Manual: Primary Care Access and Preventive Care Measures Page 90 of 581 CPT only copyright 2024 American Medical Association. All rights reserved. cytology/high-risk human papillomavirus (hrHPV) co-testing within the last 5 years.	49.64%	67.46% 90th %tile
Colorectal Cancer Screening	Percentage of adults 45-75 years of age who had appropriate screening for colorectal cancer.	57.98%	57.98% 90th %tile
Glycemic status assessment of patients with diabetes	The percentage of individuals 18–75 years of age with diabetes (types 1 and 2) whose most recent glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) was >9.0% during the measurement year	29.94%	27.01% 90th %tile
Controlling High Blood Pressure	percentage of individuals 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90 mm Hg) during the measurement year.	63.86%	72.75% 90th %tile
Child and Adolescent Well-Care Visits	The percentage of individuals who had the following number of well-child visits with a PCP during the last 15 months. The following rates are reported: 1. Well-Child Visits in the First 15 Months. Children who turned 15 months old during the measurement year: Six or more well-child visits. 2. Well-Child Visits for Age 15 Months–30 Months. Children who turned 30 months old during the measurement year: Two or more well-child visits.	49.85%	64.74% 90th %tile
TNAA Primary Care - Return	Median of all third next available appointment for Return patient visit for Primary Care	10	2
TNAA Specialty Care -Return	Median of all third next available appointment for Return patient visit for specialty Care	15	2
% of Specialty Clinics with an average of less than or equal to 15 days for New Patients Appointments*	The average of days between when a new patient to AHS requests an appointment with a specialty to the day of appointment. This metric tracks the percentage of clinics that are, on average, less than or equal to 15 business days		80%
% of Adult Primary Care Clinics with an average of less than or equal to 10 days for New Patients Appointments *	The average of days between when a new patient to AHS requests an appointment with a primary care to the day of appointment. This metric tracks the percentage of clinics that are, on average, less than or equal to 10 business days		100%
Likelihood to recommend (Dental)	Percentage of patients who indicated that they would definitely recommend the clinic Percent of surveyed discharges where patient response was highest of the scale (Top Box Score)	63.51%	79.10%
Likelihood to recommend (Primary/Specialty)	Percentage of patients who indicated that they would definitely recommend the clinic Percent of surveyed discharges where patient response was highest of the scale (Top Box Score)	74.18%	80.00%
Communication with Care Provider (Primary/Specialty)	Percentage of patients who indicated that they would definitely recommend the clinic Percent of surveyed discharges where patient response was highest of the scale (Top Box Score)	77.48%	83.20%

Highland FY 2026 Detailed Quality OKR and KPI Dashboard

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

Safe Care - Caring, Healing, Teaching All			Performance			FY26 Goals	
OBJECTIVES	KEY RESULTS	Detailed KPIs	Feb 2026	FY26 YTD	FY25 Actual	Improvement	Benchmark
Provide safe care	Eliminate Patient Harms	Total Patient Harms	13	69	136	108	66
		CLABSI # Events/SIR	0/NA	0/0	0/0	2/.317	0/0
		CAUTI # Events/SIR	0/NA	2/0.56	8/0.94	4/.55	2/.264
		MRSA # Events/SIR	0/0	0/0	2/0.97	1/.658	0/0.335
		C. Difficile # Events/SIR	1/0.47	8/0.46	18/0.67	15/.579	9/.346
		SSI # Events/SIR	0/0	5/0.83	36/2.35	20/1.32	12/.849
		Falls with Injury/% Per 1000 Days	8/0.97	26/0.44	36/0.44	32/0.396	13/0.24
		Reportable HAPI #/% per 1000 Discharges	1/1.179	7/0.93	0/0	0/0	0/0
		Behavior Events with Physical Injury	3/0.73	21/0.57	36/0.63	32/0.567	28/0.504
		HAPI all Stages #/% per 1000 Discharges	4/4.717	41/5.42	78/7.01	70/6.309	62/5.608
		Serious Safety Events (F or Greater)	2	10	11		
	Reduce Mortality from Sepsis	Sepsis Mortality Observed:Expected & Total Deaths	NA	1.09	1.10	1	0.93
		Bundle Compliance Sepsis Early Management	50.00%	69.74%	57.94%	75%	88%
	Embed Critical Behaviors	Hand Hygiene Compliance	91.70%	93.85%	89.36%		95%

Fiscal Year Starts in July 1 and Ends June 30

FY25 YTD is results from July 2024 to Feb 2026

Highland FY 2026 Detailed Quality OKR and KPI Dashboard

Timely, Effective, and Efficient Care			Performance			FY26 Goals	
OBJECTIVES	KEY RESULTS	Detailed KPIs	Feb 2026	FY26 YTD	FY25 Actual	Improvement	Benchmark
Promote wellbeing	Provide the right care at the right time	All Cause 30-Day Readmission Rate	7.71%	11.74%	11.27%	11.69%	11.12%
Provide accessible care	Minimize Time Spent Waiting for our Patients	ED Boarding Time for Admitted Patients	8:35	8:55	12:57	8:28	4:00
Equitable Care			**Performance**			**FY26 Goals**	
OBJECTIVES	KEY RESULTS	Detailed KPIs	Feb 2026	FY26 YTD	FY25 Actual	Improvement	Benchmark
Serving all: Deliver equitable care	Health-related social needs recognized and addressed	Health-related social needs assessment completed on inpatients	79.00%	84.00%	76.00%	82%	89%
		% of patients that screened positive for at least 1 Health-related social needs	25.00%	29.00%	NA		
Patient-Centered Care			**Performance**			**FY26 Goals**	
OBJECTIVES	KEY RESULTS	Detailed KPIs	Feb 2026	FY26 YTD	FY25 Actual	Improvement	Benchmark
Be the most welcoming system to receive care	Optimize performance regarding patient experience	Likelihood to recommend Acute	80.25%	82.15%	76.10%	77.35%	78.30%
		Likelihood to recommend ED	54.69%	59.52%	58.28%	59.36%	71.60%
		Likelihood to recommend Amb Surg	83.33%	80.52%	77.82%	81.43%	86.70%
		Communication with Nurses	75.55%	78.21%	73.68%	74.68%	79.90%
		Communication with Providers	82.53%	84.91%	82.93%	83.93%	93.60%
Fiscal Year Starts in July 1 and Ends June 30			FY26 YTD is results from July 2025 to Feb 2026				

Fiscal Year 2025

OKR Metric Definitions for QPSC

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

Fiscal Year 2025

OKR Metric Definitions for QPSC

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

Fiscal Year 2025

OKR Metric Definitions for QPSC

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

John George FY 2026 Detailed Quality OKR and KPI Dashboard

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

Safe Care - Caring, Healing, Teaching All			Performance			FY26 Goals	
OBJECTIVES	KEY RESULTS	Detailed KPIs	Feb 2026	FY26 YTD	FY25 Actual	Improvement	Benchmark
Provide safe care	Eliminate Patient Harms	Total Patient Harms	7	46	69	62	55
		Falls with Injury/% Per 1000 Days	1/0.54	13/0.73	16/0.59	14	12
		Behavior Events with Physical Injury	6/3.21	33/1.84	53/1.96	48	42
		Serious Safety Events (F or Greater)	0	0	1	0	0

Patient-Centered Care			Performance			FY26 Goals	
OBJECTIVES	KEY RESULTS	Detailed KPIs	Feb 2026	FY26 Actual	FY25 Actual	Improvement	Benchmark
Be the most welcoming system to receive care	Optimize performance regarding patient experience	Overall Rating of Care		55.29%	57.67%	58.67%	67.50%

Fiscal Year Starts in July 1 and Ends June 30

FY26 YTD is results from July 2025 to Performance

Fiscal Year 2025

OKR Metric Definitions for QPSC

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

San Leandro Hospital FY 2026 Detailed Quality OKR and KPI Dashboard

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

Safe Care - Caring, Healing, Teaching All			Performance			FY26 Goals	
OBJECTIVES	KEY RESULTS	Detailed KPIs	Feb 2026	FY26 YTD	FY25 Actual	Improvement	Benchmark
Provide safe care	Eliminate Patient Harms	Total Patient Harms	1	29	45	32	21
		CLABSI # Events/SIR	0/0	0/0	0/0	0/0.317	0/0
		CAUTI # Events/SIR	0/0	1/1.57	0/0	0/0.55	0/0.264
		MRSA # Events/SIR	0/0	0/0	2/4.12	0/0.658	0/0.335
		C. Difficile # Events/SIR	0/0	2/0.54	13/2.07	3/0.58	2/0.346
		SSI # Events/SIR	0/0	0/0	2/1.19	2/1.324	1/0.849
		Falls with Injury/% Per 1000 Days	0/0	5/0.35	11/0.56	9/0.504	3/0.24
		Reportable HAPI #/% per 1000 Discharges	1/4.032	9/4.48	6/0	7/2.295	6/2.04
		Behavior Events with Physical Injury	0/0	12/1.4	11/0.78	9/0.603	8/0.536
		HAPI all Stages #/% per 1000 Discharges	7/28.23	49/24.38	64/20.4	57/18.36	51/16.32
		Serious Safety Events (F or Greater)	0	2	1		
	Reduce Mortality from Sepsis	Sepsis Mortality Observed: Expected	NA	1.37	1.08	1	0.93
		Bundle Compliance Sepsis Early Management	66.67%	64.58%	59.24%	75%	88%
	Embed Critical Behaviors	Hand Hygiene Compliance	89.50%	92.26%	94.46%		95%

Fiscal Year Starts in July 1 and Ends June 30

FY26 YTD is results from July 2025 to Feb 2026

Timely, Effective, and Efficient Care			Performance			FY26 Goals	
OBJECTIVES	KEY RESULTS	Detailed KPIs	Feb 2026	FY26 YTD	FY25 Actual	Improvement	Benchmark
Promote wellbeing	Provide the right care at the right time	All Cause 30-Day Readmission Rate	12.62%	13.42%	12.73%	11.69%	11.12%
Provide accessible care	Minimize Time Spent Waiting for our Patients	ED Boarding Time for Admitted Patients	2:52	2:40	2:20	2:12	1:30

Equitable Care			Performance			FY26 Goals	
OBJECTIVES	KEY RESULTS	Detailed KPIs	Feb 2026	FY26 YTD	FY25 Actual	Improvement	Benchmark
Serving all: Deliver equitable care	Health-related social needs recognized and addressed	Health-related social needs assessment completed on inpatients	98.00%	94.00%	92.30%	82%	89%
		% of patients that screened positive for at least 1 Health-related social needs	31.00%	28.00%	NA		

Patient-Centered Care			Performance			FY26 Goals	
OBJECTIVES	KEY RESULTS	Detailed KPIs	Feb 2026	FY26 YTD	FY25 Actual	Improvement	Benchmark
	Optimize performance regarding patient experience	Likelihood to recommend Acute	82.63%	74.38%	67.39%	68.39%	71.10%
		Likelihood to recommend ED	68.57%	68.05%	58.67%	59.67%	71.60%
		Likelihood to recommend Amb Surg	85.71%	84.21%	76.92%	77.92%	86.70%
		Communication with Nurses	71.52%	74.26%	72.60%	73.60%	79.90%
		Communication with Providers	41.06%	38.95%	77.85%	78.85%	79.20%

Fiscal Year Starts in July 1 and Ends June 30

FY26 YTD is results from July 2025 to Feb 2026

Fiscal Year 2025

OKR Metric Definitions for QPSC

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

Fiscal Year 2025

OKR Metric Definitions for QPSC

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

Fiscal Year 2025

OKR Metric Definitions for QPSC

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

FY 2026 QPSC OKR Dashboard

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

Safe Care - Caring, Healing, Teaching All		Performance			Goals		
OBJECTIVES	KEY RESULTS	Feb 2026	FY26 YTD	FY2025 Actual	Improvement	Benchmark	Accountable Leaders
Provide safe care	Total Patient Harms*	29	223	410	204	164	R. Lofton, L. Laurent
	Bundle Compliance Sepsis Early Management	72.73%	75%	55%	75%	88%	R. Lofton, L. Laurent
	Sepsis Mortality O/E Ratio	0.93	1.05	1.05	1.00	0.93	R. Lofton, L. Laurent
Timely, Effective, and Efficient Care							
OBJECTIVES	KEY RESULTS	Feb 2026	FY26 YTD	FY2025 Actual	Improvement	Benchmark	Accountable Leaders
Promote wellbeing	All Cause 30-day readmission rate	14.42%	12.73%	12.26%	11.69%	11.12%	D. Littlepage, A. Wu
Provide accessible care	% of Specialty Clinics with an average of less than or equal to 15 days for New Patients Appointments*	17%		11.76%		80%	T. Amoruwa, P. Mack
	% of Adult Primary Care Clinics with an average of less than or equal to 10 days for New Patients Appointments *	0%		0%		100%	T. Amoruwa, P. Mack
	ED Boarding Time for Admitted Patients Community Hospital	2:57	2:36	3:10	2:12	1:30	R. Lofton, A.Wu
	ED Boarding Time for Admitted Patients Highland	8:35	8:55	12:57	8:28	4:00	R. Lofton, A. Wu
Equitable Care							
OBJECTIVES	KEY RESULTS	Feb 2026	FY26 YTD	FY2025 Actual	Improvement	Benchmark	Accountable Leaders
Serving all: Deliver equitable care	Health-related Social Needs Assessment Completed on Inpatients	84.00%	85.00%	64.58%	81.95%	89.40%	R. Lofton
	% of Inpatients positive for at least 1 Health-related Social Need	28.00%	30.00%	NA			
Patient-Centered Care							
OBJECTIVES	KEY RESULTS	Feb 2026	FY26 YTD	FY2025 Actual	Improvement	Benchmark	Accountable Leaders
Be the most welcoming system to receive care	Likelihood to recommend care composite	82.30%	84.40%	72.54%	73.54%	79.67%	R. Lofton, A. Ng

Fiscal Year Starts in July 1 and Ends June 30

FY26 YTD is results from July 2025 to FY26YTD

* AHS' ultimate goal is Zero Hospital Acquired Harm

Fiscal Year 2025

OKR Metric Definitions for QPSC

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

QPSC BOT Executive Summary: Post-Acute Quality Report
Richard Espinoza, NHA, CAO Post-Acute Services
4/22/26

Key Point 1: **Quality Star ratings – Overall, Health Inspection, Quality Measures**
Fairmont: 5 stars all categories
Alameda: 5 stars Quality Measures

Key Point 2: **CDPH visits:**
Zero visits in March

Key Point 3: **Post-Acute Workers' Compensation claims:**
Zero across all post-acute sites – huge achievement – each site team is keeping our staff safe with education and standard work processes. Strong processes and education.

Key Point 4: **AHS Workers Compensation cases:**
Zero cases for all post-acute sites. Second month there have been zero claims in the last three months. Park Bridge and Fairmont both with lower AR days than budget. 52.6 PB and 52.5 FMT.

Key Point 5: **Post-Acute Cash Collection:**
Teresa "Tex" Flora and the PA billing teams surpassed cash collections for the month of March by $401, 857. Sub-Acute and St Rose continue to work with insurances on collections.

Key Point 6: **Pusle Survey**
Post acute leadership at 100% response rate and post-acute as a whole reached 79% with 70% being the system goal. Debriefs and neutral facilitators are being scheduled.

Key Point 7: **St. Rose/Stanford Collaboration:**
Kick off was 3/16/26 – unit currently at 78% occupancy with 70% of Stanford beds being utilized.

Post-Acute Quality Report 4/22/26

Richard Espinoza, NHA, CAO Post-Acute Services

CMS Overall Quality Star Rating

Care Compare Five-Star Ratings of Nursing Homes

Provider Rating Report for March 2026

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

Care Compare Five-Star Ratings of Nursing Homes

Provider Rating Report for March 2026

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

CDPH/CMS Visits

- CDPH visits: 0 visits for all campuses
- Survey window open for all sites
- DHCS - St Rose received their Medi-Cal rate letter

Post-Acute Workers Compensation Claims

Zero claims or late claims in the month of March for the Post-Acute sites. The teams continue to support the staff as best as possible to maintain safe environments and practices. This is the second month in the last three months that has resulted in zero claims.

Alameda Health System **Post-Acute Units**

Workers' Compensation Claim Summary **March 2026**

New Claims Filed in March

Date of Injury	Claim #	Occupation	Department	Injury Cause	Injury Cause Group	Loss Type	Nature of Injury	Body Part
NONE								

ALAMEDA HEALTH SYSTEM

Post-Acute January Cash Collection

	ACTUAL		GOAL		VARIANCE			
	COLLECTIONS	AR DAYS	COLLECTIONS	AR DAYS	COLLECTIONS			AR DAYS	
FAIRMONT	$ 2,397,027.92	52.5	$ 2,199,574.43	58	$ 197,453.49	Over	★	(5.5)	★
PARK BRIDGE	$ 2,233,832.06	52.6	$ 2,102,387.96	58	$ 131,444.10	Over	★	(5.4)	★
SOUTH SHORE	$ 618,267.06	62.5	$ 444,663.05	58	$ 173,604.01	Over	★	4.5	
SUB-ACUTE AH	$ 1,120,057.93	64.4	$ 1,126,263.04	58	$ (6,205.11)	Under		6.4	
ST ROSE	$ 423,080.85	104	$ 517,520.00	58	$ (94,439.15)	Under		46.0	
TOTAL	$ 6,792,265.82	67.20	$ 6,390,408.48	58	$ 401,857.34	Over	★	9.2	★

ALAMEDA HEALTH SYSTEM

Pulse Survey

Final participation score: Post-Acute 79%

Teams sharing the results of their individual site surveys and neutral facilitator meetings are being scheduled.

St Rose/Stanford Collaboration

- Total beds on the St. Rose unit: 27
- Census as of 4/16/26: 21
- Total Stanford patients in house: 14
- Unit is 78% full

- Start date of collaboration: 3/16/26

Thank you

Questions?