BOARD OF TRUSTEES MEETING

WEDNESDAY, MAY 13, 2026
5:00pm to 9:00pm

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

LOCATION:

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

ZOOM Meeting Link:[1]
https://alamedahealthsystem.zoom.us/j/9361457125?pwd=4JnAmhDnBaLqY4GWf4PQBwp3w0Puy2.1&omn=82178688701
Meeting ID: 936 145 7125
Meeting Password: 20200513

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

MEMBERS

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

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

BOARD OF TRUSTEES MEETING AGENDA

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

Public Comment Instructions
If you 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. DISCUSSION: HR-1/Public Hospital Funding
Katie Rodriguez, Interim President and CEO California Association of Public Hospitals and Health Systems

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

C. MEDICAL STAFF REPORTS

AHS Medical:	Berenice Perez, MD, Chief of Medical Staff
AH Medical:	Manasa Kalluri MD, Chief of Medical Staff

D. COMMITTEE AND TRUSTEE REPORTS

D1. Human Resources Committee: April 15, 2026
Donna Linton, Chair

D2. Quality Professional Services Committee: April 22, 2026
Lilavati Indulkar, MD, Trustee

D3. Finance Committee: May 6, 2026
Alan Fox, Trustee

E. CONSENT AGENDA: ACTION

E1. Approval of the Minutes of the April 8 Board of Trustees Meeting.

E2. 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

E3. 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

E4. Contracts

E4a. Agreement with Contra Costa Pathology Associates for provision of anatomic pathology and histology laboratory services. The term of this agreement is effective May 20, 2026 through May 19, 2029. The estimated impact of this agreement is $2,700,000.
Mark Fratzke, Chief Operating Officer

E4b. Renewal agreement with Quest Diagnostics for provision of reference laboratory testing services. The term of this agreement is effective June 1, 2026 through May 31, 2033. The estimated impact of this agreement is $25,619,650.
Mark Fratzke, Chief Operating Officer

END OF CONSENT AGENDA

ACTION/DISCUSSION

F. DISCUSSION: FY 2027 Preliminary Budget
Kim Miranda, Chief Financial Officer

G. DISCUSSION: Center for Operational Transformation (COT) Update
Christy Roberg, Vice President, Business Planning COT

H. DISCUSSION: AHS Governance Legislation Update
Jeanette Dong, Chief of Public Affairs and Community Engagement

I. DISCUSSION: Board Calendar and Tracking

J. STAFF REPORTS (Written)

I1. Chief Financial Officer Report, March Financial Report
Kimberly Miranda, Chief Financial Officer

I2. Chief Operating Officer Report, Contract Savings Initiative Report
Mark Fratzke, Chief Operating Officer

CLOSED SESSION

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

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

(Reconvene to Open Session)

General Counsel Report on Action Taken in Closed Session

TRUSTEE COMMENTS

ADJOURNMENT

Our Mission
Caring, Healing, Teaching, Serving All

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

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

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

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

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

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

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

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

DISCUSSION: HR-1/Public Hospital Funding

CAPH

California's Public Hospital Systems: Policy Impacts and the Road Ahead

Katie Rodriguez, Interim President & CEO
California Association of Public Hospitals and Health Systems (CAPH)
May 13, 2026

Objectives

1. **State and Federal actions impacting public hospital systems (PHS)**
   - H.R. 1
   - 2025-26 state budget
2. **How public hospital systems are responding**
3. **2026-27 state budget and implications for PHS**
4. **Next steps**
5. **Answer questions**

CALIFORNIA'S PUBLIC HOSPITAL SYSTEMS: 17 Systems, 43 Hospitals & 150+ Clinics

Together, these systems care for one in six Californians on Medi-Cal and serve as a crucial access point for uninsured residents.

Alameda Health System
- Alameda Hospital
- Fairmont Rehabilitation and Wellness
- John George Psychiatric Hospital
- Park Ridge Rehabilitation and Wellness
- San Leandro Hospital
- South Shore Rehabilitation and Wellness
- St. Rose Hospital
- Wilma Chan Highland Hospital

Arrowhead Regional Medical Center

Contra Costa Health Services

Contra Costa Regional Medical Center

Kern Medical
- Kern Medical Hospital

LA County Department of Health Services
- Harbor/UCLA Medical Center
- Los Angeles General Medical Center
  - Olive View/UCLA Medical Center
  - Rancho Los Amigos National Rehabilitation Center

Natividad Medical Center

Riverside University Health System

San Francisco Department of Public Health
- Zuckerberg San Francisco General
- Laguna Honda Hospital and Rehabilitation Center

San Joaquin General Hospital

San Mateo Medical Center

County of Santa Clara Health System
- O'Connor Hospital
- Santa Clara Valley Medical Center
- St. Louise Regional Hospital
- Regional Medical Center

Ventura County Health Care Agency
- Santa Paula Hospital
- Ventura County Medical Center

UC Health
- **UC Davis Health**
  - UC Davis Sacramento Medical Center
- **UC Irvine Health**
  - UC Irvine Health, Fountain Valley
  - UC Irvine Health, Lakewood
  - UC Irvine Health, Los Alamitos
  - UC Irvine Health, Orange
  - UC Irvine Health, Placentia
- **UC San Diego Health**
  - UC San Diego East Campus Medical Center
  - UC San Diego Health, Hillcrest Medical Center
  - UC San Diego Health, Jacobs Medical Center
- **UC San Francisco Health**
  - UCSF Helen Diller Medical Center at Parnassus Heights
  - UCSF Health Saint Francis Hospital
  - UCSF Health Saint Mary's Hospital
  - UCSF Mission Bay Medical Center
  - UCSF Mount Zion Medical Center
- **UCLA Health**
  - Ronald Reagan UCLA Medical Center
  - UCLA Resnick Neuropsychiatric Hospital
  - UCLA Santa Monica Medical Center
  - UCLA West Valley Medical Center

CAPH

Key Provisions of H.R. 1 Impacting CA's PHS

- Changes to **State Directed Payments**
  - **$2.3 billion** annual net loss to PHS by 2032.
- Reductions to **Federal Medical Assistance Percentage (FMAP)**
  - Likely result in a loss of **$120 to $331 million** annually for PHS.
- New **Medi-Cal eligibility requirements,** including work requirements, cost sharing, and more frequent eligibility checks
  - DHCS estimates up to **1.8 million** Medi-Cal members could lose coverage due to these eligibility changes, resulting in **$800 million** in annual losses for PHS

Combined impact: **$3.4 billion** annual net loss by 2032

2025-26 State Budgetary Implications

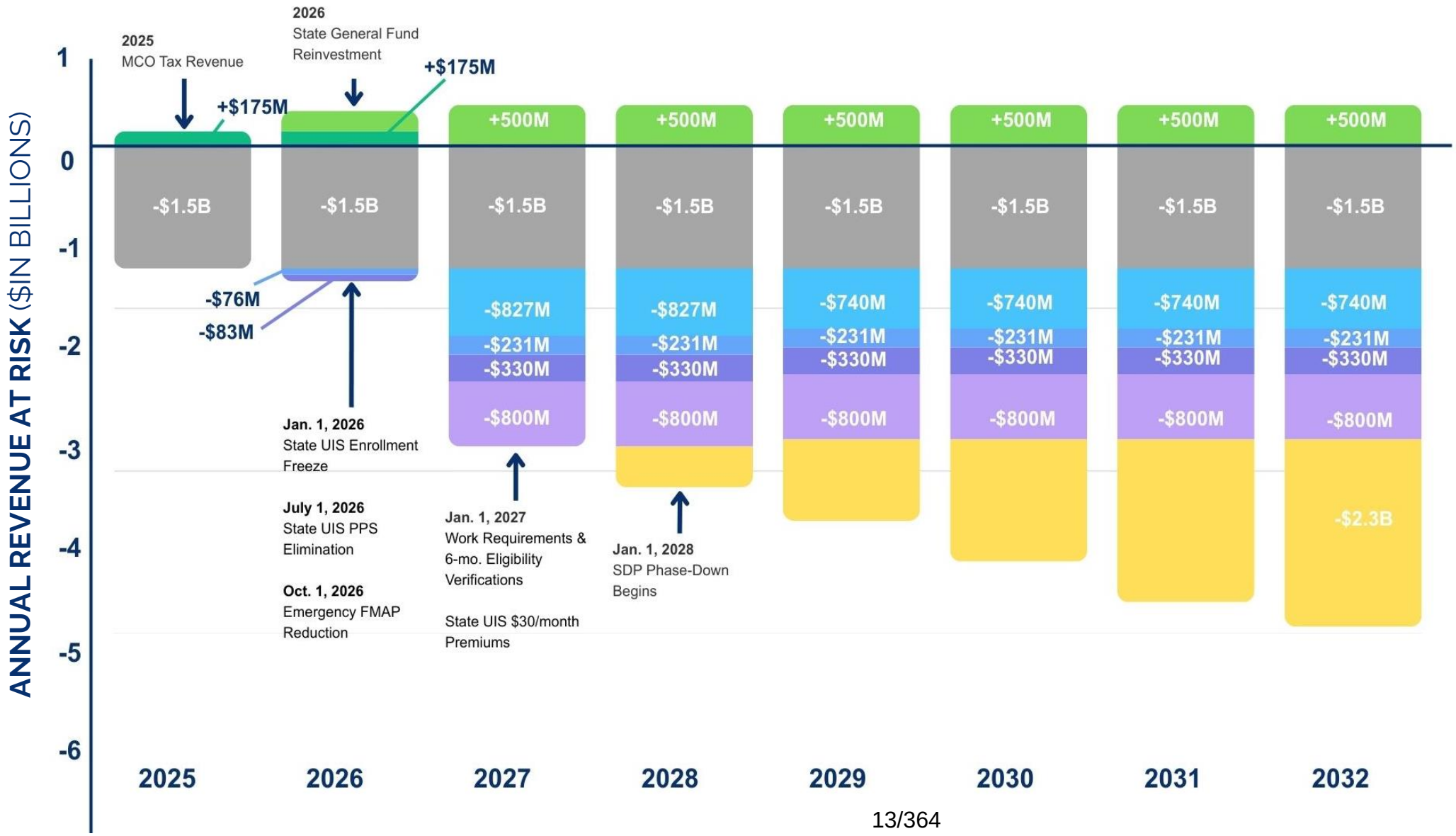
State budget reductions will result in $231 million in annual losses for California's public hospital systems when fully implemented in 2027.

- Key changes impacting losses include:
  - **January 2026:** Medicaid enrollment freeze for undocumented adults (ages 19+)
  - **July 2026:** changes to reimbursement rates for Federally Qualified Health Centers (FQHCs) to eliminate PPS rate for UIS population
  - **July 2027:** $30 monthly premiums for individuals with Unsatisfactory Immigration Status (UIS)

Public hospital systems are core safety-net providers in counties with large immigrant populations meaning any shifts to health coverage policies for UIS communities directly affects their operations and patients.

2025-2032 PROJECTED CUMULATIVE IMPACT:

STATE AND FEDERAL POLICY CHANGES AFFECTING CALIFORNIA'S PUBLIC HOSPITAL SYSTEMS



KEY:

- EXISTING STRUCTURAL DEFICIT
  Does not Include PHS' historical deficit of $1.7B.
- DSH/GLOBAL PAYMENT PROGRAM (GPP) NON-RENEWAL
- STATE UNSATISFACTORY IMMIGRATION STATUS (UIS) CHANGES
- EMERGENCY FMAP REDUCTION
- FEDERAL ELIGIBILITY CHANGES
  Includes Medicaid work requirements and six-month re-verification thereby reducing Medi-Cal enrollment, lowering federal funding, and increasing uncompensated care costs.
- STATE DIRECTED PAYMENT (SDP) REDUCTIONS
  SDP impact shown between 2028-2031 assumes gradual reduction through FY 2032, ending with $2.3B annual loss. Actual amounts depend on federal implementation.
- MCO TAX
- STATE GENERAL FUND SUPPORT

How are public hospital systems responding?

- **Individual public hospital systems:**
  - Reducing costs and increasing efficiencies where possible, though insufficient to address the scale of the cuts.
  - Some systems have already begun implementing service reductions, layoffs and facility closures, while others are considering them.
- **Local tax measures**
  - Santa Clara, Contra Costa and L.A.
- **State budget advocacy**
- **In the future:** advocacy to delay or repeal H.R. 1 (or sections of it)

CAPH State Budget Advocacy

- **Advocating** for $500 million for public hospital systems to help offset the $3.4 billion in annual impacts from H.R. 1.
  - This would represent a down-payment rather than a solution.
- **Supporting:**
  - Other county funding requests, including support for additional county eligibility and enrollment workers and funding to help reestablish indigent care programs
  - Efforts to delay Medi-Cal coverage reductions for individuals with unsatisfactory immigration status

Governor's Revised Budget Expected Tomorrow

May Revise:

- The Governor must release a revised budget on or before May 14.
  - State revenues are currently tracking above projections, though deficits are expected in future budget years. This may lead to a focus on one-time funding and possibly some funding reductions.
- What CAPH is watching for in the May Revise:
    - Does it include $500M General Fund for public hospital systems, funding for eligibility supports and indigent care programs?
    - Is the Administration proposing to move the UIS population from managed care to fee-for-service?
    - Are there any other proposed Medi-Cal cuts that could impact public hospital systems and their patients?

What's next?

- **Continued advocacy through final state budget negotiations (likely end of June)**
- **2026 Elections (June and November)**
- **1115 Waiver Renewal (December 2026)**
- **Opportunities to delay/eliminate portions of H.R. 1 (2027)**
- **Medicaid DSH Cuts (October 2027)**
- **Federal Regulations**
  - H.R. 1 implementation
  - Additional changes to payment structures

Discussion

CEO REPORT

AHS CEO Board Report

James Jackson
5/13/2026
Board of Trustee Meeting

I AM addressing this letter to Mr. Paul Jones and whom it may concern ;

I AM a patient of the Alameda Health System, Mr. P. Jones is my assigned case manager. I joined the ranks of the homeless in January of 2024 due to health challenges. In the short time Mr. Jones has worked with me he has accomplished a lot towards my quality of life & given me the courage to be more optimistic & move forward despite challenges I AM dealing with. Mr. Jones has scheduled appointments with medical agencies, scheduled ride-sharing, and personally (on several occasions) located my whereabouts before going to work, to ensure I make it to these appointments. He has given me necessities I greatly needed, and located a temporary place for me & my service dog to live.

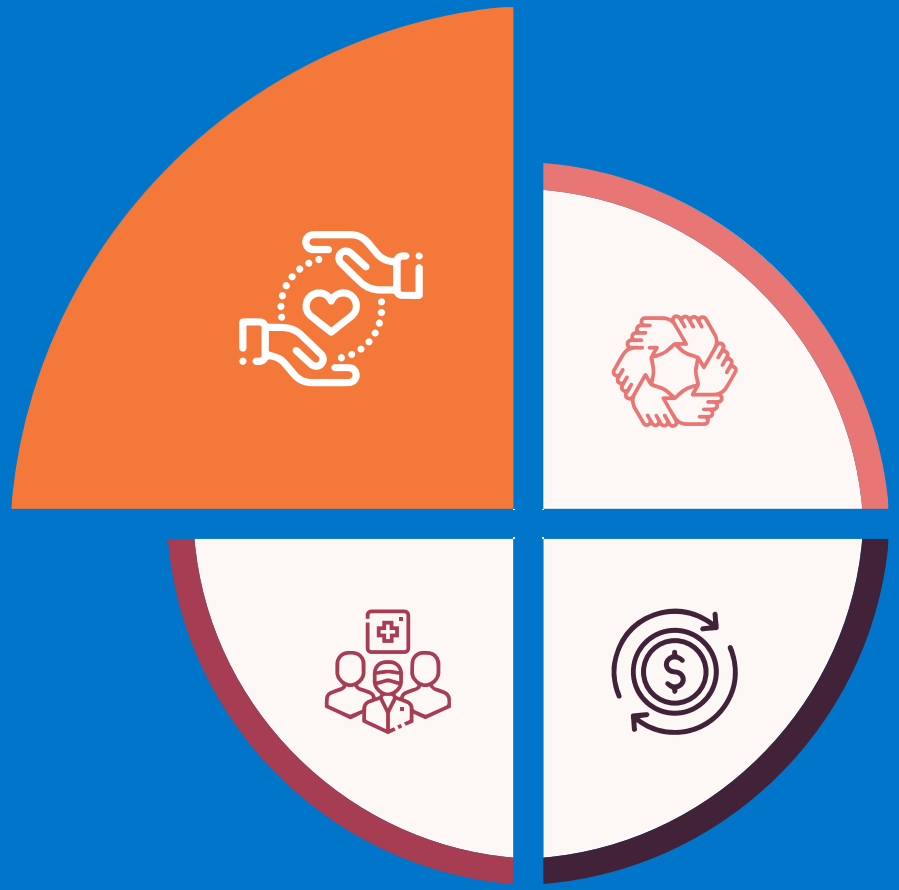
At this time I would like to commend Mr. Paul Jones for his kindness, helpfulness, and work efficiency. He has gone up and beyond the standards of ppl I've encountered working in his field. And I greatly appreciate being apart of his workload.

I couldn't have prayed for anyone more efficient. Gratefully,

AHS Pillars

Quality Care

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



Alameda Hospital Receives 'A' Safety Grade From Watchdog Group
"Providing exceptional care to all, especially the most vulnerable, is at the core of who we are," the hospital's CEO said.

ALAMEDA, CA — An Alameda hospital earned an "A" grade for its ability to protect patients from often preventable harm, according to a new safety report released Wednesday by a national watchdog.

Alameda Hospital received an 'A' grade from The Leapfrog Group, after being given 'Bs' through 2025. It last received an "A" grade during the fall of 2024.

"Ensuring patient safety is our highest priority. This recognition affirms the rigorous standards and evidence-based practices our teams follow every day to deliver safe, high-quality care," said Lisa Laurent, MD, MBA, MS, Chief Medical Officer and Chief Physician Executive.

The Leapfrog Group says its report is the only one in the country that offers ratings focused exclusively on patient safety. The report is based on over 30 performance measurements that look into errors, accidents, injuries and what systems are in place for hospitals to address them.

"An 'A' Grade is a strong sign that Washington Health is deeply committed to protecting patients from harm," said Leah Binder, president and CEO of The Leapfrog Group. "We commend the leadership, Board, clinicians, staff and volunteers for the role each played in earning this distinction."

Alameda Hospital appears to have achieved the standard in several categories, including billing ethics, nursing and bedside care and safe medication administration.

The Leapfrog Group marked that the hospital has "limited achievement" in informed consent, and "some achievement" in health care equity, having not met the watchdog's top standard in those areas.

"This recognition is a testament to the dedication and excellence of our staff," said James Jackson, Chief Executive Officer of Alameda Health System, which operates Alameda Hospital. "We believe every patient deserves outstanding care, and we are proud to deliver it in a setting that prioritizes safety, trust, and compassion."

Alameda Hospital's Skilled Nursing Facilities also received top honors recently, being ranked among America's Best Nursing Homes by Newsweek.

California ranks 10th among all states for the percentage of hospitals receiving "A" grades in the spring 2026 report card.

Leapfrog said its biannual report shows improvement in 17 measures, including health care-associated infections, medication safety systems and patient experience.

"The good news is that hospitals across the country are making meaningful strides in patient safety and helping save countless lives," Leah Binder, the group's president and CEO, said in a news release.

After peaking in fall 2022, several health care-associated infections declined sharply, according to the report. Central line-associated bloodstream infections fell by half; catheter-associated urinary tract infections dropped 45 percent; methicillin-resistant Staphylococcus aureus infections declined 42 percent; and serious intestinal infections linked to antibiotic use went down 30 percent.

The report also found gains in medication safety. Use of computerized physician order entry systems, which can flag prescribing errors, rose from 66 percent of hospitals meeting Leapfrog standards in 2018 to 90 percent in 2025. Adoption of barcode medication administration systems increased from 47 percent to 93 percent over the same period.

Patient experience scores, measured through Medicare and other federal surveys, have improved since hitting a low in fall 2023, rising by about one point on average across five safety-related measures, including communication with nurses and doctors and responsiveness of hospital staff.

Among states, Connecticut, Virginia and South Carolina had the highest share of A-rated hospitals, followed by Utah, Montana, New Jersey, Florida, Maryland, North Carolina and California. Montana and Maryland entered the top 10 for the first time, while Florida rose from 15th place in fall 2025 to seventh. No hospitals in North Dakota, South Dakota, Vermont or Wyoming received an A grade.

About 450 hospitals were not assigned grades after a federal court ruling in South Florida involving several facilities that did not participate in Leapfrog's 2024 or 2025 survey. The group said it applied the change nationwide and is appealing the decision while reviewing its methodology.

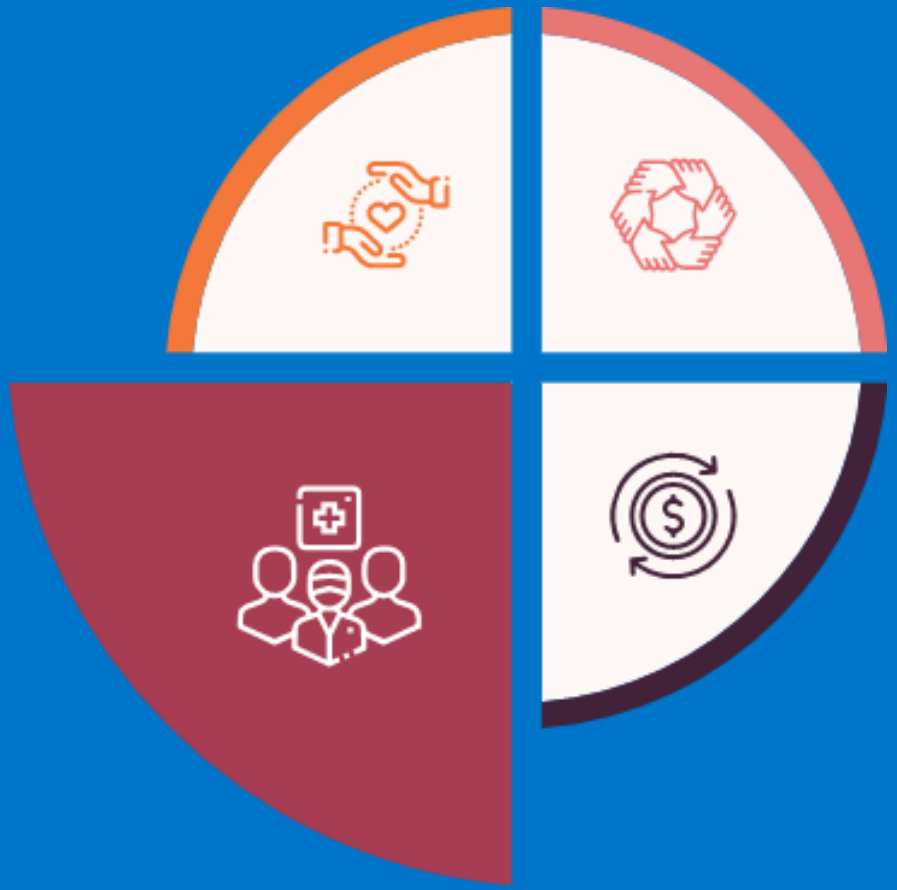
Local Editor Kristina Houck contributed to this report.

SRH Epic Community Connect project

- AHS will extend our Epic to SRH as a Community Connect entity
- SRH EHR will be on Epic but ERP (HR, Finance, Supply Chain) remains on Meditech after go-LIVE
- Community Connect will allow two organizations to share patient and clinical contents but separate from financial perspectives
- Project Steering Committee was established and Project Kickoff at SRH on Monday 5/11 where SRH leadership team demonstrated high enthusiasm and engagement
- Project estimated go-LIVE in Feb 2027

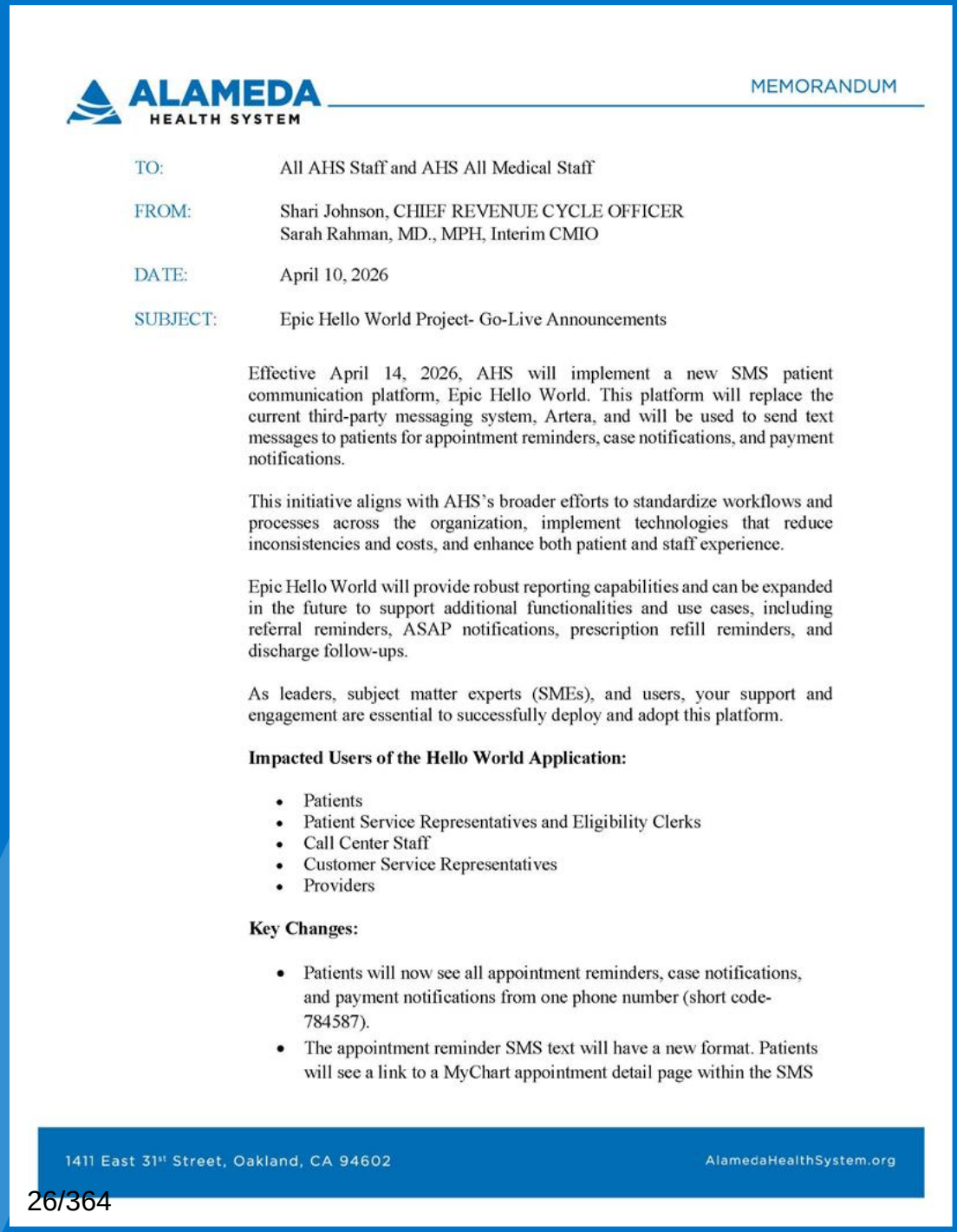
AHS Pillars

Staff & Physician Experience



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

Epic Hello World Project



ALAMEDA HEALTH SYSTEM

MEMORANDUM

TO: All AHS Staff and AHS All Medical Staff

FROM: Shari Johnson, CHIEF REVENUE CYCLE OFFICER
Sarah Rahman, MD., MPH, Interim CMIO

DATE: April 10, 2026

SUBJECT: Epic Hello World Project- Go-Live Announcements

Effective April 14, 2026, AHS will implement a new SMS patient communication platform, Epic Hello World. This platform will replace the current third-party messaging system, Artera, and will be used to send text messages to patients for appointment reminders, case notifications, and payment notifications.

This initiative aligns with AHS's broader efforts to standardize workflows and processes across the organization, implement technologies that reduce inconsistencies and costs, and enhance both patient and staff experience.

Epic Hello World will provide robust reporting capabilities and can be expanded in the future to support additional functionalities and use cases, including referral reminders, ASAP notifications, prescription refill reminders, and discharge follow-ups.

As leaders, subject matter experts (SMEs), and users, your support and engagement are essential to successfully deploy and adopt this platform.

Impacted Users of the Hello World Application:

- Patients
- Patient Service Representatives and Eligibility Clerks
- Call Center Staff
- Customer Service Representatives
- Providers

Key Changes:

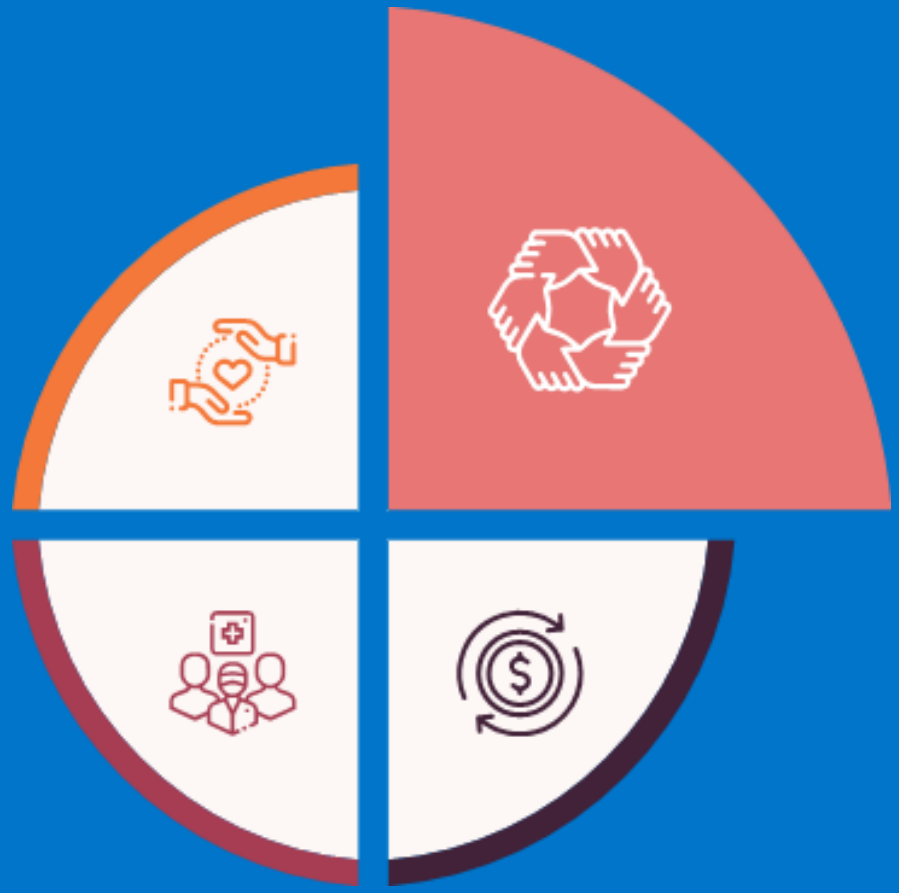
- Patients will now see all appointment reminders, case notifications, and payment notifications from one phone number (short code-784587).
- The appointment reminder SMS text will have a new format. Patients will see a link to a MyChart appointment detail page within the SMS

1411 East 31st Street, Oakland, CA 94602 AlamedaHealthSystem.org

We are honored to have been selected to join the Change Maker Accelerators Program led by the National Academy of Medicine's Action Collaborative. The highly competitive initiative brings together organizations committed to reducing burnout and supporting clinician well-being.

Community Connection

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




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


IN CASE OF FIRE
TO LOWER FIRE CURTAIN.
COVER AND PUSH RED
James
Jackson


Melanie
Shelby
Tim
Reed

Let's spruce up our neighborhood!

Saturday, May 23, 2026
9 a.m. – 11 a.m.

Please join CEO James Jackson for our "Spring" clean-up of the surrounding area around the Wilma Chan Highland Hospital Campus.

We'll meet under the AHS canopy located at the entrance to the Highland Care Pavilion (HCP) parking garage!

Cleaning tools and refreshments are provided. Bring along your co-workers, family, and friends!

Wear your AHS blue caps and t-shirts (we'll have a supply on hand).

Clean-up will be canceled if it rains.

Please RSVP by May 20, 2026 | PACE@alamedahealthsystem.org

ALAMEDA HEALTH SYSTEM

Questions

James Jackson
5/13/2026
Board of Trustee Meeting

MEDICAL STAFF REPORTS

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

May 13, 2026

Manasa Kalluri, MD, AH Chief of Staff

Berenice Perez, MD, AHS Chief of Staff

Alameda Hospital
Medical Executive Committee Report

- **Regulatory & Accreditation**
  - TJC Stroke Certification
    - May 18, 2026 Announced survey
- **The Leapfrog Group**
  - 'A' Hospital Safety Grade
- **Patient Experience**
  - Elevating Care & Sustaining Improvement Award
  - FYTD 26 Inpatient Domains
    - Seven (7) of the nine (9) metrics are performing above goal

Medical Staff Committees

Combined Medical Staff committees provide systemwide clinical governance to ensure consistent quality, aligned standards and cohesive medical staff oversight.

AHS & AH Credentials Committee (April 2026)

- Routine credentialing and privileging including telemedicine by proxy
- Ongoing Professional Practice Evaluation (OPPE) incorporated into reappointment decisions
- Updates to credentialing and privileging policies

Clinical Practice Council (April 2026)

- Reviews and approves systemwide protocols, policies and care plans affecting the delivery of patient care
- MEC approved multiple systemwide policies/protocols and medication order sets
- Ensures clinical alignment across AHS to support safe, consistent patient care

Quality Steering Committee: Oversight of QAPI Plan, OKR dashboards and CMS 5-star performance

AHS Patient Safety Committee: Oversight of Root Cause Analysis and operational improvement opportunities

Clinical Impact and Joint Conference Committees

Open Communication	Transparency Alignment Understanding
Clinical Input	Service Coverage Tier 1 Community Tier 2 Acute / Specialty Tier 3 - Tertiary
Prioritization of Level 1 Trauma Recertification	Level 1 Trauma Taskforce Staff, Space Equipment Operating Room Availability
MEC Integration in Decisions	Capital Committee Core Membership

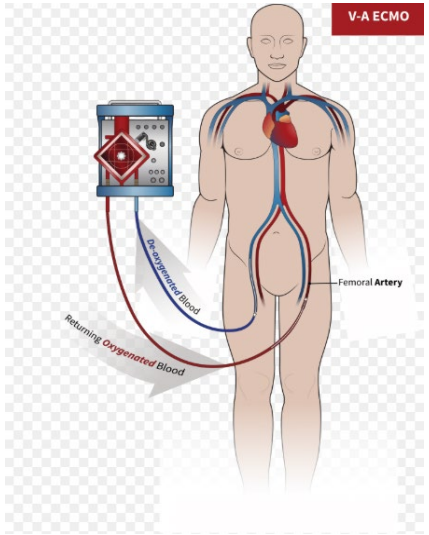
Procedural Innovation Committee (PIC)

Purpose

- Prevents ad-hoc or siloed adoption of new invasive procedures
- Ensures safety, readiness, and value before new procedures can move forward

How does PIC work?

- Monthly standardized, multidisciplinary review of new invasive procedures before privileging granted
- Assesses clinical need, quality safeguards, staffing, equipment needs
- Active oversight of high-impact innovations
- Clear governance pathway: PIC – Credentials – MEC – QPSC - Board



April 2026 meeting

- Multidisciplinary representation
- Physicians (Anesthesiology, Emergency Medicine, Medicine, Surgery)
- Nursing, Revenue Cycle, Supply Chain

Active Reviews

- Neuro endovascular privileges for Neurosurgery – completed
- Extracorporeal Cardiopulmonary Resuscitation (ECPR) proposal from Emergency Medicine – *Assessment and review in process*

Annual Department Reports

- Department of Anesthesiology, Perioperative and Pain Medicine

May 2026 Medical Staff News

ALAMEDA HEALTH SYSTEM

May 2026

AHS MEDICAL STAFF NEWS

Spotlight: REACH Program Now Live Across Alameda Health System

Alameda Health System AHS officially launched REACH - Resources and Engagement After Care in the Hospital - a partnership between the Community Health and Emergency Medicine Department providing post-discharge telehealth visits to all patients within 72 hours of hospital discharge. A coordinated team of Community Health Workers and physicians focus visits on answering questions, reviewing medications, clarifying care plans, coordinating follow-up appointments, and addressing social needs like food and transportation. Early results show dramatic reductions in repeat ED visits, readmissions, and hospital days. The REACH team is excited to collaborate with providers across specialties to improve care for patients after leaving the hospital. Patients consistently expressed appreciation for this level of support. See patient comments below!

For questions or to learn more, contact Evan Rusoja, MD PhD, Lilly MacRae, RN PHN, and Andrea Wu, ACMO.

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

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

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

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

A Note from the Medical Staff Officers

We recognize the REACH team for their dedication and compassion to putting our patients first. Their work makes our health system stronger, supports our patients through difficult transitions, and represents what can be accomplished through extensive collaboration. We are grateful for their leadership and impact they continue to make.

WELCOMING NEW PROVIDERS ACROSS OUR SYSTEM

John Evans, MD
Medicine Department
Cardiology

Kaosolushi Enendu, MD
Psychiatry Department

Kerri Yoshiyama, OD
Surgery Department
Optometry

Ramesh Gopi, MD
Radiology/Imaging Department

Zachary Bonzell, MD
Psychiatry Department

Cameron Jones, MD
Emergency Medicine Department

Susan Wong, MD
Anesthesiology, Perioperative and Pain Medicine Department

Monthly reports of Initial Appointment and Resignation approvals by the Board of Trustees can be accessed via Medical Staff Services Page.

- Alameda Health System
- Alameda Hospital

ALAMEDA HEALTH SYSTEM

May 2026

AHS MEDICAL STAFF NEWS

Are you interested in shaping clinical practice?

The Clinical Practice Committee (CPC) is a multidisciplinary medical staff committee that plays a critical role in overseeing the review and approval of all clinical protocols, policies, and care plans that affect the delivery of patient care across the health system. Joining the CPC offers a meaningful opportunity to engage in governance, collaborate across disciplines, and help drive continuous performance improvement at a system level. If interested, please email medicalstaff@alamedahealthsystem.org.

Medical Staff Peer Review Redesign

As part of the redesign of the peer review process, we are establishing a single, multidisciplinary Medical Staff Peer Review Committee (MS-PRC) to provide systemwide oversight of peer review activities. Details regarding the MS-PRC composition, membership terms, and meeting cadence can be found in the Medical Staff Peer Case Review Policy: MS-PRC policy

Bylaws, Policies and Procedures

Click here to access the full Medical Staff Services division page

- AHS Medical Staff Bylaws
- AH Medical Staff Bylaws
- Medical Staff Immunization and Vaccinations
- Medical Staff Ongoing Professional Practice Evaluation (OPPE)
- Medical Staff Professionalism and Conduct Policy
- AHS Medical Staff Committees
- AH Medical Staff Committee

National Resident Matching Program

We are thrilled to share that all our residency programs filled in the National Resident Matching Program (NRMP), attracting outstanding medical students and physicians from diverse backgrounds as we continue to recruit future physicians who reflect the community we serve. AHS proudly sponsors programs in EM, IM, OMFS, and Dental, as well as fellowships in Addiction Medicine and EM Ultrasound. The UCSF Eastbay Surgery Program based at AHS also had a highly successful match. This is a true testament to the strength and reputation of our training programs, one of which even earned a shout out on *The Pitt*! Watch the video and wait until the end! The Pitt Video Link

Resignations

- Chitra Akileswaran, MD – Obstetrics, Midwifery and Gynecology – effective 3/31/2026
- Kathryn Beane, PA-C – Medicine – effective 3/24/2026
- Amelia Breyre, MD – Emergency Medicine – 3/31/2026
- Thomas Chen, DO - Ambulatory and Preventive Medicine – effective 4/1/2026
- Alexandra Friedman, MD – Emergency Medicine – effective 3/18/2026
- Mohammad Hussain, MD - Medicine – effective 3/4/2026
- Aahit Jain, MD – Medicine – effective 3/31/2026
- Daisy Leon-Martinez, MD – Obstetrics, Midwifery and Gynecology – effective 3/16/2026
- Adil Malik, MD – Orthopedic Surgery – effective 4/7/2026
- Stephanie Murphy, DDS – Surgery – effective 4/30/2026
- Michelle Petzelt, MD - Anesthesiology, Perioperative and Pain Medicine – effective 4/16/2026
- Obulareddy Ramireddy, MD - Anesthesiology, Perioperative and Pain Medicine – effective 4/30/2026
- Basant Singh, MD – Psychiatry – effective 3/20/2026
- Eliana Sosa, MD - Psychiatry – effective 4/6/2026

We extend our heartfelt thanks to our physicians for their unwavering dedication and leadership in caring for our patients.

Your commitment makes a meaningful difference every day!

Alameda Health System Medical Staff Leadership

Berenice Perez, MD
Chief of Staff

Shrett Lash, MD
Vice Chief of Staff

Shahram Aarabi, MD
Secretary

Charlotte Wills, MD
Treasurer

Lan Na Lee, MD
Immediate Past Chief of Staff

REACH Program

What does the program do?

- Telehealth follow up within 72 hours of hospital discharge
- Medication review, care plans, follow-up appointments, social needs

Who does this work?

- Partnership between EM and Community Health Workers

What are the results?

- Decreased ED visits, re-admissons and inpatient days
- Positive patient feedback

Congrats to Evan Rusoja MD PhD, Lily MacRae RN PHN, and Andrea Wu MD

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National Resident Matching Program (NRMP)

- AHS sponsors residency programs in EM, IM, OMFS, Dental
- Fellowships Addiction Medicine and EM Ultrasound
- UCSF Eastbay Surgery Program based at AHS
- 100% match across all residencies and fellowship programs
- Attract talented and diverse resident physicians who reflect the community we serve
- Testament to the strength of our programs
- Call out on The Pitt

National Resident Matching Program

We are thrilled to share that all our residency programs filled in the National Resident Matching Program (NRMP), attracting outstanding medical students and physicians from diverse backgrounds as we continue to recruit future physicians who reflect the community we serve. AHS proudly sponsors programs in EM, IM, OMFS, and Dental, as well as fellowships in Addiction Medicine and EM Ultrasound. The UCSF Eastbay Surgery Program based at AHS also had a highly successful match. This is a true testament to the strength and reputation of our training programs, one of which even earned a shout out on *The Pitt*! Watch the video and wait until the end! The Pitt Video Link

ALAMEDA HEALTH SYSTEM

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COMMITTEE AND TRUSTEE REPORTS

ALAMEDA HEALTH SYSTEM

Human Resources Report

Board of Trustees

Jet Chapman, Chief Human Resource Officer
May 13, 2026

The following slides are from the HR Committee Board of Trustees meeting held on April 15, 2026.

Reduction in Force – SWOT Analysis

Strengths

- HR met critical timelines & deadlines
- Empathetic, respectful communication with impacted staff
- Partnership with PACE team on communications
- IS support for email, website, devices & system access
- Identified alternative ways to reduce cost savings (IRP/VSRP)
- Provided support to RIF individuals (e.g., external website, EAP, resume writing, priority application process

Weaknesses

- Data accuracy (e.g., seniority)
- Compressed timeline with insufficient planning
- Limited leadership inclusion, union constraints, and conflicts of interest
- Concern with timing of notifications (holidays)

Reduction in Force – SWOT Analysis

Opportunities

- Align with unions on seniority rules
- Involve all stakeholders to create a fair and equitable process
- Strengthen communication quality (proofing)
- Improve cross-functional coordination (e.g., Payroll scheduled, retirement, benefits)

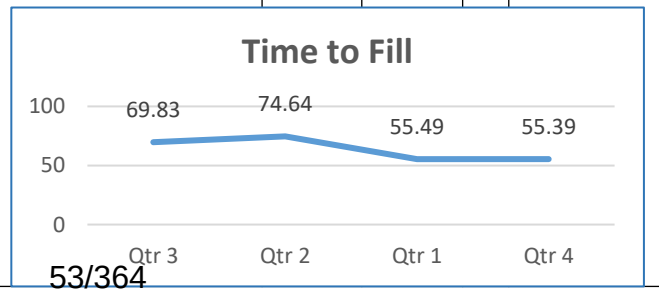
Threats

- Reputational damage and loss of credibility
- Risk to care quality and patient safety reputation
- Declining employee engagement

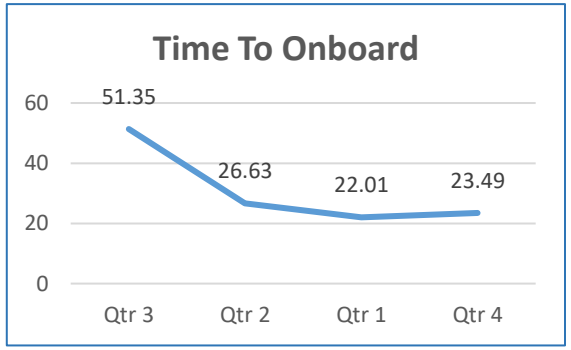
Human Resources Dashboard Updates

HR Dashboard

Dashboard Item	Description	Current Qtr/FY Q3 FY26 (Jan 1 - Mar 30 2026)	Previous Qtr/FY Q2 FY26 (Oct 1 to Dec 31 2025)	Benchmark / Source	Target goal		Strategic Alignment	Details
Time to Fill	Days it takes to fill a position after an opening has been posted	**All numbers are calendar days, total number of positions filled per category in parenthesis:** Admin, Business & Clinical Support (4): 96.25 Allied Health (12): 65.25 Business Professional & IT (3): 39 Care Management: (0): 0 Management (5): 84.6 Mental Health & Social Services (0): 0 Nurse Practitioner/PA (1): 210 Nursing (30): 64.1 Physicians & Dentists (16): 94.125 Service & Trade (0): 0 **Total Jobs Filled**: 71 (41 External, 30 Internal) **Total Average time to Fill**: 69.83 Days **Total Average Time to Fill (External)**: 107.66 Days **Physician Average Time To Fill:** 75.30 Days **Physician Average Time to Fill (External):** 95.56 Days	**All numbers are calendar days, total number of positions filled per category in parenthesis:** Admin, Business & Clinical Support (18): 46.62 Allied Health (50): 96.54 Business Professional & IT (14): 69.57 Care Management: (9): 74.33 Management (14): 59.79 Mental Health & Social Services (10): 52.8 Nursing (73): 71.73 Physicians & Dentists (13): 109.69 Service & Trade (18): 48.67 **Total Jobs Filled**: 219 (116 External, 103 Internal) **Total Average time to Fill**: 74.64 Days **Total Average Time to Fill (External)**: 91.48 Days **Physician and NP/PA metrics are not included	51 days	51 days	↑	Workforce Sustainability	In Q3 FY26, Alameda Health System filled 71 positions, a 68% decrease from Q2 FY26 (219), reflecting the continued and more acute impact of the system-wide reduction in force (RIF), sustained hiring restrictions, and deliberate workforce stabilization efforts. Hiring activity was significantly limited to only the most critical roles, resulting in 41 external and 30 internal hires. This shift highlights a heightened focus on redeploying internal talent, and aligning staffing with revised operational priorities. Average time to fill decreased slightly from 74.64 days to 69.83 days (-6.4%), indicating improved efficiency within a significantly constrained hiring environment. This modest improvement was driven by a lower overall requisition volume, more targeted hiring aligned to pre-approved critical roles, and streamlined decision-making within a narrower scope of recruitment activity. However, external time to fill increased from 91.48 days to 107.66 days (+17.7%). External searches were more selective and subject to additional layers of scrutiny, approval validation, and funding confirmation. These dynamics extended timelines, particularly for specialized or hard-to-fill roles. Hiring activity remained concentrated in Nursing, Allied Health, and Physicians & Dentists, which continue to be essential to patient care delivery, mission criticality, revenue cycle stability. There was limited to no hiring in areas such as Care Management, Mental Health, and Service & Trade, reflecting intentional pauses. Administrative, Business, and Management hiring was also significantly reduced or highly selective, aligning with broader efforts to streamline non-clinical functions.

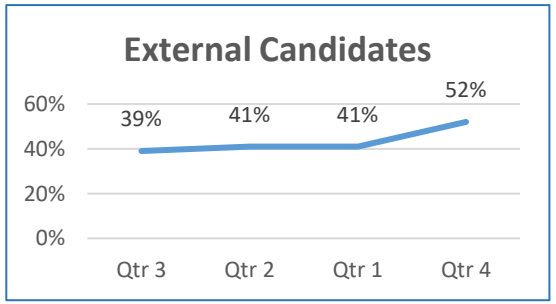


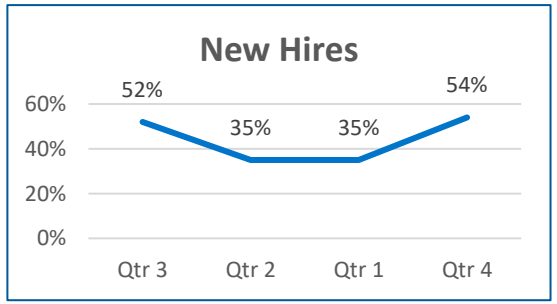
HR Dashboard

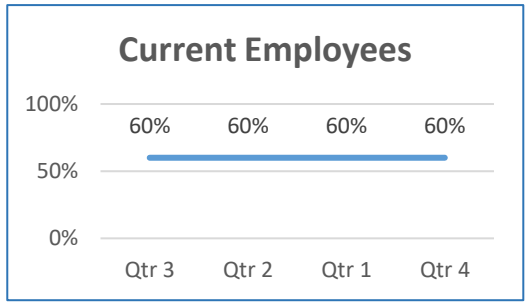
Dashboard Item	Description	Current Qtr/FY Q3 FY26 (Jan 1 - Mar 30 2026)	Previous Qtr/FY Q2 FY26 (Oct 1 to Dec 31 2025)	Benchmark / Source	Target goal		Strategic Alignment	Details
Time to Onboard Employees	Days from offer accepted to first day at work	**All numbers are calendar days, total number of positions filled per category in parenthesis:** Admin, Business & Clinical Support (4): 67 Allied Health (12): 47.58 Business Professional & IT (3): 33.33 Care Management: (0): 0 Management (5): 74.6 Mental Health & Social Services (0): 0 Nurse Practitioner/PA (1): 57 Nursing (30): 57.46 Physicians & Dentists (16): 34.56 Service & Trade (0): 0 **Total Jobs Filled**: 71 (41 External, 30 Internal) **Total Average Time to onboard**: 51.35 **Total Average Time to onboard (External)**: 50.43 Days **Physician Average Time To Onboard:** 34.56 Days **Physician Average Time to Onboard (External):** 39.35 Days	**All numbers are calendar days, total number of positions filled per category in parenthesis:** Admin, Business & Clinical Support (18): 48.44 Allied Health (50): 22.12 Business Professional & IT (14): 449.00 Care Management: (9): 18.33 Management (14): 35.43 Mental Health & Social Services (10): 13.60 Physicians & Dentists (13): 37 Nursing (73): 20.99 Service & Trade (18):19.94 **Total Jobs Filled**: 219 (116 External, 103 Internal) **Total Average Time to onboard**: 26.63 Days **Total Average Time to onboard (External)**: 27.47 Days **Physician and NP/PA metrics are not included		19 days	↑	Workforce Sustainability	In Q3 FY26, average time to onboard increased from 26.63 days to 51.35 days (+92.8%), reflecting the impacts following the RIF. As hiring slowed and became more selective, onboarding processes were also impacted by tighter resource allocation and coordination across HR, IT, and hiring departments. External time to onboard increased from 27.47 days to 50.43 days (+83.6%), driven by similar constraints, as well as extended pre-employment clearances and start date coordination amid ongoing organizational changes. Overall, the increase in onboarding timelines reflects a post-RIF stabilization period, where processes adjusted to lower hiring volume, delayed starts, and evolving operational workflows, rather than a decline in team performance. 

HR Dashboard

Dashboard Item	Description	Current Qtr/FY Q3 FY26 (Jan 1 - Mar 30 2026)	Previous Qtr/FY Q2 FY26 (Oct 1 to Dec 31 2025)	Benchmark / Source	Target goal		Strategic Alignment	Details
Residents of Alameda County **External Applicants** **New Hires** **Current Employees**	Percent of external applicants, new hires, and current employees that reside in Alameda County	1339 out of 3421 (39%) 26 out of 50 (52%) 3621 out of 6078 (60%)	2362 out of 5789 (41%) 98 out of 267 (37%) 3713 out of 6237 (60%)				Workforce Sustainability	Resumed attending virtual and in-person job fairs. Planning university and residency outreach. Created partnerships with local community organizations. Formed partnership with the EDD. Working with niche job posting sites to increase employment of local community residents at AHS.







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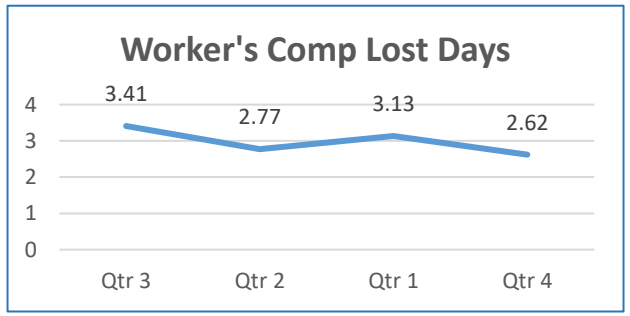
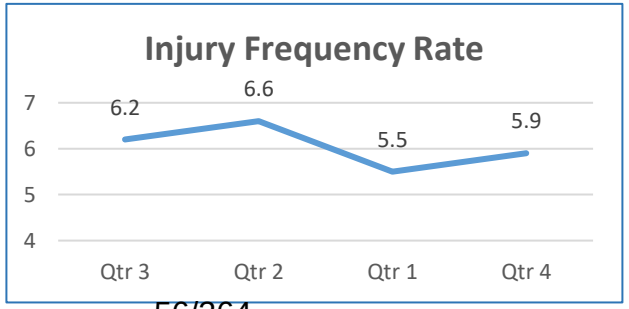
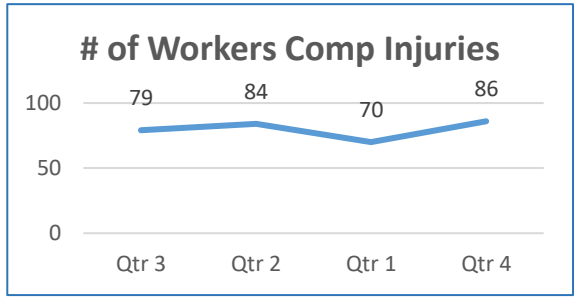
Dashboard Item	Description	Current Qtr/FY Q3 FY26 (Jan 1 - Mar 30 2026)	Previous Qtr/FY Q2 FY26 (Oct 1 to Dec 31 2025)	Benchmark / Source	Target goal		Strategic Alignment	Details
Workers' Compensation Lost Days	Days employees are unable to work due to a work-related injury	3.41 avg days per FTE	2.77 avg days per FTE	3.40 avg days per fte	3.40 avg days per fte	↑	Workforce Sustainability	Total loss days for 10/1/25 – 12/31/25 were 2833 compared to 3925 for 1/1/26 - 3/31/26. This increase is reflective of slower injury recovery and lowered return-to-work performance in the third quarter. Other factors that influence lost days are returning injured employees to modified duty and level of claim severity (which increases lost days). Overall, only .01 higher than benchmark/target.
Injury Frequency Rate	Measures how often an injury occurs relative to productive hours worked.	6.2	6.6	6.4	6.4	↓	Workforce Sustainability	For the metric of "Injury Frequency Rate" (Claim count/FTE x 100), AHS saw a 6% decrease in IFR (also below benchmark/target of 6.4). Given the decrease in claim count for 3rd Qtr., it appears IFR lowered in conjunction with the decrease in # of injuries.
# of Workers' Comp Injuries	Number of Workers' Compensation Injuries	79	84	**70 (updated for FY26)**	**70 (updated for FY26)**	↑	Workforce Sustainability	79 injuries for Q3 represents a 6% decrease over Q2. Top injury causes for Q3: Struck or injured by (patient to staff) - 24; Strain/injury by (patient handling related) - 24; Slip/trip/falls - 12. These 3 injury causes account for 76% of all injuries for Q3. All injuries are reviewed in monthly MOR meetings for staff awareness & mitigation efforts.







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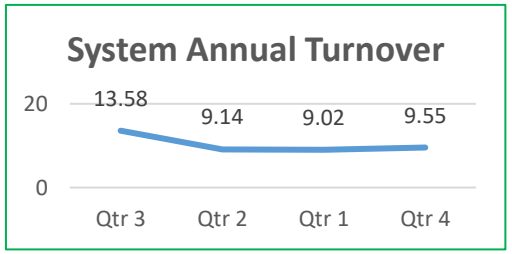
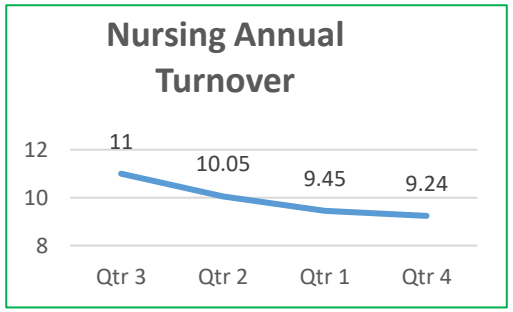
Dashboard Item	Description	Current Qtr/FY Q3 FY26 (Jan 1 - Mar 30 2026)	Previous Qtr/FY Q2 FY26 (Oct 1 to Dec 31 2025)	Benchmark / Source	Target goal		Strategic Alignment	Details
SYSTEM Annual Turnover **Overall - Annualized/Qtrly** _____ **First Year - Annualized/Qtrly** _____ **Second Year - Annualized/Qtrly**	Number of separations divided by Number of Employees	Annualized - 13.58% Quarterly - 3.40% term count = 207 _____ Annualized - 22.84% Quarterly - 5.71% term count = 37 _____ Annualized - 17.03% Quarterly - 4.26 % term count = 27	Annualized - 9.14% Quarterly - 2.29% term count = 132 _____ Annualized - 19.97% Quarterly - 4.99% term count = 33 _____ Annualized - 20.29% Quarterly - 5.07 % term count = 32	16.70%	11.80%	↑	Financial benefit - save cost of hiring, onboarding new employees / Workforce - maintaining quality of care through consistent workforce	Reviewing data on top voluntary term reasons (from exit interview data); launched turnover dashboard to leaders in April; Exit interview dashboard launched in May 2023 to provide transparency to leaders. Sharing turnover data with AHS leadership at department meeting; conducted work group exercise to discuss turnover and retention strategies. Top Term Reasons: Resignation (91); Retirement. IRP and VSRP (76); HR Non-Compliance (10); Failed Probation (5)
SYSTEM Annual Turnover (Voluntary Separations Only) **Overall - Annualized/Qtrly** _____ **First Year - Annualized/Qtrly** _____ **Second Year - Annualized/Qtrly**	Number of Voluntary separations divided by Number of Employees	Annualized - 11.55% Quarterly - 2.89% term count = 176 _____ Annualized -17.28% Quarterly – 4.32% term count = 28 _____ Annualized - 15.77% Quarterly – 3.94 % term count = 25	Annualized - 6.16% Quarterly - 1.54% term count = 89 _____ Annualized -19.97% Quarterly - 4.99% term count = 33 _____ Annualized - 12.68% Quarterly - 3.16 % term count = 20	16.70%	11.80%	↓	Financial benefit - save cost of hiring, onboarding new employees / Workforce - maintaining quality of care through consistent workforce	Top Term Reasons: Resignation (91); Retirement, IRP and VSRP (76) 

Quarterly turnover rates are annualized to get a projected annual rate. Quarterly turnover rate is multiplied by 4 to calculate annualized rates.

HR Dashboard

Dashboard Item	Description	Current Qtr/FY Q3 FY26 (Jan 1 - Mar 30 2026)	Previous Qtr/FY Q2 FY26 (Oct 1 to Dec 31 2025)	Benchmark / Source	Target goal		Strategic Alignment	Details
NURSING Annual Turnover - (all) **Overall - Annualized/Qtrly** _____ **First Year - Annualized/Qtrly** _____ **Second Year - Annualized/Qtrly**	Number of Nursing separations divided by Number of Nursing Employees	Annualized - 11.00% Quarterly - 2.75% term count = 48 _____ Annualized - 25.73% Quarterly - 6.43% term count = 11 _____ Annualized - 15.79% Quarterly - 3.95% term count = 9	Annualized - 10.05% Quarterly - 2.51% term count = 44 _____ Annualized - 24.37% Quarterly - 6.09% term count = 12 _____ Annualized - 18.26% Quarterly - 4.56% term count = 11	16.70%	11.80%	↓	Financial benefit - save cost of hiring, onboarding new employees / Workforce - maintaining quality of care through consistent workforce	Reviewing data on top voluntary term reasons (from exit interview data); launched turnover dashboard to leaders in April; Launched exit interview dashboard in May 2023 to provide transparency to leaders. Sharing turnover data with AHS leadership at department meeting; conducted work group exercise to discuss turnover and retention strategies. Top Term Reasons: Resignation (24); Retirement, IRP and VSRP (15); HR Non-Compliance (3)
NURSING Annual Turnover - Voluntary Separations Only) **Overall - Annualized/Qtrly** _____ **First Year - Annualized/Qtrly** _____ **Second Year - Annualized/Qtrly**	Number of Nursing Voluntary separations divided by Number of Nursing Employees	Annualized - 9.86% Quarterly - 2.46% term count = 43 _____ Annualized - 25.73% Quarterly – 6.43% term count = 11 _____ Annualized – 14.04% Quarterly – 3.51% term count = 8	Annualized - 6.16% Quarterly - 1.54% term count = 27 _____ Annualized - 18.27% Quarterly - 4.57% term count = 9 _____ Annualized - 11.62% Quarterly - 2.90% term count = 7	16.70%	11.80%	↓	Financial benefit - save cost of hiring, onboarding new employees / Workforce - maintaining quality of care through consistent workforce	Top Term Reasons: Resignation (24); Retirement, IRP and VSRP (15) 

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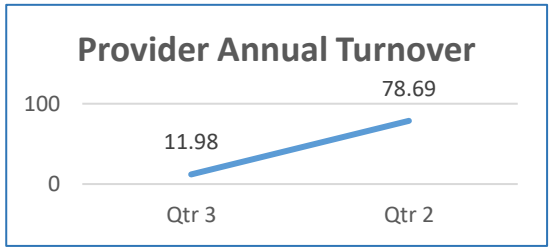
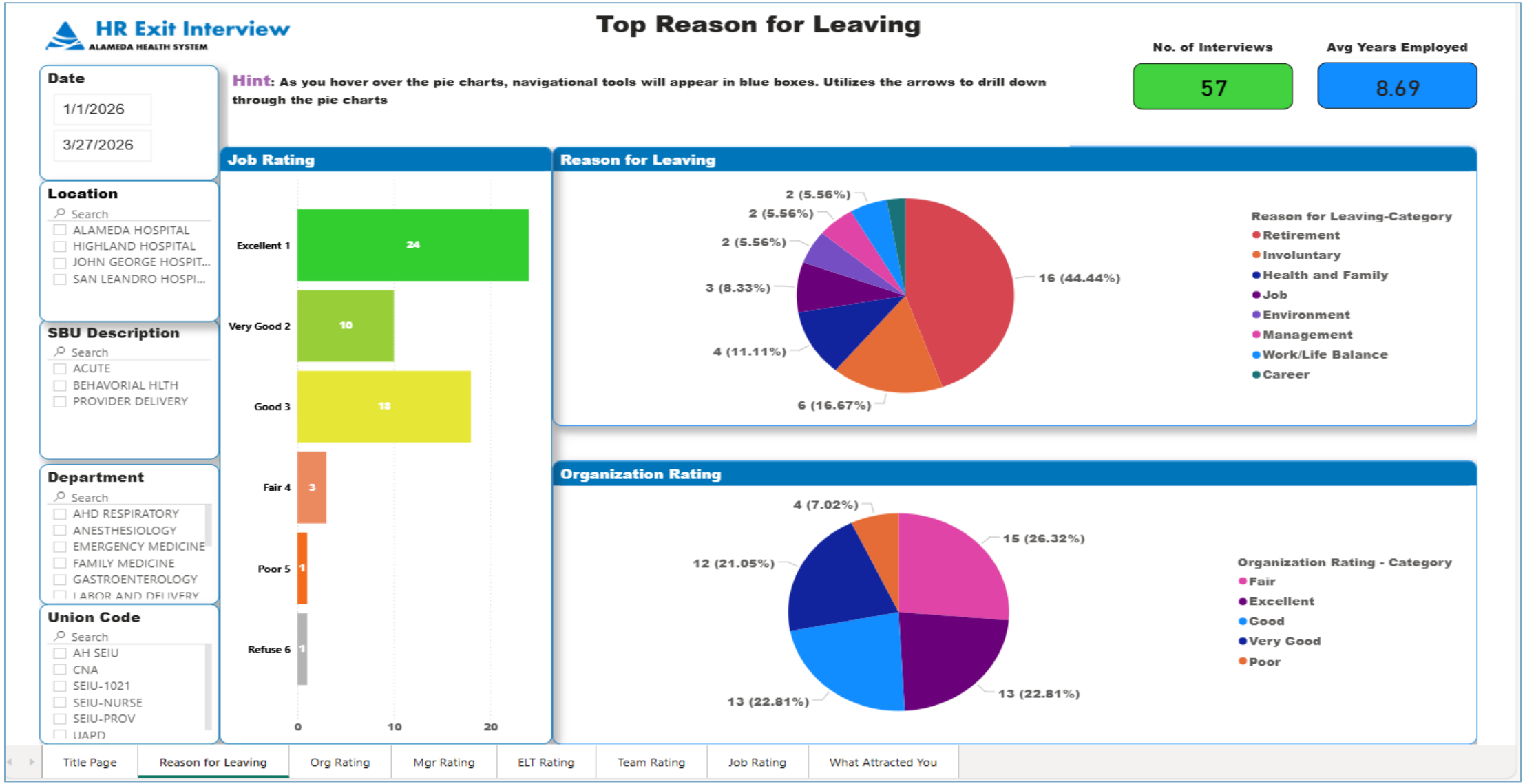
HR Dashboard

Dashboard Item	Description	Current Qtr/FY Q3 FY26 (Jan 1 - Mar 30 2026)	Previous Qtr/FY Q2 FY26 (Oct 1 to Dec 31 2025)	Benchmark / Source	Target goal		Strategic Alignment	Details
PROVIDERS Annual Turnover (excludes APPS) **Overall - Annualized/Qtrly** _____ **First Year - Annualized/Qtrly** _____ **Second Year - Annualized/Qtrly**	Number of Provider separations divided by Number of Provider Employees	Annualized - 11.98% Quarterly - 3.00% term count = 13 _____ Annualized - 0.00% Quarterly - 0.00% term count = 0 _____ Annualized - 43.75% Quarterly - 10.94% term count = 7	Annualized - 78.69% Quarterly – 19.67% term count = 24 _____ Annualized - 0.00% Quarterly – 0.00% term count = 0 _____ Annualized – 145.45% Quarterly – 36.36% term count = 8	16.70%	11.80%	↑	Financial benefit - save cost of hiring, onboarding new employees / Workforce - maintaining quality of care through consistent workforce	Reviewing data on top voluntary term reasons (from exit interview data); launched turnover dashboard to leaders in April; Launched exit interview dashboard in May 2023 to provide transparency to leaders. Sharing turnover data with AHS leadership at department meeting; conducted work group exercise to discuss turnover and retention strategies. Top Term Reasons: Resignation (10); HR Non-Compliance (1); Retirement and IRP (1)
PROVIDERS Annual Turnover (excludes APPS) Voluntary Separations Only **Overall - Annualized/Qtrly** _____ **First Year - Annualized/Qtrly** _____ **Second Year - Annualized/Qtrly**	Number of Provider Voluntary separations divided by Number of Provider Employees	Annualized - 11.06% Quarterly - 2.76% term count = 12 _____ Annualized - 0.00% Quarterly – 0.00% term count = 0 _____ Annualized – 37.50% Quarterly – 9.38% term count = 1	Annualized - 6.16% Quarterly - 1.54% term count = 27 _____ Annualized - 18.27% Quarterly - 4.57% term count = 9 _____ Annualized - 11.62% Quarterly - 2.90% term count = 7	16.70%	11.80%	↓	Financial benefit - save cost of hiring, onboarding new employees / Workforce - maintaining quality of care through consistent workforce	Top Term Reasons: Resignation (10); Retirement and IRP (1) 

Quarterly turnover rates are annualized to get a projected annual rate.
Quarterly turnover rate is multiplied by 4 to calculate annualized rates.

HR Exit Interview Dashboard

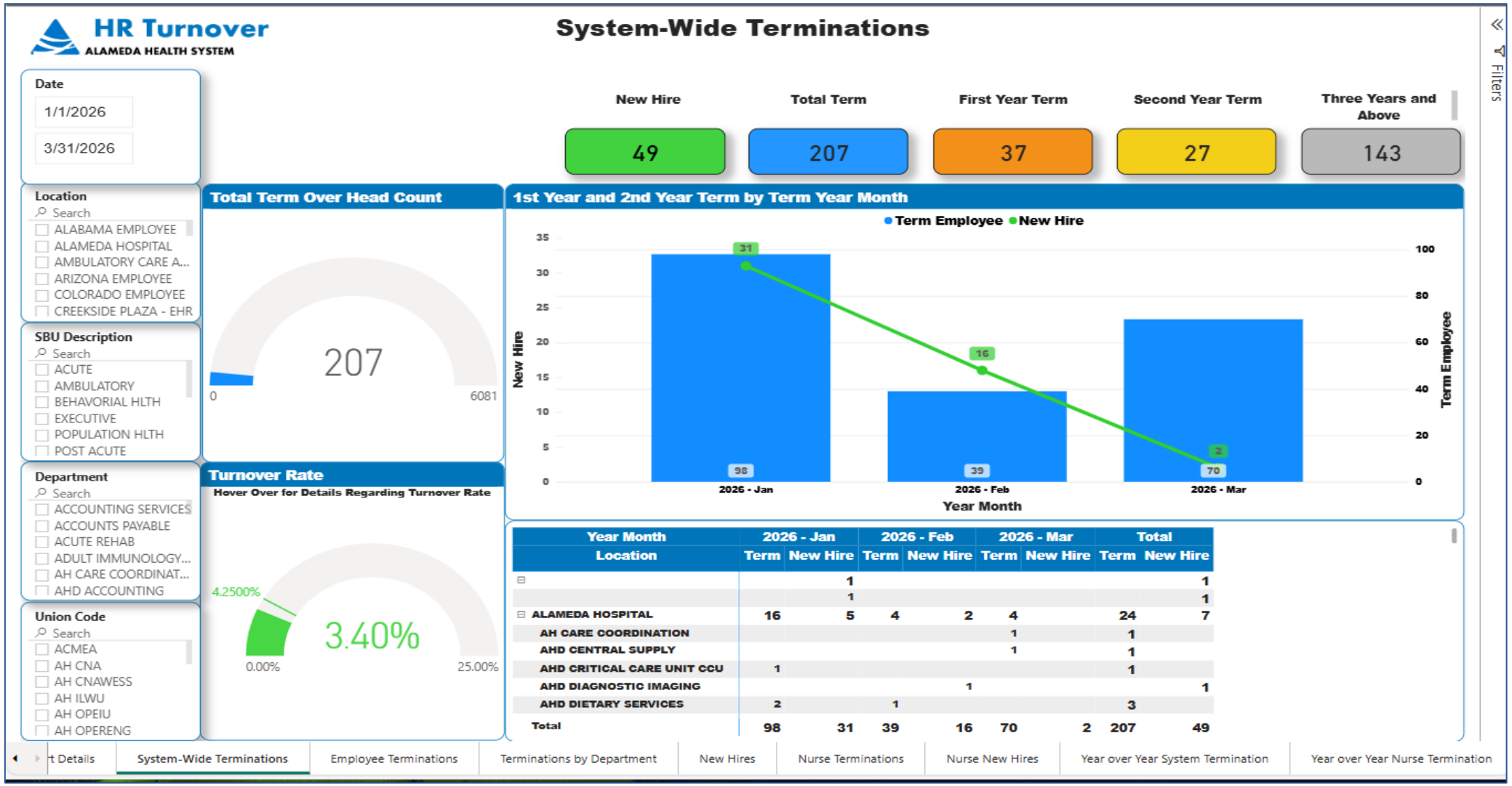


HR Dashboards

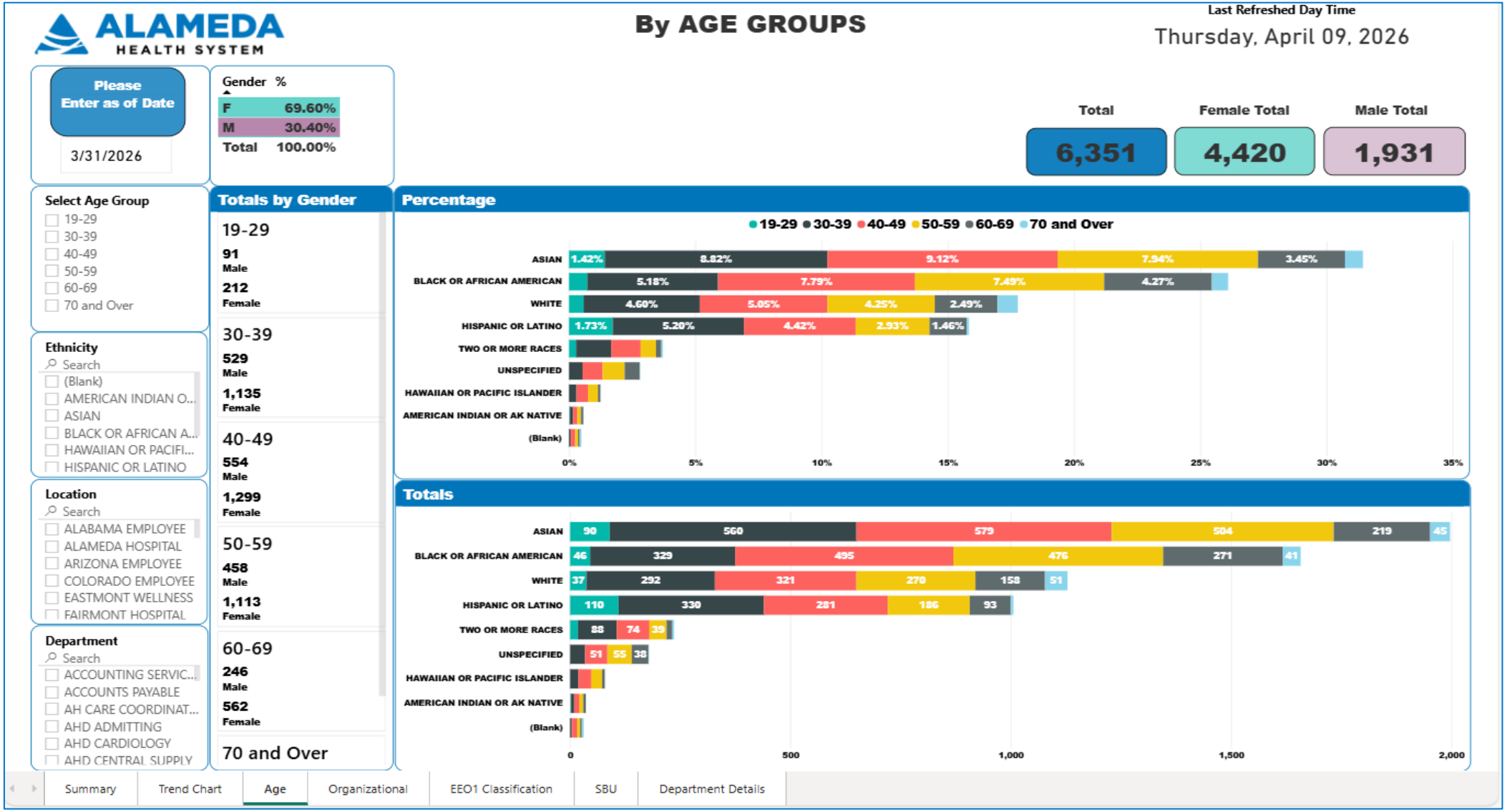
- Currently HR has 3 Dashboards
- Created with AHS Business Intelligence Team
- Access through AHS Connects (intranet page)
- HR Division
- Click on HR Dashboards

  - Diversity Dashboard – avail to all
  - Turnover Dashboard – limited to Manager and above
  - Exit Interview Dashboard – limited to Manager and above

HR Turnover Dashboard



HR Diversity Dashboard



CONSENT AGENDA: ACTION

BOARD OF TRUSTEES MEETING

WEDNESDAY, APRIL 8, 2026
5:00pm to 9:00pm

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

LOCATION:

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

MEMBERS

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

BOARD OF TRUSTEES MEETING MINUTES

THE MEETING WAS CALLED TO ORDER AT 5:06 pm

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

ABSENT: Lilavati Indulkar, MD

PUBLIC COMMENT:

Ana Liang spoke regarding shortages in the Departments of Anesthesia and Obstetrics and Gynecology. She requested the Trustees remain informed during these negotiations.

Shane Ruiz spoke regarding the AHS physicians' contract which was set to expire in three months. The critical shortage of physicians threatened the level one trauma status.

Aanchal Prakash said her department has suffered from RIFs, hiring freezes, and slowed hiring practices. They asked leadership to review their solutions and to engage in dialogue.

Melissa Myo and Stephanie Ho spoke regarding the chronically understaffed Obstetrics, Midwifery, and Gynecology department. The number of clinics currently staffed was down 50% and would be down 70% in July. They offered services that could not be found elsewhere. They had to refer patients to other facilities because of this crisis.

A. CEO REPORT

James E.T. Jackson, Chief Executive Officer

Trustee Sayen asked if the network outage that took place earlier that day had any impact on patient safety. Mr. Jackson said he wasn't aware of adverse patient outcomes as a result. It certainly impacted the ability to provide care. They had runners moving blood, they were using white boards and other downtime procedures. The downtime procedures worked.

Trustee Linton asked about the diversion from trauma. Mr. Jackson said two staff were out, and it took time to replace them. When two critical staff members call out it was an unanticipated event. While he agreed they had to do what was necessary to be adequately staffed, he hesitated to draw a line between the RIFs and that diversion. Dr. Perez said the usual staffing for the night shift was a physician anesthesiologist, a backup physician anesthesiologist, and two nurse anesthesiologists. The two nurse anesthesiologists called out.

Trustee Linton asked why it took 12 hours to find someone to come in. Mr. Fratzke said calls were made, but no one was able to come in. The night shift is a hardship. He wasn't sure if there was a call schedule staffed up or not. Dr. Perez said she believed the anesthesia service was currently thinly staffed and they were unable to provide a backup. Dr. Lang said when a team that should have 25 anesthesiologists were down to 15, you lose your buffer to pull people in. The situation that took place last week was the first time it has happened in her time at Highland. She said these conditions were created by decisions that were made. Four physicians in her department received RIF letters. One of them did not come back. Morale was low. People were not wanting to work above their commitment.

Trustee Linton asked about the status of the vacant positions. Dr. Lang said they needed a clear understanding of the FTE budget. They needed to continue to fill positions. It took year around work. She has not had much opportunity to work with Dr. Laurent on the situation. The positions have been approved for hiring. It does take about six months to actually get someone in the door. Trustee Linton said they needed to operationalize the goal and vision so they did not end up in this situation again.

Trustee Garrett asked if this could jeopardize the trauma certification. Mr. Jackson said it certainly would be part of the consideration.

Trustee Garrett asked Dr. Lang if she was part of the Trauma Center Certification Task Force. Dr. Lang said they had not started meeting yet, but she was hoping to participate.

Trustee Richman asked what was happening with the Behavioral Health money. Mr. Jackson said they had the contract with Behavioral Health. They have received assurances that they will have a 10% pullback for this fiscal year retroactive to the beginning of the year. That would offset the savings they would have realized if they had the RIF this fiscal year. The 20% withhold began in 2023 and AHS believed they should receive some portion of that after any denials have been addressed. The County is processing that now, though they have not issued a definitive answer.

B. MEDICAL STAFF REPORTS

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

Trustee Linton asked if the list of equipment noted by the MEC was included in the upcoming budget. Mr. Fratzke said the capital committee was receiving all the submissions. They will sit down and try to match strategy with capital. Much of the lab equipment was more replacement than strategic. Trustee Linton asked to see which of their recommendations has been funded and which has not been funded on the budget.

Trustee Garrett said the Board needed to set priorities which would then inform strategy.

C. COMMITTEE AND TRUSTEE REPORTS

C1. Audit and Compliance Committee: March 18, 2026
Sblend Sblendorio, Chair

C2. Quality Professional Services Committee: March 25, 2026
Lilavati Indulkar, MD, Trustee

C3. Finance Committee: April 1, 2026
Alan Fox, Trustee

D. CONSENT AGENDA: ACTION

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

D1. Approval of the Minutes of the March 11 Regular Meeting and the March 20-21 Special Meeting of the Board of Trustees.

D2. 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

D3. AHS and AH Medical Staff Policies and Procedures:

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

D4. Contracts

D4a. **Renewal agreement with Hyland Software, Inc. for provision of enterprise content management services. The term of this agreement is effective May 1, 2026 through April 30, 2029. The estimated impact of this agreement is $2,599,491.**
Christine Yang, Chief Information Officer

D4b. **Renewal agreement with Mission Linen Supply for provision of linen rental and cleaning services. The term of this agreement is effective May 1, 2026 through April 30, 2029. The estimated impact of this agreement is $13,325,000.**
Mark Fratzke, Chief Operating Officer

Moved by Trustee Fox and seconded by Obligacion Trustee 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: Trustees Alan Fox, Greg Garrett, Donna Linton, Nicholas Moss, MD, Nely Obligacion, Rachel Richman, David Sayen, and Sblend Sblendorio
NAYS: None
ABSTENTION: None

E. ACTION/DISCUSSION

Trustee Sayen asked if there was any public comment on agenda item E1. Ms. Jojola Gonsalves said there was not.

E1. ACTION/DISCUSSION: Approve a First Amendment to the Agreement on the Repayment of Alameda Health System Debt to the Consolidated Treasury (the March 2016 Permanent Agreement) to increase the fiscal year end Net Negative Balance (NNB) limit to $100 million for FY 2026 and FY 2027 and increase the intra year maximum from $50 million to $100 million for FY 2026 and FY 2027
James E.T. Jackson, Chief Executive Officer

Trustee Fox asked if there was understanding with the Supervisors that this was not the end of our negotiations, but they may want to continue to renegotiate. Mr. Jackson said his conversations with County staff have been that they are hopeful for more help with the net negative balance and the permanent agreement. Ms. Miranda said they were still planning to do the RIF when they negotiated this. If they were unable to get the budget to break even, they still have a $90M gap. Mr. Azizi said the letter they sent to the County included a request to open up the entire NNB.

Trustee Sayen asked if there was a prediction on how far the John George 10% withholding would fill the gap. Ms. Miranda said it was about $10M per year.

Moved by Trustee Sblendorio and seconded by Trustee Richman to approve the first amendment to the agreement on the repayment of Alameda Health System debt to the Consolidated Treasury (the March 2016 Permanent Agreement) to increase the fiscal year end Net Negative Balance (NNB) limit to $100 million for FY 2026 and FY 2027 and increase the intra year maximum from $50 million to $100 million for FY 2026 and FY 2027.

ACTION: A motion was made and seconded to approve the first amendment to the agreement on the repayment of Alameda Health System debt to the Consolidated Treasury (the March 2016 Permanent Agreement) to increase the fiscal year end Net Negative Balance (NNB) limit to $100 million for FY 2026 and FY 2027 and increase the intra year maximum from $50 million to $100 million for FY 2026 and FY 2027. A roll call was taken, and the motion passed.
AYES: Trustees Alan Fox, Greg Garrett, Donna Linton, Nicholas Moss, MD, Nely Obligacion, Rachel Richman, David Sayen, and Sblend Sblendorio
NAYS: None
ABSTENTION: None

E2. ACTION/DISCUSSION: FY 27 Preliminary Budget Update
Kim Miranda, Chief Financial Officer

Trustee Linton asked if any of the open positions that were not in the budget were related to the anesthesiologists discussed earlier or have the complement of staffing for the trauma center been included in the budget. Ms. Miranda said if they were there in February they were included. They sent this to every department leader, and they depended on the leaders to confirm what they needed. Mr. Fratzke said that Dr. Laurent has approved of the positions discussed. The next step in the budget process was to adjust the number of positions.

Trustee Garrett said it was huge to have entity based financials, even if they could not have service line financials. Ms. Miranda said within each entity they have captured the individual components, such as sub-acute, IOP, and SNF. Trustee Garrett said the progress was to be complimented. It was important because they needed to consider what service lines needed to be kept or reduced if they are lesser priorities. Without knowing what the service line budget was they would not be able to make those decisions as efficiently. Mr. Fratzke said they needed to make decisions based on what services were available in the community and who they could partner with as well as the financial aspect.

Trustee Obligacion said she needed to understand the changes that were made. There were items in the report that would generate savings and revenue, but they were removed when the packet was updated. Mr. Fratzke said this was still early in the process and the document would probably change daily.

Trustee Sayen said the attrition management set at $63M seemed really high. Ms. Miranda said the RIF was originally $73M. They still had the ad hoc process to go through. There was a lot of work still to be done. Mr. Fratzke said the attrition numbers had to be prorated throughout the year. It could not be done by July 1.

Trustee Obligacion said it was a problem when they put something out publicly then it all changed. They should not put it out there if they were not sure. She said they needed to be careful.

Trustee Fox said they could stamp “DRAFT” on every page.

Trustee Sayen said he felt like they didn’t have a financial plan to go forward. Ms. Miranda agreed. Mr. Jackson they had committed to the ad hoc process where they will listen to the County’s proposals and also bring their own proposals. If they could, in a collaborative way, find the things that can drive us to change, that’s how we can get a budget that works.

Trustee Obligacion said it did not help to see something that was public and might change. If they were not sure they shouldn’t put it out there. It was not good for trust.

Trustee Fox asked what plan B would be if the ad hoc committee did not yield $63.8M. Mr. Jackson said they have not had that conversation yet, but the RIFs were deferred, not turned off. Labor has said there may need to be a RIF, but they wanted to be more engaged.

Trustee Linton said they needed to be extraordinarily clear about the gap at the next ad hoc meeting and state clearly that they did not see incoming revenue that would offset those expenses. She was not sure how it could be done without RIFs. Both labor and the County Supervisors needed to understand the implications of what they were looking at.

Trustee Garrett said he understood that what was approved was that they postpone the RIFs and until June 30 or July 1. Unless some money comes out of the ad hoc process, those layoffs will occur without action by the BOT. He asked if those RIFs were in the budget. Ms. Miranda there were 24 people who were not coming back. They still had to work through the list of open positions. They would need to review the list of the positions to determine which ones would be laid off.

Trustee Sblendorio said the messaging has been not to labor's liking. Trustee Obligacion should help develop the messaging. They were $90M in the hole, 75% of the budget was labor. They needed to bridge that gap over the entire year.

Trustee Obligacion said she was concerned about when they put something out there it needed to be clearly communicated as a draft. It was a problem when they started changing things. Putting something out when they were not sure about was real was a problem.

Trustee Linton agreed that having a watermark that said "DRAFT" would be helpful. But they also needed the conversation to be that there was no malintent. She said there was a County or State statute that allowed for an August adoption of the budget, but on July 1, the existing budget would roll over. The issue would be if they needed to make reductions, they would have to go deeper with an August adoption. There was no easy way around a July 1 start. They needed to figure out how refined things would be on the dates listed on the budget calendar. Ms. Miranda said the ad hoc meetings would not wrap up until June. But there was some flexibility in the calendar. She was hoping for agreement on how to move forward.

Trustee Fox asked if they could roll the current year's budget into the department reports for July or July and August so managers would have something to hold to in their budgeting. Mr. Fratzke said if they didn't think, operationally that the schedule would work, then they would have to work on that and bring it back to the Board.

Trustee Sblendorio agreed that there was a messaging issue. But also, some of the words like, attrition, meant that people would retire or quit. But when they look at the $90M, that would be about a 5% reduction in labor. Even if our attrition was that high, it needed to be communicated that those spots would not be filled. But they know there are some departments that needed to be fully staffed, they needed to figure out what to do with attrition in those departments.

Trustee Sayen said they needed some options, such as what to get rid of, or find some money somewhere. Mr. Jackson said they needed to do both. They had to work in parallel paths and seek the money. They needed an orderly transitional path. Applying it in the blunt way they did before was not going to work. They needed to see what could be gained from the ad hoc committee and be prepared to make informed reductions to get us to the delta.

Trustee Fox asked what the timeline was for determining what services they would keep under the AHS banner. If by July 1st they know how many RIFs they had to do, it would be helpful to know that they couldn't touch ED, or the labs, but maybe these other departments could have RIFs.

Trustee Sayen said he would be inclined to go to the Health Committee with a budget that eliminates programs. And let them know if they want these programs AHS could not do it. We

could not do all these things. There were some things others needed to do. Ms. Miranda said realistically they've moved approval out to the end of July and once even until September. But this calendar did not make sense. Even if they rolled the RIF back, they wouldn't meet the gap.

Trustee Sblendorio said the consensus seemed to be a must have to do a census of what the people in Alameda County needed to have that were not that first level. Then the nice-to-have. The nice-to-have was then a challenge to work with other providers to see what they could provide and what we could cover. In essence, they would create a priority pyramid to indicate what they were required to have. But everything above that was open.

Trustee Linton said the physicians presented a framework of the specific services that would be needed for the patient population. It wasn't anything the Board adopted, but there was an opportunity to explore it further. They had to go forward and indicate what they thought they could fund. And then determine what had priority to be able to maintain with what they ended up with.

Trustee Garrett asked what the process was to develop those priorities.

Trustee Sblendorio said it would not likely happen for 2027. But they could at least give some thought to it and be able to have programs they could find partners for. Mr. Fratzke said they would be happy to do that. They were hesitant to do that as the Board has in dictated that they wanted to provide that guidance.

Trustee Moss asked if that meant staff would bring the Board a preliminary framework. Mr. Fratzke said yes. And the question would be where to present that. He asked if they should go to the ad hoc with it.

Trustee Sblendorio said they should all agree on what they are legally required to provide to keep their certifications. Everything beyond that is what they needed the framework for.

Trustee Sayen suggested the JCC could be a place to start. Mr. Fratzke said they could get a draft going soon and start working with the Medical Staff.

Trustee Garrett asked for management's response to labor's top areas where reductions or revenue increases could occur. The Board of Trustees should see that before the ad hoc sees it. Mr. Jackson said they would not have a meeting prior to the next ad hoc meeting. But they could share it.

E3. ACTION/DISCUSSION: Adoption of Resolution of Commitment to Trauma Care

Trustee Sayen asked if there was any public comment on agenda item E3. Ms. Jojola Gonsalves said there was not.

Trustee Richman asked if the resolution called for working with an existing committee or a new committee. Mr. Azizi said there was an existing committee.

Moved by Trustee Linton and seconded by Trustee Richman to adopt the Resolution of Commitment to Trauma Care.

ACTION: A motion was made and seconded to adopt the Resolution of Commitment to Trauma Care. A roll call was taken, and the motion passed.
AYES: Trustees Alan Fox, Greg Garrett, Donna Linton, Nicholas Moss, MD, Nely Obligacion, Rachel Richman, David Sayen, and Sblend Sblendorio
NAYS: None
ABSTENTION: None

F. DISCUSSION: Board Calendar and Tracking

Trustee Garrett said he would like to see a report in the future on reopening the ambulatory care clinics.

Trustee Linton asked for an update on the legislation on governance. She would also like to review the priority list, the criteria that was being used for the development of the budget. Ms. Miranda said they reviewed the guiding principles.

Trustee Sayen said it would be worthwhile to get information on the compensation and bonus programs of other institutions. It would help ensure they were not being excessive. Mr. Jackson said he welcomes the conversations. There have been accusations that millions of dollars in bonuses were handed out to executives, which was patently false. It was the entirety of the unrepresented staff who received those bonuses. They were discussing that with the ad hoc committee. And they were not planning on having bonuses this year. But they needed to stay competitive in the marketplace.

Mr. Azizi announced that there would not be a closed session.

CLOSED SESSION

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

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

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

ADJOURNMENT 7:52pm

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

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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

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

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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

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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

ALAMEDA HEALTH SYSTEM	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.

ALAMEDA HEALTH SYSTEM	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.

ALAMEDA HEALTH SYSTEM	Policy	
	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.

ALAMEDA HEALTH SYSTEM	Policy	
	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

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

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.

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

ALAMEDA HEALTH SYSTEM	Policy	
	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,

[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

[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

ALAMEDA HEALTH SYSTEM	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)

ALAMEDA HEALTH SYSTEM	Policy	
	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)

ALAMEDA HEALTH SYSTEM	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

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)

ALAMEDA HEALTH SYSTEM	Policy	
	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)

ALAMEDA HEALTH SYSTEM	Policy	
	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. Parking Validations (Wilma Chan Highland Hospital Campus) 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. Parking Time-limit Restrictions - 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.

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

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

	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)

	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	

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.

	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	

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.

	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

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

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

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

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

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,

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.

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

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

ALAMEDA HEALTH SYSTEM	Policy	
	Food and Nutrition Services: Clinical Nutrition Neonatal Initial Assessment and Prioritization	**29623 2**
	LEVEL [x] 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:

- 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

- 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

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

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:**

	Policy	
	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

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**		

	Policy	
ALAMEDA HEALTH SYSTEM	**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**		

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: _

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

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 recommendations, 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**

Alameda Health System

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:

Refill Clinic Supervisor: 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

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

1) Lip GYH, Banerjee A, Boriani G, Chiang CE, Fargo R, et al. Antithrombotic Therapy for Atrial Fibrillation: CHEST Guideline and Expert Panel Report. Chest. 2018;154(5):1121-1201. doi: 10.1016/j.chest.2018.07.040.
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.
3) Douketis JD, Lip GYH. Perioperative management of patients receiving anticoagulants. Leung LLK, ed. UpToDate. Waltham, MA: UpToDate Inc. http://www.uptodate.com. Accessed January 26, 2019.
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5) McCaughan GJB, Favaloro EJ, Paslic L, Curnow J. Anticoagulation at the extremes of body weight: choices and dosing. Expert Review of Hematology. 2018;11:817-828.
6) Tittl L, Endig S, Marten S, et al. Impact of BMI on clinical outcomes of NOAC therapy in daily care – Results of the prospective Dresden NOAC Registry. International Journal of Cardiology. 2018;262:85-91.
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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**	

	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	

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	
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	

- 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.

	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**		

ALAMEDA HEALTH SYSTEM

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

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.

References

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**		

ALAMEDA HEALTH SYSTEM

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

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

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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

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	
	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.

	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	
	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	**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	
	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.

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	

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).

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

	Procedure	
ALAMEDA HEALTH SYSTEM	**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: _____

	Procedure FBC NURSE STANDARDIZED PROCEDURE FOR NEWBORN ADMISSION ORDER ENTRR	
ALAMEDA HEALTH SYSTEM	**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.

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		

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

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

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

APPENDIX B

ALAMEDA HEALTH SYSTEM | Highland Hospital

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.			

ALAMEDA HEALTH SYSTEM | Highland Hospital

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**

Page 2 of 2

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

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

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.

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

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

Purpose

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

Policy Statement

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

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

Credentialing is required for all physicians (medical or osteopathic), dentists, podiatrists, or clinical psychologists as well as those advanced practice providers approved by the Board of

Trustees, which include acupuncturists, audiologists, optometrists, nurse practitioners, certified registered nurse anesthetists, certified nurse midwives and physician assistants.

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

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

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

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

18. Timeliness of Information
    The established processing time is estimated at 60-90 days following receipt of completed application. Applications for Behavioral Health providers will be assessed for completion and verification of qualifications within 60 days of receipt of an application. Such applicants will be notified within seven (7) business days of receipt and confirmation of whether the

application is complete. An application must be signed within 120 days of Credentials Committee review. The attestation must be signed within 180 days of Credentials Committee review. Verification of licensure, board certification, sanctions, current work history, malpractice claims history must be verified within 120 days of Credentials Committee review.

Requests for Modification of Privileges

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

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

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

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

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

Appointment/Privilege Approval Notifications

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

Application Fees

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

1. Medical Staff Fees:
   a. AHS/AH application fee for Temporary Privileges 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.

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

Approvals:

		AHS	AH
Credentials Committee	**Date:**	**4/9/26**	
Medical Executive Committee	**Date:**	**4/15/26**	**4/17/26**
QPSC	**Date:**	**4/22/26**	
Board of Trustees	**Date:**	**5/13/26**	

Medical Staff Credentialing and Privileging of Providers
Attachment A

The email templates below will be used as reminders and final notices.

First reminder to provider (*if reappointment application was not submitted after 10 days of invitation*):

> *Subject: **Action Needed** Application for Reappointment Alameda Health System and/or Alameda Hospital*
>
> *Dear <Full Name>,*
>
> *Please consider this a friendly reminder that your application for reappointment to the Alameda Health System and/or Alameda Hospital Medical Staff has not been received. Please submit this information to Medical Staff Services using the below link to access the application portal:*
>
> *https://onlineapp.alamedahealthsystem.org/PractitionerPortal/Login.aspx?ReturnUrl=%2fPractitionerPortal%2fmain.aspx*
>
> *Per the Medical Staff Bylaws, failure to submit a completed application for reappointment with all supporting or requested documentation shall result in automatic termination of your Medical Staff Membership and/or Privileges.*

Second/Third reminders to provider, copied to chief and chair (*if reappointment application was not submitted after 20 days/30 days of invitation*):

> *Subject: **Action Needed - 2nd (or 3rd) Reminder** - Application for Reappointment AHS / AH*
>
> *Dear <Full Name>,*
>
> *This is a second reminder to notify that your application for reappointment to the Alameda Health System/Alameda Hospital Medical Staff has not been received. It has been 20 (or 30) days since the initial notification to apply for reappointment was sent. Your application for reappointment is due within 35 days from the date of initial notification. Should your application not be submitted, it will be considered a voluntary resignation of medical staff membership and privileges at Alameda Health System/Alameda Hospital.*
>
> *Following voluntary resignation, you will be required to reapply for membership and privileges via initial application for appointment. If you have any questions, please contact Medical Staff Services at Alameda Health System/Alameda Hospital.*
>
> *If you wish to maintain your membership and privileges, please submit the application using the below link to access the Practitioner Portal:*

https://onlineapp.alamedahealthsystem.org/PractitionerPortal/Login.aspx?ReturnUrl=%2fPractitionerPortal%2fmain.aspx

**Note: Mozilla Firefox Browser is NOT supported by the vendor. Please do not attempt to complete your application using this browser.*

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

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

Dear (insert provider's name),

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

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

- First reminder – *[enter month/date/year]*
- Second reminder - *[enter month/date/year]*
- Third reminder – *[enter month/date/year]*

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

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

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

Please contact your Department Chair regarding the above.

Partial Action on Application for Reappointment: *Used if the application has been started but was not completed/submitted.*

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

Dear (insert provider's name)

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

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**	

Contract Approvals
May 2026

1) Agreement with Contra Costa Pathology Associates for provision of anatomic pathology and histology laboratory services. The term of this agreement is effective May 20, 2026 through May 19, 2029. The estimated impact of this agreement is $2,700,000.
Mark Fratzke, Chief Operating Officer

2) Renewal agreement with Quest Diagnostics for provision of reference laboratory testing services. The term of this agreement is effective June 1, 2026 through May 31, 2033. The estimated impact of this agreement is $25,619,650.
Mark Fratzke, Chief Operating Officer

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

Contractor/Vendor Name:	Contra Costa Pathology Associates ("CCPA")
Description:	Alameda Health System ("AHS") seeks to enter into a three-year agreement, in the total amount of $2,700,000, with Contra Costa Pathology Associates ("CCPA"), a California-based provider specializing in anatomic pathology and histology laboratory services. This agreement follows the recent acquisition of AHS' prior reference laboratory (IMB-Path), which discontinued local histology services with limited notice, necessitating an expedited transition to maintain continuity of care. CCPA provides comprehensive technical pathology support to healthcare systems, including advanced laboratory capabilities and experienced histotechnologists. Their infrastructure and expertise allow them to deliver high-quality, consistent, and compliant histology services at large. Under this agreement, CCPA will provide outsourced anatomic pathology technical ("Histology") services for AHS, including receipt and tracking of tissue cassettes, tissue processing, embedding, microtomy, slide preparation, routine hematoxylin and eosin ("H&E") staining, additional levels and recuts, special stains, and immunohistochemistry ("IHC"), as well as technical support for tumor IHC analysis. CCPA will also be responsible for quality control, labeling, packaging, and delivery of completed slides back to AHS, where AHS pathologists will perform the final diagnostic interpretation. AHS is now seeking to enter into this agreement to ensure continuity, reliability, and timeliness of critical pathology services, particularly in light of the IMD-PSI local lab closure and the increasing demand for histology and IHC services. Outsourcing these technical components allows AHS to maintain consistent turnaround times for diagnostic materials, reduce operational strain on internal laboratory resources, and avoid potential delays in patient diagnosis and treatment. By leveraging CCPA's specialized expertise and established processes, AHS can ensure that all histology services are performed in accordance with industry standards and regulatory requirements. Additionally, partnering with CCPA provides an efficient solution that supports AHS's broader clinical and operational goals. This arrangement allows AHS to focus internal resources on diagnostic and patient-facing activities while relying on a trusted vendor for the technical preparation of slides. The agreement ultimately enhances patient care by ensuring accurate, timely, and high-quality pathology services, while also providing operational stability and predictability over the three-year term.
Contract Type and Term:	Statement of Work 05/20/2026 through 5/19/2029
Termination Clause:	Either Party may terminate this Agreement without cause and without further liability by providing sixty (60) days' notice, in writing, to the other Party.

Board of Trustees Contract Summary | 2026

<table>
<tr><td>Total Spend with Vendor:</td><td>
<table>
<tr><th>Description</th><th>Board Approval</th><th>Total</th></tr>
<tr><td>Anatomic Pathology Technical Services</td><td>$2,700,000</td><td>$2,700,000</td></tr>
<tr><td>Total Requested Amount:</td><td>Approval Requested</td><td>$2,700,000</td></tr>
</table>
</td></tr>
<tr><td>Cost Savings:</td><td>Financially, the agreement provides a favorable cost structure compared to the prior vendor. AHS' previous annual spend was approximately $970,000; under this agreement, projected annual spend is approximately $900,000, resulting in estimated savings of $70,000 annually and $210,000 over the three-year term. Additional savings are anticipated due to significantly lower IHC pricing, which is approximately 48% less than prior rates, and is expected to drive further cost reductions based on projected volumes.</td></tr>
<tr><td>Fiscal Implications:</td><td>Included in FY 26 budget.</td></tr>
<tr><td>Reasons for Recommendation:</td><td>AHS recommends partnering with CCPA because it provides a reliable and scalable solution to support critical histology services amid internal capacity constraints, ensuring consistent turnaround times and high-quality diagnostic support. In addition, the agreement offers a more favorable cost structure and improved pricing for key services, supporting AHS's goal of maintaining operational efficiency while delivering high standards of patient care.</td></tr>
<tr><td>Impacted Facilities:</td><td>
<table>
<tr><th>JGPH</th><th>Highland</th><th>Fairmont</th><th>San Leandro</th><th>Alameda</th><th>Clinic(s)</th></tr>
<tr><td>X</td><td>X</td><td>X</td><td>X</td><td>X</td><td>X</td></tr>
</table>
</td></tr>
<tr><td>Coordination with Medical Staff:</td><td>This agreement was reviewed and approved by the Department Chair of Laboratory Medicine & Pathology</td></tr>
<tr><td>Administrative Review:</td><td>System Director, Clinical Lab Operations</td></tr>
<tr><td>Prior BOT Review/Action:</td><td>N/A</td></tr>
<tr><td>Executive Sponsor</td><td>Chief Operating Officer</td></tr>
</table>

Contractor/Vendor Name:	Quest Diagnostics ("Quest")
Description	In 2019, Alameda Health System ("AHS") entered into a system-wide agreement ("Current Agreement") with Quest for esoteric laboratory testing—low-volume, highly specialized assays such as genetic, molecular, oncology, immunology, and specialty infectious disease testing. These diagnostics are essential to patient care but are not feasible to perform in-house due to the significant capital investment, facility modifications, and specialized personnel required. The Current Agreement was executed in conjunction with our group purchasing organization partner ("Vizient"). This has ensured continued access to these essential advanced services while avoiding substantial startup and ongoing operational costs, making outsourcing the most cost-effective and operationally sound approach. Given the importance of retaining these essential services and in light of the reliable performance of the incumbent, AHS leadership is proposing to enter into a renewal agreement ("Renewal") with an initial 3-year term ("Initial Term") followed by 2 optional 2-year automatic renewal periods ("Auto-Renewal Terms"). • Proven Quality and Compliance – Quest maintains several regulatory accreditations, delivering high-quality, accurate, and defensible results necessary to care for AHS patients. • Large Cost Savings – Quest has agreed to significant price reductions, which would amount to an estimated $499,404 annual savings or $3,495,828 over the course of the 7-year agreement for AHS. • Price Stability – Quest maintains Vizient GPO supplier status, qualifying all AHS spend for an annual share-back, and provides AHS with reduced locked-in pricing for the 7-year term. • Established Logistics – Quest has courier routes in place across AHS Labs (WCHHC, SLH, ALH) for timely, efficient specimen transport. • Seamless Data Integration – Quest has an existing bi-directional interface with AHS through Epic for orders and results, ensuring accurate, secure, streamlined data exchange. In light of the above and based on past and projected utilization, and utilization savings, AHS leadership is requesting Board approval to enter the proposed Renewal.
Contract Type and Term:	Vizient End User Agreement to Reference Lab Testing Agreement with Quest Initial Term: June 1, 2026 – May 31, 2029 Auto-Renewal period 1: June 1, 2029 – May 31, 2031 Auto-Renewal period 2: June 1, 2031 – May 31, 2033
Termination Clause:	Without Cause: The agreement may be terminated by either party upon 90 days' written notice to the other party prior to the expiration of the Initial Term or a Renewal Term.

<table>
<tr><td>Total Spend with Vendor:</td><td>
<table>
<tr><th>Description</th><th>Board Approval</th><th>Total</th></tr>
<tr><td>Initial Term (June 1, 2026 – May 31, 2029)</td><td></td><td>$10,979,850</td></tr>
<tr><td>Renewal (June 1, 2029 – May 31, 2031)</td><td></td><td>$7,319,900</td></tr>
<tr><td>Renewal (June 1, 2031 – May 31, 2033)</td><td></td><td>$7,319,900</td></tr>
<tr><td>Total Estimated Spend</td><td>Approval Requested</td><td>$25,619,650</td></tr>
</table>
</td></tr>
<tr><td>Estimated Cost Savings:</td><td>AHS realizes two categories of cost savings under the Current Agreement: 1) direct contractual savings, and 2) share back (AHS portion of GPO-negotiated vendor discount). Total cost savings over the 7-year term is $3,495,829.</td></tr>
<tr><td>Fiscal Implications:</td><td>Included in FY 26 budget.</td></tr>
<tr><td>Reasons for Recommendation:</td><td>Allows for full funding of a key services agreement ensuring uninterrupted provision of services through the term of the agreement.</td></tr>
<tr><td>Impacted Facilities:</td><td>
<table>
<tr><th>AHS</th><th>JGPH</th><th>Highland</th><th>Fairmont</th><th>San Leandro</th><th>Alameda</th><th>SNFs</th></tr>
<tr><td>X</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
</table>
</td></tr>
<tr><td>Coordination with Medical Staff:</td><td>The Current Agreement was reviewed and approved by the Department Chair of Laboratory Medicine & Pathology.</td></tr>
<tr><td>Administrative Review:</td><td>System Director, Clinical Laboratory Services</td></tr>
<tr><td>Prior BOT Review/Action:</td><td>The Board of Trustees approved the Current Agreement on September November 10, 2025.</td></tr>
<tr><td>Executive Sponsor:</td><td>Chief Operating Officer</td></tr>
</table>

ALAMEDA HEALTH SYSTEM

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

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

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

24	Fisher Scientific Company LLC dba Fisher Healthcare	$6,600,000	4/1/2026	3/31/2029	FC - 3-4-26 BOT Approved 3-11-26	Laboratory supplies		Chief Operating Officer
25	Hill-Rom Company, Inc.	$1,430,000	3/12/2026	3/11/2027	FC - 3-4-26 BOT Approved 3-11-26	Replacement nurse call system for SNFs		Chief Operating Officer
26	Hyland Software, Inc.	$2,599,491	5/1/2026	4/30/2029	FC - 4-1-26 BOT Approved 4-8-26	Provision of enterprise content management services		Chief Information Officer
27	Mission Linen Supply	$13,325,000	5/1/2026	4/30/2029	FC - 4-1-26 BOT Approved 4-8-26	Provision of linen rental and laundry services.		Chief Operating Officer
	Total Amount for FY 26 year to date	$559,509,167						

DISCUSSION: FY 2027 Preliminary Budget

ALAMEDA HEALTH SYSTEM

FY 27 Preliminary Budget Update
Board of Trustees

Kimberly Miranda
May 13, 2026

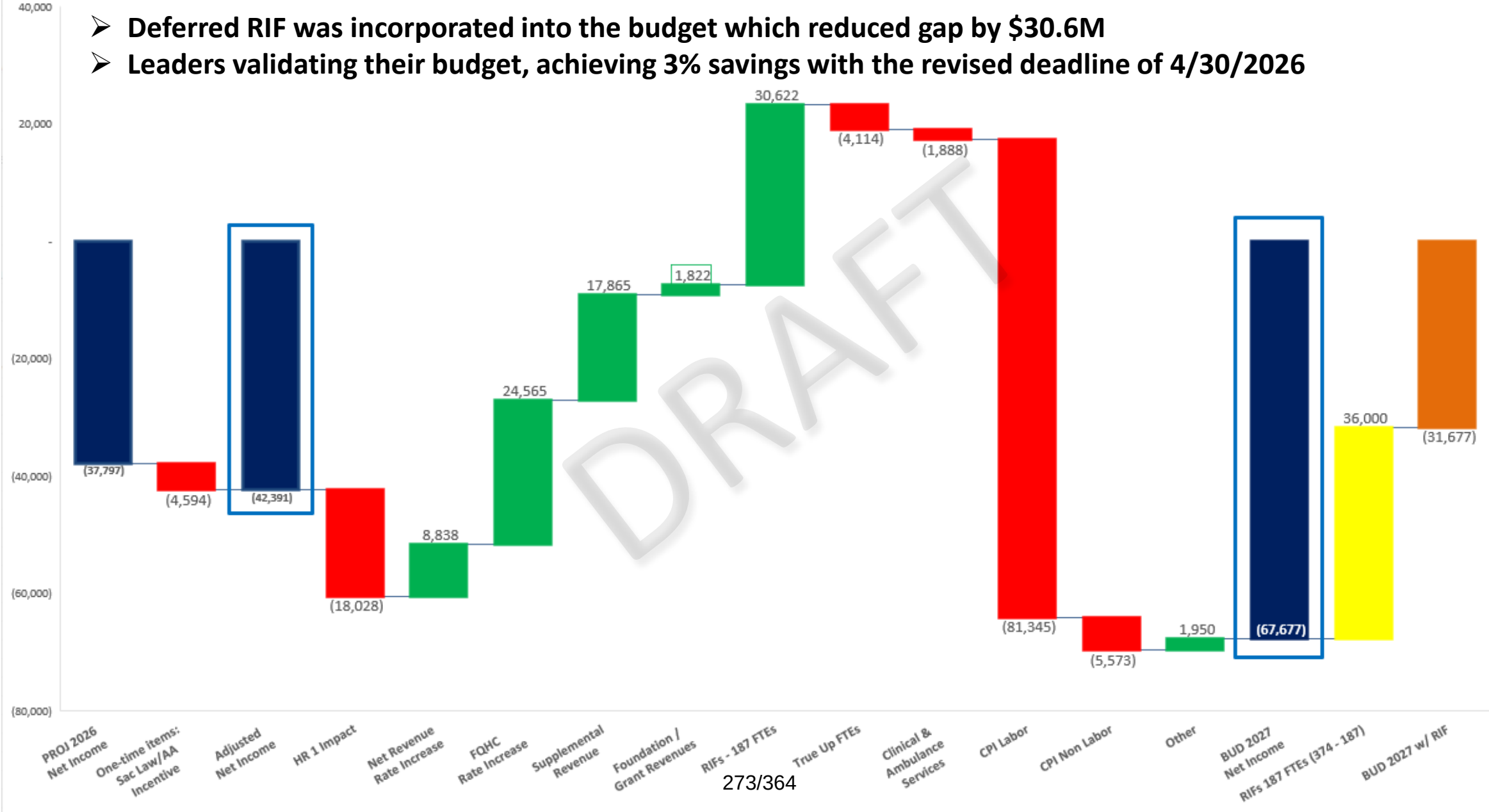
Budget Calendar

Tasks	Responsibility	Target Due Date
Preliminary Budget Status Update for Finance Committee (FC)	Chief Financial Officer	5/6/2026 Post 5/1/2026
AdHoc Committee Meeting	Executive Leadership	5/6/2026
Preliminary Budget Status Update for Board of Trustees (BOT)	Chief Financial Officer	5/13/2026 Post 5/8/2026
Vetting and finalizing Preliminary Capital Budget	Capital Committee	5/20/2026
Complete department reviews; Incorporate adjustments in Strata Incorporate Performance Improvement Initiatives Preparation of Preliminary Budget Update for FC and BOT	Department Leaders / COT / Finance Department	4/27 - 5/25/2026
Preliminary Budget Status Update for Executive Operations Team	Chief Financial Officer	5/26/2026
Preliminary Budget Status Update to the Finance Committee	Chief Financial Officer	6/3/2026 Post 5/29/2026
Preliminary Budget Status Update to Board of Supervisors: Health Committee	Chief Financial Officer	6/8/2026
AdHoc Committee Meeting	Executive Leadership	6/8/2026
Preliminary Budget Status Update the Co-Applicant Board (CAB)	Chief Financial Officer	6/9/2026 Post 6/2/2026
Preliminary Budget Status Update to the Board of Trustees	Chief Financial Officer	6/10/2026 Post 6/5/2026
Finance Committee & Board of Trustees Approval 272/364	Finance Committee & Board of Trustees	TBD

ALAMEDA HEALTH SYSTEM

Updated Net Income Roll Forward / Reconciliation

- **Deferred RIF was incorporated into the budget which reduced gap by $30.6M**
- **Leaders validating their budget, achieving 3% savings with the revised deadline of 4/30/2026**



Preliminary Budget as of 4/30/2026

(in thousands)	Actual 2025	Projection 2026	Budget 2027	Variance Proj2026 vs Budget 2027	% Variance (Proj 2026 vs. Budget2027)
Operating Revenue ----------					
Net Patient Revenue	$ 942,426	$ 970,539	$ 988,774	$ 18,236	1.9%
Capitation Revenue	55,600	53,599	53,601	2	0.0%
Other Government Programs	563,927	530,716	541,080	10,365	2.0%
Other Revenues	63,966	72,500	70,264	(2,236)	-3.1%
Total Revenue - All Sources	**$ 1,625,920**	**$ 1,627,353**	**$ 1,653,720**	**$ 26,366**	**1.6%**
Collection %	***19.6%***	***19.4%***	***19.4%***	***0.0%***	
Operating Expenses ----------					
Salaries & Wages	$ 675,936	$ 732,135	$ 752,548	20,412	2.8%
Salaries & Wages (Providers)	150,009	155,329	165,093	9,764	6.3%
Registry	52,211	39,924	36,344	(3,580)	-9.0%
Physician Contract Services	41,338	45,084	42,819	(2,265)	-5.0%
Employee Benefits (Taxes, Ins)	196,870	202,404	219,023	16,619	8.2%
Retirement	96,797	98,709	104,340	5,631	5.7%
Total Labor Expenses	**$ 1,213,161**	**$ 1,273,586**	**$ 1,320,167**	**$ 46,581**	**3.7%**
Purchased Services	$ 105,279	$ 105,072	$ 108,780	3,707	3.5%
Materials and Supplies	154,414	167,472	171,182	3,709	2.2%
Facilities	41,248	44,851	46,258	1,407	3.1%
Depreciation & Amortization	37,542	28,304	28,153	(151)	-0.5%
General and Administration	53,335	42,013	43,006	993	2.4%
Total Non-Labor Expenses	**$ 391,817**	**$ 387,713**	**$ 397,378**	**$ 9,665**	**2.5%**
Total Operating Expenses	**$ 1,604,978**	**$ 1,661,298**	**$ 1,717,545**	**$ 56,246**	**3.4%**
Operating Income (Loss)	***$ 20,941***	***$ (33,945)***	***$ (63,825)***	***$ (29,880)***	**88.0%**

Preliminary Budget

(in thousands)	Actual 2025	Projection 2026	Budget 2027	Variance Proj2026 vs Budget 2027	% Variance (Proj 2026 vs. Budget2027)
Non-Operating Activity ----------					
Interest Income (Expense)	$ 2,899	$ (3,860)	$ (3,860)	(0)	0.0%
Other nonoperating Revenue	(253)	8	8	(0)	0.0%
Total Non Operating Activity	**$ 3,152**	**$ (3,852)**	**$ (3,852)**	**$ (0)**	**0.0%**
Net Income (Loss)	**$ 17,790**	**$ (37,797)**	**$ (67,677)**	**$ (29,880)**	**79.1%**
EBIDA Adjustments					
Interest Income (Expense)	$ 2,899	$ 3,860	$ 3,860	0	0.0%
Depreciation & Amortization	37,542	28,304	28,153	(151)	-0.5%
Amortization (GASB-68, GASB-75)*	160	-	-	-	
Total EBIDA Adjustments	**$ 40,601**	**$ 32,164**	**$ 32,013**	**$ (151)**	**-0.5%**
EBIDA	**$ 58,390**	**$ (5,633)**	**$ (35,664)**	**$ (30,031)**	**533.2%**
Operating Margin	1.3%	-2.1%	-3.9%	-1.8%	
EBIDA %	3.6%	-0.3%	-2.2%	-1.8%	
FTEs	**5,166**	**5,204**	**5,026**	**(178)**	**-3.4%**
Salaries per FTE (incl Registry)	**$ 169,975**	**$ 178,207**	**$ 189,810**	**$ 11,603**	**6.5%**
Adjusted Patient Days	**364,454**	**368,736**	**368,097**	**(639)**	**-0.2%**

- *Projection 2026 reflects FY2026 Feb Actual Annualized, adjusted for Other Government Supplementals based on current information available*

Budget Changes from Department Leaders – In Process

- Leaders have reviewed and submitted budget adjustments for both labor and non-labor items, as outlined below; however, these changes have not yet been incorporated into the financials presented. Efforts are ongoing to achieve the target of 3% non-labor savings.

Expense Category	FTE	Add/Reduction
FTE adjustments hired staff, run rate	(4.0)	($0.8M)
Insurance for Property, Bond, Crime: updated estimate from vendor		1.3M
IS Software Applications (ie Track Mgr, Careport, CounselLink, CyberSecurity)		1.5M
Pharmacy equipment related (i.e Pyxis) maintenance contract		0.4M
Pharmaceuticals for new EWC Dental, Marina Specialty		0.3M
Depreciation Expenses		0.3M
Other, Misc.		0.2M
3% Non Labor Savings		(8.6M)
Total	**(4.0)**	**($5.4M)**

Entity Financials by Service Line

Entity Financial Statement - Summary

In Thousands	ALAMEDA	FAIRMONT	FQ CLINIC	HIGHLAND	JOHN GEORGE	SAN LEANDRO	SYSTEM OVERHEAD	Grand Total
Operating Revenue ----------								
Net Patient Revenue	128,630	30,488	134,561	467,181	96,645	131,270	-	988,774
Capitation Revenue	2,213	388	17,383	25,991	-	7,625	-	53,601
Other Government Programs	34,451	9,646	112	118,579	-	25,287	-	188,075
Other Revenues	1,091	763	1,612	64,710	754	1,334	-	70,264
Total Revenue - All Sources	**166,385**	**41,285**	**153,669**	**676,461**	**97,399**	**165,516**	**-**	**1,300,715**
Projected 2026 Total Revenue	*164,727*	*41,347*	*124,096*	*703,385*	*96,124*	*166,766*	*223*	*1,296,668*
Collection %	***15.9%***	***23.0%***	***59.6%***	***16.7%***	***30.1%***	***15.9%***		***19.4%***
Projected 2026 Collection %	*16.0%*	*18.9%*	*48.7%*	*17.6%*	*31.6%*	*16.3%*		*19.4%*
Operating Expenses ----------								
Salaries & Benefits	130,478	48,813	91,045	453,096	90,929	118,071	179,824	1,112,255
Purchased Services	7,528	2,409	1,595	35,169	3,837	6,314	51,927	108,780
Contracted and Provider	6,572	1,776	47,688	107,526	19,588	23,859	903	207,912
Materials and Supplies	11,999	4,441	7,309	126,801	1,921	16,996	1,713	171,182
Facilities	7,108	3,092	2,001	17,743	2,183	4,167	9,963	46,258
Depreciation	4,721	449	3,789	4,522	323	3,234	11,114	28,153
General & Administration	474	99	213	1,908	45	325	39,942	43,006
Total Operating Expenses	**168,881**	**61,081**	**153,641**	**746,764**	**118,827**	**172,965**	**295,386**	**1,717,545**
Projected 2026 Total Operating Expenses	*157,369*	*64,236*	*129,769*	*738,616*	*113,666*	*161,541*	*296,102*	*1,661,298*
Contribution Margin	**(2,496)**	**(19,796)**	**28**	**(70,303)**	**(21,428)**	**(7,449)**	**(295,386)**	**(416,830)**
Projected 2026 Contribution Margin	*7,358*	*(22,888)*	*(5,673)*	*(35,231)*	*(17,541)*	*5,225*	*(295,879)*	*(364,630)*
Var Contribution Margin	**(9,854)**	**3,092**	**5,701**	**(35,071)**	**(3,887)**	**(12,675)**	**493**	**(52,200)**
Total Non Operating Activity	**(448)**	**(188)**	**(379)**	**(2,033)**	**(332)**	**(472)**	**0**	**(3,852)**
Non-Op Activity, Measure A, GPP, QIP & System OH Allocation	(1,694)	3,024	9,479	31,653	8,436	6,722	295,386	353,005
Net Income (Loss)	**(4,639)**	**(16,960)**	**9,129**	**(40,684)**	**(13,325)**	**(1,199)**	**0**	**(67,677)**
Projected 2026 Net Income (Loss)	*6,628*	*(21,163)*	*791*	*(24,663)*	*(6,696)*	*7,307*	*0*	*(37,797)*
Total FTEs	**625**	**272**	**511**	**1,940**	**382**	**508**	**788**	**5,026**
Projected FY2026 FTEs	*640*	*299*	*497*	*1,958*	*396*	*497*	*816*	*5,203*
Adjusted Patient Days/Clinic Visits	**111,209**	**42,189**	**378,839**	**88,175**	**28,624**	**40,193**		**660,605**
Projected FY2026 Adjusted Patient Days/Clinic Visits	*111,616*	*51,448*	*362,030*	*89,276*	*28,611*	*40,504*		*654,872*

- *ProjFY2026 FTEs total include 101 providers FTEs that has been allocated to the entities for Budget 2027*

Alameda Hospital by Service Line

In Thousands	Acute	SNF and Subacute	Wound Care & Marina Specialty	Direct Facility Shared Services	Grand Total
Operating Revenue ----------					
Net Patient Revenue	77,730	45,603	5,297	0	128,629,725
Capitation Revenue	1,539	647	27	0	2,213,165
Other Government Programs	19,419	14,526	506	0	34,451,286
Other Revenues	489	280	40	282	1,090,832
Total Revenue - All Sources	**99,177**	**61,055**	**5,871**	**282**	**166,385**
Projected 2026 Total Revenue	*102,863*	*56,962*	*4,489*	*412*	*164,727*
Collection %	***13.8%***	***20.9%***	***20.0%***		***15.9%***
Projected 2026 Collection %	*14.2%*	*20.7%*	*16.7%*	*0.0%*	*16.0%*
Operating Expenses ----------					
Salaries & Benefits	64,291	41,703	2,782	21,701	130,477,843
Purchased Services	1,741	1,726	575	3,486	7,528,192
Contracted and Provider	5,232	309	1,032	0	6,572,451
Materials and Supplies	6,452	3,027	844	1,677	11,999,324
Facilities	364	81	169	6,494	7,108,115
Depreciation	423	1,033	405	2,861	4,721,493
General & Administration	56	50	13	354	473,722
Total Operating Expenses	**78,559**	**47,930**	**5,819**	**36,573**	**168,881**
Projected 2026 Total Operating Expenses	*73,783*	*42,184*	*6,019*	*35,383*	*157,369*
Contribution Margin	**20,617**	**13,125**	**51**	**(36,290)**	**(2,496)**
Projected 2026 Contribution Margin	*29,080*	*14,779*	*(1,530)*	*(34,971)*	*7,358*
Non-Op Activity, Measure A, GPP, QIP & System OH Allocation	4,479	2,227	741	(9,141)	(1,694)
Net Income (Loss)	**24,889**	**15,229**	**775**	**(45,532)**	**(4,639)**
Projected 2026 Net Income	*33,693*	*17,647*	*(825)*	*(43,888)*	*6,628*

- *Variance in operating expenses driven by Labor COLA*

ALAMEDA HEALTH SYSTEM

Alameda Hospital by Service Line

Statistics	Budget 2027 Acute	SNF and Subacute	Wound Care & Marina Specialty	Direct Facility Shared Services	Grand Total	Projected 2026 Acute	SNF and Subacute	Wound Care & Marina Specialty	Direct Facility Shared Services	Grand Total	Total Variance
Patient Days	11,531	61,834			73,365	11,669	61,985			73,653	(288)
Discharges	2,741	127			2,868	2,697	146			2,843	25
Length of Stay	4.2	487.2			25.6	4.3	426.0			25.9	(0.3)
Observation Care Days	2,949				2,949	2,949				2,949	(0)
Adj Patient Days	21,002				21,599	21,572				21,572	27
Adj Discharges	4,669				5,047	4,986				4,986	61
Cost per Adj Patient Day	$ 3,741				$ 7,819	$ 3,420				$ 7,295	$ 524
Cost per Adj Discharge	$ 16,826				$ 33,462	$ 14,798				$ 31,562	$ 1,900
Average Daily Census		169.4			169.4		169.8			169.8	(0.4)
Occupancy %		94%			94%		94%			94%	0%
ED Visits	20,344				20,344	20,522				20,522	(178)
IP Surgeries	165				165	170				170	(5)
OP Surgeries	61				61	69				69	(8)
Total Surgeries	226				226	239				239	(13)
Total Clinic Visits			15,968		15,968			16,136		16,136	(168)
Total FTEs	235.9	245.7	20.1	123.1	624.8	236.9	254.3	21.3	127.7	640.3	(15.4)

Fairmont Hospital by Service Line

In Thousands	OP Rehab	SNF	Direct Facility Shared Services	Grand Total
Operating Revenue ----------				
Net Patient Revenue	1,334	29,154	0	30,488
Capitation Revenue	295	93	0	388
Other Government Programs	3	9,181	462	9,646
Other Revenues	38	321	403	763
Total Revenue - All Sources	**1,670**	**38,749**	**865**	**41,285**
Projected 2026 Total Revenue	*1,447*	*36,713*	*780*	*38,939*
Collection %	***10.8%***	***24.3%***		***23.0%***
Projected 2026 Collection %	*9.2%*	*22.6%*		*18.9%*
Operating Expenses ----------				
Salaries & Benefits	5,273	28,953	14,587	48,813
Purchased Services	9	407	1,993	2,409
Contracted and Provider	0	1,776	0	1,776
Materials and Supplies	196	1,778	2,468	4,441
Facilities	5	47	3,041	3,092
Depreciation	8	90	352	449
General & Administration	3	25	71	99
Total Operating Expenses	**5,493**	**33,076**	**22,511**	**61,081**
Projected 2026 Total Operating Expenses	*5,747*	*31,286*	*22,065*	*59,098*
Contribution Margin	**(3,823)**	**5,673**	**(21,646)**	**(19,796)**
Projected 2026 Contribution Margin	*(4,300)*	*5,426*	*(21,286)*	*(20,159)*
Non-Op Activity, Measure A, GPP, QIP & System OH Allocation	456	3,334	(766)	3,024
Net Income (Loss)	**(3,383)**	**8,900**	**(22,477)**	**(16,960)**
Projected 2026 Net Income	*(4,011)*	*7,760*	*(22,424)*	*(18,676)*

- *Proj2026 excludes IOP*

Fairmont Hospital by Service Line

	Budget 2027				Projected 2026				
Statistics	**OP Rehab**	**SNF**	**Direct Facility Shared Services**	**Grand Total**	**OP Rehab**	**SNF**	**Direct Facility Shared Services**	**Grand Total**	**Total Variance**
Patient Days		39,123		39,123		39,000		39,000	123
Discharges		78		78		96		96	(18)
Length of Stay		501.3		501.3		406.3		406.3	95.1
Average Daily Census		107.2		107.2		106.8		106.8	0.3
Occupancy %		98%		98%		98%		98%	0%
Cost per Patient Day		$ 845		$ 845		$ 802		$ 802	$ 43
Cost per Discharge		$ 423,837		$ 423,837		$ 325,898		$ 325,898	$ 97,939
Total FTEs	23.5	152.2	96.1	271.8	23.3	151.5	101.5	298.8	(27.0)

ALAMEDA HEALTH SYSTEM

- *ProjFY2026 FTEs total include 23 FTEs for IOP*

FQHC Clinics by Site

In Thousands	Eastmont	Highland	Hayward	Newark	Direct Facility Shared Services	Grand Total
Operating Revenue ----------						
Net Patient Revenue	37,321	74,459	14,368	8,414	0	134,561
Capitation Revenue	4,819	6,019	3,928	2,618	0	17,383
Other Government Programs	29	63	13	7	0	112
Other Revenues	914	429	102	58	108	1,612
Total Revenue - All Sources	**43,084**	**80,970**	**18,410**	**11,097**	**108**	**153,669**
Projected 2026 Total Revenue	*41,759*	*55,573*	*15,968*	*10,570*	*226*	*124,096*
Collection %	***63.0%***	***58.8%***	***56.2%***	***58.9%***		***59.6%***
Projected 2026 Collection %	*56.4%*	*42.4%*	*54.2%*	*56.6%*		*48.7%*
Operating Expenses ----------						
Salaries & Benefits	19,629	44,336	8,764	5,172	13,143	91,045
Purchased Services	346	91	436	338	385	1,595
Contracted and Provider	11,176	29,058	5,084	2,370	0	47,688
Materials and Supplies	3,162	2,087	1,359	652	49	7,309
Facilities	999	209	630	129	35	2,001
Depreciation	2,794	287	615	93	0	3,789
General & Administration	67	89	22	8	27	213
Total Operating Expenses	**38,173**	**76,156**	**16,910**	**8,762**	**13,639**	**153,641**
Projected 2026 Total Operating Expenses	*35,417*	*64,431*	*15,143*	*8,598*	*6,179*	*129,769*
Contribution Margin	**4,911**	**4,814**	**1,500**	**2,335**	**(13,531)**	**28**
Projected 2026 Contribution Margin	*6,342*	*(8,858)*	*825*	*1,972*	*(5,953)*	*(5,673)*
Non-Op Activity, Measure A, GPP, QIP & System OH Allocation	2,274	6,997	1,047	763	(1,601)	9,479
Net Income (Loss)	**7,081**	**11,623**	**2,502**	**3,072**	**(15,150)**	**9,129**
Projected 2026 Net Income	*7,284*	*(5,069)*	*1,764*	*2,829*	*(6,018)*	*791*

- *Collection % increase due to HGH FQHC settlement and increase in EWC rate*
- *Variance due to moving Bridge Clinic from HGH to FQHC and Labor COLA*

FQHC Clinics by Site

Statistics	Budget 2027 Eastmont	Highland	Hayward	Newark	Direct Facility Shared Services	Grand Total	Projected 2026 Eastmont	Highland	Hayward	Newark	Direct Facility Shared Services	Grand Total	Total Variance
Primary Care Clinics	49,113	69,608	44,127	24,162		187,010	52,386	69,014	39,089	24,875		185,363	1,647
Dental Services	17,342	23,106				40,448	16,431	24,099				40,530	(82)
Speciality Clinics	17,868	125,073	6,396	1,531		150,868	19,511	108,788	5,666	1,577		135,540	15,328
Psych Clinic	513					513	597					597	(84)
Total Clinic Visits	84,836	217,787	50,523	25,693		378,839	88,925	201,900	44,754	26,451		362,030	16,810
Gross Revenues per Visit	$ 698	$ 581	$ 506	$ 556		595.86	$ 718	$ 576	$ 491	$ 530		$ 597	$ (1)
Costs per Visit	$ 450	$ 350	$ 335	$ 341		$ 406	$ 398	$ 322	$ 338	$ 325		$ 360	$ 45
Total FTEs	123.4	277.1	54.1	30.5	25.4	519.6	126.2	259.9	53.9	31.7	25.0	504.0	15.7

- *Specialty Clinics increased due to HGH Bridge Clinic FQHC designation (17,102) offset by Eastmont Specialty (1,643)*

John George Psychiatric

In Thousands	Total
Operating Revenue ----------	
Net Patient Revenue	96,645
Capitation Revenue	0
Other Government Programs	0
Other Revenues	754
Total Revenue - All Sources	**97,399**
Projected 2026 Total Revenue	*96,124*
Collection %	***30.1%***
Projected 2026 Collection %	*31.6%*
Operating Expenses ----------	
Salaries & Benefits	90,929
Purchased Services	3,837
Contracted and Provider	19,588
Materials and Supplies	1,921
Facilities	2,183
Depreciation	323
General & Administration	45
Total Operating Expenses	**118,827**
Projected 2026 Total Operating Expenses	*113,666*
Contribution Margin	**(21,428)**
Projected 2026 Contribution Margin	*(17,541)*
Non-Op Activity, Measure A, GPP, QIP & System OH Allocation	**8,436**
Net Income (Loss)	**(13,325)**
Projected 2026 Net Income	*(13,325)*

- *Variance due to Labor COLA*

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John George Psychiatric

Statistics	Budget 2027	Projected 2026	Variance
Patient Days	24,093	24,026	68
Discharges	2,420	2,490	(70)
Length of Stay	10.0	9.6	0.3
Adj Patient Days	28,413	28,608	(195)
Adj Discharges	3,155	2,965	190
Cost per Adj Patient Day	$ 4,182	$ 3,973	$ 209
Cost per Adj Discharge	$ 37,663	$ 38,336	$ (673)
ED Visits / PES	9,618	9,618	(0)
Total FTEs	382.3	395.8	(13.5)

Highland Hospital by Service Line

In Thousands	Total
Operating Revenue ----------	
Net Patient Revenue	467,181
Capitation Revenue	25,991
Other Government Programs	118,579
Other Revenues	64,710
Total Revenue - All Sources	**676,461**
Projected 2026 Total Revenue	*702,300*
Collection %	***16.7%***
Projected 2026 Collection %	*17.6%*
Operating Expenses ----------	
Salaries & Benefits	453,096
Purchased Services	35,169
Contracted and Provider	107,526
Materials and Supplies	126,801
Facilities	17,743
Depreciation	4,522
General & Administration	1,908
Total Operating Expenses	**746,764**
Projected 2026 Total Operating Expenses	*735,850*
Contribution Margin	**(70,303)**
Projected 2026 Contribution Margin	*(33,551)*
Non-Op Activity, Measure A, GPP, QIP & System OH Allocation	31,653
Net Income (Loss)	**(40,684)**
Projected 2026 Net Income	*(23,207)*

- *Proj2026 excludes IOP*
  HGH Bridge Clinic moved to FQHC
  Variance in operating expenses due to Labor and Supplies COLA

Highland Hospital by Service Line

Statistics	Budget 2027	Projected 2026	Variance
Patient Days	49,013	49,698	(685)
Discharges	10,346	9,129	1,217
Length of Stay	4.7	5.4	(0.7)
Observation Care Days	3,297	3,300	(3)
Adj Patient Days	91,854	89,282	2,573
Adj Discharges	15,940	16,403	(463)
Cost per Adj Patient Day	$ 6,692	$ 6,737	$ (45)
Cost per Adj Discharge	$ 37,895	$ 36,662	$ 1,233
ED Visits / PES	56,836	57,734	(898)
IP Surgeries	2,357	2,850	(493)
OP Surgeries	2,551	2,655	(104)
Total Surgeries	4,908	5,505	(597)
Infusion Services Center Visits	9,384	9,183	201
Total FTEs	1,939.8	1,958.1	(18.3)

- *ProjFY2026 FTEs total include 12 FTEs for IOP*

San Leandro Hospital by Service Line

In Thousands	Acute	Rehab	Direct Facility Shared Services	Grand Total
Operating Revenue ----------				
Net Patient Revenue	98,881	32,389	0	131,270
Capitation Revenue	7,481	145	0	7,625
Other Government Programs	23,187	2,100	0	25,287
Other Revenues	746	154	433	1,334
Total Revenue - All Sources	**130,296**	**34,787**	**433**	**165,516**
Projected 2026 Total Revenue	*131,316*	*35,044*	*406*	*166,766*
Collection %	***13.4%***	***36.5%***		***15.9%***
Projected 2026 Collection %	*13.8%*	*37.6%*		*16.3%*
Operating Expenses ----------				
Salaries & Benefits	80,072	21,344	16,655	118,071
Purchased Services	1,953	1,222	3,139	6,314
Contracted and Provider	21,790	2,069	0	23,859
Materials and Supplies	15,244	305	1,447	16,996
Facilities	202	3	3,962	4,167
Depreciation	1,724	100	1,409	3,234
General & Administration	131	2	192	325
Total Operating Expenses	**121,116**	**25,046**	**26,804**	**172,965**
Projected 2026 Total Operating Expenses	*112,630*	*22,246*	*26,665*	*161,541*
Contribution Margin	**9,180**	**9,741**	**(26,371)**	**(7,449)**
Projected 2026 Contribution Margin	*18,686*	*12,798*	*(26,259)*	*5,225*
Total Non Operating Activity	**(329)**	**(65)**	**(78)**	**(472)**
Non-Op Activity, Measure A, GPP, QIP & System OH Allocation	9,622	592	(3,493)	6,722
Net Income (Loss)	**18,473**	**10,269**	**(29,942)**	**(1,199)**
Projected 2026 Net Income	*24,755*	*13,161*	*(30,610)*	*7,307*

- *Variance in operating expenses due to Labor COLA ($5.4M) & Contracted & Provider ($5.7M)*

ALAMEDA HEALTH SYSTEM

San Leandro Hospital by Service Line

	Budget 2027				Projected 2026				
Statistics	Acute	Rehab	Direct Facility Shared Services	Grand Total	Acute	Rehab	Direct Facility Shared	Grand Total	Total Variance
Patient Days	10,673	8,402		19,075	10,827	8,333		19,160	(85)
Discharges	2,954	633		3,587	2,952	612		3,564	23
Length of Stay	3.6	13.3		16.9	3.7	13.6		5.4	11.5
Observation Care Days	2,671			2,671	2,671			2,671	0
Adj Patient Days	26,210			26,210	26,616			26,799	(589)
Adj Discharges	7,254			7,254	7,257			7,287	(32)
Cost per Adj Patient Day	$ 4,621			$ 6,599	$ 4,203			$ 4,203	$ 2,396
Cost per Adj Discharge	$ 16,696			$ 23,843	$ 15,457			$ 15,457	$ 8,386
Average Daily Census		23.0		23.0		22.8		22.8	0.2
Occupancy %		82%		82%		82%		82%	1%
ED Visits / PES	34,617			34,617	34,535			34,535	83
IP Surgeries	494			494	465			465	29
OP Surgeries	1,899			1,899	1,821			1,821	78
Total Surgeries	2,393			2,393	2,286			2,286	107
Total FTEs	323.8	78.1	105.8	507.7	313.4	74.4	109.4	497.1	10.6

Performance Improvement Initiatives

Revenue Improvement Tactics

In Thousands

#	Accountable	Tactic Name	Description	FY27 Target (Range)**	Variance	Metric	Budget Linked	Status
1	Shari Johnson	Charge Capture Optimization	• Improve Charge Capture • Clinical Documentation Improvement • Epic Build for Revenue Capture	$1,000 - $3,300	0		X	
2	Dr. Mack/Temi	Ambulatory Access & Revenue Improvement	• Improve Clinic Staffing Efficiency	$450 – $900	0		X	
3	Shari Johnson	Ambulatory Access & Revenue Improvement	• Reduce Cancellations & No-Shows	$1,000 – $3,000	0		X	
			Potential Impact	**$2,500 - $7,200**				

**Revenue improvement targets are measured in Year over Year incremental improvements

- Ongoing refinement and governance: **Initiatives will continue to evolve through Ad Hoc Committee discussions,** including key decisions such as **the scale and timing of RIF actions**, which remain under evaluation and introduce uncertainty to the current estimates.
- Initial gap coverage identified: Current initiatives represent a partial solution to the FY27 budget shortfall, reflecting early-stage opportunities across revenue, labor, and non-labor levers.
- Figures reflect preliminary submissions and require validation and refinement by accountable owners; amounts are expected to evolve through iterative budget cycles. Not included preliminary budget.

Expense Improvement Tactics

In Thousands

#	Accountable	Tactic Name	Description	FY27 Target (Range)**		Variance	Metric	Budget Linked	Status
1	Salma Adin Dr. Wu	Length of Stay Optimization	Leverage new EPIC module and nursing control tower system.	$4,000	$12,000	0	YoY LOS Reduction of 0.2. From (5.8 to 5.6)		
2	Ahmad Azizi	Contract Management	Identify savings during negotiations of expiring contracts.	$4,000	$12,000	0	Contracts	X	
3	Mark Fratzke/Jet Chapman	Workforce Planning	Align staffing levels to volume demand by maximizing productivity, redesigning processes to eliminate inefficiencies, and optimizing scheduling.	$15,000	$24,000	0	Labor Expense. 4% attrition (200 FTE) achieved by mid year. Include Paid Admin Leave as part of analysis.	X	
4	Mark Fratzke	Non Labor Budget Cuts	2.6% YoY savings with budget leader submission/review of annual spend.	$8,000	$12,000	0	2.6% Non Labor Expense	X	
5	Dr. Laurent/Terrance FS	OT Reduction	Reduce OT by 20%	$2,000	$5,000	0	OT System Level		
6	Jet Chapman / Arleen Gomez	Performance Management	Enhance performance management through consistent evaluations, targeted coaching, and clear accountability to improve workforce effectiveness.	$1,000	$3,000	0	Productivity Gross Revenue/FTE Increase	X	
7	Doug Johnson	SC Cost Downs	Supply Chain Cost Downs (YoY decline)	$2,000	$6,000	0	Non Labor Expense. ($6,000 gross savings). Savings from YoY amount.	X	
8	James Helena	Facility Repair Cost Controls	Establish planned maintenance program to reduce reactive repair spend.	$3,000	$6,000	0	Non Labor Expense. Align invoice payment timing with construction cost budgeting. YoY Savings.	X	
9	Jet Chapman	VR/ER	Conduct FY27 Voluntary Resignations/Early Retirement	$250	$1,000	0	Labor Expense. Savings start in October. Estimate of 25 FTEs	X	
10	Mark F/ Dr. Laurent	Travel	Reduce Travel Expense by 25% from FY26	$200	$500	0	25% reduction from FY26 YE expense.	X	
11	Jet Chapman	PTO Payouts	Reduce max PTO by 20% for all employees. Policy conversion to 'use it or lose it' model	$500	$2,000	0	Labor Expense	X	
12	Dr. Laurent/Terrance FS	Meal Breaks	Reduce Meal Break Penalties	$500	$1,500	0	Labor Expense	X	
13	Preston Walton	Foundation	Incremental contribution to AHS.	$4,000	$8,000	0	YoY $ Funds contributed to AHS.	X	
14	Jet Chapman	HR Program Review	Review HR programs to identify efficiency opportunities and cost management strategies	$5,000	$8,000	0	TBD		
15	Board of Trustees	Reorganization	July 20 – Announce . Beilenson Aug 25th. Decision 9/1.	$7,500	$20,000	0	Labor Expense	X	
			Potential Impact	$58,000	$120,000				

- Ongoing refinement and governance: **Initiatives will continue to evolve through Ad Hoc Committee discussions.**
- Figures reflect preliminary submissions and require validation and refinement by accountable owners. Not included in preliminary budget.

APPENDIX

Budget Goals & Guiding Principles

Preliminary Budget Framework

- Use Run Rate actuals from CY2025 for volume, revenue and cost assumptions as Budget starting point.
- Scrub for known changes/differences:
  - Correct for any material one-time items that impacted the baseline.
  - Update supplemental program revenue to reflect latest available information
- Incorporate factors that may not be reflected in the baseline but likely impact the budget, such dental services, Union COLAs and contracts.
- Incorporated full year staffing, as needed, including physician services.

External and Financial Drivers

- Address HR 1 and other state and federal budgetary changes that will likely increase the uninsured, reduce utilization and lead to delayed care and worsening health outcomes.
  - Utilization decreases/no volume growth
  - Outreach to fill provider schedules
  - Assignment of Medi-Cal members
  - Partner with county on HPAC growth
  - Uncompensated care
- Maintain fiscal discipline to control expenses necessary to stabilize operations from fluctuations in funding.

Sustainable Continuous Improvement

- Ensure compliance with the County Permanent Agreement including NNB requirements
- Prioritize revenue capture over volume growth.
- Prioritize funding toward initiatives that demonstrate near-term financial impact or risk mitigation, while limiting or deferring investments that do not meet defined return or strategic thresholds.
- Execute GRIT and other key initiatives to reduce costs and strengthen financial performance

Key Budget Assumptions

Baseline is based on CY2025

Volumes

- In light of HR 1 and expected and unknown utilization changes, volumes and charges are slightly lower and consistent with current trends; overall adjusted patient days decreased 0.2%

Revenues

- Increase in pricing (chargemaster) 3%
- Net revenue rate increases
  - Commercial based on contracts $2.2M
  - Government Payors $6.3M
- Behavioral Health Contract at current rate of $81.2M
- FQHC rate increases at HGH ($453) and EWC ($479 Rate) of $24.6M
- Deferred RIF Impact for IOP closure reduction of revenue ($4.6M)

Labor Expenses

- Budgeted FTEs based on:
  - Variable FTEs: determined by current labor standard based on CY2025 volumes
  - Fixed FTEs: hired as of February 1, 2026; excludes vacancies
  - SEIU Physicians FTEs: hired as of February 1, 2026
  - Registry FTEs: at run rate adjusted for hired employees
- Labor COLA - Consistent with union contracts, includes registry and UNREP at $50.5M
- Deferred RIF Impact reduction ($25.7M)

Key Budget Assumptions

- Employee Benefits ($16.6M)
  - FICA is based on same percentage of salary as FY25
  - FICA HI is based on 1.45% of salary
  - Health Self Funded is based on Amount per FTE with CPI at 9.5% effective January 2027
  - Health (Kaiser) is based on Amount per FTE with CPI at 9.1% effective January 2027
  - Dental is based on Jan 2026 annualized expense with 5.0% CPI effective January 2027
  - Deferred RIF savings ($5.9M)
- Retirement at same percentage of salary as FY25 ($5.6M)
  - Increase due to CPI ($8.2M)
  - Deferred RIF savings ($2.8M)

Contracted Physicians

- Physician Contracts based on CY25 run rate adjusted for increase rates as of 7/2026.
- Savings identified not in budget yet

Non-Labor

- Non labor overall increase is 2.3%
  - Utilities CPI: Electricity 3%; Gas 9%; Water 7%
  - Supplies: 2.4% effective 1/1/27
  - Drugs CPI: 3.6 to 3.9% effective 1/1/27
  - Purchased Services, IT, Repairs & Maintenance at CY2025
- Donation to St. Rose at $9.5M, consistent with current year

Key Budget Assumptions

Foundation

- Funded total operating cost of $5.2M
- Grants and fundraising revenue is $10.9M, an increase of $1.8M over projected FY2026

Capital

- Historically, AHS spent an average of $20.6M cash per year on capital

Volumes

- ***Note: Budget 2027 is based on CY2025 (same store) due to HR 1 impact***
- ***Budget 2027 excludes IOP visits (30,703) and HGH Psych Clinic (1,100) due to Deferred RIFs***

	ACTUAL2025	ACTUAL2026 Ann Feb 2026	BUDGET 2027	Var to Act Annl Mar 2026	% to Act Annl Mar 2026 Orig
Campus: AHS ALL CAMPUS					
Total Adjusted Patient Days	215,173	212,969	212,288	(680)	*-0.3%*
Total Adjusted Discharges	34,863	36,424	36,300	(124)	*-0.3%*
Physician wRVU	1,671,512	1,627,055	1,623,746	(3,309)	*-0.2%*
FQHC & Other Clinic Visits	411,554	428,879	395,119	(33,760)	*-7.9%*
GENERAL ACUTE					
Patient Days	76,737	72,194	71,217	(977)	*-1.4%*
Discharges	14,554	14,780	14,681	(99)	*-0.7%*
ALOS: Average Length of Stay	*5.3*	*4.9*	*4.9*	*0.0*	*-0.7%*
Occupancy %	*70.5%*	*66.4%*	*65.5%*	*-0.9%*	
CMI	1.6340	*1.6190*	*1.6190*	-	*0.0%*
Observation Days	7,768	8,911	8,911	0	*0.0%*
Emergency Visits	109,570	112,790	111,797	(990)	*-0.9%*
Trauma Cases	3,659	3,648	3,602	(50)	*-1.3%*
Surgeries	8,480	8,030	7,979	(51)	*-0.6%*
Deliveries	1,541	1,602	1,555	(47)	*-2.9%*
PSYCH					
Patient Days	23,788	24,026	24,093	68	*0.3%*
Discharges	2,473	2,490	2,420	(70)	*-2.8%*
ALOS: Average Length of Stay	*9.6*	*9.6*	*10.0*	*0.3*	*3.2%*
PES Equivalent Days	8,392	8,342	8,689	348	*4.2%*
REHAB					
Patient Days	8,360	8,333	8,402	70	*0.8%*
Discharges	615	612	633	21	*3.4%*
ALOS: Average Length of Stay	*13.6*	*13.6*	*13.3*	*(0.3)*	*-2.5%*
Occupancy %	*81.8%*	*81.5%*	*82.2%*	*0.7%*	
SNF					
SNF Patient Days	100,381	100,985	100,957	(27)	*0.0%*
Average Daily Census	275.0	276.7	276.6	(0)	*0.0%*
Occupancy %	*94.8%*	*95.4%*	*95.4%*	*0.0%*	
Bed Holds	1,072	957	960	3	*0.3%*
Payor Mix					
Insurance %	7.5%	6.7%	6.5%	-0.2%	
Medi-Cal %	56.2%	59.6%	59.9%	0.3%	
Medicare %	34.7%	29.5%	29.4%	-0.1%	
Other Govt %	1.2%	1.5%	1.6%	0.1%	
Self-Pay %	0.5%	2.8%	2.7%	-0.2%	
Total Payor Mix %	100.0%	100.0%	100.0%	0.0%	

ALAMEDA HEALTH SYSTEM

Other Government Revenues

In Thousands

Programs	Actual FY25	Projected FY26	Budget FY27	Cash Flow FY27	FY28	FY29	FY30	FY31	Comments
Global Payment Program (GPP)	$ 139,537	$ 103,437	$ 91,320	$ 91,426	$ 78,419	$ 78,230	$ 79,013	$ 79,803	GPP reduction reflects loss of SNCP portion due to expiration of federal waiver 12/31/2026 (renewal submission has presupposed loss of that portion). Most likely remainder amount will revert to being Medicaid DSH, which is available under federal statute without requiring federal approvals, but does require traditional cost-based claiming excluding non-hospital facilities.
Old Waiver	1,000	(1,961)	-	-	-	-	-		Adjustment from $31.1M on books to $29.2M to be received as cash by 5/26/2026
Medi-Cal Waiver	***$ 140,537***	***$ 101,476***	***$ 91,320***	***$ 91,426***	***$ 78,419***	***$ 78,230***	***$ 79,013***	***$ 79,803***	
Measure A	$ 146,177	$ 148,245	$ 148,000	$ 148,000	$ 148,000	$ 148,000	$ 148,000	$ 148,000	Based on sales tax increment approved by county voters (one-half cent).
AHD Parcel Tax	4,049	4,049	4,049	4,049	4,049	4,049	4,049	4,049	Tax per property parcel in City of Alameda.
Measure A & Parcel Tax	***$ 150,226***	***$ 152,294***	***$ 152,049***	***$ 152,049***	***$ 152,049***	***$ 152,049***	***$ 152,049***	***$ 152,049***	
FEMA FUNDING	5,830	223	-						Approved claims from FEMA for COVID relief.
Covid Funding	***$ 5,830***	***$ 223***	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***	

Other Government Revenues

In Thousands

Programs	Actual FY25	Projected FY26	Budget FY27	Cash Flow FY27	FY28	FY29	FY30	FY31	Comments
HPAC Amendment	$ 50,125	$ -	$ -	$ -	$ -	$ -	$ -		$0 revenue expected in FY27 due to increase in supp. revenues which flow through a model to project zero "gain". Will update in May Revise if any potential Amendment money is projected at that near-final point.
AB85 Redirection Reserve	(42,093)	-	-	4,789	(45,600)	-	-	-	True-up of FY24 received during FY27 estimating a small amount regained (we received no HPAC Amendment during FY24); then true-up of FY25 during FY28 estimating almost all received will be paid back (we received full HPAC Amendment during FY25); thereafter zero amendment, zero true-up
Medi-Cal SNF Cost Settlement	382	420	462	(1,659)	462	478	531	586	Decreases started Jan 2023 and deepened as virtually all Medi-Cal FFS SNF service moved to Medi-Cal Managed Care where this supplemental is unavailable; HR1 results in small cuts FY27; payback in FY27 reflects FY22 final reconciliation hitting FY27 cash (not yet calculated but likely similar to FY21)
PNPP (Physician SPA)	3,450	1,707	1,778	1,778	1,839	1,876	1,951	4,141	Reflects adjustment to closer to what is being actually received in cash, since CMS has never started paying the ACA portion and the audits that would allow this payout have no schedule to restart, so even if we are technically owed it we do not have any immediate prospect of getting it
Rate-Range IGT (RR)	42,592	51,953	38,775	45,831	44,081	41,187	40,735	41,550	Actual 2024 amounts trended forward, with HR1 reduction est.; higher cash in FY27 reflects payout of CY2025 with less reduction, but 5% reserve added
Enhanced Payment Program (EPP)	68,131	83,085	84,833	114,733	84,833	84,833	76,281	67,728	Like last year, budget incorporates 25% increase 2024 (seen in payment cycle Spring 2026) followed by 48% increase 2025, plus reduction reflecting some of the new new money being tied to Cost, Efficiency, Productivity, and Access Program (CEPA) which we may not earn 100%; reduction from FY26 budget reflects slightly lower utilization than projected; cash is higher only because EPP payment acceleration will pay us for 18 months during the year on a one-time basis, whereas budget amount is the lower amount earned for services in the year. HR1 cuts will not kick in until 1/1/2028, & will not be seen in cash until fall 2029, FY30.
Quality Incentive Program (QIP)	82,504	80,964	113,685	113,685	113,685	113,685	102,317	90,948	CMS approved 70% increase to overall program starting CY2025, grandfathered thereafter; 100% of CY2024 assumed earned, 90% of CY2025 and onward; constant distribution. Settlement typically 2 years after year earned. This increase was not reflected in FY26 budget as it would not be in cash for some time, but CY 2025 is expected to be paid out in full during FY 2027 so the full increase is assumed. Under HR1, like EPP, cuts will kick in from 1/1/2028 and cash will affected starting fall 2029 (FY30)

Other Government Revenues

In Thousands

Programs	Actual FY25	Projected FY26	Budget FY27	Cash Flow FY27	FY28	FY29	FY30	FY31	Comments
Hospital Fee	7,129	3,720	3,670	3,670	3,670	3,670	3,670	3,670	Direct grant portion only. 50% reduction for FY26, FY27, and onward reflects that under new HR1-related constraints, entire HQAF for CY 2025 may significantly reduce, and related to that, hospital community may reduce public hospital portion of it.
Medi-Cal Graduate Medical Education (GME)	18,191	14,199	14,153	14,232	13,732	13,492	13,334	3,748	Some HR1 cuts assumed due to lower Medi-Cal utilization, otherwise has relatively stabilized
AB915	6,535	8,740	8,759	8,812	8,759	8,041	8,310	8,588	Trending based on 3% cost trend, 1% revenue trend, known FMAP changes, and some drop for state-only transition out of FFS, and small HR1 cuts due to lower Medi-Cal utilization.
DPNF Pass Through	19,281	23,775	23,447	23,447	-	-	-	-	3-year limited-time program, calendar 2023-2025. Little transparency on amounts paid before they are actually paid. Amount received for CY2024 in Dec 2025 was about $2M less than expected in budget. FY27 amount is final year of program to be paid during FY27.
Prop 56	(830)	240	240	240	240	240	240	240	State tobacco tax revenue spent on Medi-Cal enhancements. Amount is subject to change. Alliance overpaid us the past two years, new # reflects expected payment.
County EMS	395	395	395	395	395	395	395	395	Same amount each year.
County Trauma	5,266	5,266	5,266	5,266	5,266	5,266	5,266	5,266	Funded through Measure C (parcel tax for trauma services approved 1997). Same amount each year.
CalAim ECM (Enhanced Care Mgmt)	1,383	1,048	1,048	1,048	1,048	1,048	1,048	1,048	Patient care funding for Enhanced Care Management services, a Medi-Cal managed care benefit created under CalAim for patients approved as eligible by Alameda Alliance. Reimbursement is only provided if Medi-Cal managed care member is eligible for services in a month, received ECM services from AHS in that month and AHS submits appropriate documentation and billing.
Other (P4P, BHCS)	4,892	1,209	1,200	1,200	1,200	1,200	1,200	1,200	P4P
Supplemental Programs	***$ 267,333***	***$ 276,722***	***$ 297,711***	***$ 337,467***	***$ 233,610***	***$ 275,411***	***$ 255,278***	***$ 229,108***	
Total Other Government Programs	***$ 563,927***	***$ 530,715***	***$ 541,080***	***$ 580,942***	***$ 464,078***	***$ 505,690***	***$ 486,340***	***$ 460,960***	

HPAC, Capitation & Other Gov't Revenue Allocation

Supplemental Revenue Allocation Methodology			
Account	**Description**	**Allocation Method**	**Amount**
36100	COUNTY HPAC	HPAC FY2026 Actual Gross Revenues	$39.4M
36150	CAPITATION (Alameda Alliance)	Directly Assigned to FQHC by Site	$14.2M
36115	COUNTY EMS FUNDING	Directly Assigned to HGH	$0.4M
36120	COUNTY TRAUMA FUNDING	Directly Assigned to HGH	$5.3M
36300	GLOBAL PMT PROG (1115 WAIVER)	Based on FY2026 Actual Operating Expense excl JGP	$91.3M
36302	CalAIM ECM (Enhanced Care Management)	Directly Assigned to HGH	$1.0M
36303	DP-NF PASS-THROUGH	Based on Medi-Cal Managed Care SNF days by Site	$23.4M
36305	STATE SNF SUPPLEMENTAL	Based on SNF Days by Site	$0.5M
36314	SPA#17-030 Prop#56	PF Gross Revenue excl JGP	$0.2M
36315	DHCS PHYSICIANS SPA 05-023 PNPP	PF Gross Revenue excl JGP	$1.8M
36325	RATE RANGE: MCal Mngd Care Supp	Medi-Cal Mngd Care Gross Revenues excl JGP, FQ & SNF	$38.8M
36328	EPP-Enhanced Payment Program	Medi-Cal Mngd Care Gross Revenues excl FQ & JGP	$84.8M
36329	QIP-Quality Improvement Program	Based on FY2026 Actual Operating Expense	$113.7M
36331	SB239 HOSPITAL FEE (MGD CARE)	Based on HB Gross Revenues excl FQ & JGP & SNF	$3.7M
36332	MEDI-CAL GME (Graduate Medical Education)	Directly Assigned to HGH	$14.2M
36333	Incentive P4P (Alliance Anthem)	Directly Assigned to HGH	$1.2M
36340	AB915 CERT PUBLIC EXPENDITURE	Medi-Cal OP Gross Revenues for Acute Hospitals Only	$8.8M
36342	FEMA Funding	Based on FY2026 Actual Operating Expense	$0.0M
36400	Measure A	Based on FY2026 Actual Operating Expense	$148.0M
36410	AHD Parcel Tax	Direct Assignment to AH	$4.0M
	Grand Total		**$594.7M**

ALAMEDA HEALTH SYSTEM

DISCUSSION: Center for Operational Transformation (COT) Update

No Written Materials

Agenda Item G COT Update

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

ALAMEDA HEALTH SYSTEM

Update: SB 1400 (Arreguin)

AHS Governance Legislation

Jeanette Dong, Chief of Public Affairs and
Community Engagement
May 13, 2026
AHS Board of Trustees

OVERVIEW

SB 1400 (Arreguin)

SB 1400 (Arreguín) is a California Senate bill addressing governance and operational authority related to the Alameda Health System (AHS).

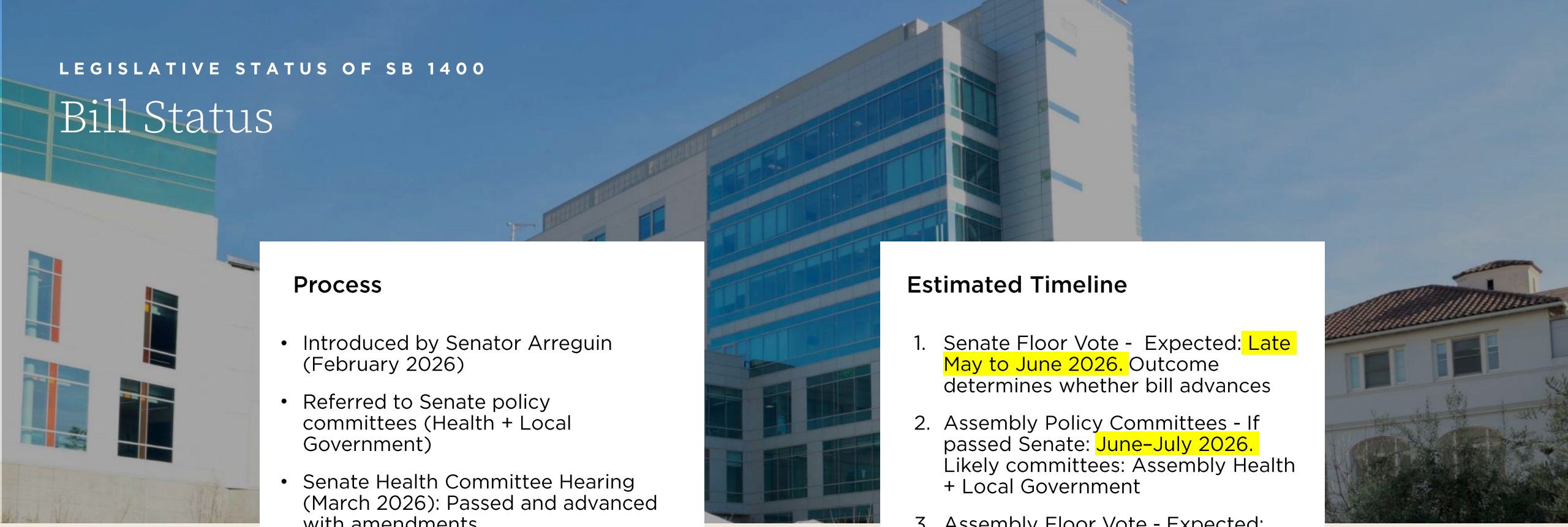
SB 1400 would update California law governing the Alameda Health System hospital authority

Key proposed changes include:

1. Permits the Alameda County Board of Supervisors to amend the enabling ordinance of AHS, and permits the enabling ordinance to authorize the membership of the AHS governing board to include, with the approval of the Board of Supervisors, a representative of any local public entity that contributes financial or other support to AHS pursuant to a joint powers agreement or other affiliation agreement.
2. Permits, at the Board of Supervisors' discretion, the AHS governing board to consist entirely of the Board of Supervisors or to include any number of Supervisors or county officers or employees appointed to represent the interests of the county.
3. Permits the Board of Supervisors to change the composition of the AHS governing board, or to revoke the duties and responsibilities of AHS and transfer the hospital authority back to the county.
4. Permits the AHS governing board to delegate day-to-day operational responsibilities to one or more subsidiary bodies it establishes, consisting of members possessing relevant expertise. Requires this delegation to involve reasonable safeguards to ensure that the AHS governing board retains ultimate control over the hospital authority, consistent with applicable law.
5. Permits AHS to affiliate with, or acquire ownership or control of, additional public or private hospitals, clinics, or programs to further its mission, at the discretion of the governing board.

SB 1400 (Arreguin) – cont'd

6. Permits AHS, at the discretion of its governing body, and when not inconsistent with the bylaws adopted by the Board of Supervisors, to maintain the private character of any private hospitals, clinics, and other health care facilities for which it assumes ownership or control.



LEGISLATIVE STATUS OF SB 1400

Bill Status

Process

- Introduced by Senator Arreguin (February 2026)
- Referred to Senate policy committees (Health + Local Government)
- Senate Health Committee Hearing (March 2026): Passed and advanced with amendments
- Senate Local Government Committee Hearing (April 2026): Passed and advanced with admendments
- Now placed on the Senate “third reading” file

Estimated Timeline

1. Senate Floor Vote - Expected: Late May to June 2026. Outcome determines whether bill advances
2. Assembly Policy Committees - If passed Senate: June–July 2026. Likely committees: Assembly Health + Local Government
3. Assembly Floor Vote - Expected: August–September 2026
4. Concurrence (if amended) - Typically: September 2026
5. Governor Review - Deadline: October 2026 (end of session window). Governor signs, vetoes, or allows passage without signature

Questions?

I1. Chief Financial Officer Report, March Financial Report

ALAMEDA HEALTH SYSTEM

March 2026 Financial Report
Finance Committee

Kimberly Miranda, Chief Financial Officer
May 6, 2026

March 2026 Financial Report
Finance Dashboard

March-2026

	Metric	FY2026 Goal YTD	Actual YTD	YTD	Trend Lines
Volume					
	Total Adjusted Discharges	24,194	24,409		
	Total Adjusted Patient Days	273,712	278,458		
Revenue Cycle					
	Collection Ratio	19.5%	19.2%		
	Cash as % of Net Revenue	100.0%	102.6%		
	Gross Days in Patient Receivables	62.0	62.7		
Labor					
	Productivity %	100.0%	108.5%		
	Registry as % of Total FTEs	4.2%	3.6%		
	Overtime % excl Company 30	4.5%	5.7%		
	Total FTEs	5,132	5,183		
	FTE per Adjusted Discharge	0.21	0.21		
	*Labor Cost/FTE w/o GASB	$242,076	$246,379		
Profitability					
	Total Cost per Adjusted Discharge	$49,943	$50,733		
	Total Cost per Adjusted Patient Days	$4,415	$4,447		
	Net Income	$6,241	($9,163)		
	EBIDA Margin	2.6%	1.2%		
	NNB (Net Negative Balance)	<$95M	-$65,963		
	Net Position	>$0	-$70,793		
Capital					
	Capital Spent	$22,368	$13,272		
	% of Capital Spent		59.3%		

*Labor costs excludes contracted physicians; Includes Registry travel & housing costs

March 2026 Financial Report
Volume Highlights – Part 1

	March 2026				FY2026 Year-To-Date				FY2025 Year-To-Date		
	Actual	Budget	Var	% Var	Actual	Budget	Var	% Var	Actual	Var	% Var
Campus: AHS ALL CAMPUS											
Total Adjusted Patient Days	32,668	30,928	1,740	5.6%	278,458	273,712	4,746	1.7%	273,068	5,390	2.0%
Total Adjusted Discharges	2,738	2,764	-26	-0.9%	24,409	24,194	215	0.9%	23,462	947	4.0%
Physician wRVU	150,911	119,322	31,590	26.5%	1,235,615	1,065,845	169,769	15.9%	1,300,439	-64,824	-5.0%
FQHC & Other Clinic Visits	40,181	36,770	3,411	9.3%	326,137	327,675	-1,538	-0.5%	308,523	17,614	5.7%
GENERAL ACUTE											
Patient Days	6,733	6,689	44	0.7%	54,862	58,093	-3,231	-5.6%	58,178	-3,316	-5.7%
Discharges	1,244	1,305	-61	-4.6%	11,096	11,271	-175	-1.5%	11,039	57	0.5%
Average Length of Stay	5.4	5.1	-0.3	-5.6%	4.9	5.2	0.2	4.1%	5.3	0.3	6.2%
Occupancy %	73.0%	72.0%	0.0%		67.0%	71.0%	-4.0%		71.0%	-4.0%	
CMI	1.6530	1.5970	0.0560	3.5%	1.6220	1.5660	0.0550	3.5%	1.6390	-0.0170	-1.0%
Emergency Visits	9,986	9,576	410	4.3%	85,179	82,231	2,948	3.6%	82,175	3,004	3.7%
Trauma Cases	353	273	80	29.3%	2,785	2,701	84	3.1%	2,747	38	1.4%
Observation Equivalent Days	830	651	179	27.5%	6,776	5,980	796	13.3%	5,746	1,031	17.9%
Surgeries	714	694	20	2.8%	6,067	6,011	56	0.9%	6,514	-447	-6.9%
Deliveries	132	149	-17	-11.2%	1,200	1,260	-60	-4.8%	1,206	-6	-0.5%
PSYCH											
Psych Patient Days	2,037	1,992	45	2.3%	18,054	17,847	207	1.2%	17,603	451	2.6%
Psych Discharges	204	221	-17	-7.8%	1,864	1,990	-126	-6.3%	1,859	5	0.3%
Average Length of Stay	10.0	9.0	-1.0	-10.9%	9.7	9.0	-0.7	-8.0%	9.5	-0.2	-2.3%
PES Equivalent Days	629	636	-7	-1.1%	6,190	5,928	263	4.4%	6,045	145	2.4%

March 2026 Financial Report
Volume Highlights – Part 2

	March 2026				FY2026 Year-To-Date				FY2025 Year-To-Date		
	Actual	Budget	Var	% Var	Actual	Budget	Var	% Var	Actual	Var	% Var
Campus: AHS ALL CAMPUS											
REHAB											
Rehab Patient Days	762	747	15	2.0%	6,317	6,628	-311	-4.7%	6,308	9	0.1%
Rehab Discharges	56	57	-1	-0.9%	464	501	-37	-7.4%	465	-1	-0.2%
Average Length of Stay	13.6	13.2	-0.4	-2.9%	13.6	13.2	-0.4	-3.0%	13.6	0	-0.4%
Occupancy %	88.0%	86.0%	0.0%		82.0%	86.0%	0.0%		82.0%	0.0%	
SNF WITH SUB-ACUTE											
SNF Patient Days	8,650	8,546	104	1.2%	75,973	75,533	440	0.6%	75,340	633	0.8%
Average Daily Census	279	275.7	3.4	1.2%	277.3	275.7	1.6	0.6%	275	2.3	0.8%
Occupancy %	96.0%	95.0%	0%		96.0%	95.0%	0.0%		95.0%	0.0%	
Bed Holds	132	72	60	83.3%	770	724	46	6.4%	791	-21	-2.7%
PAYOR MIX											
Insurance %	7.4%	6.7%	0.8%		6.8%	7.1%	-0.3%		7.0%	-0.2%	
Medi-Cal %	59.9%	60.7%	-0.9%		59.6%	60.4%	-0.8%		60.5%	-0.9%	
Medicare %	28.1%	27.9%	0.2%		29.3%	27.6%	1.7%		28.3%	1.0%	
Other Govt %	2.6%	1.5%	1.0%		1.6%	1.8%	-0.2%		1.7%	-0.1%	
Self-Pay %	2.1%	3.2%	-1.1%		2.7%	3.1%	-0.3%		2.7%	0.1%	
Total Payor Mix %	100.0%	100.0%	0.0%		100.0%	100.0%	0.0%		100.0%	0.0%	

March 2026 Financial Report
YTD Highlights

- Favorable YTD revenue variance of $14.8M.
  - Net patient revenue above budget ($5.3M), higher charges/volumes partially offset by collection percentage - 0.3% below budget
  - Other government programs above budget ($0.5M) with offsetting supplemental revenue impacts.
  - Other operating income above budget by ($9.2M) driven from retail pharmacy ($4.4M) and one-time items of SAC law settlement on older claims ($3.1M).

- Unfavorable YTD expense variance of $30.0M.
  - Labor costs unfavorable by $26.0M due to higher FTE and wage rates ($17.1M), employee benefits ($6.9M), retirement ($1.9M).
  - Non-labor cost unfavorable by $4.0M from unfavorable variances in pharmaceuticals ($4.2M), medical/surgical supplies ($2.1M), facilities ($3.7M) offset by favorable outside medical services ($2.5M) and software licenses ($3.5M).
    - OMS budget overstated reflecting duplicate invoices.

	March 2026				Year-To-Date				FY 2025	
	Actual	Budget	Variance	% Var	Actual	Budget	Variance	% Var	YTD	% Var
Operating revenue	$ 140,341	$ 138,162	$ 2,179	1.6%	$ 1,231,981	$ 1,217,142	$ 14,839	1.2%	$ 1,199,858	2.7%
Operating expense	140,427	137,991	(2,436)	(1.8)%	1,238,335	1,208,325	(30,010)	(2.5)%	1,181,731	(4.8)%
Operating income (loss)	**(86)**	**171**	**(257)**	**(150.3)%**	**(6,354)**	**8,817**	**(15,171)**	**(172.1)%**	**18,127**	**(135.1)%**
Other non-operating activity	(242)	(127)	(115)	(90.6)%	(2,809)	(2,576)	(233)	(9.0)%	(3,468)	19.0%
Net Income (loss)	**$ (328)**	**$ 44**	**$ (372)**	**(845.5)%**	**$ (9,163)**	**$ 6,241**	**$ (15,404)**	**(246.8)%**	**$ 14,659**	**(162.5)%**
EBIDA adjustments	2,663	2,558	105		24,106	25,058	(952)		33,003	
EBIDA	**$ 2,335**	**$ 2,602**	**$ (267)**		**$ 14,943**	**$ 31,299**	**$ (16,356)**		**$ 47,662**	
Operating Margin	(0.1)%	0.1%	(0.2)%		(0.5)%	0.7%	(1.2)%		1.5%	
EBIDA Margin	1.7%	1.9%	(0.2)%		1.2%	2.6%	(1.4)%		4.0%	
Total FTEs	5,019	5,086	67	1.3%	5,183	5,132	(51)	(1.0)%	5,093	

March 2026 Financial Report
Net Patient Services Revenue Highlights

- Gross patient service revenue favorable driven by outpatient services.
  - General Acute inpatient days above budget; Length of Stay was higher and CMI increased above trend.
  - Trauma cases higher than budget by 29.3% for month and 3.1% YTD.
  - Inpatient surgery below budget 7.8% for month and 5.8% YTD.
  - ED visits above budget by 4.3%,for the month and 3.6% YTD.
  - Outpatient surgery above budget 11.5% and 6.7% YTD.
  - Clinic visits above budget 9.3% and lower than budget by 0.5% YTD.
  - SNF census at 96%, exceeding budget.
  - JGP census above budget; PES visits above budget 5.5% and below budget 0.9% YTD.
- NSPR Collection ratio consistent with YTD at 19.2% and below target.
  - Medicare cost report adjustment in the month ($2.4M).
  - Mix of services changed from inpatient to outpatient with a lower collection percentage.

	March 2026				Year-To-Date				FY 2025	
	Actual	Budget	Variance	% Var	Actual	Budget	Variance	% Var	YTD	% Var
Inpatient service revenue	$ 239,830	$ 232,916	$ 6,914	3.0%	$ 1,996,547	$ 2,003,157	$ (6,609)	(0.3)%	$ 1,927,199	3.6%
Outpatient service revenue	169,838	151,470	18,367	12.1%	1,423,014	1,318,799	104,215	7.9%	1,284,162	10.8%
Professional service revenue	46,064	42,410	3,654	8.6%	379,757	377,452	2,305	0.6%	386,056	(1.6)%
Gross patient service revenue	455,732	426,796	28,935	6.8%	3,799,319	3,699,408	99,910	2.7%	3,597,417	5.6%
Deductions from revenue	(368,196)	(343,366)	(24,830)	(7.2)%	(3,070,823)	(2,976,249)	(94,574)	(3.2)%	(2,896,905)	6.0%
Net patient service revenue	**87,535**	**83,430**	**4,105**	**4.9%**	**728,496**	**723,160**	**5,336**	**0.7%**	**700,512**	**(4.0)%**
Collection % - NPSR	19.2%	19.5%	(0.3)%		19.2%	19.5%	(0.3)%		19.5%	
Capitation and HPAC	4,420	4,520	(101)	(2.2)%	40,153	40,392	(240)	(0.6)%	41,537	(3.3)%
Other government programs	42,672	45,415	(2,743)	(6.0)%	409,283	408,735	548	0.1%	411,460	(0.5)%
Other operating revenue	5,714	4,797	917	19.1%	54,048	44,856	9,191	20.5%	46,349	16.6%
Total operating revenue	**$ 140,341**	**$ 138,162**	**$ 2,179**	**1.6%**	**$ 1,231,979**	**$ 1,217,143**	**$ 14,836**	**1.2%**	**$ 1,199,858**	**2.7%**

March 2026 Financial Report
Governmental and Other Revenue Highlights

- Other government programs unfavorable from SNF Medi-Cal FY21 final reconciliation ($2.4M), DP-NF Pass-through ($0.2M), and Prop56 ($0.1M). YTD, favorable from Rate Range CY2024 ($4.2M), Alameda Alliance P4P ($1.2M), parcel tax ($0.8M), FEMA ($0.2M) offset by unfavorable variance for SNF Medi-Cal FY21 final reconciliation payment ($2.4M), Prop56 ($1.6M), Measure A ($0.5M). DP-NF Pass-through payment for CY2024 was $23.8 million which was $1.5M lower than the anticipated funding of $25.8M and will be an on-going variance.

- Other operating revenue favorable from higher retail pharmacy ($0.8M), SRH management fee ($0.3M) offset by unfavorable Grant Revenue ($0.2M). YTD, favorable driven by the settlement on low pay patient accounts ($3.1M), SRH management fee excluded from the budget ($2.8M), Alameda Alliance incentive ($0.3M), higher retail pharmacy ($4.7M) offset by unfavorable grant activity ($1.2M).

	March 2026				Year-To-Date				FY 2025	
	Actual	Budget	Variance	% Var	Actual	Budget	Variance	% Var	YTD	% Var
Net patient service revenue	87,535	83,430	4,105	4.9%	728,496	723,160	5,336	0.7%	700,512	(4.0)%
Capitation and HPAC	4,420	4,520	(101)	(2.2)%	40,153	40,392	(240)	(0.6)%	41,537	(3.3)%
Medi-Cal Waiver	8,418	8,474	(55)	(0.7)%	76,403	76,262	141	0.2%	84,063	(9.1)%
Measure A and parcel tax	12,760	12,760	0	0.0%	115,082	114,836	247	0.2%	115,325	(0.2)%
Supplemental Programs	21,494	24,182	(2,688)	(11.1)%	217,797	217,637	160	0.1%	212,071	2.7%
Other government programs	**42,672**	**45,415**	**(2,743)**	**(6.0)%**	**409,283**	**408,735**	**548**	**0.1%**	**411,460**	**(0.5)%**
Grant Revenue	1,293	1,422	(129)	(9.1)%	10,336	12,132	(1,796)	(14.8)%	12,378	(16.5)%
Other Operating Revenue	4,422	3,375	1,046	31.0%	43,712	32,725	10,987	33.6%	33,971	28.7%
Other operating revenue	**5,714**	**4,797**	**917**	**19.1%**	**54,048**	**44,856**	**9,191**	**20.5%**	**46,349**	**16.6%**
Total operating revenue	**$ 140,341**	**$ 138,162**	**$ 2,179**	**1.6%**	**$ 1,231,979**	**$ 1,217,143**	**$ 14,836**	**1.2%**	**$ 1,199,858**	**2.7%**

March 2026 Financial Report
Expense Highlights excluding Labor (part 1)

- Purchased services unfavorable from budget due to management services/consultants ($0.3M), coders ($0.2M), outside medical services ($0.2M), budget timing for other purchased services ($0.4M) offset by favorable timing for IT software fees ($0.7M). YTD, favorable from software licensing ($3.5M), outside medical services ($2.5M) offset by unfavorable variances in HIM coders ($1.8M) and management services/consultants ($0.8M).
  - The favorable variance in outside medical services is expected to continue for the remainder of the fiscal year. The budget was based on higher ambulance services which were the result of duplicate invoices between sister companies. A refund of $1.2 million was received in June 2025.
  - The unfavorable variance in Health Information Services for coders is offset by a favorable variance under registry for the month and YTD.
- Material and supplies unfavorable to budget primarily from pharmaceuticals ($0.8M) offset by supplies ($0.4M). YTD, unfavorable due to pharmaceuticals ($4.2M), surgical supplies ($1.5M), medical supplies ($1.5M) offset by favorable computer equipment ($1.2M).

	March 2026				Year-To-Date				FY 2025	
	Actual	Budget	Variance	% Var	Actual	Budget	Variance	% Var	YTD	% Var
Labor costs	$ 109,316	$ 107,587	$ (1,729)	(1.6)%	$ 957,738	$ 931,750	$ (25,988)	(2.8)%	$ 892,119	(7.4)%
Purchased services	8,525	8,146	(379)	(4.7)%	77,731	81,129	3,398	4.2%	77,720	(0.0)%
Materials and supplies	14,133	13,766	(367)	(2.7)%	124,720	118,789	(5,931)	(5.0)%	115,085	(8.4)%
Facilities	3,552	3,366	(186)	(5.5)%	33,453	29,742	(3,711)	(12.5)%	29,109	(14.9)%
Depreciation and amortization	2,412	2,418	6	0.2%	21,281	22,365	1,084	4.8%	29,819	28.6%
General and administrative	2,489	2,708	219	8.1%	23,412	24,550	1,138	4.6%	37,879	38.2%
Total operating expense	**$ 140,427**	**$ 137,991**	**$ (2,436)**	**(1.8)%**	**$ 1,238,335**	**$ 1,208,325**	**$ (30,010)**	**(2.5)%**	**$ 1,181,731**	**(4.8)%**

March 2026 Financial Report
Expense Highlights excluding Labor (part 2)

- Facilities unfavorable from facility repairs ($0.4M) offset by favorable utilities ($0.2M). YTD, unfavorable from facility repairs ($5.3M), leases ($0.3M) offset by favorable utilities ($1.9M). Facility repairs occurred at Highland Hospital ($2.9M), Alameda Hospital ($1.6M), and San Leandro Hospital ($0.4M).
- Depreciation and amortization favorable from lower equipment depreciation ($0.4M) offset by higher lease and software amortization ($0.4M). YTD, favorable from lower equipment depreciation ($3.8M) offset by higher lease and software amortization ($2.7M).
- General and administrative favorable from timing of insurance ($0.2M). YTD, favorable from recruitment expense ($0.7M), insurance ($0.7M) offset by unfavorable variance ($0.3M) across many cost centers.

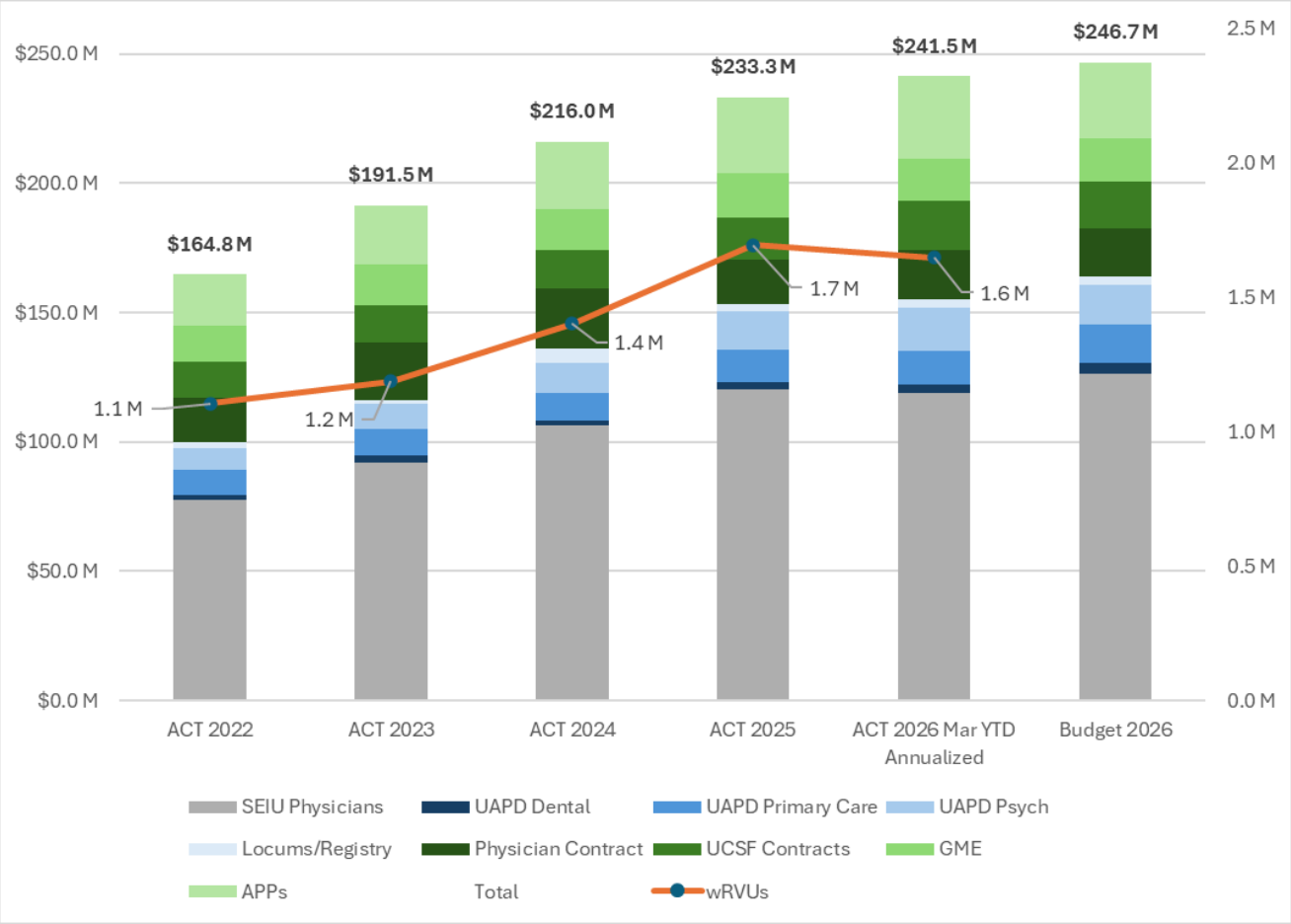
	March 2026				Year-To-Date				FY 2025	
	Actual	Budget	Variance	% Var	Actual	Budget	Variance	% Var	YTD	% Var
Labor costs	$ 109,316	$ 107,587	$ (1,729)	(1.6)%	$ 957,738	$ 931,750	$ (25,988)	(2.8)%	$ 892,119	(7.4)%
Purchased services	8,525	8,146	(379)	(4.7)%	77,731	81,129	3,398	4.2%	77,720	(0.0)%
Materials and supplies	14,133	13,766	(367)	(2.7)%	124,720	118,789	(5,931)	(5.0)%	115,085	(8.4)%
Facilities	3,552	3,366	(186)	(5.5)%	33,453	29,742	(3,711)	(12.5)%	29,109	(14.9)%
Depreciation and amortization	2,412	2,418	6	0.2%	21,281	22,365	1,084	4.8%	29,819	28.6%
General and administrative	2,489	2,708	219	8.1%	23,412	24,550	1,138	4.6%	37,879	38.2%
Total operating expense	**$ 140,427**	**$ 137,991**	**$ (2,436)**	**(1.8)%**	**$ 1,238,335**	**$ 1,208,325**	**$ (30,010)**	**(2.5)%**	**$ 1,181,731**	**(4.8)%**

March 2026 Financial Report
Expense Highlights – Labor

- Staff and registry unfavorable for month ($0.5M) and YTD ($17.0M).
  - Staff salaries and registry unfavorable driven higher rate ($1.5M).and lower FTEs (47 FTEs/$1.0M). YTD, unfavorable due to higher rate ($10.6M) and higher FTEs (70 FTEs/$6.4M).
- Provider salaries and contracts favorable for month ($0.2M) and unfavorable YTD ($0.1M).
  - Provider salaries favorable from lower FTEs (20 FTEs/$0.7M) offset by higher rate ($0.3M). YTD, favorable from lower FTEs (20 FTEs/$5.7M) offset by higher rate ($4.8M) includes paternity payout last month ($1.6M). FY26 recruitment unrealized.
  - Physician contract services approximate budget for month and unfavorable YTD ($1.0M) due to locum expense.

	March 2026				Year-To-Date				FY 2025	
	Actual	Budget	Variance	% Var	Actual	Budget	Variance	% Var	YTD	% Var
Salaries and wages (staff)	$ 61,831	$ 59,768	$ (2,063)	(3.5)%	$ 549,286	$ 523,656	$ (25,630)	(4.9)%	$ 498,639	(10.2)%
Salaries and wages (providers)	12,933	13,263	330	2.5%	116,486	117,371	885	0.8%	111,559	(4.4)%
Registry	2,739	4,338	1,599	36.9%	29,355	37,909	8,554	22.6%	39,141	25.0%
Physician contract services	3,790	3,699	(91)	(2.5)%	33,846	32,835	(1,011)	(3.1)%	32,035	(5.7)%
Employee benefits (taxes, insur	18,936	17,788	(1,148)	(6.5)%	153,871	147,008	(6,863)	(4.7)%	139,889	(10.0)%
Retirement	9,087	8,731	(356)	(4.1)%	74,894	72,971	(1,923)	(2.6)%	70,855	(5.7)%
Total labor costs	**$ 109,316**	**$ 107,587**	**$ (1,729)**	**(1.6)%**	**$ 957,738**	**$ 931,750**	**$ (25,988)**	**(2.8)%**	**$ 892,119**	**(7.4)%**
Compensation ratio	77.9%	77.9%	0.0%		77.7%	76.6%	-1.1%		74.4%	
Paid FTEs - staff	4,476	4,467	(9)	(0.2)%	4,613	4,513	(100)	(2.2)%	4,618	0.1%
Paid FTEs - providers	381	401	20	5.0%	383	403	20	5.0%	289	(32.5)%
Paid FTEs - registry	162	218	56	25.7%	187	216	29	13.4%	235	20.4%
Total FTEs	5,019	5,086	67	1.3%	5,183	5,132	(51)	(1.0)%	5,142	(0.8)%

Total Provider Expenses



Paid FTEs	ACT 2022	ACT 2023	ACT 2024	ACT 2025	ACT 2026 Mar YTD Annualized	Budget 2026
SEIU Physicians	180.0	197.1	213.2	223.1	223.1	243.1
UAPD Dental	8.7	9.8	8.3	9.0	9.4	11.4
UAPD Primary Care	27.8	28.4	30.7	32.7	30.8	34.8
UAPD Psych	17.1	17.4	19.2	23.9	26.4	23.5
GME	134.6	136.8	137.4	139.1	139.4	138.2
APPs	76.8	81.6	84.6	90.8	93.6	91.3
Subtotal Physicians	**445.0**	**471.1**	**493.3**	**518.6**	**522.7**	**542.3**
% Change		*6%*	*5%*	*5%*	*1%*	
Change Paid FTE		*26.1*	*22.2*	*25.2*	*4.1*	

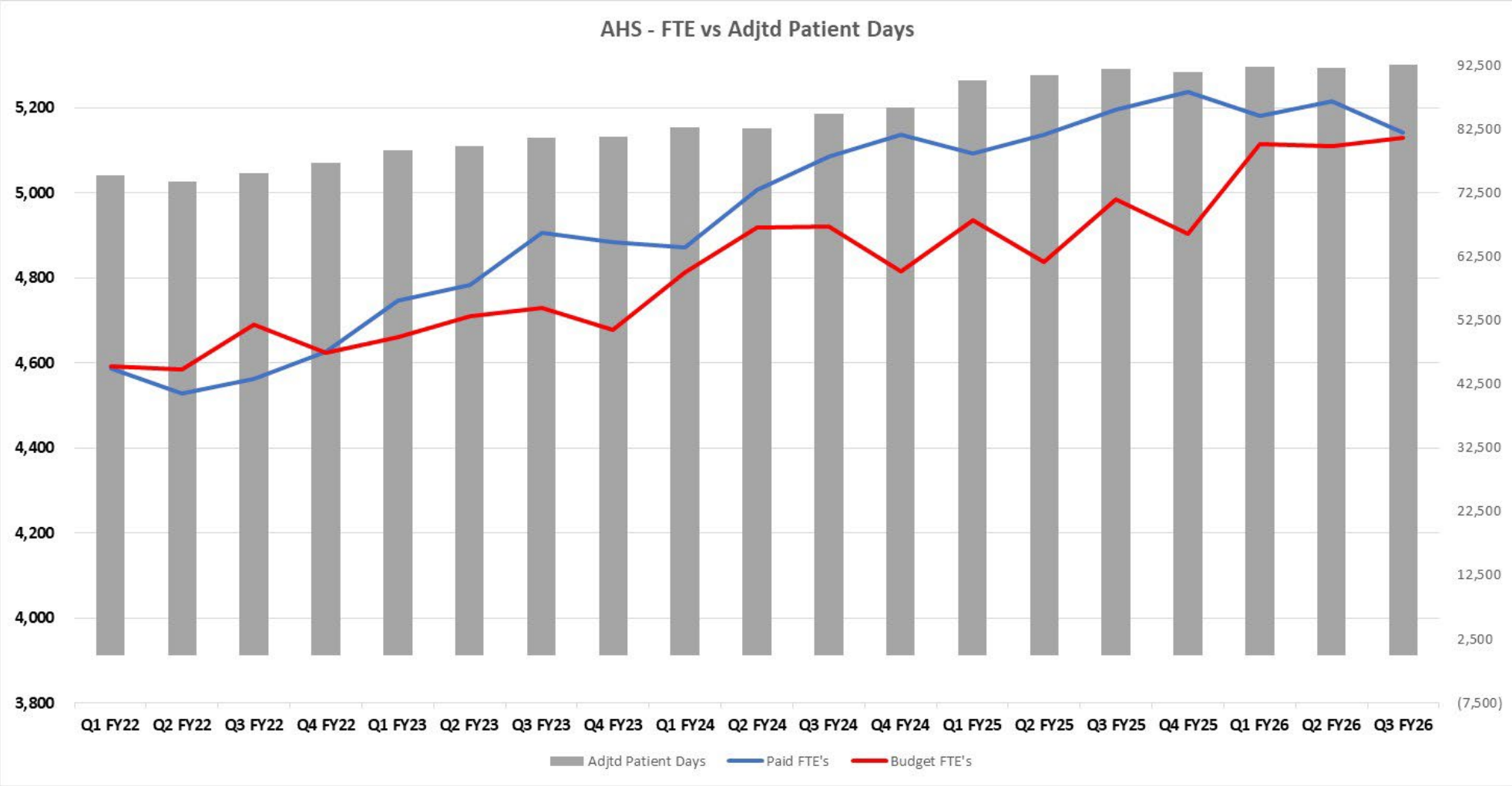
Service Type	ACT 2022	ACT 2023	ACT 2024	ACT 2025	ACT 2026 Mar YTD Annualized	Budget 2026
SEIU Physicians	$77.3 M	$91.8 M	$106.3 M	$120.2 M	$118.9 M	$126.4 M
UAPD Dental	$2.3 M	$2.7 M	$1.7 M	$2.8 M	$3.2 M	$4.1 M
UAPD Primary Care	$9.4 M	$10.3 M	$10.9 M	$12.6 M	$13.0 M	$14.7 M
UAPD Psych	$8.7 M	$9.6 M	$11.7 M	$14.7 M	$16.5 M	$15.7 M
Locums/Registry	$2.2 M	$1.7 M	$5.3 M	$3.0 M	$3.6 M	$3.2 M
Physician Contract	$17.0 M	$22.4 M	$23.3 M	$17.1 M	$18.8 M	$18.6 M
UCSF Contracts	$14.0 M	$14.0 M	$15.1 M	$16.2 M	$19.1 M	$18.1 M
GME	$13.9 M	$16.1 M	$15.6 M	$17.3 M	$16.2 M	$16.6 M
APPs	$20.0 M	$22.9 M	$26.1 M	$29.3 M	$32.2 M	$29.3 M
Subtotal Physicians	**$164.8 M**	**$191.5 M**	**$216.0 M**	**$233.3 M**	**$241.5 M**	**$246.7 M**

	ACT 2022	ACT 2023	ACT 2024	ACT2025	Act 2026 Mar YTD Annualized	Budget 2026
Clinic Visits		332,403	357,741	378,682	402,833	403,957
% Change			7.6%	5.9%	6.4%	0.3%

Notes:

1. FY26 SEIU excludes President and admin staff dollars.
2. Dignity Health GME moved to UCSF in FY26.
3. Locums: FY2024-2026 for John George-Psych, General Surgery & Eastmont Wellness center.

March 2026 Financial Report
Labor Expense – FTE Trending



Volumes or adjusted patient days have increased since FY2022.

FTEs increased, in part due to volume, but have outpaced the budget since FY2023.

March 2026 Financial Report
Expense Highlights – Benefits

- Employee Benefits unfavorable from higher self-funded health ($0.9M), FICA ($0.8M) offset by lower Kaiser health plan ($0.5M) and other benefits ($0.1M). YTD, unfavorable from higher self-funded health ($11.0M), FICA ($1.3 million) offset by lower Kaiser health plan ($3.0M), other benefits ($0.6M), and timing of resident housing allowance ($0.8M).
- Retirement unfavorable from ACERA ($0.2M) and other plans ($0.2M). YTD, unfavorable from ACERA ($0.9M) and union plans ($1.0M).

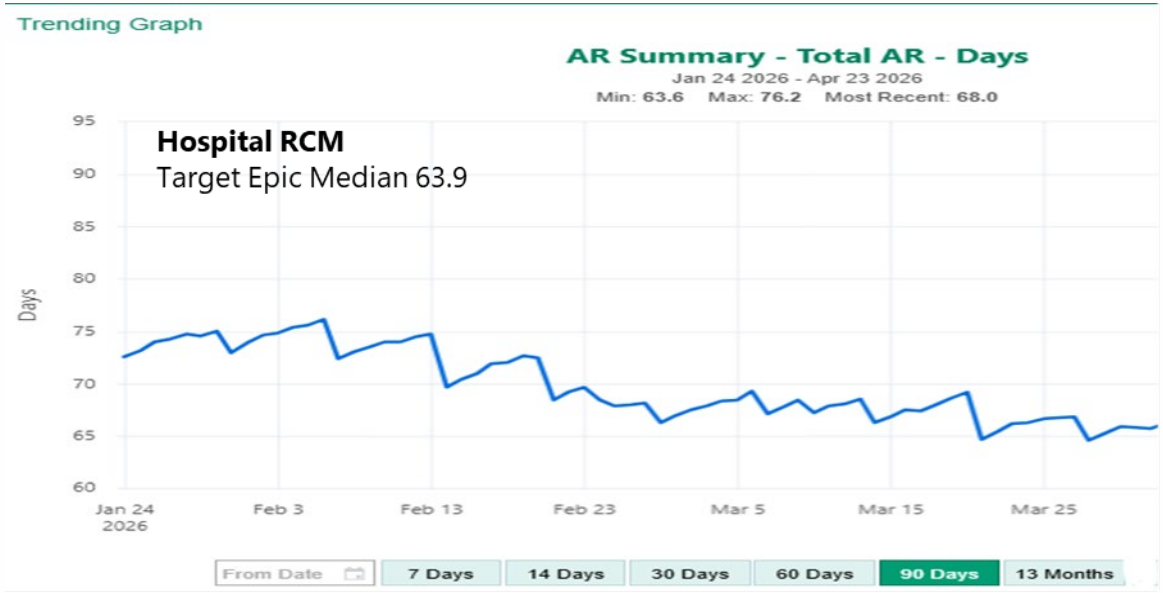
	March 2026				Year-To-Date				FY 2025	
	Actual	Budget	Variance	% Var	Actual	Budget	Variance	% Var	YTD	% Var
Salaries and wages (staff)	$ 61,831	$ 59,768	$ (2,063)	(3.5)%	$ 549,286	$ 523,656	$ (25,630)	(4.9)%	$ 498,639	(10.2)%
Salaries and wages (providers)	12,933	13,263	330	2.5%	116,486	117,371	885	0.8%	111,559	(4.4)%
Registry	2,739	4,338	1,599	36.9%	29,355	37,909	8,554	22.6%	39,141	25.0%
Physician contract services	3,790	3,699	(91)	(2.5)%	33,846	32,835	(1,011)	(3.1)%	32,035	(5.7)%
Employee benefits (taxes, insur	18,936	17,788	(1,148)	(6.5)%	153,871	147,008	(6,863)	(4.7)%	139,889	(10.0)%
Retirement	9,087	8,731	(356)	(4.1)%	74,894	72,971	(1,923)	(2.6)%	70,855	(5.7)%
Total labor costs	**$ 109,316**	**$ 107,587**	**$ (1,729)**	**(1.6)%**	**$ 957,738**	**$ 931,750**	**$ (25,988)**	**(2.8)%**	**$ 892,119**	**(7.4)%**
Compensation ratio	77.9%	77.9%	0.0%		77.7%	76.6%	-1.1%		74.4%	
Paid FTEs - staff	4,476	4,467	(9)	(0.2)%	4,613	4,513	(100)	(2.2)%	4,618	0.1%
Paid FTEs - providers	381	401	20	5.0%	383	403	20	5.0%	289	(32.5)%
Paid FTEs - registry	162	218	56	25.7%	187	216	29	13.4%	235	20.4%
Total FTEs	5,019	5,086	67	1.3%	5,183	5,132	(51)	(1.0)%	5,142	(0.8)%

March 2026 Financial Report
Balance Sheet Key Metrics

- Days in Cash are 0.6 days and lower than year-end; typically, below 5.0 days.
- Gross AR Days decreased 3.2 days and Net AR Days decreased by 0.4 days. See next slide for additional detail.
- Days in Accounts Payable increased due to timing of the check run and implementation of Hyland/Onbase (automation of AP processes). The target is 30 days.
- Net Position is negative $70.8M and increased $8.9M from June 30, 2025 reflecting YTD Net Loss.
- Net Negative Balance is a payable of $66.0M. NNB consists of the liquidity facility (loan) of $94.3M offset by the restricted cash of $28.3M; and is expected to be below the June 30, 2026 credit ceiling of $95.0M at the end of the fiscal year.

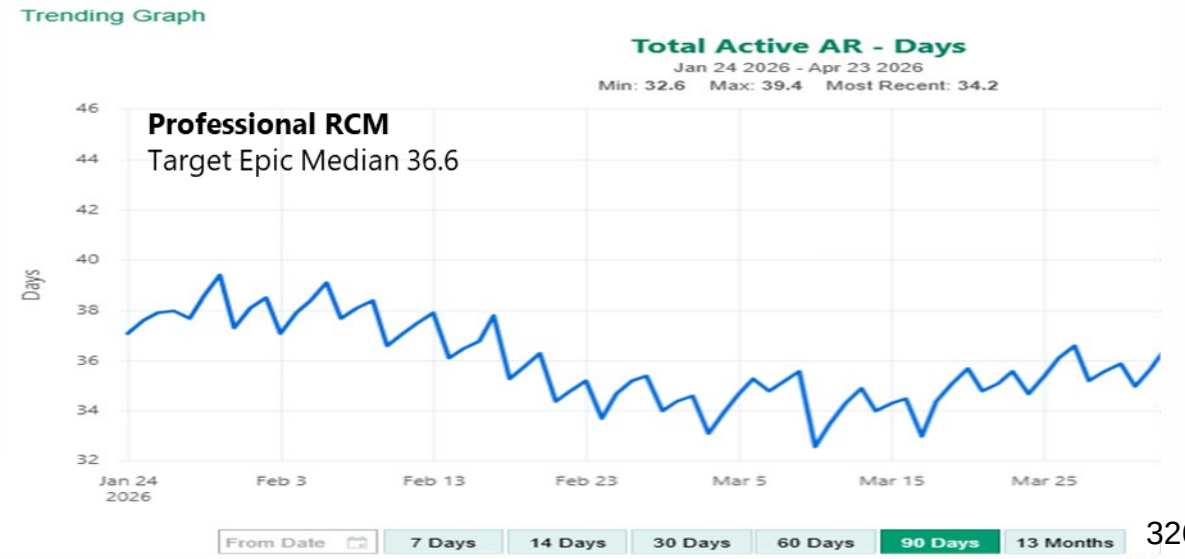
	Mar-26	Feb-26	FY 2025
Days in cash	0.6	0.7	2.9
Gross days in patient receivable	62.7	65.9	62.4
Net days in patient receivable	40.7	41.1	43.8
Due from/(to) third-party payors	$ 387,608	$ 288,913	$ 158,555
Due from/(to) County	$ (117,719)	$ (34,106)	$ 49,680
Days in accounts payable	38.7	33.7	38.3
% of AP over 60 days	3.7%	3.9%	4.0%
Net position - fund balance/(deficit)	$ (70,793)	$ (70,467)	$ (61,798)
Net negative balance - receivable/(payable)	$ (65,963)	$ (54,264)	$ 26,949

March 2026 Financial Report
Patient Accounts Receivable Trending



Hospital Revenue Cycle Key Indicators

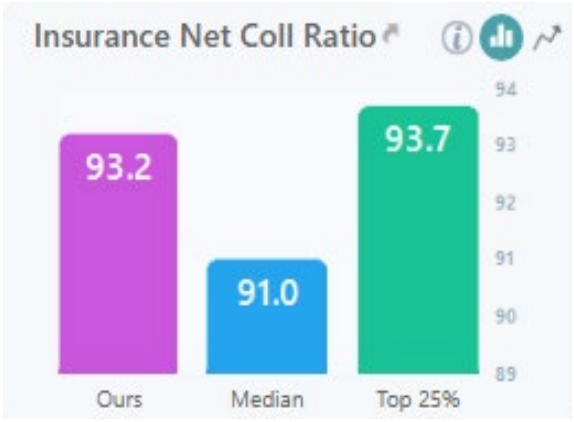
- HB AR Days decreased by 1.1 days compared to prior month. February AR Days were 66.9 days, and March AR Days ended at 65.8 days.
- March collections were higher at $64.1M compared to monthly trend of approximately $59.6M.
- The coding work queue has stabilized and is 2.3 days



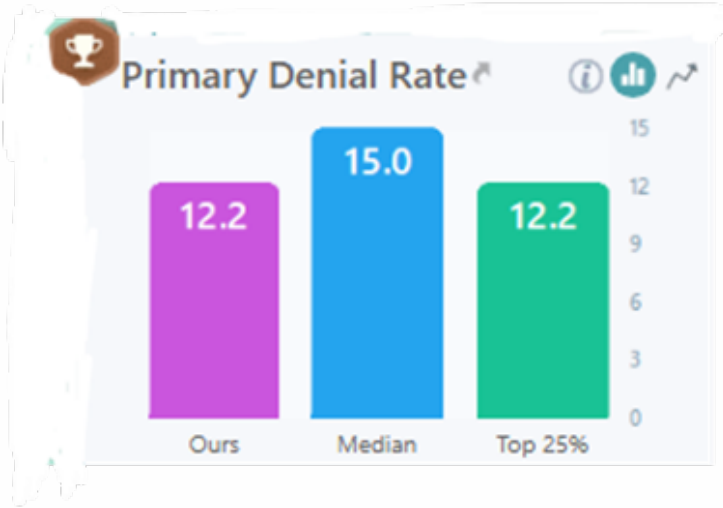
Professional Revenue Cycle Key Indicators

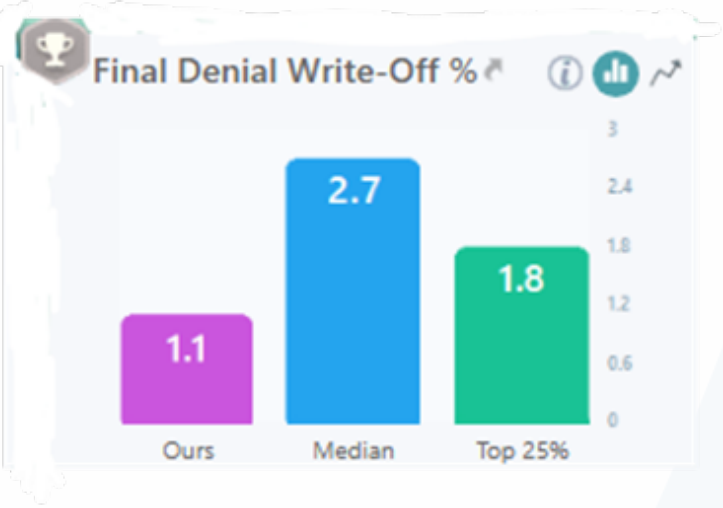
- PB AR Days increased by 1.3 days compared to prior month. February AR Days were 34.4 days, and March AR Days ended at 35.7
- March collections reported was $14.2M. This is above the monthly trend of approximately $8.4M.
- Enterprise CDI launched to address provider clinical documentation along with charge automation, and usage of Epic tools. Pilot project in progress with Inpt. Critical Care, Obstetrics & Gynecology. Outpatient continues with Neurology, Optometry, Pediatrics, Critical Care, and Nephrology. Orthopedics, OMG, and ENT closed.

March 2026 Financial Report
Net Collection/Denials Comparison to Epic Customer Database



- AHS is currently collecting 93.2% of expected payments which is better than the median. We are typically, at or near the top 25th percentile of all safety net hospitals
- Net collection ratio metric shows the ratio of payments collected (less any refunds) to expected reimbursement for hospital accounts that were fully resolved within the past 91 days.





- Primary denial rate is 12.2% of net collections and is at top 25% percentile of safety net hospitals and represents all claim that payers have adjudicated. Less work rework and steady cash flows.
- Final denial write-off rate is 1.1% of net collections and approximates the top 25th percentile of safety net hospitals and represents all claims with a final denial and closed accounts.

March 2026 Financial Report
Patient collections are growing year over year

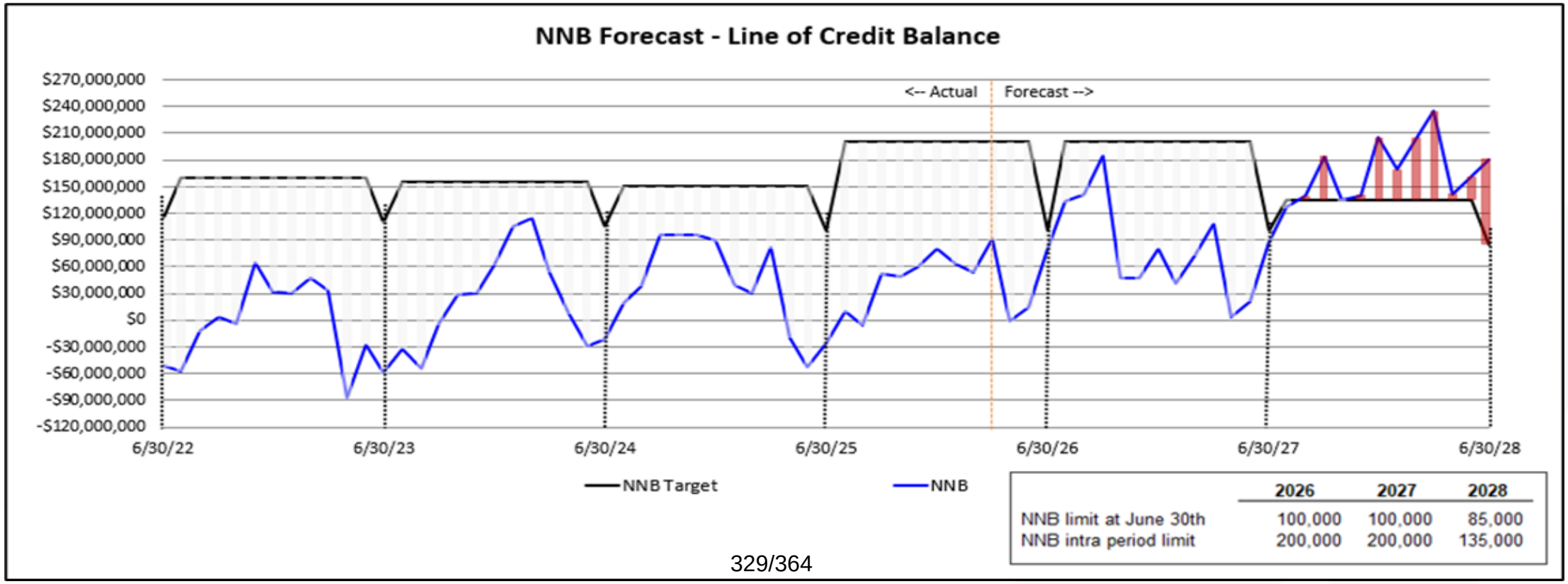
PATIENT COLLECTIONS
(in thousands)

	Behavioral Health	Epic	Total FY 2026	FY 2025	FY 2024	FY 2023	FY 2022
Jul	11,928	67,883	79,811	72,694	79,592	74,260	59,732
Aug	28,651	82,136	110,787	79,768	69,313	58,590	57,374
Sep	-	66,819	66,819	69,741	63,322	76,063	61,968
Oct	868	82,323	83,191	76,783	63,122	59,796	49,923
Nov	11,569	71,370	82,939	78,747	57,781	56,939	52,057
Dec	7,275	65,241	72,516	94,631	63,867	67,018	68,121
Jan	6,034	63,286	69,320	89,014	68,757	71,452	62,292
Feb	4,293	90,269	94,562	68,511	75,852	57,886	52,269
Mar	9,323	78,320	87,643	91,851	54,720	65,320	62,888
Apr	-	-	-	74,892	61,895	55,307	56,235
May	-	-	-	74,339	102,015	63,795	69,591
Jun	-	-	-	72,211	71,208	70,027	53,187
Total	**79,941**	**667,647**	**747,588**	**943,182**	**831,444**	**776,453**	**705,637**
% change between fiscal years			3.6%	13.4%	7.1%	10.0%	

- Behavioral Health representing payments from Alameda County for JGP. The FY26 contract was executed at $81.2M. The maximum contract have been paid for prior years.
- Since the conversion to SmartCare/CalAIM in July 2023, the County has withheld approximately 20% of AHS invoices. The County has agreed to reduce the withhold to 10% for the current fiscal year. The maximum contract amount has not been changed. Previous year withholds have not been adjusted.

March 2026 Financial Report
Line of Credit (NNB) and AHS Business Cycle

- The graph shows the business cycle driven by timing of the supplemental funding. The graph reflects the recent change in the NNB Permanent Agreement for FY2026 and FY2027 to increase NNB limit on June 30th to $100.0M and the intra year maximum to $200.0M.
- The NNB is projected to exceed the NNB in future fiscal years if interventions are not taken.
- The forecast does not include the FY2027 budget which has a significant gap, looming HR1 and other state impacts, performance improved initiatives, or actions from the BOS Ad hoc meetings.



March 2026 Financial Report
Impact on NNB from the Preliminary FY2027 Budget

	(in thousands)	
NNB forecast 6/30/26	$	80,794
FY2027 budget loss		67,677
NNB forecast 6/30/27		148,471
NNB limit at 6/30/27		100,000
Over NNB limit	**$**	**48,471**

- The FY2027 preliminary budget currently reflects a significant gap with a net loss of $67.7 million.
  - Work is in play to balance the budget. The gap is fluid and not part of NNB line of credit forecast.
  - The forecast projects using current revenue and expense activity.
- If AHS is unable to correct the budget imbalance and utilizes the NNB to fund operations, the revisions to the Permanent Agreement/NNB will not be sufficient.
  - AHS would exceed the revised NNB limit at 6/30/27.
  - AHS would also exceed the revised intra-period maximum of $200.0 million.

March 2026 Financial Report
Material Items Impacting NNB Forecast

Material Items Included in NNB Forecast
(in thousands)

	Apr-26	May-26	Jun-26	FY27 Q1	FY27 Q2	FY27 Q3	FY27 Q4
GPP (quarterly)	$ 51,788	$ -	$ -	$ 22,352	$ 22,352	$ 27,394	$ 19,325
EPP (semi-annual)	31,166	-	-	-	72,317	-	42,417
QIP	40,527	-	-	-	56,842	-	56,842
Medi-Cal Rate Range	-	-	-	-	-	45,831	-
BHCS (JGP/Alameda County) - fy26	12,103	6,084	6,084	12,167	-	-	-
BHCS (JGP/Alameda County) - fy27	-	-	-	-	18,900	18,900	25,200
HPAC	10,313	-	-	-	21,600	10,800	10,800
AB85 Realignment	-	-	-	-	4,789	-	-
SNF DP-NF (final pmt Jan-27)	-	-	-	-	-	26,000	-
Waiver recoupment (fy11, fy12)	-	19,815	9,354	-	-	-	-
Donation to St. Rose Hospital	-	-	-	10,507	-	10,507	-
	$ 145,897	$ 25,899	$ 15,438	$ 45,026	$ 196,800	$ 139,432	$ 154,584

Prior Year Reimbursement Settlements

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

- Overall, activity consistent with prior month's forecast
- GPP CY2026 Q1 funding based on DHCS notification increased by $3.8M.
- BHCS FY26 funding (July-December 2025) increased based on receipts by $5.8M.
- St. Rose LOC currently at $10.6M and no projected activity in forecast.
- St. Rose donation for IGT moved from April 2026 to July 2026 pending notification from State.

March 2026 Financial Report
Growing Responsibly Through Innovation & Teamwork GRIT

- Charge capture and CDI teams yielding significant improvement.
- LOS work showing positive progress.
- EWC dental expansion ramp up slower than plan
- Labor improvements behind target

#	Project Name	FY2026 Target YTD Q3	FY2026 Actual YTD Q3	Variance	$ Impact (in Millions)	Metric	
1	OP Non-FQ Charge Capture(Enterprise CDI)	$5,407	$5,889	$482	$13.3M	Charge per case increase	
2	OR Charge Level	$17,417	$24,449	$7,032	$7.0M	Charge per case increase	
3	Provider Productivity	20%	16%	-4%	$0.2M	Provider productivity for Ortho(22nd percentile), Urology(10th percentile), and GI(14th percentile).	
4	Reduce Overtime %	4.5%	5.7%	-1.2%	-$5.3M	Actual OT % at 5.7% to a target of 4.5%	
5	Staffing Efficiency	45	-	(45)	-$8.8M	Total reduction for the year is 45 FTEs.	
6	EWC Dental Expansion	18,960	12,665	(6,295)	-$0.2M	Variance in clinic visits	
7	Decrease in Opportunity Days	9,770	8,522	1,248	$1.9M	Decrease in opportunity days	

January 2026 Consolidated Results
Financial Summary & YTD Highlights

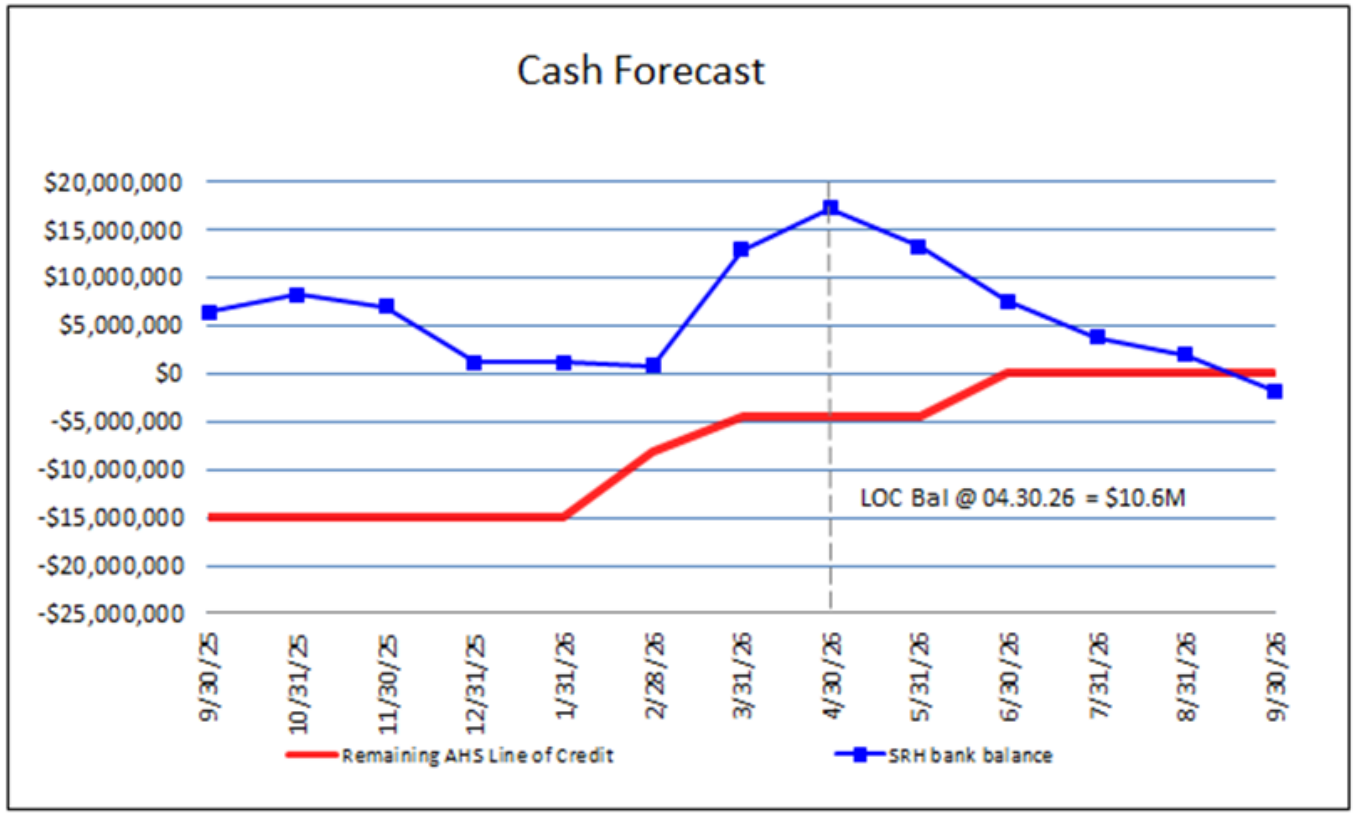
- SRH's YTD net loss ($10.9M), $6.9M favorable to budget
  - Gross charges above budget in line with increased census primarily in SNF unit due to collaboration with Stanford starting March 16, 2026.
  - Net patient service revenue variance, favorable 10.6% ($5.5M), driven by higher gross patient revenue ($7.7M).
  - QAF continues to be recognized based on the contractor's analysis and recommendation, while awaiting CMS approval of the new program.
  - Expenses approximates budget.

- MOB's YTD net income ($32K), $57K favorable to budget.
  - Repairs and maintenance delay helps offset higher utility costs.

- Foundation's YTD net income ($132K), $184K unfavorable to budget largely driven by reported losses in investment.

	March 31, 2026				FY2026 Year-To-Date				FY2025 Year-To-Date			
CONSOLIDATED	**Actual**	**Budget**	**Var ($)**	**Var (%)**	**Actual**	**Budget**	**Var ($)**	**Var (%)**	**FY2026**	**FY2025**	**Var ($)**	**Var (%)**
Total Net Patient Service Revenue	$11,090	$9,244	$1,846	20.0%	$57,810	$52,270	$5,540	10.6%	$57,810	$50,284	$7,526	15.0%
Total Other Revenue	$398	$171	$227	132.7%	$1,290	$1,051	239	22.8%	$1,290	$9,349	(8,059)	-86.2%
TOTAL OPERATING REVENUE	**$11,489**	**$9,415**	**$2,073**	**22.0%**	**$59,100**	**$53,321**	**$5,780**	**10.8%**	**$59,100**	**$59,634**	**($533)**	**-0.9%**
Less: Operating Expenses	$11,338	$11,399	$62	0.5%	$68,436	$69,063	$627	0.9%	$68,436	$69,534	$1,098	1.6%
EBITDA	**$151**	**($1,984)**	**$2,135**	**-107.6%**	**($9,336)**	**($15,742)**	**$6,406**	**-40.7%**	**($9,336)**	**($9,900)**	**$564**	**-5.7%**
Total Non-Operating Exp/(Income)	$400	$453	($53)	-11.7%	$1,337	$1,695	($358)	-21.1%	$1,337	$2,647	($1,310)	-49.5%
NET INCOME/(LOSS)	**($249)**	**($2,436)**	**$2,188**	**-89.8%**	**($10,673)**	**($17,437)**	**$6,764.18**	**-38.8%**	**($10,673)**	**($12,547)**	**$1,874.40**	**-14.9%**

November 2025
Cash Flow Projection



- Additional draw from AHS LOC to maintain liquidity, $3.8M (YTD total - $10.6M).
- Forecast include prepayment received in March from the Stanford collaboration ($16.0M).
- QAF CY2024 received in April ($6.0M).
  - QAF CY2025 not reflected in cash projection, pending CMS notice.
- Full IGT funding ($36M) is delayed pending CMS approval with timing is unknown. As a result, the AHS LOC is expected to be fully drawn and the Stanford prepayment will be used to support operations, with funds projected to be exhausted by August.
  - When approved, the local share will be provided by AHS ($9.5M), Eden ($750K), Sup Marquez ($1M). Last week, Eden increased contribution from $500K to $750K and naming recognition conversation underway.

ALAMEDA HEALTH SYSTEM

1411 East 31st Street
Oakland, CA 94602

MEMORANDUM

TO: AHS Finance Committee
FROM: Kim Miranda, CFO
DATE: April 30, 2026
SUBJECT: March 2026 Financial Report

Financial Summary

	March 2026				Year-To-Date				FY 2025	
	Actual	Budget	Variance	% Var	Actual	Budget	Variance	% Var	YTD	% Var
Operating revenue	$ 140,341	$ 138,162	$ 2,179	1.6%	$ 1,231,981	$ 1,217,142	$ 14,839	1.2%	$ 1,199,858	2.7%
Operating expense	140,427	137,991	(2,436)	(1.8)%	1,238,335	1,208,325	(30,010)	(2.5)%	1,181,731	(4.8)%
Operating income (loss)	**(86)**	**171**	**(257)**	**(150.3)%**	**(6,354)**	**8,817**	**(15,171)**	**(172.1)%**	**18,127**	**(135.1)%**
Other non-operating activity	(242)	(127)	(115)	(90.6)%	(2,809)	(2,576)	(233)	(9.0)%	(3,468)	19.0%
Net Income (loss)	**$ (328)**	**$ 44**	**$ (372)**	**(845.5)%**	**$ (9,163)**	**$ 6,241**	**$ (15,404)**	**(246.8)%**	**$ 14,659**	**(162.5)%**
EBIDA adjustments	2,663	2,558	105		24,106	25,058	(952)		33,003	
EBIDA	**$ 2,335**	**$ 2,602**	**$ (267)**		**$ 14,943**	**$ 31,299**	**$ (16,356)**		**$ 47,662**	
Operating Margin	(0.1)%	0.1%	(0.2)%		(0.5)%	0.7%	(1.2)%		1.5%	
EBIDA Margin	1.7%	1.9%	(0.2)%		1.2%	2.6%	(1.4)%		4.0%	
Total FTEs	5,019	5,086	67	1.3%	5,183	5,132	(51)	(1.0)%	5,093	

Net Income for the month was a loss of $0.3 million compared to a budget of $0.0 million and unfavorable to budget by $0.4 million and 845.5%. Operating Revenue was $140.3 million and favorable to budget by $2.2 million and 1.6%. Operating Expense was $140.4 million and unfavorable to budget by $2.4 million and 1.8%. Earnings before interest, depreciation, and amortization (EBIDA) was $2.3 million and the EBIDA Margin was 1.7% compared to a budget EBIDA of $2.6 million and a budget EBIDA Margin of 1.9%. For the month, EBIDA was unfavorable by $0.3 million to budget.

Net Income year-to-date (YTD) was a loss of $9.2 million compared to a budget of $6.2 million and unfavorable to budget by $15.4 million and 246.8%. Operating Revenue was $1.2 billion and favorable to budget by $14.8 million and 1.2%. Operating Expense was $1.2 billion and unfavorable to budget by $30.0 million and 2.5%. EBIDA was $14.9 million and the EBIDA Margin was 1.2% compared to the budget EBIDA of $31.3 million and a budget EBIDA Margin of 2.6%. For the year, EBIDA is unfavorable by $16.4 million to budget.

Operating Revenue

	March 2026				Year-To-Date				FY 2025	
	Actual	Budget	Variance	% Var	Actual	Budget	Variance	% Var	YTD	% Var
Inpatient service revenue	$ 239,830	$ 232,916	$ 6,914	3.0%	$ 1,996,547	$ 2,003,157	$ (6,609)	(0.3)%	$ 1,927,199	3.6%
Outpatient service revenue	169,838	151,470	18,367	12.1%	1,423,014	1,318,799	104,215	7.9%	1,284,162	10.8%
Professional service revenue	46,064	42,410	3,654	8.6%	379,757	377,452	2,305	0.6%	386,056	(1.6)%
Gross patient service revenue	455,732	426,796	28,935	6.8%	3,799,319	3,699,408	99,910	2.7%	3,597,417	5.6%
Deductions from revenue	(368,196)	(343,366)	(24,830)	(7.2)%	(3,070,823)	(2,976,249)	(94,574)	(3.2)%	(2,896,905)	6.0%
Net patient service revenue	**87,535**	**83,430**	**4,105**	**4.9%**	**728,496**	**723,160**	**5,336**	**0.7%**	**700,512**	**(4.0)%**
Collection % - NPSR	19.2%	19.5%	(0.3)%		19.2%	19.5%	(0.3)%		19.5%	
Capitation and HPAC	4,420	4,520	(101)	(2.2)%	40,153	40,392	(240)	(0.6)%	41,537	(3.3)%
Other government programs	42,672	45,415	(2,743)	(6.0)%	409,283	408,735	548	0.1%	411,460	(0.5)%
Other operating revenue	5,714	4,797	917	19.1%	54,048	44,856	9,191	20.5%	46,349	16.6%
Total operating revenue	**$ 140,341**	**$ 138,162**	**$ 2,179**	**1.6%**	**$ 1,231,979**	**$ 1,217,143**	**$ 14,836**	**1.2%**	**$ 1,199,858**	**2.7%**

Gross Patient Revenue

Gross Patient Service Revenue (patient charges) was $455.7 million for the month and favorable to budget by $28.9 million and 6.8%. Inpatient, Outpatient and Professional Fee charges were above budget by 3.0%, 12.1% and 8.6%, respectively. For the year, Gross Patient Service Revenue was $3.8 billion and favorable to budget by $99.9 million and 2.7%. Inpatient charges were lower than budget by 0.3% offset by Outpatient and Professional Fee charges which exceeded budget by 7.9% and 0.6%, respectively. For the month, inpatient charges were higher than budget driven by higher patient days and trauma cases. The Case Mix Index (CMI) is higher than budget for the month, YTD trend and prior year. CMI is an indicator of the overall complexity of inpatient illness and services being provided. General Acute Length of Stay (LOS) was 5.4 slightly higher primarily due to higher CMI. YTD LOS is lower than prior year which indicates patients are staying fewer days over the expected LOS. Favorable Outpatient charge variance for the month was driven by high acuity patients generating a higher charge per visit in the Emergency Room. Emergency Room visits were also above budget by 4.3% for the month and 3.6% YTD. Outpatient surgeries exceeded budget for the month and YTD by 11.5% and 6.7%, respectively. Favorable Professional Fees charges were driven by Clinic visits exceeding budget 9.3% for the month; however, clinic visits are below budget by 0.5% YTD. Physician wRVU were above budget for the month and YTD driven by hospital activity; however, the budget for physician wRVU is artificially low. Physician wRVU are actually below prior year by 5.0%. Overall, adjusted patient days were higher than budget by 5.6% for the month and 1.7% YTD. Adjusted discharges are below budget by 0.9% for the month and above budget by 0.9% YTD.

Net Patient Revenue

Net Patient Service Revenue (NPSR) was $87.5 million and favorable to budget by $4.1 million and 4.9%. YTD, NPSR was $728.5 million favorable to budget by $5.3 million and 0.7%. The favorable variance is being driven higher gross charges from volume. The collection ratio was 19.2% for the month and consistent with trend; however unfavorable to budget of 19.5%. Trauma cases tend to drive a higher commercial mix which occurred this month. Both the trauma cases and commercial payer mix were above budget. However, an unfavorable FY16 Medicare cost report adjustment for Alameda Hospital lowered the collection by 0.5% or $2.4 million. The mix of services shift to more outpatient services also negatively impacts the collection rate.

Other Government Program Revenue
Other Government Program Revenue for the month was $42.7 million and unfavorable to budget by $2.7 million and 6.0% based on the transactions below.

- SNF Medi-Cal FY21 final reconciliation was unfavorable $2.4 million
- DP-NF Pass-through CY2024 was lower than plan by $0.2 million.
- Prop 56 was lower than budget by $0.1 million.

For the year, the Other Government Program Revenue is $409.3 million and favorable to budget by $0.5 million and 0.1% based on the transactions below.

- SNF Medi-Cal final reconciliation decreased revenue due to a payment of $2.4 million
- Measure A FY2026 Q1-Q2 decreased based on receipts by $0.5 million.
- Alameda Parcel Tax increased based on receipts by $0.8 million.
- Pay-for-Performance (P4P) revenue increased from successfully meeting CY2024 Alameda Alliance quality metrics for additional payment of $1.2 million.
- DP-NF Pass-through CY2024 payment was received for $23.8 million which was $2.0 million less than budget. As of March, the revenue was reduced by $1.5 million, and remaining $0.4 million variance will be recognized over the next three months.
- Medi-Cal Rate Range CY2024 revenue increased based on receipts by $4.2 million.
- FEMA revenue received for successful filing of Covid-related expenditure was $0.2 million. Total FEMA receipts, starting in FY2024, are $7.1 million.
- Prop 56 was lower than budget by $1.6 million. The budget was based on FY25 receipts that included an overpayment from Alameda Alliance. It is anticipated that this unfavorable variance will continue for the remainder of the fiscal year.
- The remaining variance, netting to a positive $0.1 million, is spread across many programs.

Other Operating Revenue
Other Operating Revenue for the month was $5.7 million and favorable to budget by $0.9 million and 19.1% based on the transactions below.

- Retail pharmacy revenue was favorable by $0.8 million.
- St. Rose Hospital management fee favorable by $0.3 million, which was not included in the budget.
- Grant revenue was unfavorable from timing differences of $0.2 million.

For the year, Other Operating Revenue was $54.0 million and favorable by $9.2 million and 20.5% based on the transactions below.

- Payor settlement received on older patient accounts of $3.1 million.
- Retail pharmacy revenue favorable by $4.7 million.
- St. Rose Hospital management fee $2.8 million, which was not included in the budget.
- Alameda Alliance Equity and Practice Transformation CY2024 incentive payment of $0.3 million.
- Grant revenue was unfavorable from timing differences of $1.2 million.
- The remaining variance, netting to a negative $0.5 million, was spread across many programs.

Operating Expense

	March 2026				Year-To-Date				FY 2025	
	Actual	Budget	Variance	% Var	Actual	Budget	Variance	% Var	YTD	% Var
Labor costs	$ 109,316	$ 107,587	$ (1,729)	(1.6)%	$ 957,738	$ 931,750	$ (25,988)	(2.8)%	$ 892,119	(7.4)%
Purchased services	8,525	8,146	(379)	(4.7)%	77,731	81,129	3,398	4.2%	77,720	(0.0)%
Materials and supplies	14,133	13,766	(367)	(2.7)%	124,720	118,789	(5,931)	(5.0)%	115,085	(8.4)%
Facilities	3,552	3,366	(186)	(5.5)%	33,453	29,742	(3,711)	(12.5)%	29,109	(14.9)%
Depreciation and amortization	2,412	2,418	6	0.2%	21,281	22,365	1,084	4.8%	29,819	28.6%
General and administrative	2,489	2,708	219	8.1%	23,412	24,550	1,138	4.6%	37,879	38.2%
Total operating expense	**$ 140,427**	**$ 137,991**	**$ (2,436)**	**(1.8)%**	**$ 1,238,335**	**$ 1,208,325**	**$ (30,010)**	**(2.5)%**	**$ 1,181,731**	**(4.8)%**

Operating Expense was $140.4 million for the month and unfavorable to budget $2.4 million and 1.8%. Non-labor expense variances were unfavorable to budget by $0.7 million for the month as follows and labor costs are discussed in a subsequent section.

- Purchased services were unfavorable to budget by $0.4 million and 4.7% driven by unfavorable variances in management services/consultants ($0.3 million), Health Information Management (HIM) coders ($0.2 million), outside medical services ($0.2 million), budget timing for other purchased services ($0.4 million) offset by favorable variance in IT software fees ($0.7 million).
- Materials and supplies were unfavorable to budget by $0.4 million and 2.7% driven by unfavorable variances in pharmaceutical ($0.8 million) offset by favorable variance in minor equipment ($0.3 million) and non-medical supplies ($0.1 million).
- Facilities were unfavorable to budget by $0.2 million and 5.5% driven by unfavorable variance in building repairs ($0.4 million) offset by favorable variance in utilities ($0.2 million). The largest variance for building repairs was Highland Hospital ($0.2 million).
- Depreciation and amortization were at budget. A favorable variance for equipment depreciation ($0.4 million) offset by higher lease/software amortization ($0.4 million).
- General and administrative costs were favorable to budget by $0.2 million and 8.1% driven by a timing variance for insurance ($0.2 million).

For the year, Operating Expense was $1.2 billion and unfavorable to budget by $30.0 million and 2.5%. Non-labor expense variances net to an unfavorable variance of $4.0 million as follows and labor costs are discussed in a subsequent section.

- Purchased services were favorable to budget by $3.4 million and 4.2% driven by favorable variances in software licensing ($3.5 million), outside medical services ($2.5 million) offset by unfavorable variances in HIM coders ($1.8 million) and management services/consultants ($0.8 million). The favorable variance in outside medical services is expected to continue for the remainder of the fiscal year. The budget was based on higher ambulance costs which were the result of duplicate invoices between sister companies. A refund of $1.2 million was received in June 2025. The unfavorable variance in HIM is related to coders and offset by a positive variance in registry ($2.1 million).
- Materials and supplies were unfavorable to budget by $5.9 million and 5.0% driven by unfavorable variance in pharmaceuticals ($4.2 million), surgical supplies ($1.5 million), medical supplies ($1.5 million) offset by favorable variance in computer equipment ($1.2 million).
- Facilities were unfavorable to budget by $3.7 million and 12.5% driven by unfavorable variance in facility repairs ($5.3 million), facility leases ($0.3 million) offset by a favorable variance for utilities

($1.9 million). The facility repairs occurred at Highland Hospital ($2.9 million), Alameda Hospital ($1.6 million), and San Leandro Hospital ($0.4 million).

- Depreciation and amortization were favorable to budget by $1.1 million and 4.8% driven by favorable variance from timing of equipment depreciation ($3.8 million) and offset by higher than anticipated amortization of leases and software agreements ($2.7 million).
- General and administrative costs were favorable to budget $1.1 million and 4.6% driven by favorable variance for recruitment ($0.7 million), insurance ($0.7 million) offset by unfavorable variance ($0.3 million) across many cost centers.

Labor Costs

	March 2026				Year-To-Date				FY 2025	
	Actual	Budget	Variance	% Var	Actual	Budget	Variance	% Var	YTD	% Var
Salaries and wages (staff)	$ 61,831	$ 59,768	$ (2,063)	(3.5)%	$ 549,286	$ 523,656	$ (25,630)	(4.9)%	$ 498,639	(10.2)%
Salaries and wages (providers)	12,933	13,263	330	2.5%	116,486	117,371	885	0.8%	111,559	(4.4)%
Registry	2,739	4,338	1,599	36.9%	29,355	37,909	8,554	22.6%	39,141	25.0%
Physician contract services	3,790	3,699	(91)	(2.5)%	33,846	32,835	(1,011)	(3.1)%	32,035	(5.7)%
Employee benefits (taxes, insur	18,936	17,788	(1,148)	(6.5)%	153,871	147,008	(6,863)	(4.7)%	139,889	(10.0)%
Retirement	9,087	8,731	(356)	(4.1)%	74,894	72,971	(1,923)	(2.6)%	70,855	(5.7)%
Total labor costs	**$ 109,316**	**$ 107,587**	**$ (1,729)**	**(1.6)%**	**$ 957,738**	**$ 931,750**	**$ (25,988)**	**(2.8)%**	**$ 892,119**	**(7.4)%**
Compensation ratio	77.9%	77.9%	0.0%		77.7%	76.6%	-1.1%		74.4%	
Paid FTEs - staff	4,476	4,467	(9)	(0.2)%	4,613	4,513	(100)	(2.2)%	4,618	0.1%
Paid FTEs - providers	381	401	20	5.0%	383	403	20	5.0%	289	(32.5)%
Paid FTEs - registry	162	218	56	25.7%	187	216	29	13.4%	235	20.4%
Total FTEs	5,019	5,086	67	1.3%	5,183	5,132	(51)	(1.0)%	5,142	(0.8)%

Labor costs for the month were $109.3 million, unfavorable to budget by $1.7 million and 1.6%. YTD, labor costs were $957.7 million and unfavorable to budget by $26.0 million and 2.8%. Starting in September 2025, physician contract services were moved to the labor cost section to show a complete picture of staffing.

Total staff salaries and registry costs for the month were $64.6 million and unfavorable to budget by $0.5 million and 0.7% from higher rates ($1.5 million) and lower FTEs (47 FTEs/$1.0 million). Staff FTEs are running closer to budget reflecting administrative actions to address growth and reduce costs. Registry FTE are also favorable and at a lower than budget rate. YTD, this category unfavorable by $17.0 million driven by higher rates ($10.6 million) and higher FTEs (70 FTEs/$6.4 million). Additional detail as follows.

FTEs below budget:

- Departments outperforming labor standards - 156 FTEs month, 90 FTEs YTD
- HIM coders in purchased service, not registry – 18 FTEs month, 17 FTEs YTD

Offset by FTEs over budget:

- Departments not achieving labor standards – 47 FTEs month, 84 FTEs YTD
- GRIT initiative not realized – 45 FTEs month, 45 FTEs YTD
- Volume related increases – 5 FTEs month,14 FTEs YTD

- Higher sitter utilization for SNF care – 11 FTEs month, 14 FTEs YTD
- Higher sitter utilization for acute care at HGH – 10 FTEs month, 9 FTEs YTD
- New FTEs, not included in the budget - 10 FTEs month, 5 FTEs YTD

Total provider salaries and physician contract services for the month were $16.7 million and favorable to budget by $0.2 million and 1.4%. YTD, this category was $150.3 million and unfavorable to budget by $0.1 million and 0.1%. Unrealized recruitment included in the budget is offset by the paternity benefit payout ($1.6 million) made in January 2026. Contract physician was driven by locum usage. As a reminder, contract providers do not provide hours to calculate an FTE.

Employee benefits were higher than budget by $1.1 million for the month driven by higher self-funded health insurance ($0.9 million), FICA ($0.8 million), offset by positive variance in Kaiser insurance plan ($0.5 million) and other benefits ($0.1 million). YTD, employee benefits were unfavorable to budget by $6.9 million and 4.7% driven by higher self-funded health ($11.0 million), FICA ($1.3 million) offset by positive variances for Kaiser insurance plan ($3.6 million), other benefits ($0.6 million), residents/interns housing allowance adjustment ($0.8 million) and the remaining positive variance of $0.4 million is spread across many categories.

Retirement expense unfavorable for the month by $0.4 million and 4.1% driven by employer contributions for ACERA ($0.2 million) and other retirement plans ($0.2 million). YTD, retirement expense was unfavorable $1.9 million and 2.6% from ACERA ($0.9 million) and union plans ($1.0 million).

Balance Sheet and Financial Condition

The Balance Sheet key financial metrics are reflected in the table below.

	Mar-26	Feb-26	FY 2025
Days in cash	0.6	0.7	2.9
Gross days in patient receivable	62.7	65.9	62.4
Net days in patient receivable	40.7	41.1	43.8
Due from/(to) third-party payors	$ 387,608	$ 288,913	$ 158,555
Due from/(to) County	$ (117,719)	$ (34,106)	$ 49,680
Days in accounts payable	38.7	33.7	38.3
% of AP over 60 days	3.7%	3.9%	4.0%
Net position - fund balance/(deficit)	$ (70,793)	$ (70,467)	$ (61,798)
Net negative balance - receivable/(payable)	$ (65,963)	$ (54,264)	$ 26,949

Days in Cash

Days in Cash are low as all AHS cash receipts are swept to the County Treasury. The Days in Cash can fluctuate based on timing of cash draws from the County treasury and timing of vendor payments and payroll.

Accounts Receivable (AR)

The Gross Days in AR were 62.7 days and 3.2 days lower than last month and Net Days in AR were 40.71 and 0.4 days lower than last month. The calculation reflects 90 days versus actual days for the quarter to standardize

the calculation. Utilizing a 90-day period does lead to more fluctuations. Cash collections for the month with higher than trend reducing AR Days.

Key updates on work in progress within Revenue Cycle are noted below:

- Settlements through arbitration using Sac Law continue to support GRIT. In August, a settlement of $3.1 million was received and recorded as other operating income due to the age of the patient accounts.
- Enterprise CDI continues to address providers' clinical documentation along with charge automation and usage of Epic tools. Inpatient CDI is under review to determine improvements for specific DRGs that may not be coded to include complication or comorbidity.
- Inpatient charge reconciliation is in process for women's services, bedside procedures, implants, and Code Blue.
- Working to improve ambulatory patient access including patient scheduling.
- An AR Reduction Task Force was launched on February 3, 2026 to bring in more cash quickly.

Patient collections are reflected in the table and were strong in the month of March and YTD exceeding prior year. Behavioral Health represents the County receipts under contract for JGP services which total $79.9 million. The FY2026 interim contract was signed for $81.2 million on October 13, 2025. Payments on the FY2026 contract total $38.5 million through March 2026. AHS has not received information on how the maximum contract amount was determined. AHS is unable to trend, research or follow up on payment denials or other discrepancies leading to underpayment. The County has agreed to reduce the 20 percent withhold on invoices submitted to 10 percent for the current fiscal year. The maximum contract has not been changed.

PATIENT COLLECTIONS
(in thousands)

	Behavioral Health	Epic	Total FY 2026	FY 2025	FY 2024	FY 2023	FY 2022
Jul	11,928	67,883	79,811	72,694	79,592	74,260	59,732
Aug	28,651	82,136	110,787	79,768	69,313	58,590	57,374
Sep	-	66,819	66,819	69,741	63,322	76,063	61,968
Oct	868	82,323	83,191	76,783	63,122	59,796	49,923
Nov	11,569	71,370	82,939	78,747	57,781	56,939	52,057
Dec	7,275	65,241	72,516	94,631	63,867	67,018	68,121
Jan	6,034	63,286	69,320	89,014	68,757	71,452	62,292
Feb	4,293	90,269	94,562	68,511	75,852	57,886	52,269
Mar	9,323	78,320	87,643	91,851	54,720	65,320	62,888
Apr	-	-	-	74,892	61,895	55,307	56,235
May	-	-	-	74,339	102,015	63,795	69,591
Jun	-	-	-	72,211	71,208	70,027	53,187
Total	**79,941**	**667,647**	**747,588**	**943,182**	**831,444**	**776,453**	**705,637**
% change between fiscal years			3.6%	13.4%	7.1%	10.0%	

Accounts Payable

Days in Accounts Payable are 38.7 at the end of the month and were 5.0 days higher than the prior month from timing of recurring check runs versus the last day of the calendar month and resolution of ongoing

implementation issues with OnBase. The Percent over 60 Days is 3.7% and is below the 5.0% target. Purchasing and Accounts Payable teams are making positive progress resolving older invoices held in work queues.

Supplemental Program Revenue Receivable/Payable

Net Reimbursement Supplemental Programs					
Net Reimbursement Supplemental Programs as of 3/31/2026					
Programs	**FY97-20**	**FY21-25**	**FY26**	**Net Balance**	**Comments**
Medicare Cost Report	(1,617)	(4,676)	(498)	(6,791)	Older years pending disputed SSI ratio and outlier holds for both OPPS/IPPS services from CMS.
Medi-Cal P14 Waiver	4,225	(1,780)	(6,646)	(4,200)	P14 audits are in various stages of completion. Currently DHCS has
Current Waiver (GPP & CalAIM)	-	26,198	93,814	120,012	Global Payment Program (GPP) subsidizing remaining uninsured. GPP extended to 2026 as CalAIM.
AB85 Realignment	0	(48,869)	-	(48,869)	Realignment reserves for HPAC amendment passing through the County for physical health for Medi-Cal and Indigent populations.
Physician SPA	(6,000)	1,160	8,505	3,665	Reconciliation based on P14 utilization file with the State. FY14-FY16 Finalized. Catch-up ACA interim payments began during FY22.
FQHC	(7,922)	(15,405)	(3,750)	(27,078)	Negotiating settlement for a new FQ rate. The difference between the new FQ rate and FFS rate will determine the settlement for the impacted years. AHS started FQ billing in March 2022.
Medi-Cal Managed Care EPP	0	119,748	49,704	169,452	EPP (Enhanced Payment Program). New supplemental program for services provided to Medi-Cal Managed Care.
Medi-Cal Managed Care QIP	0	93,294	59,775	153,070	QIP (Quality Incentive Program). New supplemental program for services provided to Medi-Cal Managed Care.
Medi-Cal Managed Care Rate	(0)	24,917	37,867	62,784	Subsidize rates for Medi-Cal Managed Care members in Alameda County.
Medi-Cal Managed Care GME	0	3,635	1,279	4,915	CMS approved in March 2020. GME is paying concurrently with fiscal
Medi-Cal Managed Care DP-NF Pass-Through	-	(5,944)	-	(5,944)	New payment program assisting AHS with LTC carve-in from FFS to managed care, time-limited CY2023 through CY2025. Full CY2024 amount paid Dec. when only 6 mos. had been accrued, resulting in negative
Medi-Cal SNF Cost Settlement	0	734	507	1,241	The State began their reconciliation.
AB915	-	2,353	6,606	8,959	The State began their reconciliation.
Old Waiver (FY11 & FY12)	29,169	-	-	29,169	FY11 & FY12 will be finalized by June 2026.
All Other Supplemental Programs	0	3,682	5,542	9,223	The State began their reconciliation.
Subtotal	**$ 17,856**	**$ 199,048**	**$ 252,705**	**$ 469,609**	
AB915 (FY14-FY20)	(17,000)	0	0	(17,000)	FY14-FY20 Reserve pending on audits.
Physician SPA (FY08-12)	(25,000)	0	0	(25,000)	FY13 final settled.
FQHC (FY12-18)	(40,000)	0	0	(40,000)	Negotiating settlement for Highland FQ clinics and HGH K-6 clinic.
Subtotal	**$ (82,000)**	**$ -**	**$ -**	**$ (82,000)**	
Grand Total	**$ (64,144)**	**$ 199,048**	**$ 252,705**	**$ 387,609**	

The information presented in the table provides subsidiary information for Supplemental Program receivables and payables on the Balance Sheet. The net receivable balance for Supplemental Programs is $387.6 million, which increased by $98.7 million over last month. Key items are noted below.

- Medicare cost report payments for multiple years ($1.9 million).
- Payment received for GME FY2026 Q3 ($6.5 million).
- IGT funded for GPP CY2025 Q4 ($36.7 million).
- IGT funded for GPP CY2026 Q1 ($39.9 million).
- Minor cost report adjustments and monthly accruals ($30.5 million).

Estimates are necessary to record supplemental income because the ultimate amount that may be collected under the program is uncertain, dependent on costs for services that were ultimately provided, quality metrics achieved, Medi-Cal enrollment, and our ability to identify and claim related costs. AHS has significant liability estimates dating back more than 5 years as reflected at the bottom of the schedule, which includes AB915, Physician SPA and Highland FQHC. The total estimated amount due is $82.0 million.

Net County Receivable and Payable

Due To/From County of Alameda

	Mar-26	Feb-26	FY 2025
Due from County of Alameda	$ 13,361	$ 23,135	$ 54,713
Capital designation receivable	-	-	7,000
Due from County of Alameda	**13,361**	**23,135**	**61,713**
Due to County of Alameda	(2,262)	(1,550)	(1,153)
County IGT funding	(122,222)	(49,095)	-
Capital cost payable	(6,596)	(6,596)	(10,880)
Due to County of Alameda	**(131,080)**	**(57,241)**	**(12,033)**
Net due from/(to) County	**$ (117,719)**	**$ (34,106)**	**$ 49,680**

The net County receivable and payable due under arrangements with the County are reflected as part of the Due to and Due From accounts reported on the Balance Sheet as follows:

- The County receivable includes the HPAC contract, John George Pavilion (JGP) services agreement and grants.
- The Capital Designation receivable reflects reimbursement expected from the County ($7 million per year) to help fund the Sapphire project. An annual invoice is sent to the County after AHS transfers the funds, and certain contractual requirements are met at the end of the fiscal year. The FY2025 invoice was paid by the County in February 2026.
- Inter-government transfers (IGT) are ongoing to draw down federal supplemental funding and once they have received the funds are returned to the County. The Waiver GPP CY2026 Q1 IGT ($39.9 million) and GPP CY2025 Q4 IGT ($36.7 million) were funded in March, which increased the payable by $77.6 million and still outstanding is the QIP/EPP CY2024 Final ($45.7 million).
- The Capital Cost Transfer reflects a payable based on the balance remaining on open cost report settlements associated with County owned buildings ($6.6 million). AHS transfers cost reimbursement estimates to the County each year and AHS has the contractual ability to benefit from these funds to

help maintain and invest in County owned facilities. AHS paid 90% for the FY2023 filing ($4.3 million) in September 2025. In May 2024, the County spent $1.2 million to pay for an emergency transformer on the Fairmont campus. AHS is working with the County to develop a workflow to allow AHS to capture costs timely for future cost reimbursement. AHS is not aware of any additional expenditures made by the County.

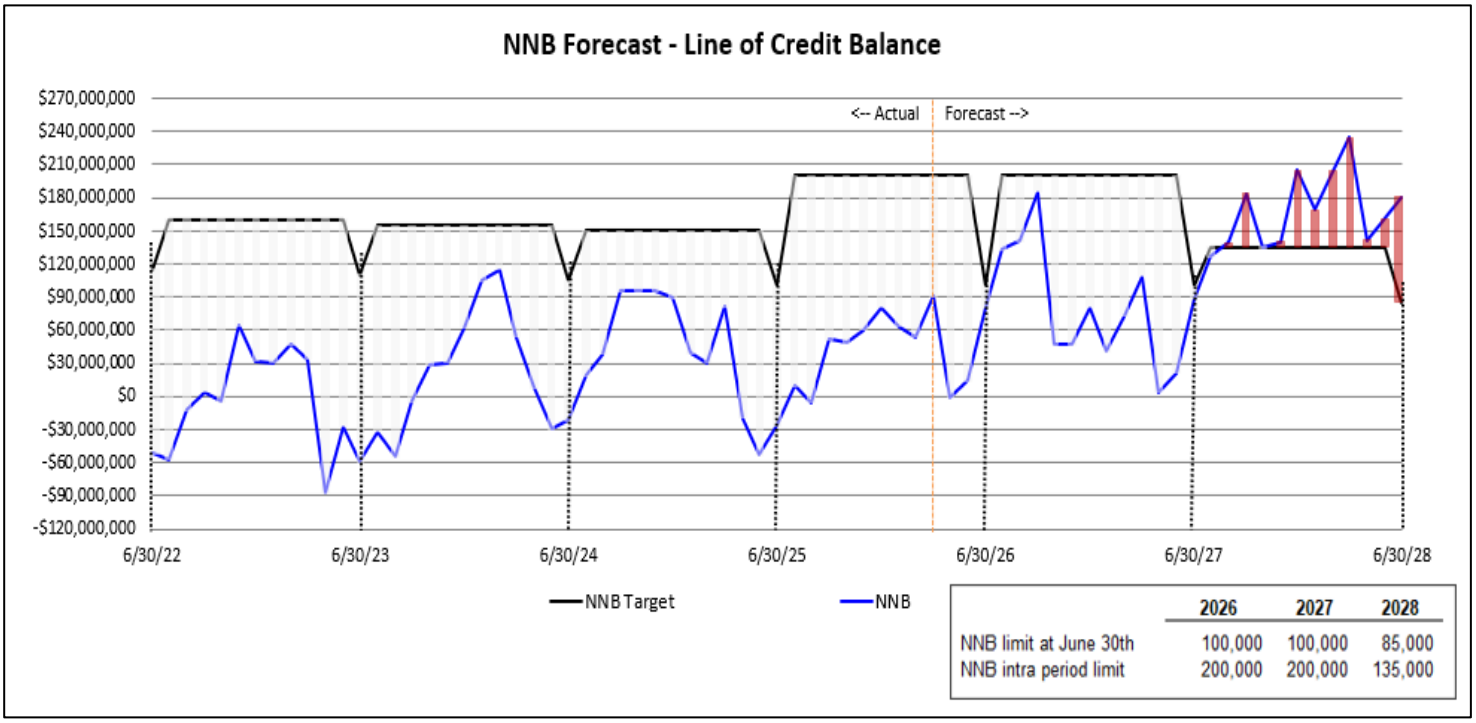
Net Position
The Net Position or Fund Balance of AHS as of March 31, 2026, is negative $70.8 million, which increased $9.0 million over last fiscal year on June 30, 2025 reflecting the YTD net loss.

Net Negative Balance
The Net Negative Balance (NNB) or Line of Credit with the county is $66.0 million payable on March 31, 2026, and remains compliant with the terms of the Permanent Agreement. The Working Capital Loan is reported on the Balance Sheet as a long-term liability labeled "Liquidity Facility – County of Alameda." To calculate the NNB, the Liquidity Facility ($94.3 million payable) decreased by the County Restricted Cash Fund ($28.3 million) which is included in Cash.

Contingencies
John George Pavilion (JGP)
The county continues to struggle with the implementation of new software, SmartCare, for claims beginning in July, 2023 under Cal Aim. JGP technical and professional services have been input into SmartCare to be billed by the county and paid for by the State. The county is paying up to the maximum contract amount; however, AHS has not received any information from the county on denials or payments they have received. The County recently reduced invoice withholding to 10 percent for FY26; however, AHS believes additional funding is due based on claims in EPIC which were input into SmartCare for payment.

Highland Federally Qualified Healthcare Center (FQHC) Settlement
The State reached out to AHS inquiring about a new application that AHS submitted to establish the dental clinic located at Highland as a new FQHC. The State wanted to understand the new application request which started a conversation that ultimately resulted in the State verbally agreeing that AHS could resume billing previously denied service locations on the Highland campus as FQHC. AHS began billing as an FQHC for these service locations on March 1, 2022. AHS and the State have made noteworthy progress in the negotiations on a retroactive settlement going back to FY2012. Once estimates are completed, AHS will adjust the current liability on the balance sheet. AHS currently has a pending recoupment of $40.0 million. AHS continues to be paid at the historical Highland FQ rate for all service locations.

Line of Credit (Net Negative Balance) Forecast
The Line of Credit Balance or the Net Negative Balance (NNB) held with the County is forecasted in the line graph below through June 30, 2028 for planning purposes. The County Board of Supervisors approved a modification to the Permanent Agreement on March 20, 2026 for FY2026 and FY2027. The modification fixed the fiscal year end NNB limit at $100.0 million and increased the intra-year maximum from $100 million to $200.0 million for the next fiscal year. Based on these terms, the NNB reverts to the original agreement on July 1, 2027. The NNB ceiling would be $85.0 million, and the intra-year maximum would drop to $135.0 million for FY2028.



AHS continues to forecast that the NNB will be compliant with the terms of the original debt arrangement through June 30, 2026 and 2027. The revised agreement increased the NNB intra-period maximum to $200.0 million which solves the immediate funding shortfall for the first quarter of FY2027. The forecast is based on current cashflows and assumes AHS will close the FY2027 budget gap and will not incur losses from operations requiring additional draws on the NNB. The graph also shows that AHS will not be compliant with the debt agreement in FY2028 if actions are not taken to improve financial performance.

The FY2026 forecast slightly deteriorated over last month's projection, primarily due to the net income losses driven by the SNF reconciliation payment and Medicare cost report adjustments. The forecast updates as actual activity is reflected in the cashflow model and does not include budget projections, performance improvement initiatives or looming future impacts from HR1. As a reminder, the approved FY2026 budget required cashflow in excess of operations causing the organization to project approximately $100 million of new debt by year-end. The BOT approved the FY2026 budget with the understanding that administration would take immediate action to prevent AHS from maximizing the NNB. The projection reflects the increased debt as actions have not resulted in adequate revenue enhancements or expense reductions to change the debt trajectory to date.

Material items impacting the NNB are summarized in the table below. The top portion of the table provides expected cash flow from sizable items included in NNB forecast.

- QIP CY2026 Q1 funding based on DHCS notification increased by $3.8M.
- BHCS (JGP/Alameda County) funding based on receipts increased by $5.8M.
- St. Rose IGT funding is delayed; donation moved to from April 2026 to July 2026 pending notification from State.
- St. Rose LOC may hit the maximum limit of $15.0 million in the upcoming months, which may require modifications to the LOC agreement.

The bottom portion of the table below reflects older year's liability estimates which are not included in the forecast (blue line) due to unknown timing for resolution. The Federal Qualified Health Center (FQHC) recoupment is a conservative settlement estimate based on the difference between reimbursement rates for services provided at Highland campus locations that were considered qualified and subsequently denied by the State. AHS is in current discussions with the State and once an agreement is reached with the State the FQHC liability will be adjusted. Lastly, Physician SPA reconciliations are delayed because the State is having difficulty obtaining claim data.

Material Items Included in NNB Forecast
(in thousands)

	Apr-26	May-26	Jun-26	FY27 Q1	FY27 Q2	FY27 Q3	FY27 Q4
GPP (quarterly)	$ 51,788	$ -	$ -	$ 22,352	$ 22,352	$ 27,394	$ 19,325
EPP (semi-annual)	31,166	-	-	-	72,317	-	42,417
QIP	40,527	-	-	-	56,842	-	56,842
Medi-Cal Rate Range	-	-	-	-	-	45,831	-
BHCS (JGP/Alameda County) - fy26	12,103	6,084	6,084	12,167	-	-	-
BHCS (JGP/Alameda County) - fy27	-	-	-	-	18,900	18,900	25,200
HPAC	10,313	-	-	-	21,600	10,800	10,800
AB85 Realignment	-	-	-	-	4,789	-	-
SNF DP-NF (final pmt Jan-27)	-	-	-	-	-	26,000	-
Waiver recoupment (fy11, fy12)	-	19,815	9,354	-	-	-	-
Donation to St. Rose Hospital	-	-	-	10,507	-	10,507	-
	$ 145,897	$ 25,899	$ 15,438	$ 45,026	$ 196,800	$ 139,432	$ 154,584

Prior Year Reimbursement Settlements

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

FY2027 Budget Implications

The FY2027 preliminary budget currently reflects a net loss of $67.7 million which is not included in the cashflow forecast. If AHS is unable to correct the budget imbalance and utilizes the NNB to fund operations, the table below reflects the impact on the revised NNB at 6/30/2027. AHS would exceed the June 30, 2027 limit and the revised intra-period maximum of $200.0 million. This supplemental information is being provided to ensure mutual understanding that the current budget gap needs to be closed to comply with the revised terms of the Permanent Agreement with the County.

	(in thousands)
NNB forecast 6/30/26	$ 80,794
FY2027 budget loss	67,677
NNB forecast 6/30/27	148,471
NNB limit at 6/30/27	100,000
Over NNB limit	**$ 48,471**

AHS is working with union partners and the Alameda County Board of Supervisors through a series of ad hoc meetings to address and correct the ongoing financial imbalance and stabilize the organization. Completing the FY2027 budget to achieve breakeven profitability is the first milestone and necessary to achieve the cashflow projections shown in the NNB Forecast - Line of Credit graph above. The modification of the Permanent Agreement and NNB does provide immediate relief in terms of cashflow, but it also increases debt which AHS is expected to pay back adding additional financial pressure. The Long Range Strategic Financial Plan is necessary and requires alignment between the key stakeholders on assumptions and development of key strategies to maintain the safety net and address the ever-widening financial imbalance of AHS. As a reminder, HR1 and other State changes are expected to grow and have a material and significant impact on AHS and Medi-Cal funding.

ALAMEDA HEALTH SYSTEM (consolidated)
Balance Sheet
As of March 31, 2026
(In Thousands)

	Current Month	Prior Month	FYE 2025
ASSETS			
Cash & cash equivalents	$ 2,787	$ 3,203	$ 14,556
Patient account receivables, net	111,729	106,238	101,401
Due from third-party payors	562,490	462,632	338,189
Due from County of Alameda	13,361	23,135	61,713
Due from State of California	26,574	24,394	25,635
Inventories	11,516	11,488	12,267
Other current assets	28,473	30,467	20,054
TOTAL CURRENT ASSETS	**756,930**	**661,557**	**573,815**
Restricted cash equivalents	28,342	28,342	27,781
Right-to-use lease assets, net	26,177	26,786	31,604
Right-of-use subscription assets, net	11,204	10,553	8,190
Capital assets - nondepreciable	9,021	9,021	9,021
Capital assets - depreciable, net	132,587	130,645	129,675
TOTAL NONCURRENT ASSETS	**207,331**	**205,347**	**206,271**
DEFERRED OUTFLOWS OF RESOURCES	**105,570**	**105,570**	**105,570**
TOTAL ASSETS & DEFERRED OUTFLOWS	**$ 1,069,831**	**$ 972,474**	**$ 885,656**
LIABILITIES & NET ASSETS			
Accounts payable and accrued expenses	$ 91,780	$ 91,532	$ 89,527
Accrued compensation	46,942	36,519	65,654
Due to third-party payors	174,882	173,719	179,634
Due to County of Alameda	131,080	57,241	12,033
Other Payables	53,617	53,032	43,509
TOTAL CURRENT LIABILITIES	**498,301**	**412,043**	**390,357**
Liquidity facility - County of Alameda	94,305	82,606	832
Net pension obligation	369,632	369,632	370,400
Post employment benefit asset	43,255	43,255	43,255
Accrued compensated absences, net of current portion	22,604	22,604	26,667
Self-insurance liabilities, net of current portion	41,231	41,231	41,231
Lease obligations, net of current portion	25,437	25,995	29,739
Subscription obligations, net of current portion	4,657	4,373	3,771
Other long-term liabilities	0	0	0
TOTAL LONG TERM LIABILITIES	**601,121**	**589,696**	**515,895**
DEFERRED INFLOWS OF RESOURCES	**41,202**	**41,202**	**41,202**
Fund balance - capital contribution	86,653	86,653	86,484
Fund balance - prior years	(148,283)	(148,283)	(166,072)
Current year income/(loss)	(9,163)	(8,837)	17,790
FUND BALANCE	**(70,793)**	**(70,467)**	**(61,798)**
TOTAL LIABILITIES, DEFERRED INFLOWS, & FUND BALANCE	**$ 1,069,831**	**$ 972,474**	**$ 885,656**

ALAMEDA HEALTH SYSTEM (consolidated)
Statement of Revenues and Expenses
For the Period Ended March 31, 2026
(In Thousands)

	March 2026				Year-To-Date				FY 2025		
	Actual	Budget	Variance	% Variance	Actual	Budget	Variance	% Variance	YTD	Variance	% Variance
Operating revenue											
Net patient service revenue	$ 87,535	$ 83,430	$ 4,105	4.9%	$ 728,496	$ 723,159	$ 5,337	0.7%	$ 700,512	$ 27,984	4.0%
Capitation revenue	4,420	4,520	(100)	(2.2)%	40,153	40,392	(239)	(0.6)%	41,537	(1,384)	(3.3)%
Other government programs	42,672	45,415	(2,743)	(6.0)%	409,284	408,735	549	0.1%	411,460	(2,176)	(0.5)%
Other operating revenue	5,714	4,797	917	19.1%	54,048	44,856	9,192	20.5%	46,349	7,699	16.6%
Total operating revenue	**140,341**	**138,162**	**2,179**	**1.6%**	**1,231,981**	**1,217,142**	**14,839**	**1.2%**	**1,199,858**	**32,123**	**2.7%**
Operating expense											
Labor costs	109,316	107,587	(1,729)	(1.6)%	957,738	931,750	(25,988)	(2.8)%	892,119	(65,619)	(7.4)%
Purchased services	8,525	8,146	(379)	(4.7)%	77,731	81,129	3,398	4.2%	77,720	(11)	(0.0)%
Materials and supplies	14,133	13,766	(367)	(2.7)%	124,720	118,789	(5,931)	(5.0)%	115,085	(9,635)	(8.4)%
Facilities	3,552	3,366	(186)	(5.5)%	33,453	29,742	(3,711)	(12.5)%	29,109	(4,344)	(14.9)%
Depreciation and amortization	2,412	2,418	6	0.2%	21,281	22,365	1,084	4.8%	29,819	8,538	28.6%
General and administrative	2,489	2,708	219	8.1%	23,412	24,550	1,138	4.6%	37,879	14,467	38.2%
Total operating expense	**140,427**	**137,991**	**(2,436)**	**(1.8)%**	**1,238,335**	**1,208,325**	**(30,010)**	**(2.5)%**	**1,181,731**	**(56,604)**	**(4.8)%**
Operating income (loss)	**(86)**	**171**	**(257)**	**(150.3)%**	**(6,354)**	**8,817**	**(15,171)**	**(172.1)%**	**18,127**	**(24,481)**	**(135.1)%**
Non-operating activity											
Interest income (expense)	(251)	(140)	(111)	(79.3)%	(2,825)	(2,693)	(132)	(4.9)%	(3,184)	359	11.3%
Other nonoperating revenue	9	13	(4)	(30.8)%	16	117	(101)	(86.3)%	(284)	300	105.6%
Total non-operating activity	**(242)**	**(127)**	**(115)**	**(90.6)%**	**(2,809)**	**(2,576)**	**(233)**	**(9.0)%**	**(3,468)**	**659**	**19.0%**
Net income (loss)	**$ (328)**	**$ 44**	**$ (372)**	**(845.5)%**	**$ (9,163)**	**$ 6,241**	**$ (15,404)**	**(246.8)%**	**$ 14,659**	**$ (23,822)**	**(162.5)%**
EBIDA adjustments											
Interest income (expense)	251	140	111		2,825	2,693	132		3,184	(359)	
Depreciation and amortization	2,412	2,418	(6)		21,281	22,365	(1,084)		29,819	(8,538)	
Total EBIDA adjustments	2,663	2,558	105		24,106	25,058	(952)		33,003	(8,897)	
EBIDA	**$ 2,335**	**$ 2,602**	**$ (267)**		**$ 14,943**	**$ 31,299**	**$ (16,356)**		**$ 47,662**	**$ (32,719)**	

ALAMEDA HEALTH SYSTEM (consolidated)
Statement of Cash Flows
For the Period Ended March 31, 2026
(in thousands)

	Current Month	Year-to Date	FYE 2025
CASH FLOWS FROM OPERATING ACTIVITIES			
Operating income (loss)	$ (86)	$ (6,354)	$ 20,942
Depreciation and amortization	2,412	21,281	37,542
Net changes in operating assets and liabilities:			
Patient account receivables, net	(5,491)	(10,328)	4,695
Due from/to third-party payors	(98,695)	(229,053)	(13,222)
Due from/to County	83,613	167,399	(24,880)
Due from State	(2,180)	(939)	(1,371)
Inventory	(28)	751	(280)
Other current assets	1,994	(8,419)	(2,432)
Accounts payable and accrued expenses	248	2,252	4,040
Accrued compensation	10,425	(18,712)	9,387
Other current payables	585	10,108	10,867
Net pension liability	-	(768)	(55,607)
Other postemployment benefits obligations	-	-	4,881
Other long-term liabilities	-	(4,063)	7,347
Deferred outflows/inflows	-	-	50,894
Net cash provided by (used in) operating activities	**(7,203)**	**(76,845)**	**52,803**
CASH FLOWS FROM NONCAPITAL FINANCING ACTIVITIES			
Change in liquidity facility	11,699	93,473	(4,269)
Interest payments on working capital loan	370	3,295	3,604
Proceeds from grants for COVID-19 pandemic	-	-	-
Receipts of rental income	9	16	(253)
Net cash provided by (used in) noncapital financing activities	**12,078**	**96,784**	**(918)**
CASH FLOWS FROM CAPITAL AND FINANCING ACTIVITIES			
Purchase and construction of capital assets	(3,231)	(15,013)	(19,936)
Proceeds from disposals of capital assets	0	0	0
Repayment of other long-term liabilities	0	0	(2,783)
Payments of lease liabilies	(559)	(4,421)	(6,730)
Interest payments on lease liabilities	83	796	1,232
Payments of subscription obligations	(880)	(5,762)	(6,587)
Interest payments on subscription obligations	10	116	131
Capital contributions and transfers	-	169	1,033
Net cash provided by (used in) capital and financing activities	**(4,577)**	**(24,115)**	**(33,640)**
CASH FLOWS FROM INVESTING ACTIVITIES			
Interest and investment income	(714)	(7,032)	(7,866)
Net cash provided by (used in) investing activities	**(714)**	**(7,032)**	**(7,866)**
CHANGES IN CASH AND CASH EQUIVALENTS	**(416)**	**(11,208)**	**10,379**
CASH AND CASH EQUIVALENTS, beginning of period	31,545	42,337	31,958
CASH AND CASH EQUIVALENTS, end of period	**$ 31,129**	**$ 31,129**	**$ 42,337**

ALAMEDA HEALTH SYSTEMS Volume Reports

Month: March

	MONTH				YEAR-TO-DATE				PRIOR YEAR-TO-DATE		
	MTD Actual	MTD Budget	Var	% Var	YTD Actual	YTD Budget	Var	% Var	YTD PY Actual	Var	% Var
Campus: HIGHLAND											
Total Patient Days	4,598	4,398	200	4.6%	37,730	39,330	-1,600	-4.1%	39,421	-1,691	-4.3%
Total Discharges	741	763	-22	-2.9%	6,827	6,825	2	0.0%	6,664	163	2.4%
Total Adjusted Patient Days	8,149	7,724	425	5.5%	67,671	68,968	-1,297	-1.9%	68,946	-1,275	-1.8%
Total Adjusted Discharges	1,313	1,340	-27	-2.0%	12,245	11,968	276	2.3%	11,655	590	5.1%
GENERAL ACUTE											
Patient Days	4,598	4,398	200	4.6%	37,730	39,330	-1,600	-4.1%	39,421	-1,691	-4.3%
Discharges	741	763	-22	-2.9%	6,827	6,825	2	0.0%	6,664	163	2.4%
OP Factor	1.7761	1.762	-0.0142	-0.8%	1.7989	1.7598	-0.0391	-2.2%	1.7549	-0.044	-2.5%
Average Daily Census	148.3	141.9	6.5	4.6%	137.7	143.5	-5.8	-4.1%	143.9	-6.2	-4.3%
Average Length of Stay	6.2	5.8	-0.4	-7.7%	5.5	5.8	0.2	4.1%	5.9	0.4	6.6%
Adjusted Patient Days	8,167	7,749	418	5.4%	67,874	69,214	-1,340	-1.9%	69,180	-1,306	-1.9%
Adjusted Discharges	1,316	1,345	-29	-2.1%	12,281	12,011	271	2.3%	11,695	587	5.0%
Occupancy %	88%	84%	4%	4.6%	81%	85%	-3%	-4.1%	85%	-4%	-4.3%
Emergency Visits	4,998	4,874	124	2.5%	43,487	40,950	2,537	6.2%	40,945	2,542	6.2%
Left Without Being Seen (LWBS)	368	415	47	12.8%	2,807	4,245	1,438	51.2%	4,148	1,341	47.8%
Trauma Cases	353	273	80	29.3%	2,785	2,701	84	3.1%	2,747	38	1.4%
Observation Equivalent Days	272	252	20	8.0%	2,472	2,498	-26	-1.1%	2,166	306	14.1%
IP Surgeries	221	251	-30	-11.9%	2,121	2,167	-46	-2.1%	2,160	-39	-1.8%
OP Surgeries	229	208	21	9.9%	1,999	1,651	348	21.1%	1,778	221	12.4%
Total Surgeries	450	459	-9	-2.0%	4,120	3,818	302	7.9%	3,938	182	4.6%
Deliveries	132	149	-17	-11.2%	1,200	1,260	-60	-4.8%	1,206	-6	-0.5%
TOTAL FTE, HOURS, WRVU											
Total Paid FTE	1,930	1,796	-134	-7.5%	1,954	1,812	-142	-7.9%	1,810	-144	-7.9%
Total Productive FTE	1,716	1,572	-145	-9.2%	1,672	1,563	-109	-6.9%	1,546	-126	-8.1%
Total Paid FTE per AOB	7.34	7.21	-0.13	-1.9%	7.91	7.2	-0.71	-9.9%	7.19	-0.72	-10.0%
Worked Hours Per APD	37.3	36	-1.3	-3.5%	38.7	35.5	-3.2	-9.0%	35.1	-3.6	-10.2%
Worked Hours Per AD	231	208	-24	-11.5%	214	205	-9	-4.5%	208	-6	-2.9%
Physician wRVU	53,627	4	53,624	1465852.1%	184,364	47	184,318	395307.5%	51	184,313	358585.3%
OTHER STATS											
GI Procedures	408	444	-36	-8.2%	3,434	3,047	387	12.7%	2,981	453	15.2%
Cardiac Procedures	149	64	85	134.1%	1,068	519	549	106.0%	567	501	88.4%
HGH Cath Lab and IR Procedures	703	613	90	14.6%	6,183	4,577	1,606	35.1%	5,383	800	14.9%
TOTAL CLINIC VISITS	828	1,422	-594	-41.8%	11,265	11,744	-479	-4.1%	11,965	-700	-5.9%
Specialty	0	632	-632	-100.0%	5,107	4,775	332	7.0%	5,604	-497	-8.9%
Behavioral Health	828	790	38	4.8%	6,158	6,969	-811	-11.6%	6,361	-203	-3.2%
PAYOR MIX											
Insurance %	7.8%	6.7%	1.2%		7.4%	8.1%	-0.8%		7.92%	-0.57%	
Medi-Cal %	59.4%	61.4%	-2.1%		58.3%	60.3%	-2.0%		60.36%	-2.02%	
Medicare %	27.0%	26.5%	0.5%		29.1%	26.1%	3.1%		26.90%	2.23%	
Other Govt %	3.3%	1.9%	1.4%		1.9%	2.1%	-0.1%		1.92%	0.02%	
Self-Pay %	2.5%	3.5%	-1.0%		3.2%	3.5%	-0.2%		2.90%	0.35%	
Total Payor Mix %	100.0%	100.0%	0.0%		100.0%	100.0%	0.0%		100.00%	0.00%	
CAMPUS CMI											
CMI Highland	1.764	1.695	0.069	4.1%	1.713	1.657	0.056	3.4%	1.72	-0.007	-0.4%

ALAMEDA HEALTH SYSTEMS Volume Reports

Month: March

	MONTH				YEAR-TO-DATE				PRIOR YEAR-TO-DATE		
	MTD Actual	MTD Budget	Var	% Var	YTD Actual	YTD Budget	Var	% Var	YTD PY Actual	Var	% Var
Campus: ALAMEDA											
Total Patient Days	6,506	6,433	73	1.1%	55,608	56,061	-453	-0.8%	55,629	-21	0.0%
Total Discharges	265	266	-1	-0.5%	2,160	2,175	-15	-0.7%	2,134	26	1.2%
Total Adjusted Patient Days	9,842	9,206	636	6.9%	84,251	81,218	3,033	3.7%	82,408	1,843	2.2%
Total Adjusted Discharges	401	381	20	5.2%	3,273	3,152	121	3.8%	3,161	111	3.5%
GENERAL ACUTE											
Patient Days	1,189	1,143	46	4.0%	8,968	9,300	-332	-3.6%	9,425	-457	-4.8%
Discharges	251	254	-3	-1.2%	2,049	2,068	-19	-0.9%	2,043	6	0.3%
OP Factor	1.8031	1.6946	-0.1086	-6.4%	1.8428	1.738	-0.1048	-6.0%	1.7874	-0.0553	-3.1%
Average Daily Census	38.4	36.9	1.5	4.0%	32.7	33.9	-1.2	-3.6%	34.4	-1.7	-4.8%
Average Length of Stay	4.7	4.5	-0.2	-5.3%	4.4	4.5	0.1	2.7%	4.6	0.2	5.1%
Adjusted Patient Days	2,144	1,937	207	10.7%	16,526	16,163	363	2.2%	16,847	-321	-1.9%
Adjusted Discharges	453	431	22	5.1%	3,776	3,593	182	5.1%	3,652	124	3.4%
Occupancy %	58.0%	56.0%	2.0%		50.0%	51.0%	-2.0%		52.0%	-3.0%	
Emergency Visits	1,902	1,664	238	14.3%	15,583	14,827	756	5.1%	14,952	631	4.2%
Left Without Being Seen (LWBS)	73	0	-73	-100.0%	531	0	-531	-100.0%	479	-52	-9.8%
Observation Equivalent Days	252	164	88	53.5%	2,218	1,794	423	23.6%	1,913	305	16.0%
IP Surgeries	21	17	4	23.2%	134	159	-25	-15.9%	133	1	0.8%
OP Surgeries	2	0	2	0.0%	48	0	48	0.0%	448	-400	-89.3%
Total Surgeries	23	17	6	34.9%	182	159	23	14.2%	581	-399	-68.7%
SNF with Sub-Acute											
SNF Patient Days	5,317	5,290	27	0.5%	46,640	46,761	-121	-0.3%	46,204	436	0.9%
SNF Discharges	14	12	2	14.7%	111	108	3	2.9%	91	20	22.0%
SNF OP Factor	1.003	1.0017	-0.0013	-0.1%	1.0057	1.0016	-0.0042	-0.4%	1.0049	-0.0009	-0.1%
Average Daily Census	171.5	170.7	0.9	0.5%	170.2	170.7	-0.4	-0.3%	168.6	1.6	0.9%
Average Length of Stay	379.8	433.3	53.5	12.3%	420.2	433.4	13.2	3.0%	507.7	87.6	17.2%
Adjusted Patient Days	5,333	5,299	34	0.6%	46,908	46,834	74	0.2%	46,429	479	1.0%
Adjusted Discharges	14	12	2	14.8%	112	108	4	3.3%	91	20	22.1%
Occupancy %	95.0%	94.0%	0.0%		94.0%	94.0%	0.0%		93.0%	0.0%	
Bed Holds	88	38	50	134.5%	476	428	48	11.2%	458	18	3.9%
TOTAL FTE, HOURS, WRVU METRICS											
Total Paid FTE	624	622	-2	-0.2%	638	625	-14	-2.2%	625	-13	-2.1%
Total Productive FTE	561	549	-12	-2.2%	554	545	-9	-1.6%	545	-8	-1.5%
Total Paid FTE per AOB	1.96	2.09	0.13	6.2%	2.08	2.11	0.03	1.5%	2.08	0	0.2%
Worked Hours Per APD	10.1	10.6	0.5	4.4%	10.3	10.5	0.2	2.1%	10.4	0.1	0.7%
Worked Hours Per AD	248	255	7	2.8%	265	271	6	2.1%	270	5	1.9%
Physician wRVU	11,615	0	11,615	0.0%	40,544	0	40,544	0.0%	0	40,544	0.0%
TOTAL CLINIC VISITS	1,366	1,271	95	7.4%	12,123	11,163	960	8.6%	11,734	389	3.3%
Specialty	1,343	1,260	83	6.6%	11,982	11,018	964	8.7%	11,591	391	3.4%
Telehealth Specialty	23	11	12	109.1%	352/364	145	-4	-2.8%	143	-2	-1.4%

ALAMEDA HEALTH SYSTEMS Volume Reports

Month: March

	MONTH				YEAR-TO-DATE				PRIOR YEAR-TO-DATE			
	MTD Actual	MTD Budget	Var	% Var	YTD Actual	YTD Budget	Var	% Var	YTD PY Actual	Var	% Var	
PAYOR MIX												
Insurance %	8.1%	6.5%	1.6%		7.2%	6.8%	0.4%		7.2%	0.1%		
Medi-Cal %	57.6%	54.2%	3.4%		57.6%	55.3%	2.3%		55.7%	1.9%		
Medicare %	32.2%	35.9%	-3.8%		32.8%	34.5%	-1.7%		34.3%	-1.5%		
Other Govt %	1.6%	1.2%	0.4%		1.1%	1.5%	-0.3%		1.3%	-0.2%		
Self-Pay %	0.5%	2.1%	-1.6%		1.3%	1.9%	-0.6%		1.6%	-0.3%		
Total Payor Mix %	100.0%	100.0%	0.0%		100.0%	100.0%	0.0%		100.0%	0.0%		
CAMPUS CMI												
CMI Alameda	1.477	1.413	0.064	4.6%	1.427	1.392	0.035	2.5%	1.469	-0.042	-2.9%	

ALAMEDA HEALTH SYSTEMS Volume Reports

Month: March

	MONTH				YEAR-TO-DATE				PRIOR YEAR-TO-DATE		
	MTD Actual	MTD Budget	Var	% Var	YTD Actual	YTD Budget	Var	% Var	YTD PY Actual	Var	% Var
Campus: SAN LEANDRO											
Total Patient Days	1,708	1,896	-188	-9.9%	14,481	16,090	-1,609	-10.0%	15,640	-1,159	-7.4%
Total Discharges	308	344	-36	-10.5%	2,684	2,879	-195	-6.8%	2,797	-113	-4.0%
Total Adjusted Patient Days	3,649	3,561	88	2.5%	30,652	31,191	-540	-1.7%	30,815	-164	-0.5%
Total Adjusted Discharges	658	646	12	1.9%	5,681	5,581	100	1.8%	5,511	170	3.1%
GENERAL ACUTE											
Patient Days	946	1,149	-203	-17.7%	8,164	9,462	-1,298	-13.7%	9,332	-1,168	-12.5%
Discharges	252	287	-35	-12.3%	2,220	2,378	-158	-6.6%	2,332	-112	-4.8%
OP Factor	2.4888	2.1074	-0.3814	-18.1%	2.4619	2.2144	-0.2475	-11.2%	2.2491	-0.2128	-9.5%
Average Daily Census	30.5	37.1	-6.5	-17.7%	29.8	34.5	-4.7	-13.7%	34.1	-4.3	-12.5%
Average Length of Stay	3.8	4.0	0.2	6.1%	3.7	4.0	0.3	7.6%	4.0	0.3	8.1%
Adjusted Patient Days	2,354	2,421	-67	-2.8%	20,099	20,954	-855	-4.1%	20,989	-890	-4.2%
Adjusted Discharges	627	606	21	3.5%	5,465	5,266	200	3.8%	5,245	221	4.2%
Occupancy %	48.0%	59.0%	-10.0%		47.0%	55.0%	-8.0%		54.0%	-7.0%	
Emergency Visits	3,086	3,038	48	1.6%	26,109	26,454	-345	-1.3%	26,278	-169	-0.6%
Left Without Being Seen (LWBS)	137	42	-95	-69.2%	1,065	345	-720	-67.6%	942	-123	-11.5%
Observation Equivalent Days	306	235	71	30.3%	2,087	1,688	399	23.6%	1,668	419	25.1%
IP Surgeries	46	45	1	3.2%	356	446	-90	-20.2%	439	-83	-18.9%
OP Surgeries	195	173	22	12.4%	1,409	1,588	-179	-11.2%	1,556	-147	-9.4%
Total Surgeries	241	218	23	10.5%	1,765	2,034	-269	-13.2%	1,995	-230	-11.5%
REHAB											
Rehab Patient Days	762	747	15	2.0%	6,317	6,628	-311	-4.7%	6,308	9	0.1%
Rehab Discharges	56	57	-1	-0.9%	464	501	-37	-7.4%	465	-1	-0.2%
Rehab OP Factor	1	1	0	0.0%	1	1	0	0.0%	1	0	0.0%
Average Daily Census	24.6	24.1	0.5	2.0%	23.1	24.2	-1.1	-4.7%	23	0	0.1%
Average Length of Stay	13.6	13.2	-0.4	-2.9%	13.6	13.2	-0.4	-3.0%	13.6	0	-0.4%
Adjusted Patient Days	762	747	15	2.0%	6,317	6,628	-311	-4.7%	6,308	9	0.1%
Adjusted Discharges	56	57	-1	-0.9%	464	501	-37	-7.4%	465	-1	-0.2%
Occupancy %	88.0%	86.0%	0.0%		82.0%	86.0%	0.0%		82.0%	0.0%	
Bed Holds	0	0	0	0.0%	3	1	2	177.8%	0	3	0.0%
TOTAL FTE, HOURS, WRVU											
Total Paid FTE	501	476	-26	-5.4%	498	476	-22	-4.6%	478	-19	-4.0%
Total Productive FTE	438	414	-24	-5.9%	423	408	-15	-3.7%	410	-14	-3.3%
Total Paid FTE per AOB	4.26	4.14	-0.12	-2.8%	4.45	4.18	-0.27	-6.4%	4.25	-0.19	-4.5%
Worked Hours Per APD	21.3	20.6	-0.7	-3.4%	21.6	20.5	-1.1	-5.5%	20.8	-0.8	-3.9%
Worked Hours Per AD	118	113	-5	-4.0%	117	115	-2	-1.8%	116	0	-0.2%
Physician wRVU	19,561	0	19,561	0.0%	69,068	0	69,068	0.0%	0	69,068	0.0%
PAYOR MIX											
Insurance %	9.1%	7.5%	1.6%		6.7%	6.4%	0.3%		6.1%	0.6%	
Medi-Cal %	51.3%	55.9%	-4.6%		54.5%	56.3%	-1.8%		56.3%	-1.8%	
Medicare %	35.0%	30.3%	4.6%		34.1%	32.8%	1.3%		33.6%	0.5%	
Other Govt %	2.1%	2.0%	0.1%		1.8%	1.4%	0.4%		1.3%	0.5%	
Self-Pay %	2.5%	4.2%	-1.8%		2.9%	3.1%	-0.3%		2.8%	0.1%	
Total Payor Mix %	100.0%	100.0%	0.0%		100.0%	100.0%	0.0%		100.0%	0.0%	
CAMPUS CMI											
CMI San Leandro	1.432	1.451	-0.019	-1.3%	1.456	1.435	0.022	1.5%	1.507	-0.051	-3.4%

ALAMEDA HEALTH SYSTEMS Volume Reports

Month: March

	MONTH				YEAR-TO-DATE				PRIOR YEAR-TO-DATE		
	MTD Actual	MTD Budget	Var	% Var	YTD Actual	YTD Budget	Var	% Var	YTD PY Actual	Var	% Var
Campus: JOHN GEORGE											
Total Patient Days	2,037	1,992	45	2.3%	18,054	17,847	207	1.2%	17,603	451	2.6%
Total Discharges	204	221	-17	-7.8%	1,864	1,990	-126	-6.3%	1,859	5	0.3%
Total Adjusted Patient Days	2,416	2,383	33	1.4%	21,491	21,247	244	1.1%	21,078	413	2.0%
Total Adjusted Discharges	242	265	-23	-8.6%	2,219	2,369	-151	-6.4%	2,226	-7	-0.3%
PSYCH											
Psych Patient Days	2,037	1,992	45	2.3%	18,054	17,847	207	1.2%	17,603	451	2.6%
Psych Discharges	204	221	-17	-7.8%	1,864	1,990	-126	-6.3%	1,859	5	0.3%
Psych OP Factor	1.2183	1.2316	0.0134	1.1%	1.2267	1.2225	-0.0042	-0.3%	1.2335	0.0068	0.6%
Average Daily Census	65.7	64.2	1.5	2.3%	65.9	65.1	0.8	1.2%	64.2	1.6	2.6%
Average Length of Stay	10	9	-1	-10.9%	9.7	9	-0.7	-8.0%	9.5	-0.2	-2.3%
Adjusted Patient Days	2,482	2,453	29	1.2%	22,147	21,818	328	1.5%	21,713	433	2.0%
Adjusted Discharges	249	272	-24	-8.8%	2,287	2,433	-147	-6.0%	2,293	-7	-0.3%
PES Equivalent Days	629	636	-7	-1.1%	6,190	5,928	263	4.4%	6,045	145	2.4%
PES Visits	829	786	43	5.5%	7,241	7,304	-63	-0.9%	7,061	180	2.5%
PES Hours	15,100	16,637	-1,537	-9.2%	148,568	143,749	4,820	3.4%	145,084	3,484	2.4%
PES Hours per Visit	18	21	3	13.9%	21	20	-1	-4.3%	21	0	0.1%
TOTAL FTE, HOURS, WRVU											
Total Paid FTE	374	361	-13	-3.5%	393	369	-24	-6.6%	387	-7	-1.7%
Total Productive FTE	331	314	-16	-5.2%	335	316	-19	-5.9%	333	-2	-0.7%
Total Paid FTE per AOB	4.8	4.7	-0.1	-2.1%	5.01	4.76	-0.26	-5.4%	5.03	0.01	0.3%
Worked Hours Per APD	24.2	23.3	-0.9	-3.8%	24.4	23.3	-1.1	-4.7%	24.7	0.3	1.2%
Worked Hours Per AD	242	210	-32	-15.1%	237	209	-27	-13.1%	234	-2	-1.1%
Physician wRVU	2,813	4,821	-2,007	-41.6%	49,951	63,937	-13,986	-21.9%	176,149	-126,198	-71.6%
PAYOR MIX											
Insurance %	2.83%	8.85%	-6.02%	-68.0%	4.94%	6.19%	-1.25%	-20.2%	5.59%	-0.65%	-11.6%
Medi-Cal %	74.04%	63.55%	10.49%	16.5%	67.59%	64.12%	3.47%	5.4%	64.37%	3.22%	5.0%
Medicare %	20.25%	28.04%	-7.79%	-27.8%	25.34%	24.37%	0.97%	4.0%	25.34%	-0.01%	0.0%
Other Govt %	0.72%	-2.39%	3.12%	-130.3%	-0.26%	2.03%	-2.28%	-112.6%	1.35%	-1.61%	-118.9%
Self-Pay %	2.16%	1.95%	0.21%	10.6%	2.39%	3.30%	-0.91%	-27.6%	3.34%	-0.96%	-28.6%
Total Payor Mix %	100.00%	100.00%	0.00%	0.0%	100.00%	100.00%	0.00%	0.0%	100.00%	0.00%	0.0%
CAMPUS CMI											
CMI Behavioral Health	1.307	1.323	-0.016	-1.2%	1.355	1.276	0.079	6.2%	1.351	0.004	0.3%

ALAMEDA HEALTH SYSTEMS Volume Reports

Month: March

	MONTH				YEAR-TO-DATE				PRIOR YEAR-TO-DATE		
	MTD Actual	MTD Budget	Var	% Var	YTD Actual	YTD Budget	Var	% Var	YTD PY Actual	Var	% Var
Campus: FAIRMONT											
Total Patient Days	3,333	3,255	78	2.4%	29,333	28,772	561	1.9%	29,136	197	0.7%
Total Discharges	6	12	-6	-49.5%	70	105	-35	-33.3%	72	-2	-2.8%
OP Factor	1.3853	1.3331	-0.0522	-3.9%	1.3266	1.3496	0.023	1.7%	1.3412	0.0146	1.1%
Total Adjusted Patient Days	4,617	4,340	278	6.4%	38,914	38,831	83	0.2%	39,077	-163	-0.4%
Total Adjusted Discharges	8	16	-8	-47.6%	93	142	-49	-34.5%	97	-4	-3.8%
SNF WITH SUB-ACUTE											
SNF Patient Days	3,333	3,255	78	2.4%	29,333	28,772	561	1.9%	29,136	197	0.7%
SNF Discharges	6	12	-6	-49.5%	70	105	-35	-33.3%	72	-2	-2.8%
SNF OP Factor	1.0013	1.001	-0.0003	0.0%	1.0444	1.0016	-0.0428	-4.3%	1.0722	0.0278	2.6%
Average Daily Census	107.5	105	2.5	2.4%	107.1	105	2	1.9%	106.3	0.7	0.7%
Average Length of Stay	555.5	273.8	-281.7	-102.9%	419	274	-145.1	-53.0%	404.7	-14.4	-3.6%
Adjusted Patient Days	3,337	3,259	79	2.4%	30,635	28,817	1,817	6.3%	31,240	-605	-1.9%
Adjusted Discharges	6	12	-6	-49.5%	73	105	-32	-30.5%	77	-4	-5.3%
Occupancy %	99%	96%	0%	0.0%	98%	96%	0%	0.0%	98%	0%	0.0%
Bed Holds	44	34	10	27.6%	294	296	-2	-0.6%	333	-39	-11.7%
TOTAL FTE, HOURS, WRVU											
Total Paid FTE	279	284	5	1.6%	297	292	-5	-1.6%	296	-1	-0.4%
Total Productive FTE	249	249	1	0.2%	253	253	0	-0.2%	255	1	0.5%
Total Paid FTE per AOB	1.88	2.03	0.15	7.5%	2.09	2.06	-0.03	-1.4%	2.07	-0.02	-0.8%
Worked Hours Per APD	9.5	10.2	0.6	6.2%	10.2	10.2	0	0.0%	10.2	0	0.1%
Worked Hours Per AD	5302	2786	-2516	-90.3%	4271	2793	-1478	-52.9%	4129	-141	-3.4%
Physician wRVU	1,078	0	1,078	0.0%	4,098	0	4,098	0.0%	0	4,098	0.0%
CLINIC / TELEHEALTH VISITS											
Behavioral Health	2,321	1,976	345	17.4%	16,919	18,930	-2,011	-10.6%	18,325	-1,406	-7.7%
Rehab	11	11	0	-3.0%	104	90	14	16.1%	107	-3	-2.8%
Clinic Visits	2,332	1,988	344	17.3%	17,023	19,020	-1,997	-10.5%	18,432	-1,409	-7.6%
Telehealth Behavioral Health	86	54	32	60.4%	864	536	328	61.1%	519	345	66.5%
Telehealth Visits	86	54	32	60.4%	864	536	328	61.1%	519	345	66.5%
TOTAL CLINIC VISITS	2,418	2,041	377	18.5%	17,887	19,556	-1,669	-8.5%	18,951	-1,064	-5.6%
PAYOR MIX											
Insurance %	1.2%	0.9%	0.3%		1.6%	1.0%	0.6%		1.1%	0.5%	
Medi-Cal %	72.5%	78.4%	-5.9%		77.3%	76.7%	0.7%		77.4%	-0.1%	
Medicare %	25.6%	19.8%	5.8%		20.5%	21.4%	-1.0%		21.0%	-0.6%	
Other Govt %	0.3%	0.1%	0.2%		0.2%	0.2%	0.0%		0.2%	0.0%	
Self-Pay %	0.4%	0.8%	-0.4%		0.4%	0.7%	-0.3%		0.3%	0.1%	
Total Payor Mix %	100.0%	100.0%	0.0%		100.0%	100.0%	0.0%		100.0%	0.0%	

ALAMEDA HEALTH SYSTEMS Volume Reports

Month: March

	MONTH				YEAR-TO-DATE				PRIOR YEAR-TO-DATE		
	MTD Actual	MTD Budget	Var	% Var	YTD Actual	YTD Budget	Var	% Var	YTD PY Actual	Var	% Var
Campus: FQ CLINIC											
TOTAL FTE, HOURS, WRVU											
Total Paid FTE	519	484	-35	-7.1%	499	497	-2	-0.4%	463	-36	-7.8%
Total Productive FTE	457	415	-42	-10.2%	415	420	5	1.2%	385	-29	-7.6%
Physician wRVU	61,530	41,948	19,582	46.7%	446,382	361,097	85,285	23.6%	373,332	73,050	19.6%
OTHER STATS											
Covid Immunization	484	588	-104	-17.7%	4,598	7,989	-3,391	-42.4%	7,989	-3,391	-42.4%
CLINIC / TELEHEALTH VISITS											
Primary Care	15,746	14,190	1,556	11.0%	128,265	127,757	508	0.4%	128,494	-229	-0.2%
Specialty	12,037	11,898	139	1.2%	99,781	105,698	-5,917	-5.6%	87,717	12,064	13.8%
Behavioral Health	18	0	18	0.0%	152	0	152	0.0%	39	113	289.7%
Clinic Visits	27,801	26,088	1,713	6.6%	228,198	233,455	-5,257	-2.3%	216,250	11,948	5.5%
Telehealth Primary Care	3,062	2,829	233	8.2%	24,305	25,366	-1,061	-4.2%	23,106	1,199	5.2%
Telehealth Specialty	2,715	2,072	643	31.0%	20,861	18,536	2,325	12.5%	19,081	1,780	9.3%
Telehealth Behavioral Health	27	27	0	0.0%	291	243	48	19.8%	160	131	81.9%
Telehealth Visits	5,804	4,928	876	17.8%	45,457	44,145	1,312	3.0%	42,347	3,110	7.3%
TOTAL CLINIC VISITS	33,605	31,016	2,589	8.3%	273,655	277,600	-3,945	-1.4%	258,597	15,058	5.8%
FQHC Visits	33,605	31,016	2,589	8.3%	273,655	277,600	-3,945	-1.4%	258,597	15,058	5.8%
PAYOR MIX											
Insurance %	3.6%	2.5%	1.1%		3.2%	2.5%	0.8%		2.7%	0.6%	
Medi-Cal %	77.3%	80.1%	-2.8%		76.7%	80.1%	-3.4%		78.8%	-2.1%	
Medicare %	14.4%	12.7%	1.7%		15.0%	12.8%	2.2%		13.9%	1.2%	
Other Govt %	1.9%	1.7%	0.2%		1.8%	1.7%	0.1%		1.8%	0.0%	
Self-Pay %	2.8%	3.0%	-0.2%		3.2%	2.9%	0.3%		2.9%	0.3%	
Total Payor Mix %	100.0%	100.0%	0.0%		100.0%	100.0%	0.0%		100.0%	0.0%	

ALAMEDA HEALTH SYSTEM

Contract Review Initiative

AHS $100M Together Initiative

EXECUTIVE SPONSOR

Fratzke, Mark

SUMMARY: AHS is conducting a comprehensive review of all active contracts to identify savings opportunities in support of systemwide efforts to optimize utilization of system resources and reduce spend. AHS has engaged Guidehouse Consulting to provide expert advice and implementation support to fast-track and maximize impact.

Background

Opportunity

- AHS is faced with a $100M funding gap due to passage of HR.1.
- Total expense procurement, including contracting and supply chain, spend is approximately $325M (CY 25).
- Targeted reductions realized thru selective sunsetting/termination coupled with renegotiation of key contracts will contribute significantly to system savings goals.

Solution

- Partner with Guidehouse to complete a deep-dive review of ~ 2,000 active contracts and associated spend.
- AHS leadership develops savings strategy informed by Guidehouse analysis and key internal stakeholders.
- AHS taps Guidehouse to support complex renegotiation efforts to reduce spend and realign utilization with revised spend targets.

Background

Guidehouse

- Leading global professional services firm providing advisory and management consulting services with a focus on the governmental/public sector.
- Employs 18,000 professionals across + 55 global locations.
- Combines public sector and commercial market expertise to tackle complex challenges.
- One of the nation's largest healthcare consultancies, supporting major gov't agencies (i.e. CDC, NIH) and large health networks.
- Prior AHS experience – supporting AHS COVID expense reimbursement application process to FEMA. In process, but if approved AHS could receive + $1M in funding from FEMA.

Background

Process

- Work allocated into tranches of 375 contracts. Each tranche includes two phases:
  - Phase 1 (Guidehouse deep review of contract terms and opportunity identification
  - Phase 2 (Selected contract renegotiations by Guidehouse at direction of AHS leadership)

Timeline

Milestone 1

- Contracting with GH team
- Scoping process

Dec 2025

Milestone 2

- Phase 1 completed for Tranche 1
- Phase 2 in progress for Tranche 1

Apr 2026

Milestone 3

- Initiate Tranche 2 work pending Board approval of GH amendment

May 2026

Milestone 4

To Come

Milestone 5

To Come

Financials

$100M Initiative: Advisory Council Approved Initiative

Category	FY26 YTD (*Annualized*)	FY27 Forecast	FY28 Forecast
Investment/Cost (Fixed Costs)	$210,000 *($302,500 forecast)*	$80,000	TBD
Projected Savings	$144,782 *($834,835 forecast)*	$9,754,447	$11,820,455
Projected Cost (Variable) (based on 20% fee for GH attributed realized savings)	$0 *($138,011 forecast)*	$1,950,889	$2,364,091
Net Savings	($65,218) *($394,324 forecast)*	$7,723,558 (cumulative)	$9,456,364 (cumulative)

Questions?