QUALITY PROFESSIONAL SERVICES COMMITTEE MEETING *

Wednesday, May 27, 2026
4:00pm-7:00pm

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

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

Members of the public may also participate at the following ZOOM Meeting Link:[1]https://alamedahealthsystem.zoom.us/j/9361457125?pwd=4JnAmhDnBaLqY4GWf4PQBwp3w0Puy2.1&omn=82887749172
https://alamedahealthsystem.zoom.us/j/9361457125?pwd=4JnAmhDnBaLqY4GWf4PQBwp3w0Puy2.1&omn=81584776793
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Find your local number: https://alamedahealthsystem.zoom.us/u/aeojyFgeyI

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

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

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

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

*** THIS MEETING IS ALSO NOTICED AS A SPECIAL MEETING OF THE BOARD OF TRUSTEES**

BOARD OF TRUSTEES MEMBERS

Alan E. Fox   Greg Garrett
Lilavati Indulkar, MD   Donna Linton
Nicholas Moss, MD   Nely Obligacion
Rachel Richman   David Sayen
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QUALITY PROFESSIONAL SERVICES COMMITTEE REGULAR MEETING AND BOARD OF TRUSTEES SPECIAL 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. ACTION: Consent Agenda

A1. Approval of the Minutes of the April 22, 2026, Quality Professional Services Committee Meeting

A2. Recommendation to the Board of Trustees for approval of the Systemwide AHS Medical Staff Policies and Procedures listed below:

- CRO Infection Prevention and Control Plan
- HR Section 2.00 - Policy 2.63 Lactation Rooms
- HR Section 1.00 - Policy 1.31 Conditions of Employment - Identification Badge
- Laser Safety
- AHS Pain Assessment and Management
- Legal Medical Record Definition
- Medical Record-Content and Documentation Requirements
- Medical Record Forms Requirements and Approval Process

- Corrections of Errors and Omissions in the Medical Record
- Medical Record Retention and Destruction
- Documentation by Proxy Power Signature
- Administrative Closure of Incomplete Records
- Brain Death Policy
- CME Honoraria and Reimbursement Policy and Management of Commercial Support
- Smoking Policy
- Scope of Assessment Policy
- Eastmont Wellness Scope of Services
- Hayward Wellness Scope of Services
- Highland Hospital Scope of Services
- Newark Wellness Scope of Services
- System Medication Samples Policy
- Vancomycin Pharmacy Dosing Protocol (AHS)
- Medication Carts, Kits and Transport Boxes for Specific Depts. And Divisions

A3.Approval of the revised Medical Staff Forms listed below:

Medical Staff Forms for AHS & AH:

- Focused Professional Practive Evaluation (FPPE) Proctoring Single Case Evaluation Form
- Focused Professional Practive Evaluation (FPPE) Proctoring Multiple Case Evaluation Form

Privilege Form for AHS:

- Certified Registered Nurse Anesthetist

Recommendation: Motion to Approve

END OF CONSENT AGENDA

B. REPORT/DISCUSSION: Medical Staff Reports (Written Report)
AHS Medical Staff: Berenice Perez, MD, Chief of Medical Staff
AH Medical Staff: Manasa Kalluri MD, Chief of Medical Staff

C. REPORT/DISCUSSION: Quality Reports

C1.Quality Reports

- **Draft FY 2027 Quality Metrics (Verbal Report)**
- **Monthly OKR Dashboards (Written Report)**
- **Regulatory Affairs (Written Report)**

Ana Torres, Vice President, Quality

C2.Post Acute (Written Report)
Richard Espinoza, Chief Administrative Officer, Post Acute

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

E. REPORT/DISCUSSION: Evaluation of System Programs, Services, and Operations
Mark Fratzke, Chief Operations Officer
Christy Roberg, Vice President, Business Planning COT

F. REPORT/DISCUSSION: Committee Planning, Issues Tracking
Lilavati Indulkar, MD, Chair

G. WRITTEN REPORT: Regulatory Affairs Report
Nilda Perez, System Director of Regulatory Affairs

H. CLOSED SESSION

H1.Conference with Labor Negotiators
[Government Code Section 54957.6]
AHS Designated Representatives: Jet Chapman, CHRO
Employee Organization: ACMEA SEIU CIR

H2. Consideration of Confidential Medical Staff Credentialing Reports
Chief of Staff, AHS Medical Staff
Chief of Staff, AH Medical Staff

H3. Regulatory Affairs, Risk Management, Patient Safety
[Health and Safety Code 101850(ai) (1)]

(Reconvene to Open Session)

I. OPEN SESSION

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

ADJOURNMENT

ADDENDUM: QPSC Acronyms

Our Mission
Caring, Healing, Teaching, Serving All

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

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

Meeting Procedures
All items appearing on the agenda are subject to action by the Board of Trustees. Staff recommendations are subject to action and change by the Board of Trustees.
The Board of Trustees is the Policy Body of the Alameda Health System. The Board has several standing Committees where Board matters are the subject of discussion at which members of the public are urged to testify. Board procedures do not permit: 1) persons in the audience at a Committee meeting to vocally express support or opposition to statements by Board Members or by other persons testifying; 2) ringing and use of cell phones, pagers, and similar sound-producing electronic devices; 3) signs to be brought into the meeting or displayed in the room; 4) standing in the meeting room. Citizens are encouraged to testify at Committee meetings and to write letters to the Clerk of the Board or to its members, 1411 East 31st Street Oakland, CA 94602.
Members of the public are advised that all Board and Committee proceedings are recorded (audio), including comments and statements by the public in the course of the meetings. Copies of the audio recordings will be made available to the public. Copies of the agendas and supporting documents can be found here: http://www.alamedahealthsystem.org/meeting-agendas-and-minutes/**. By attending and participating in Board/Committee meetings, members of the public consent to audio recording of any statements they may make during the proceedings.**

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

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

ACTION: Consent Agenda

QUALITY PROFESSIONAL SERVICES COMMITTEE MEETING

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

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

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

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

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

QUALITY PROFESSIONAL SERVICES COMMITTEE MEETING MINUTES

THE MEETING WAS CALLED TO ORDER AT 5:07 pm

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

ABSENT: Donna Linton

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

Trustee Indulkar said she understood they were going to get a new or updated Community Needs Assessment soon.

Trustee Moss confirmed a new needs assessment was coming.

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

Trustee Indulkar said the current assessment focused on five areas: Housing, Access to Care, Income and Employment, Community Safety, and Mental and Behavioral Health. It was a big list. She said for today, she'd like to focus on Access to Care.

Trustee Indulkar said that for her, access to healthcare was making sure her patients coming from the emergency room actually had access to a hospital bed in a timely manner, and that they were getting access to OR services, IR services, specialty care services, and medicine services during their stay. After discharge, they need a safe place to go, access to food, and to their primary care office as well as any specialty services they need.

Trustee Moss said he thought of it in broad terms. Did people have care for what they needed, where they needed and when they needed. Even for preventive care. Here in Alameda County they had broad healthcare reimbursements, so people could access reimbursement in a lot of aspects of care in recent years. But could they go somewhere easy and culturally congruent to get their needs met. That was and is a big area of challenge.

Trustee Indulkar said that even though Alameda County had a higher poverty level than the State average, Medi-Cal enrollment in the County was lower than State and national health by a small percentage. She agreed with Trustee Moss in that not only did they have to be able to enroll in the programs, but they then needed to have that access.

Trustee Moss said you can have Medi-Cal and a medical home where you go regularly to get primary care, but there was an added layer of specialty care access. There were layers of access challenges.

Trustee Garrett added that in a diverse community language access was critical in access to care. Patients needed to feel comfortable approaching the institution and feel that it was a welcoming and compassionate environment.

Trustee Indulkar read some of the respondent information from the assessment. Themes included language, transportation – how much it costs them to get to care, racial disparities, long hold times on the phone, limited access to pharmacies and specialty services, the LGBTQ community felt judged and misgendered, telehealth was difficult for some patients, and concerns over legal status. The solutions they suggested included addressing structural racism by first emphasize housing and food security before they can talk about primary care. They also talked about employing mobile health vans, popup clinics, partnerships between hospitals and NGOs (non-governmental organizations) and faith-based organizations. They said finding primary care doctors, who took Medi-Cal in a language they spoke was a barrier.

B. ACTION: Consent Agenda

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

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

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

AHS and AH Medical Staff:

- False Claims Act
- Compliance Hotline Policy
- Responsibilities for Compliance Reporting
- Disclosure of Protected Health Information for Treatment, Payment and Health Care Operation
- Notice of Privacy Practice
- Release of Patient Information: Complying with ONC Final Rule Policy – Patient Access
- Privacy: Use and Disclosure of Limited Data Set (LDS)
- Privacy: AHS Directory
- Privacy Notification
- Mitigation of Improper Disclosures
- Patient Rights to Request Restrictions on Certain Uses and Disclosures of Protected Health Information
- Parking Policy
- FBC Scope Of Service Plan
- FNS Screening and Assessment/Clinical Nutrition Screening and Assessments (Acute Care)
- Stroke Center Program PLAN
- Clinical Nutrition Neonatal Initial Assessment and Prioritization
- Hazard Vulnerability Analysis Policy
- Patient Rights
- Drug Product Problem Reporting
- Medication – After Hours Retrieval of Medications
- Anticoagulant Therapy in Patients Undergoing PCI
- Vaccines for Children Program
- Adult Medicine Refill Clinics – Clinical Pharmacist Duties and Function
- Direct Oral Anticoagulation Policy
- Theft or Impairment of Pharmacy Employees
- Intra-Coronary Nitroglycerine
- Intra-Coronary Nitroprusside (Dr. Xin Yang)
- IV Adenosine for Fractional Flow Reserve in Interventional Services
- Pregnant Patients and IV Contrast Administration
- Radiopharmaceuticals: Radioactive Kit Preparation
- Highland Outpatient Pharmacy Automatic Quantity Change Policy

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

AHS Medical Staff:

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

AHS and AH Medical Staff:

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

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

Medical Staff Application Form for AHS & AH:
- Demographic Grid/Application Request

Privilege Form for AHS & AH:
- Gastroenterology

Privilege Form for AHS:
- Ob/Gyn APP

Privilege Form for AH:
- Wound Care

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

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

END OF CONSENT AGENDA

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

D. REPORT/DISCUSSION: Quality Reports

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

Trustee Garrett said in previous presentations it has been indicated that there were co-occurring issues that were actually the cause of death, but if sepsis is present, it is coded as being sepsis. Today they were saying a sepsis committee was reviewing all cases. If other issues were the actual cause of death, that committee would catch that. Ms. Torres said they were catching them and reviewing the cases. They had to capture the co-morbidities in order to get the risk adjustment.

Trustee Indulkar said that the teams were working on making sure that what they were seeing in the charts was actually what was being reported. The O:E (Observed to Expected Mortality) ratio wasn't giving them the information they were looking for. It wasn't telling them the story they were seeing. They had to question if that metric was useful as a system. They needed to know if they were providing safe patient care for patients coming in with sepsis. The chart reviews were saying yes but that metric was saying maybe.

Trustee Moss said if they improve the documentation, it might make the indicator more reflective of reality, but there were still concerns about the indicator.

Trustee Garrett asked how long ago the Reach program was implemented. Ms. Torres said it was in the last couple of months. Dr. Wu said community health workers, nurses, and physicians made the phone calls reaching out to patients. They triaged the calls by risk. The lowest risk patients were called by the community health workers, the higher risk patients were contacted via telehealth by physicians. Trustee Garrett said he was looking forward to hearing more about the program. It was best for patient outcomes.

Trustee Moss asked about the methodology for triaging the follow up calls. Dr. Wu said they were still developing it. She said there were EPIC readmission scores that were used as predictive modeling to allow them to stratify the patients. They were also looking at the clinical context of which the patient was admitted to help make the decisions.

Trustee Garrett asked if they would be getting an update on the status of referrals from the Alliance again. Dr. Mack said they were in contact with them, waiting for them to communicate the criteria going forward. AHS was on a 60-day hold, which would be over in early May. Moving forward, they wanted to be aligned with the Alliance to know what the criteria was for opening and closing. Trustee Garrett said they knew the Alliance was getting pressure from DHCS.

Trustee Moss asked for an update on the HAPI assessment documentation improvements. Ms. Torres said it remained one of the big action plans, they wanted to catch them early without claiming them if the patient came in with them. They were still doing work around ensuring that they do the assessment within 24 hours. They were at about 82%. Ms. Johnson said they did audit the assessments and present the data to the units. They were actively working on driving improvement using real-time, just-in-time education resources to help managers provide education and feedback that reinforces that training to the front-line nurses. They were also gearing up for the annual skills fair day, which will have a focus on HAPIs.

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

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

Item deferred to May QPSC meeting.

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

Trustee Garrett asked what the cause of the 150% growth in cardiology was. Dr. Trilesskaya said they added electrophysiology. AHS was the only place in the northern county where the patients could access electrophysiology services. The rate of acute heart attacks have lowered, but the rates of cardiac arrests have increased.

Trustee Garrett asked if Dr. Trilesskaya was concerned about AHS meeting the requirements for SRC/CARC ((STEMI (Heart Attack) Receiving Center/Cardiac Arrest Receiving Center)). Dr. Trilesskaya said she wasn't. She said they were already doing all the things required by the Joint Commission. They just had to show the work.

Trustee Garrett asked why there was such a dramatic increase in code stroke activations. Dr. Gaines said it started before they were stroke certified. It's when they started preparing for stroke certification and doing a lot of the education. Also, when they started having attendings at triage, they started having a lot more code strokes.

Trustee Garrett asked if they did CT scans or MRIs. Dr. Gaines said the protocol was CT-based, because they were faster. They could pivot to MRI when needed.

Trustee Garrett said AI software could save a lot of lives and money, hopefully they implement it in a timely manner. Dr. Gaines said the AI software in stroke was out in front of other fields. It was becoming more relevant.

Mr. Azizi announced the Quality Committee of the Board would move into closed session to discuss the items as set forth on the agenda.

G. CLOSED SESSION

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

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

(Reconvene to Open Session)

H. OPEN SESSION

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

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

ADJOURNMENT: 9:07pm

Calendaring:
- Reach program update
- Culture of Safety Survey
- Community Health Needs Assessment

Alameda Health System			CPC Executive Summary to AHS and AH Medical Executive Committee(s) – May 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						
CRO Infection Prevention and Control Plan	Matthew D. White, MPH, CIC Manager of Infection Prevention and Control	• Revised • • Routine 1:1 dedicated staffing no longer required for individual, non-cohorted CPO patients; aligns with current CDPH guidance and regional practice. • • Enhanced Contact Precautions (ECP) redefined: dedicated nursing staff is the sole distinction from standard Contact Precautions. • Clarified CPO vs. non-CP CRO distinction: CPO patients universally require Contact Precautions; precaution requirements for non-CPO CRO patients determined by organism type and clinical risk.		05/2029		• CPC 5/7/2026 • AH MEC 5/15/2026 • AHS MEC 5/20/2026
HR Section 2.00 - Policy 2.63 Lactation Rooms	Terri Dixon, RN, BSN, MBA	• Revised • Updated inquiry/issue communication method information • Transferred to new template – added/updated Scope, Purpose, References.		05/2029		• CPC 5/7/2026 • AH MEC 5/15/2026 • AHS MEC 5/20/2026
HR Section 1.00 - Policy 1.31 Conditions of Employment - Identification Badge	Sara McElfresh	• Revised • Transferred to new template – added/updated Definitions, References • Updated Procedure to match actual process with Security.		05/2029		• CPC 5/7/2026 • AH MEC 5/15/2026 • AHS MEC 5/20/2026
Laser Safety	Jovita Okorie, DNP, MSN, APRN, FNP-C, RN	• Revised		05/2029		• CPC 5/7/2026 • AH MEC 5/15/2026 • AHS MEC 5/20/2026

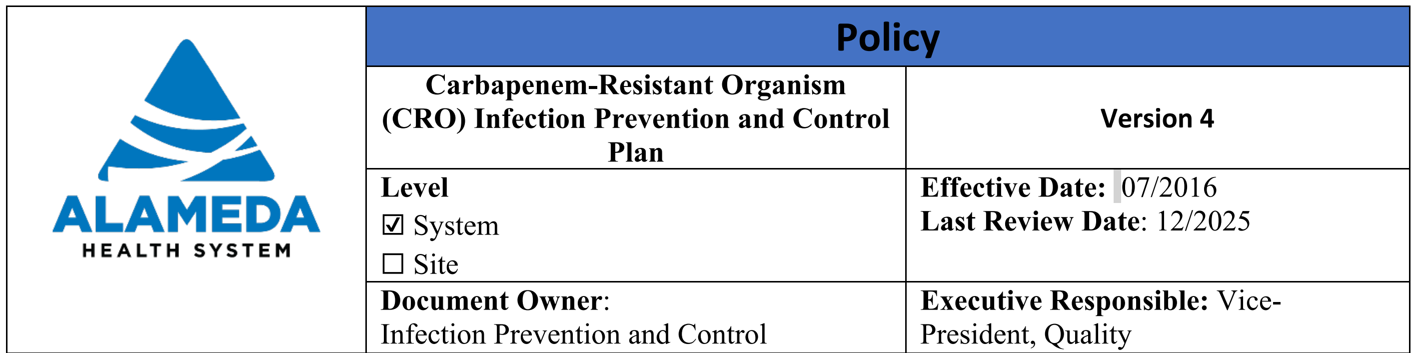
Alameda Health System			**CPC Executive Summary to AHS and AH Medical Executive Committee(s) – May 2026**			
Policies and Procedures				**Chairs: Kelley Bullard, MD & Salma Adin, MBA, BSN, RN**		
TOPIC or TITLE OF POLICY	**Document Owners**	**Summary of Changes**	**Last Approved Date**	**Next review date after BOT approval**	**Purpose**	**History of Review Committee**
AHS Pain Assessment and Management	Dawn Anderson, MSN, MBA, HCM	• Revised		05/2029		• CPC 5/7/2026 • AH MEC 5/15/2026 • AHS MEC 5/20/2026
Legal Medical Record Definition	Swaran Dwarka, MSA, RHIA Vice President , Rev Cycle	• Revised • Aligning to current standards and applying to current policy template. No revisions needed.		05/2029		• CPC 5/7/2026 • AH MEC 5/15/2026 • AHS MEC 5/20/2026
MEDICAL RECORD-CONTENT AND DOCUMENTATION REQUIREMENTS	Swaran Dwarka, MSA, RHIA Vice President , Rev Cycle	• No revisions were made to the medical record content or the documentation requirements, but the following sections were added per the new policy template: Policy Statement, • Purpose, Scope, Related Documents and References.		05/2029		• CPC 5/7/2026 • AH MEC 5/15/2026 • AHS MEC 5/20/2026
Medical Record Forms Requirements and Approval Process	Swaran Dwarka, MSA, RHIA Vice President , Rev Cycle	• Updated HIM Director to the VP of Revenue Cycle		05/2029		• CPC 5/7/2026 • AH MEC 5/15/2026 • AHS MEC 5/20/2026

Alameda Health System			**CPC Executive Summary to AHS and AH Medical Executive Committee(s) – May 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**
Corrections of Errors and Omissions in the Medical Record	Swaran Dwarka, MSA, RHIA Vice President , Rev Cycle	• Updated Procedure #1. • 1. The individual who made the original entry in a medical record is authorized to correct the entry. In instances of absence or unavailability of the individual who made the original entry, corrections may be made by the Attending who saw the patient. • If the attending is unavailable, the Department Chair would make the correction.		05/2029		• CPC 5/7/2026 • AH MEC 5/15/2026 • AHS MEC 5/20/2026
Medical Record Retention and Destruction	Swaran Dwarka, MSA, RHIA Vice President , Rev Cycle	• Revised • Aligning to the current standard and applying to the current policy template.		05/2029		• CPC 5/7/2026 • AH MEC 5/15/2026 • AHS MEC 5/20/2026
Documentation by Proxy Power Signature	Swaran Dwarka, MSA, RHIA Vice President , Rev Cycle	• Revised • Aligning to the current standard and applying to the current policy template.		05/2029		• CPC 5/7/2026 • AH MEC 5/15/2026 • AHS MEC 5/20/2026
Administrative Closure of Incomplete Records	Swaran Dwarka, MSA, RHIA Vice President , Rev Cycle	• Revised • Aligning to the current standard and applying to the current policy template.		05/2029		• CPC 5/7/2026 • AH MEC 5/15/2026 • AHS MEC 5/20/2026

Alameda Health System			CPC Executive Summary to AHS and AH Medical Executive Committee(s) – May 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**
Brain Death Policy	Nathan Gaines, MD Chief, Neurology	• Revised • Approved by the CCC		05/2029		• CPC 5/7/2026 • AH MEC 5/15/2026 • AHS MEC 5/20/2026
CME Honoraria and Reimbursement Policy and Management of Commercial Support	Jena Resner MD CME Manager	• Revised		05/2029		• CPC 5/7/2026 • AH MEC 5/15/2026 • AHS MEC 5/20/2026
Smoking Policy	James Helena, System Director, Engineering & Facilities Service	• Revised		05/2029		• CPC 5/7/2026 • AH MEC 5/15/2026 • AHS MEC 5/20/2026
Scope of Assessment Policy	Teresa (Terry) Randall, PT, OCS	• Revised • Policy reviewed by Rehab Services Management Team. Policy references updated.		05/2029		• CPC 5/7/2026 • AH MEC 5/15/2026 • AHS MEC 5/20/2026
Eastmont Wellness Scope of Services	**Temisan (Temi) Amoruwa, RN-CEN, MHA |** Vice President, Ambulatory Services	• **REVISED** – Updated with specialty services, and updated revision date • **KEYWORDS** – ambulatory, scope of services, Eastmont Wellness, Hayward Wellness, Highland Wellness, Newark Wellness		05/2029		• CPC 5/7/2026 • AH MEC 5/15/2026 • AHS MEC 5/20/2026

Alameda Health System			CPC Executive Summary to AHS and AH Medical Executive Committee(s) – May 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**
Hayward Wellness Scope of Services	**Temisan (Temi) Amoruwa, RN-CEN, MHA |** Vice President, Ambulatory Services	• **REVISED** – Updated with specialty services, and updated revision date • **KEYWORDS** – ambulatory, scope of services, Eastmont Wellness, Hayward Wellness, Highland Wellness, Newark Wellness		05/2029		• CPC 5/7/2026 • AH MEC 5/15/2026 • AHS MEC 5/20/2026
Scope of Service: Highland Ambulatory	**Temisan (Temi) Amoruwa, RN-CEN, MHA |** Vice President, Ambulatory Services	• **REVISED** – Updated with specialty services, and updated revision date • **KEYWORDS** – ambulatory, scope of services, Eastmont Wellness, Hayward Wellness, Highland Wellness, Newark Wellness		05/2029		• CPC 5/7/2026 • AH MEC 5/15/2026 • AHS MEC 5/20/2026
Newark Wellness Scope of Services	**Temisan (Temi) Amoruwa, RN-CEN, MHA |** Vice President, Ambulatory Services	• **REVISED** – Updated with specialty services, and updated revision date • **KEYWORDS** – ambulatory, scope of services, Eastmont Wellness, Hayward Wellness, Highland Wellness, Newark Wellness		05/2029		• CPC 5/7/2026 • AH MEC 5/15/2026 • AHS MEC 5/20/2026
Medication Samples Policy	Priya Patel, PharmD	• Revisions made based on Ambulatory leadership recommendations • System P&T 4/2026 • Consent Item – Policy		05/2029		• System P&T 4/2026 • CPC 5/7/2026 • AH MEC 5/15/2026 • AHS MEC 5/20/2026

Alameda Health System			CPC Executive Summary to AHS and AH Medical Executive Committee(s) – May 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**
Vancomycin Pharmacy Dosing Protocol	Matt Labreche, PharmD	• Cap vancomycin doses for Group B Strep prophylaxis in pregnancy to 2g/dose as per ACOG guidance • Update vancomycin monitoring recommendations for patients receiving Intraperitoneal vancomycin per discussion w/ Dr Manjunath • System P&T 4/2026 • Consent Item – PolicyTech		05/2029		• System P&T 4/2026 • CPC 5/7/2026 • AH MEC 5/15/2026 • AHS MEC 5/20/2026
MEDICATION_CARTS_KITS_AND_TRANSPORT_BOXES_FOR_SPECIFIC_DEPTS._AND_DIVISIONS_(34534_-1)	Priya Patel, PharmD	• TNK company now makes 25mg vials, AIS max dose is 25mg, so revise the kit to stock 25mg vials instead of the 50mg to avoid waste • System P&T 4/2026 • Consent Item – Policy		05/2029		• System P&T 4/2026 • CPC 5/7/2026 • AH MEC 5/15/2026 • AHS MEC 5/20/2026



ALAMEDA HEALTH SYSTEM	Policy	
	Carbapenem-Resistant Organism (CRO) Infection Prevention and Control Plan	**Version 4**
	Level ☑ System ☐ Site	**Effective Date:** 07/2016 **Last Review Date**: 12/2025
	Document Owner: Infection Prevention and Control	**Executive Responsible:** Vice-President, Quality

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

POLICY STATEMENT

Alameda Health System (AHS) implements active surveillance, evidence-based transmission precautions, and environmental controls to prevent the transmission of Carbapenem-Resistant Organisms (CRO) within all AHS facilities, in alignment with guidance from CDC, CDPH, and the Alameda County Public Health Department (ACPHD).

PURPOSE

To provide a plan for active surveillance of CRO and to establish precautionary measures that prevent healthcare-associated transmission of CRO to patients, staff, and the community.

SCOPE

This plan applies to all AHS facilities, departments, employees, licensed independent practitioners, students, and contracted personnel involved in the care of patients with known or suspected CRO colonization or infection.

DEFINITIONS

Multidrug-Resistant Organism (MDRO) – Microorganisms, predominantly bacteria, resistant to one or more classes of antimicrobial agents.

Carbapenem-Resistant Organism (CRO) – An organism resistant to any carbapenem antimicrobial (MIC ≥4 mcg/mL for doripenem/meropenem/imipenem, or ≥2 mcg/mL for ertapenem). Common CRO include CRE (Enterobacterales), CRAB (A. baumannii), and CRPA (P. aeruginosa).

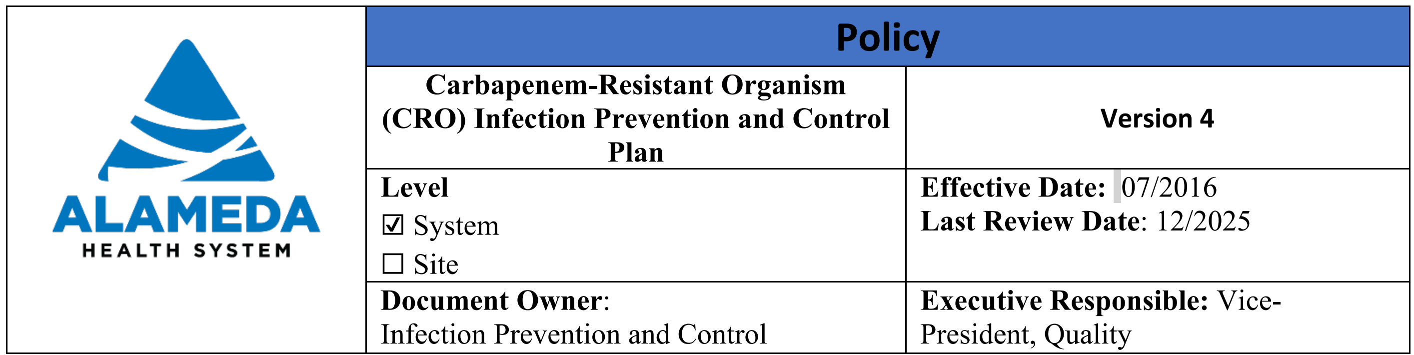
Carbapenemase-Producing Organism (CPO) – A CRO that produces carbapenemase enzyme (e.g., KPC, NDM, VIM, IMP, OXA-type), which inactivates carbapenem antibiotics. CPOs pose higher transmission risk due to plasmid-mediated gene transfer.

Non-CP CRO – A CRO that resists carbapenems through non-enzymatic mechanisms (e.g., ESBL production combined with porin mutations). Does not produce carbapenemase.

Colonization – Presence of CRO on or in the body without causing symptoms or active infection. Colonized patients can transmit CRO to others.

High-Risk Transmission Factors – Conditions that increase CRO spread risk: ventilator dependence, incontinence, indwelling devices (trach, central line, catheter, feeding tube), draining wounds, total ADL dependence, or cognitive impairment limiting personal hygiene.

Enhanced Contact Precautions – An escalated level of contact precautions with monitor assignment, used during outbreak investigation. See TBP Policy for full details.



RESPONSIBILITIES

Infection Prevention and Control is responsible for directing this plan, conducting surveillance, investigating suspected CRO clusters, consulting on precaution placement, communicating with ACPHD/CDPH, and updating guidance as recommendations evolve.

Laboratory (Microbiology) is responsible for flagging CRO/CPO results in the EHR and notifying IP of all positive CRO results.

All Clinical Staff are responsible for implementing prescribed isolation precautions, performing hand hygiene per the Hand Hygiene Policy, and adhering to environmental cleaning protocols.

Environmental Services is responsible for performing thorough daily and terminal cleaning of CRO patient rooms using IP-approved disinfectants.

Department Managers are responsible for ensuring staff compliance with this plan and for escalating concerns to IP.

POLICY

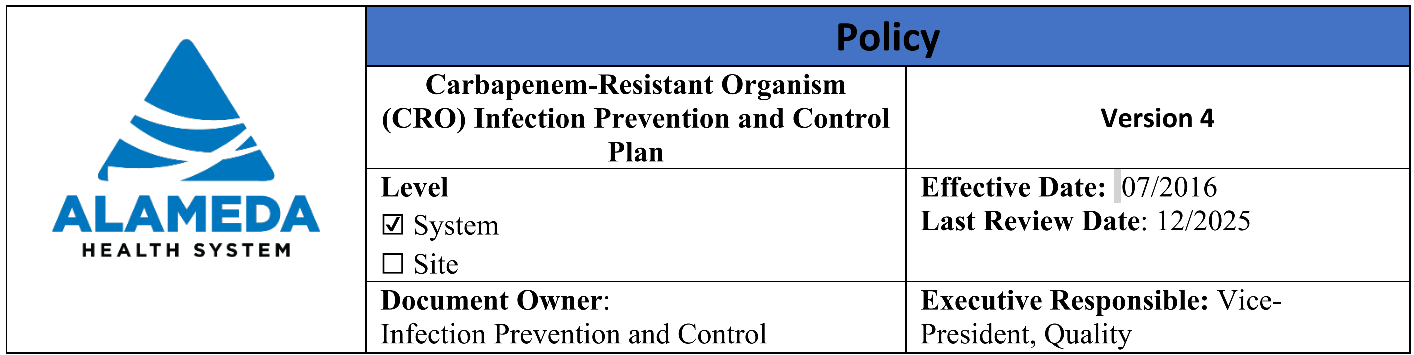
Facility-Wide Prevention Measures

1. Promote Standard Precautions for all patient care, with emphasis on hand hygiene and appropriate PPE use. Refer to the AHS Hand Hygiene Policy and the Transmission-Based Precautions in Addition to Standard Precautions Policy.
2. Electronically flag patient EHR records with known CRO/CPO infection or colonization history.
3. Promote Antimicrobial Stewardship — reduce unnecessary carbapenem and broad-spectrum antibiotic use.
4. Minimize use of invasive devices; remove devices as soon as clinically appropriate.
5. Implement daily chlorhexidine (CHG) bathing for patients in high-risk settings (ICU, patients with indwelling devices).
6. Consider admission screening for CRO in high-risk settings (ICU, patients transferred from known outbreak facilities or from facilities with high CRO prevalence).

Patient Placement and Cohorting

Consult Infection Prevention for all CRO/CPO patient placement decisions.

Cohorting is initiated exclusively at the direction of Infection Prevention and Control (IPC). IPC will proactively review all CRO/CPO cases and determine whether cohorting is clinically warranted based on organism type, patient risk factors, unit epidemiology, and available room configuration. Clinical and nursing staff may not initiate cohorting, request patient placement changes for CRO/CPO patients, or assign patients to a cohort without explicit IPC direction. No patient may be cohorted with another CRO/CPO patient without prior review, approval, and direction by IPC and/or



Infectious Diseases (ID). IP/ID must confirm organism compatibility (like organism and, for CPO, like carbapenemase type) before cohorting is initiated.

Private room priority order (highest to lowest priority):

1. Patients with CPO (carbapenemase-producing) infection or colonization
2. Patients with CRO (non-CP) infection or colonization
3. Patients transferred from a facility with an active CRO/CPO outbreak (as notified by ACPHD)
4. Patients with multiple high-risk transmission factors

Cohorting when private rooms are unavailable:

- Within-room cohort: Same organism and carbapenemase enzyme type (e.g., KPC-E. coli with KPC-E. coli) — preferred for CPO. Must be confirmed by IP/ID before placement.
- If same enzyme not available, cohort by same bacteria type (e.g., CRE with CRE, CRAB with CRAB). Requires IP/ID approval.
- Non-CP CRO: Cohort by same organism (CRE with CRE, CRAB with CRAB, CRPA with CRPA). Requires IP/ID approval.
- If no compatible cohort is available, cohort with lowest-risk patients (no indwelling devices, no open wounds, most independent in ADLs). Requires IP/ID approval.

Dedicated Nursing for Cohorted CPO Patients

Individual CPO patients in private rooms do not require dedicated nursing staff.

1. When IPC determines that cohorting is clinically indicated and formally directs cohorting of CPO patients, those patients must be placed in geographically proximate rooms (same hallway or room cluster) to the extent unit layout permits. The presence of ≥2 CPO patients on a unit does not automatically require or trigger cohorting; that determination rests exclusively with IPC.
2. IP or ID must review available culture and susceptibility data to confirm organism compatibility prior to approving cohorting. Cohorting may not proceed until this approval is documented.
3. Once IP/ID approval is obtained and patients are cohorted, a dedicated nursing team must be assigned to care exclusively for the CPO cohort for the duration of their shift. Nurses assigned to the CPO cohort must not simultaneously care for non-CPO patients.
4. IP will coordinate CPO cohort placement and dedicated nursing assignments with the charge nurse and unit manager. Nursing leadership is responsible for adjusting staffing assignments to support this requirement.
5. A compliance monitor must be assigned to the CPO cohort area whenever dedicated nursing is in effect, to verify adherence to Enhanced Contact Precautions.

Dedicated nursing applies specifically to CPO patients cohorted per IP/ID approval. Non-CP CRO patients managed under standard Contact Precautions do not require dedicated staffing unless otherwise directed by IP.

Transmission-Based Precautions

Refer to the Transmission-Based Precautions in Addition to Standard Precautions Policy for full precaution protocols, PPE requirements, and donning/doffing procedures.

Clinical Scenario	Precautions Required	Additional Guidance
Individual CPO patient — infection or colonization (non-sputum specimen)	Contact Precautions	Patient restricted to room. Dedicated equipment. Encourage patient hand hygiene. No dedicated staffing required for individual patients.
Individual CPO patient — positive sputum specimen	Contact + Droplet Precautions	Patient restricted to room. No dedicated staffing required for individual patients.
Cohorted CPO patients (≥2 CPO patients cohorted on IPC direction)	Enhanced Contact Precautions (with monitor assignment)	A dedicated nursing team must be assigned exclusively to the CPO cohort and must not provide care to non-CPO patients during their shift. A compliance monitor must be present. IP will direct cohort placement.
CRO/CPO outbreak investigation (≥2 hospital-onset cases with epi-linked transmission)	Enhanced Contact Precautions (with monitor assignment)	IP will direct escalation. Cohorted patients retain dedicated nursing team. A compliance monitor must be present for all outbreak cohort rooms.

Post-Acute Care Settings

In post-acute/SNF settings, apply MDRO Transmission Risk Assessment to determine precaution level:

- High-Risk patients (any of: ventilator-dependent; highly/totally dependent on staff for ADLs; incontinent with stool or urine not reliably contained; indwelling devices; draining wounds; cognitively unable to maintain personal hygiene): Contact Precautions.
- Not High-Risk patients: Enhanced Barrier Precautions (per CDPH AFL 22-21 / Enhanced Standard Precautions for SNFs).
- CRO/CPO with positive sputum (any risk level): Contact + Droplet Precautions.

Discontinuing Isolation

There is no universal CDC recommendation for CRO isolation discontinuation, as CRO colonization can persist >6 months. IP, in consultation with ACPHD, will make individualized decisions considering:

- ≥3–6 months since last positive culture or screen.
- At least 2 sets of negative surveillance cultures, including re-testing of originally positive sites.
- Absence of high-risk transmission factors.

Patient Care Practices

1. Dedicated medical equipment (pulse oximeter, stethoscope, BP cuff, thermometer) must be used for CRO/CPO patients. Single-use disposable devices are preferred.
2. Non-dedicated equipment (e.g., bladder scanner, weight scale, glucometer) must be cleaned and disinfected between uses.
3. Limit supplies in CRO patient rooms to essential items; do not return unused supplies to general stock.
4. Minimize patient movement within the facility. Await pending screening results before moving patients into cohort areas.
5. Schedule CRO/CPO patients for therapy, procedures, or non-dedicated equipment use at the end of the day when possible.

Environmental Cleaning

1. Daily cleaning of CRO patient rooms must use an IP-approved disinfectant effective against MDROs.
2. Terminal cleaning after CRO patient discharge must include thorough cleaning of all surfaces, furniture, equipment, and high-touch areas.
3. Environmental Services staff must be educated on CRO and precaution requirements specific to these patients.

Patient Transfer and Discharge Communication

1. When transferring or discharging a CRO/CPO patient, clearly communicate the patient's CRO/CPO status to the receiving facility using the AHS Infection Control Transfer Form (Attachment A).
2. For inter-facility transfers, notify the receiving facility verbally in advance and document CRO/CPO status in the transfer documentation.

Surveillance and Outbreak Investigation

1. Routine surveillance: IP will review all CRO/CPO positive laboratory results daily and maintain a line list.
2. Active surveillance (screening): IP will direct active screening in high-risk settings or during outbreak investigation per ACPHD/CDPH guidance.
3. Outbreak criteria: ≥2 hospital-onset CRO/CPO cases with epidemiologic linkage in the same unit constitutes a potential outbreak. IP will immediately notify ACPHD and initiate contact investigation.
4. Contact investigation: IP will identify and screen exposed patients per ACPHD/CDPH guidance. Enhanced Contact Precautions will be implemented for the duration of the investigation.

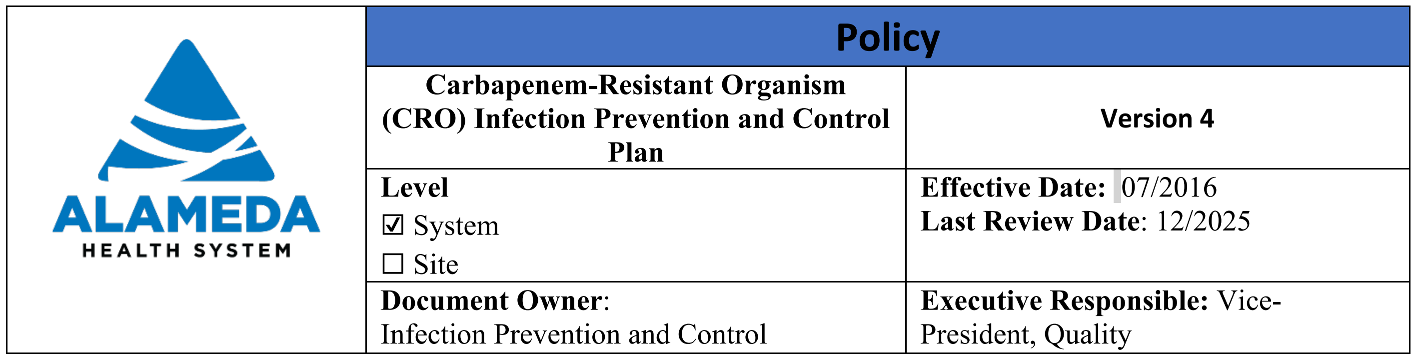
Staff Education

IP will provide annual CRO/MDRO education to all clinical staff and targeted education during any outbreak event or when new precaution protocols are implemented.

1. Annual education must cover: CRO/CPO organism types and transmission risk, Contact and Enhanced Contact Precautions, hand hygiene requirements, environmental cleaning expectations, and exposure reporting.
2. The CDC CRE Clinician Quicksheet (Attachment F) is the standard reference for staff education on carbapenem-resistant Enterobacterales organism characteristics, transmission, and infection control. IP will distribute this resource during orientation and annual training.
3. For organism-level detail on CRE, CRAB, and CRPA (specimen sources, carbapenemase types, and epidemiology), staff should refer to Attachment F and the CDPH CRO Quicksheet rather than this policy document.

References

1. CDC. CRE (Carbapenem-resistant Enterobacteriaceae): Information for Clinicians. cdc.gov/hai/organisms/cre
2. CDC. Antibiotic Resistance Threats in the United States, 2019.
3. CDPH. Guidance on Investigating CRO (CRPA/CRAB) Cases and Clusters, v1.0 (Oct 2020).
4. CDPH. Cohorting Guidance for Patients/Residents with MDRO, March 2023.
5. CDPH AFL 22-21: Enhanced Standard Precautions for Skilled Nursing Facilities (Oct 2022).
6. AHS Transmission-Based Precautions in Addition to Standard Precautions Policy.
7. AHS Hand Hygiene Policy.



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ATTACHMENTS

Attachment A: AHS Infection Control Transfer Form.

Attachment B: Contact Precautions Sign — Acute Care Setting.

Attachment C: Enhanced Standard Precautions Sign — Post-Acute Care Setting.

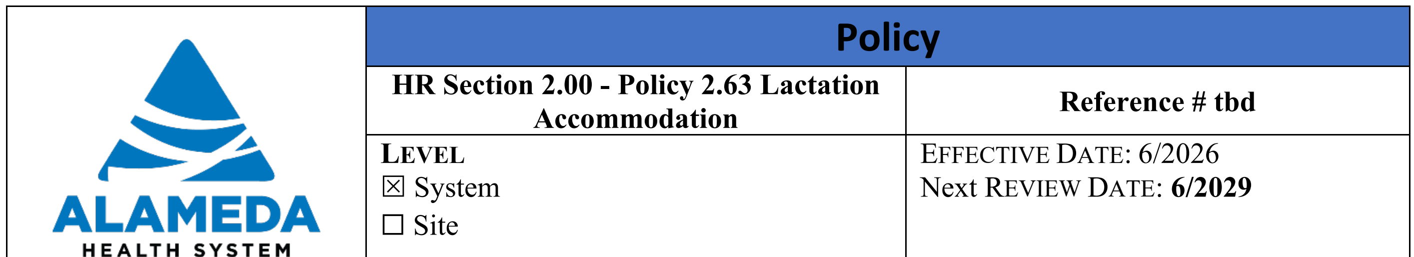
Attachment D: Enhanced Contact Precautions Sign — CRO Outbreak (Acute Care).

Attachment E: Enhanced Contact Precautions Monitor Log.

Attachment F: CDC CRE Clinician Quicksheet — Carbapenem-resistant Enterobacterales: Information for Clinicians. Available at: https://www.cdc.gov/healthcare-associated-infections/media/pdfs/CRE-handout-V7-508.pdf

APPROVALS

Committee / Group	System	Alameda	AHS/Highland/JG/SL
IP Department / Infection Control Committee	N/A	12/2025	12/2025
Clinical Practice Council (CPC)	12/2025, 5/2026	N/A	N/A
Medical Executive Committee (MEC)	5/2026	12/2025	N/A
Board of Trustees	6/2026		



Policy	
HR Section 2.00 - Policy 2.63 Lactation Accommodation	**Reference # tbd**
LEVEL ☒ System ☐ Site	EFFECTIVE DATE: 6/2026 Next REVIEW DATE: **6/2029**

POLICY STATEMENT
Alameda Health System (AHS) will make reasonable efforts to provide lactating employees lactation breaks in a private designated area, other than a bathroom, near the employee's work area, where possible, for the purpose of expressing breast milk.

PURPOSE
To provide policy guidelines for supporting lactating employees who wish to express breast milk during work hours.

SCOPE
This policy applies to the AHS workforce, which in the context of this policy includes all employees, including exempt, non-exempt, part-time, temporary, and contracted employees, regardless of gender identity, who have a need to express breast milk.

PROCEDURES
Lactating employees may request accommodation for lactation breaks by submitting a request for accommodation in writing to their department supervisor or their Designee.

The department supervisor must provide written response to the employee's request for lactation breaks. Please provide a copy of this communication in a ticket to the HR/Payroll Service Center to the Leave Management Department.

When possible, lactation breaks will be provided each time an employee needs to express breast milk. These breaks are expected to be taken at times that are the least disruptive to department operations and should run concurrently with other scheduled break periods provided. However, if lactation break periods do not run concurrently with scheduled break periods provided, or if additional time is necessary, the additional time needed shall be considered unpaid. Employees may substitute available compensable time in lieu of unpaid leave with supervisory approval.

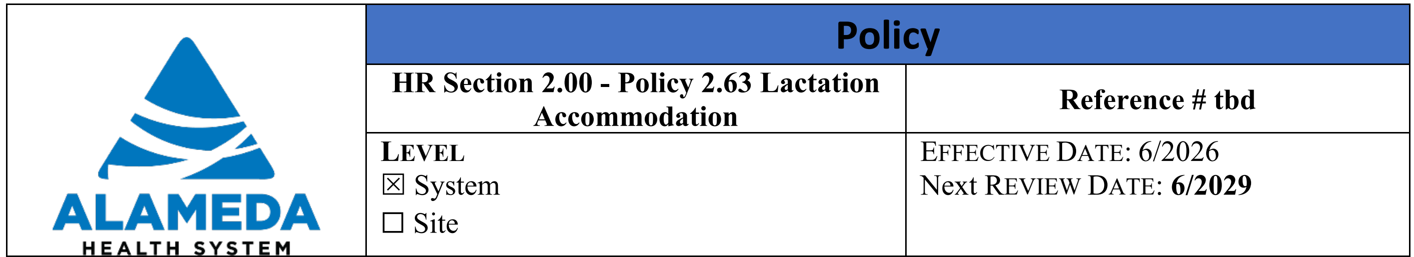
Alameda Health System expressly prohibits discrimination and retaliation against lactating employees for exercising, or attempting to exercise, their rights to lactation breaks under this policy. Breast feeding employees who feel they have been denied proper accommodation are encouraged to contact Human Resources/Leave Management department by opening a ticket in the HR/Payroll Service Center. Employees may also file a complaint with the Labor Commissioner if they feel they have been discriminated against, retaliated against, or denied proper accommodation.

Lactation Area Requirements

Whenever feasible, Lactation Areas will be near the employee's work site. The area will be shielded from view and free from intrusion from co-workers and the public. Staff may use their designated work area if the location adheres to the standards noted in this policy.

In alignment with Labor Code §§ 1030-1034, Lactation areas will:

- Be safe, clean, and free of toxic or hazardous materials.
- Contain a comfortable place to sit, a surface to place a breast pump and personal items.



- Have access to electricity.
- Have access to a sink with running water and a refrigerator suitable for storing breast milk near the employee's work area, where available.

Lactation Areas

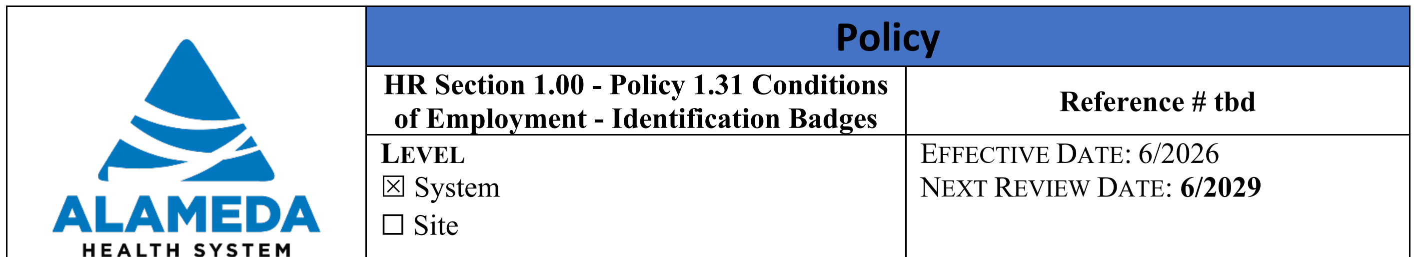
For the location of the Lactation Area for your facility, please click on this link: https://ahs-connects.acmedctr.ad/lactation-accommodation-policy/ (AHS Network Access required)

If a dedicated Lactation Area is not accessible near your department, your supervisor will identify a suitable area for staff wishing to express breast milk for their infants during work hours, that meets the guidelines of this Lactation Policy.

Multi-purpose rooms may be used as lactation space if they satisfy the requirements of this Lactation Policy.

REFERENCES

California Labor Code Section 1030-1034
Fair Labor Standards Act (FLSA), Section 7(r)



	Policy	
ALAMEDA HEALTH SYSTEM	**HR Section 1.00 - Policy 1.31 Conditions of Employment - Identification Badges**	**Reference # tbd**
	LEVEL ☒ System ☐ Site	EFFECTIVE DATE: 6/2026 NEXT REVIEW DATE: **6/2029**

POLICY STATEMENT
All workforce members of the Alameda Health System (AHS) are required to wear identification badges that bear their photograph, name, and title while on AHS property.

PURPOSE
To provide each employee with an identification badge as a means of distinguishing customers, patients and visitors from employees and to assist in identifying essential personnel during a disaster or other emergency.

SCOPE
All AHS workforce members.

DEFINITIONS
Workforce Member - in the context of this policy includes employees, contractors, medical staff, trainees, students, volunteers, and other individuals with appropriate AHS affiliations.

PROCEDURES
1. The Human Resources (HR) Department is responsible for requesting identification badges from the Security Department as part of the onboarding process.

2. Badges must be worn at chest level on the outermost garment, so they are easily visible. Department Directors, with Executive approval, may allow only first names of employees to appear on badges for security reasons; those directors will notify HR of the decision to do so.

3. Badges may not be altered in appearance by applying any type of ornamentation, e.g., decals, stickers, etc.

4. Badges that are lost will be replaced for a fee of $20 paid by the employee. If an employee has a change of name, title, or department, badges will be issued at no charge.

5. Employees are not permitted to work onsite at any AHS work location without their AHS ID Badge.

6. If an employee forgets their badge, they will be asked to return home to get their badge. If retrieving their badge is not possible, a temporary badge will be given to the employee to be able to work. It may require a replacement fee of $20.

7. Sharing of ID Badges is strictly prohibited.

8. When an employee takes leave or is placed on leave/suspended, their manager is responsible for collecting the employee's ID Badge and notifying the Badging Administrator (Security Department) of the start of the leave or suspension so credentials can be deactivated.

9. Photo identification badge must be returned to the Badging Administrator/Security Department upon termination of employment.

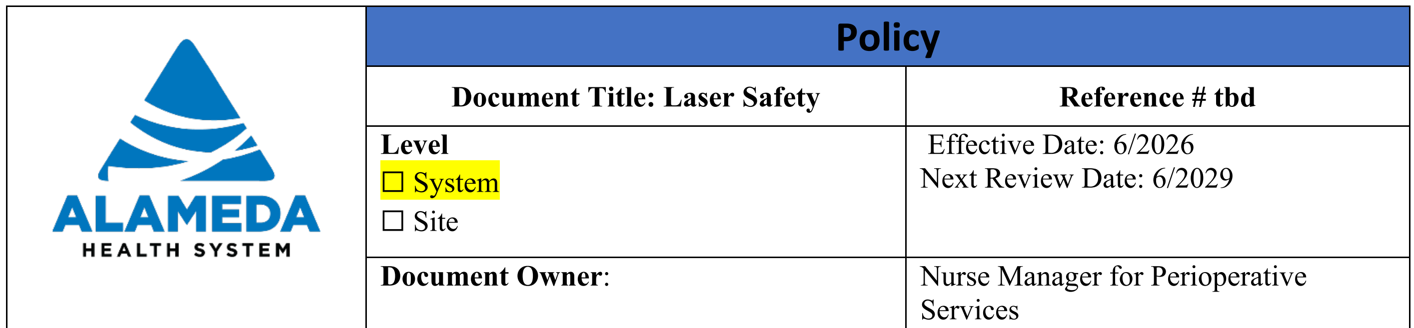
10. Badge access is managed by the Security Department. Please refer to the AHS Photo ID of Workforce Policy for more information.

Non-Compliance

Failure to follow required procedures may result in disciplinary action, up to and including termination of employment.

REFERENCES

AHS HR Section 3.00 - Policy 3.21 Personal Appearance and Grooming
AHS Photo ID of Workforce Policy



ALAMEDA HEALTH SYSTEM	Policy	
	Document Title: Laser Safety	**Reference # tbd**
	Level ☐ System ☐ Site	Effective Date: 6/2026 Next Review Date: 6/2029
	Document Owner:	Nurse Manager for Perioperative Services

POLICY STATEMENT

1. The laser safety program shall be developed by the Laser Safety Officer (LSO) (see Appendix A) and administered by a multidisciplinary Laser Safety Committee (see Appendix C) who monitors the use of non-ionizing hazardous energy in the AHS (Alameda Health System) environment.

2. Appropriate safety precautions shall be exercised in any location where medical lasers are used.

3. The Requirements of American National Standard for the Safe Use of Lasers in Health Care (ANSI Z136.3-2024) and guidance provided by the Association of Perioperative Registered Nurses (AORN) Association of perioperative Registered Nurses (AORN). Guideline Essentials – Key Takeaways: Laser Safety 2020. shall be followed.

4. Laser safety procedures shall be documented and followed by staff. (see Alameda Health Care System Medical Laser Safety Procedures)

5. Laser use will be restricted to those physicians, staff, and vendor members properly credentialed and trained in the use of lasers.

Alameda Health Care System Medical Laser Safety Procedures

PURPOSE

To comply with regulatory national standards requirements to ensure the safe use, monitoring, storing, and testing of laser devices used in the environment.

Control of Hazards

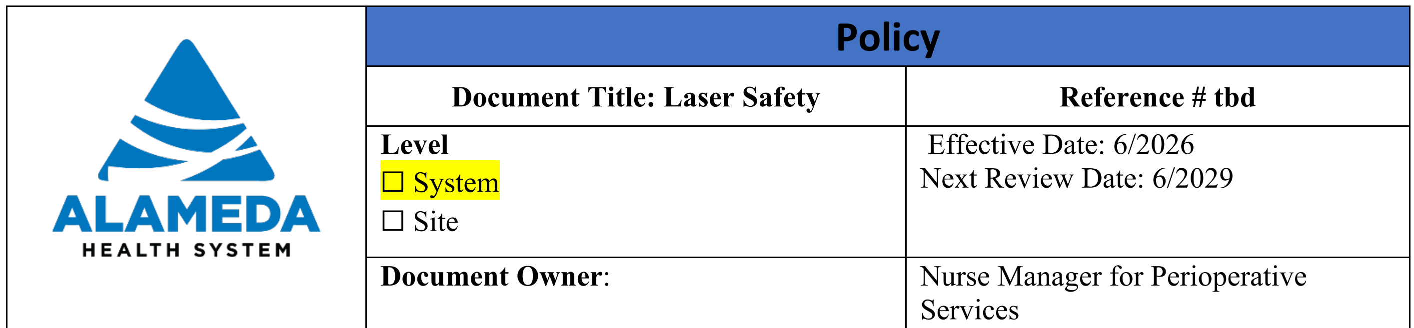
The Nominal Hazard Zone (NHZ) is the space in which the level of direct, reflected, or scattered radiation used during normal laser operation exceeds the applicable maximum permissible exposure (MPE). The NHZ is identified by the LSO Protective eyewear and practices related to the procedure being conducted shall be worn/followed if exposure to the laser can occur.

1. Laser hazard warning signs will be posted at every entrance to the NHZ along with a pair of protective eyewear labeled with the wavelength of the laser and the optical density (OD) for the specific laser and wavelength be used

2. Doors in the NHZ will remain closed during the operative procedure and access controlled.

3. Cover windows in the nominal hazard zone with a barrier that blocks transmission of the beam as applicable to the type of laser being used (e.g.: color dependent).

Protection from Unintentional Laser Beam Exposure



Policy	
Document Title: Laser Safety	**Reference # tbd**
Level ☐ System ☐ Site	Effective Date: 6/2026 Next Review Date: 6/2029
Document Owner:	Nurse Manager for Perioperative Services

1. Access to laser keys (or laser activation codes) will be restricted to Laser Operator or Physician (Laser User) who are skilled in laser operation. The laser will be placed in standby mode when not in use. The Laser Operator will verbalize to the physician the laser ready and standby modes. In some instances (e.g., Ophthalmology) the Physician is the Laser Operator. The Laser Operator will place the laser foot pedal in a position that is convenient to the physician with the activation mechanism identifier. The physician shall be the only one with access to the laser with the foot pedal. Dual foot pedals will not be utilized. When Physician is not in control of foot pedal it shall be under the control of the Laser Operator.

2. A Laser Operator trained in the safe use of lasers will be responsible for ensuring that the posting of hazard signs occurs, protective eyewear is available/worn, monitoring the NHZ and running the laser console to control the laser parameters under the supervision of the Laser User. The Laser Operator shall not have competing responsibilities that would require leaving the laser unattended during active use. If the Laser Operator is required to leave the laser, the device will be turned off and the key removed or machine is logged out. In some instances (e.g., Ophthalmology) the Laser Operator is the physician.

3. The Emergency Shut Off Switch shall be used to disable the laser in case of a component breakdown or untoward event.

4. Non-reflective instruments shall be used depending on the laser site to minimize potential laser beam refraction with subsequent damage to skin or eyes.

5. Class 4 lasers present a serious fire hazard. Proper draping of equipment shall be used to avoid contact with the laser beam. Use of noncombustible endotracheal tubes and the use of noncombustible inhalation agents shall be used near patient's airway. Exposed tissues around the surgical site should be protected with saline-saturated materials.

6. When a laser fiber is used to deliver laser energy, the exposed tip shall be covered with a moist gauze sponge or towel when it is not in use.

Protective Eyewear

1. People in NHZ shall wear protective eyewear based on recommendations of the laser manufacturer and the manufacturer's protective eyewear specifications. Note; when a laser is used inside a closed body cavity and exposure to the bean cannot occur to anyone in the NHZ or the Controlled area, the use of protective eyewear is strongly recommended but not required.

2. All protective eyewear must be labeled with appropriate optical density and wavelength for the laser in use.

3. Protective eyewear shall be available and conspicuously placed at all entrances to the room where a laser is in use and must be donned before entering the NHZ.

4. Protective eyewear shall be inspected before use, decontaminated using the manufacturer's instructions after every use and handled and stored carefully to prevent scratches.

5. Patient's eyes and eyelids shall be protected using either protective laser eyewear or wet eye pads. If eye pads are used, they must always remain moist.

Surgical Plume Hazards

1. When the potential for plume hazards exists, an individual smoke evacuation unit or in-line filter with a 0.1-micron filter shall be used.

2. Smoke evacuation filters shall be considered a potentially infectious waste and be disposed of according to hospital procedures.

3. Respiratory protection (fit-tested surgical N95 surgical mask) shall be worn in the NHZ and the Controlled area.

Electrical Hazards

1. Electrical cords and plugs shall be handled in a manner that minimizes potential for damage.

2. Electrical cords shall be inspected before use.

3. Electrical cords must be free of kinks, knots, and bends.

4. Laser plug, not the cord, shall be held when it is removed from the outlet.

5. Laser plug and cord shall be always kept dry.

6. At no time shall liquids of any kind be placed on laser units.

7. Preventative maintenance shall be performed as per laser manufacturer's instructions.

Fire Hazards

1. The following fire safety measures will be followed:
    a. The laser shall not be activated in the presence of flammable agents. All flammable agents must be allowed to appropriately dry, and the appropriate time must pass to allow vapors to dissipate.
    b. Sponges and drapes near the surgical site where a laser is being used shall be kept moist.

2. The laser shall not be used in an oxygen-enriched environment.

a. The lowest possible oxygen concentration that provides adequate patient oxygen saturation should be used.
b. Drape should be arranged to minimize buildup of oxygen under the drapes.
c. A fully charged and currently inspected fire extinguisher shall be readily available.

3. Wet towels shall be available on the sterile field to extinguish any fire that should occur. A 500 ml sterile saline solution shall also be readily available to the physician for fire extinguishing use.

4. Fuel risks shall be minimized.

5. Surgical fires shall be communicated immediately per hospital policy.

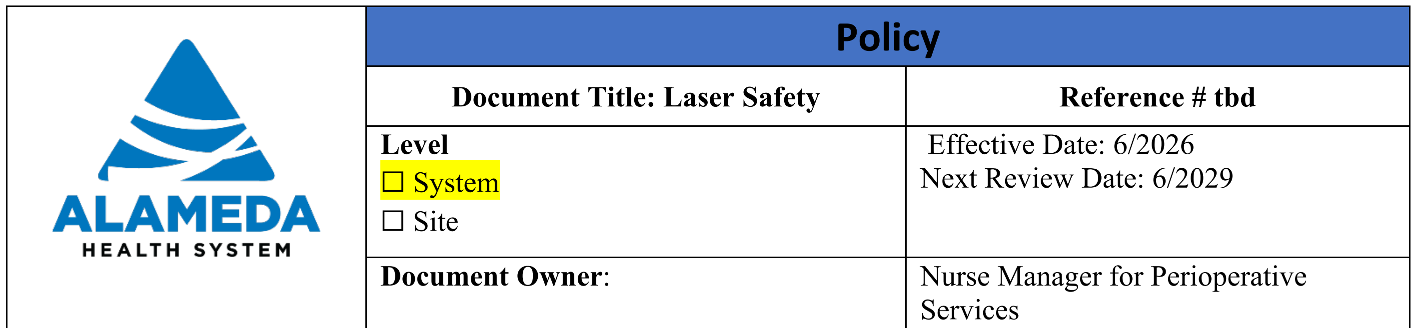
Personnel Education and Competency

1. All personnel working directly with lasers or working in the environment where lasers are used shall have initial and periodic training in laser safety. Periodic laser safety training shall be conducted yearly. This training shall include:
a. The hospital's laser safety program, policy, and procedures.
b. Laser physics and biological effects
c. System components/delivery devices/instrumentation
d. ANSI Z136.1 and Z136.3 standards
e. Hazard classification
f. Access to laser key/authorized personnel
g. Documentation/incident reporting requirements.
h. Hazards/controls (e.g., beam exposure, surgical plume, electrical, and fire)
i. Personal and patient protective equipment
j. Care of laser, safety equipment, and accessories
k. Hands-on use of the laser. (Physicians only)

2. Personnel who are involved in laser procedures shall be required to demonstrate competency when new laser equipment, accessories, or safety equipment is purchased or brought into the practice environment

Documentation

1. Documentation of laser procedures shall occur for each case. Elements of this should include:
a. Patient information
b. Surgical procedure
c. Safety measures/controls implemented
d. Type of laser used
e. Laser device identification (e.g.: serial or biomedical number)
f. Laser settings (Wavelength and Power)
g. On/Off laser activation and deactivation times for head, neck, and chest procedures
h. Unexpected laser function events shall be reported to LSO.



2. This information will be placed in the patient's medical record laser log attestation. These records will be audited periodically by the LSO.

3. Service and maintenance activities will be documented by the manufacture and/or the Biomedical Department. Devices will be labeled indicating date annual service or most recent service and repair.

Third-Party Laser Vendors

1. All components of the laser safety program shall apply to all situations in which a laser is brought into the facility by a third-party laser vendor or and use by an operator.

2. The LSO shall oversee all aspects of third-party laser services.

Continuous Quality/Performance Improvement

1. A laser safety audit will be conducted at least annually by the LSO or a designated Assistant LSO. The audit will include, but not be limited to:

   a. Examining all laser-related equipment and safety features (e.g., eyewear, warning signs, smoke plume evaluation equipment, inspection stickers).
   b. Examining laser use areas.
   c. Assessing staff members' knowledge of laser safety.
   d. Observing laser practices for compliance with policies and procedures.

This audit shall be documented and a written report sent to members of the Laser Safety Committee.

2. Incidents of failure to follow the hospital's laser safety policy, laser and related equipment failure and patient or personnel injury will be reported to the LSO immediately and investigated to determine root cause. Documentation of the investigation shall occur with follow up actions identified.

3. The Laser Safety Committee will review written results of all audits, occurrence reports and other documents and assist the LSO in developing plans for improvement.

4. Results of all quality and performance improvement audits/activities will be reported to the Alameda Health Care Systems Environment of Care Committee and/or the Alameda Health Care Environmental Health and Safety organization.

REFERENCES

1. American National Standards Institute (2018). Z136.3 Safe Use of Lasers in Health Care. Orlando, FL: Laser Institute of America.

2. Association of Perioperative Registered Nurses (2021). Guidelines for Perioperative Practice: Laser Safety. Denver, CO:

<u>Appendix A</u>

MEDICAL LASER SAFETY OFFICER

Appointment and Responsibilities of the Medical Laser Safety Officer (MLSO)

An individual will be appointed by the hospital administration to serve as the facility Medical Laser Safety Officer. This individual will have cross-departmental authority throughout the facility to manage the Laser Safety Program, as described in ANSI Z136.3 standards for the Safe Use of Lasers in Health Care Facilities. This individual may enlist the advice or assistance of laser manufacturers, consultants or knowledgeable individuals to assist in the management of the laser safety program.

1. Authority – The LSO will have the authority to suspend, restrict or terminate the operation of the Health Care Laser System (HCLS) if they deem that a hazardous condition exists. They will additionally notify the operating physician of such hazard. The LSO may delegate this authority to the dedicated Laser Operator utilizing the equipment or the Assistant LSO if one is designated.

2. Delegation of Authority – It is understood that the responsibilities of the LSO in enforcing the written laser safety policies and procedures and monitoring the laser treatment-controlled area for safety during procedures, are duly delegated to the dedicated Laser Operators and Physicians who may be operating the laser equipment.

3. Appointment of a Laser Safety Committee – A Laser Safety Committee comprised of members of the physician staff, departmental directors and hospital employees for the purpose of collaboratively addressing specific laser safety program issues shall be established. Periodic meetings of this group will occur and be documented.

4. Laser Safety Officer Credentialing Standards.

   a. The LSO will be an individual with the training, self-study and resources deemed appropriate by the hospital administration to administer the Laser Safety Program. Their background may

include, but should not be limited to, nurses, biomedical engineers, or environmental health and safety officers, who have obtained appropriate training to manage the Laser Safety Program.

b. Training will include:
- i. General laser and energy concepts (physics), tissue interactions and laser safety.
- ii. Hands-on orientation to the hospital's specific lasers.
- iii. Laser Safety Program management including familiarity with ANSI Z136.3 recommended standards for the Safe Use of Lasers in Health Care Facilities.
- iv. Completion of Laser Institute of America Medical Laser Safety Officer Training program.
- v. The facility can also recognize individuals certified by the National Council on Laser Excellence (and the administering Board of Laser Safety of the Laser Institute of America) Certified Medical Laser Safety Officer, as having met these requirements.

Duties of the LSO:

1. Manage and administer the overall laser safety program of this facility, based upon their informed judgment of the potential laser hazards and control measures that they choose to implement to protect against these hazards, utilizing the ANSI Z136.3 recommended standards as a guide.

2. Establish written laser safety policies and procedures, working collaboratively with the physician staff and other departments where needed.

3. Approve the installation, use and operation, including the suitability of the facilities for safe operation of medical lasers.

4. Conduct a Nominal Hazard Zone (NHZ) evaluation & establish an NHZ and Controlled Area medical laser use occurs.

5. Work collaboratively with the hospital physician credentialing mechanism to ensure that physicians are properly credentialed in the use of the facility's laser equipment. The hospital's physician credentialing mechanism shall keep a current list of authorized physician users for medical lasers

6. Monitor safety training that is provided for all staff working in the presence of the medical lasers.

7. Monitor safety and operational training provided to the dedicated Laser Operators.

8. Confirm the classification of lasers, assuring that the proper control measures are in place and approving substitute controls, approving standard operating procedures, recommending and/or approving eye wear and other protective equipment, specifying appropriate signs and labels, and approving overall facility controls.

9. Ensure that the proper protective safety equipment, such as laser warning signs, safety eyewear, smoke evacuation equipment, etc., is available, in good condition and appropriate for the laser procedure being performed.

10. In collaboration with the operating physicians and anesthesia, approve patient eye protection measures such as safety eyewear, opaque metal eye shields, corneal shields, moistened drapes or sponges as deemed appropriate.

11. Investigate all known or suspected accidents resulting from the operation of a laser and initiate appropriate actions including compliance with the hospital's incident reporting policy.

12. Monitor laser equipment to ensure that they are properly maintained by qualified individuals including the facility biomedical engineering department, third party service agents, or the laser manufacturer.

13. Ensure that both Laser Operating Manuals and Laser Service Manuals (complete with specific alignment and calibration information) are obtained for each laser in use within the facility.

14. Ensure that laser rental groups or any similar contract laser service that operate within this facility have supplied to the LSO documentation of appropriate training of their personnel and periodic maintenance of their equipment. The LSO will also accept NCLE2 Laser Safety Officer or Laser Operator certifications as evidence of appropriate training. The LSO will supply such rental/contract service operators with a copy of the facilities written with laser safety policies and procedures and require their compliance while operating within the facility.

15. Conduct a comprehensive Laser Safety Audit of the facilities Laser Safety Program, including physical inspection of all medical lasers and protective safety equipment, on an annual basis. This may be performed directly by the LSO or may be delegated to Assistant LSO.

16. Maintain continuing education in the area of medical/surgical laser use or safety through attendance at conferences, workshops or by other means.

Appendix B

LASER OPERATOR

Responsibilities & Training

1. The Laser Operator is an individual (either a registered nurse or surgical technologist) who sets up the laser and runs the laser console to control the laser parameters under the supervision of the Physician (Laser User). This individual should not have any other responsibilities while the laser is in use.

2. The Laser Operator is responsible for all control measures related to use of the medical laser during the operative procedure including staff and patient safety, engineering, administrative, procedural, key control, and entryway

3. Training of the Laser Operator will include, but is not limited to:
   a. Laser operation principles
   b. Laser biophysics
   c. Clinical applications
   d. Potential risks to the patient and health care personnel
   e. Safety procedures
   f. Care of the laser, safety equipment, and accessories, and
   g. Hands-on use of the laser (e.g., set-up, testing, control panel use).

Duties of the Laser Operator:

- Ensure that the medical laser is present, set up and functions in the Operating Room before it is needed for patient use.

- Ensure that approved laser warning signs all entrances to the Controlled Area where the Nominal Hazard Zone (NHZ) has been established

- Ensure that protective eyewear is appropriate for the laser being used, available, clean, in good condition and is worn by all personnel and the patient in the NHZ when required the laser is in use.

- Before the operative procedure begins, ensure that there is a fully charged fire extinguisher is readily available to the Operating Room where the medical laser will be used will be used. Ensure that that 500 ml saline is available to the Physician.

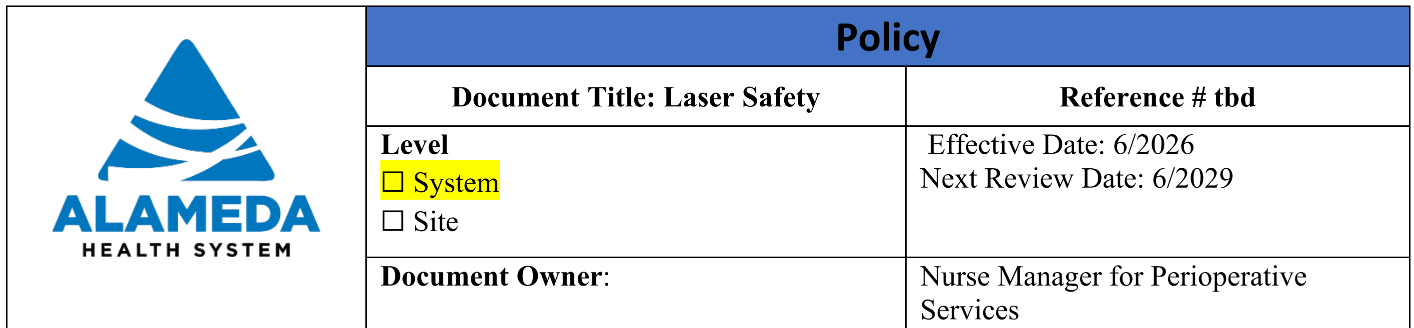
- Monitor traffic in and out of the Operating Room with assistance of circulating RN.

- Report any malfunction of the HCLS and all known or suspected accidents resulting from the operation of the medical laser to the LSO.

- After the operation, return the medical laser warning signs and protective eyewear to storage.

- Secure the laser key (if used).

Appendix C



Policy		
	Document Title: Laser Safety	**Reference # tbd**
	Level ☐ System ☐ Site	Effective Date: 6/2026 Next Review Date: 6/2029
	Document Owner:	Nurse Manager for Perioperative Services

LASER SAFETY COMMITTEE

An interdisciplinary laser safety committee that can include the following individuals or departmental representatives:

- administrators,
- the LSO,
- a biomedical engineer and/ or clinical/biomedical engineer,
- a physician representative from each specialty group that uses lasers,
- anesthesia professionals,
- perioperative services administrators,
- a perioperative educator,
- medical staff education/credentialing personnel,
- quality department personnel,
- surgical technologists,

One person may represent more than one department or role based on the organizational staffing plan.

Responsibilities

- conducting strategic planning for and acquisition of laser-related technology (e.g., technology assessment, cost analysis, product evaluation, review of marketing information from laser vendors);
- establishing requirements for credentialing.
- verifying that any physician who operates a laser has completed the health care organization-required education on laser operation and safety precautions and coursework in basic laser physics, laser-tissue interaction, and clinical applications for the specific laser for which privileges are sought.
- establishing and maintaining a laser safety program.

- establishing requirements for hazard evaluation.
- developing and enforcing laser-related policies and procedures.
- overseeing laser-related education and competency verification.
- establishing staffing requirements.
- establishing a quality assurance and improvement program.
- appointing and delegating authority and responsibility for supervising laser safety to an LSO.

AHS PAIN ASSESSMENT AND MANAGEMENT

Effective Date	6/2026	***Date Revised***	4//2026
Document Owner	DIR, CLINICAL PROFESSIONAL PRACTICE	***Next Scheduled Review***	6/2029

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

PURPOSE

To safely address pain relief in a timely manner and to monitor and evaluate the patient's response to analgesia.

POLICY

Alameda Health System shall provide patient-centered care by involving the patient in the assessment and management of their pain. All patients have the right to pain management through assessment, intervention, and reassessment.

DEFINITIONS:

Pain: An unpleasant sensory and emotional experience associated with actual or potential tissue injury or described in terms of that damage as perceived by the patient.

Non-verbal and Pre-verbal: Patients unable to verbally articulate reports of pain like infants, toddlers, confused elderly and cognitively impaired adults.

Acute pain: Pain directly related to tissue damage that lasts for less than 12 weeks. Pain of recent onset. Common causes include injury, surgery and infection. It lasts anywhere from a few hours up to a few weeks. Also includes recurrent pain as in migraine.

Chronic pain: Pain that persists for more than 12 weeks. It is often associated with neurological problems and arthritis.

Labor pain: Pain or physical discomfort caused by the physiologic process of childbirth. Labor pain is considered normal with the experience of pain being highly variable among women in the sensory and affective dimensions. Management of labor pain therefore may include non-pharmacological labor support techniques such as relaxation, position change, warm water therapy, and massage in place of or in addition to pharmacological intervention, according to the woman's informed choice. Because even severe labor pain is considered a normal aspect of physiologic birth, pain assessment in labor may include an additional pain scale that assesses coping vs. non-coping.

Patients Stated Pain Goal – A goal which is based upon the pain rating the patient requires to be able to perform necessary activities.

Staff Responsibilities in Managing Pain

1. Assess the patient's pain both objectively (vital signs), and subjectively (e.g., burning, shooting, stabbing) and understand that the patient's self-report of pain is a valid indication of pain management.

2. Teach the patient/family about pain and relief, include them in pain management decisions and establish with patients their self-reported pain goal. Include attempting non- pharmacological methods.

3. Offer pain medication or interventions per physician orders based on pain scale and frequency.

4. The hospital involves patients in the pain management treatment planning process by:
   - Developing a measurable pain goal.
   - Discussing treatment plans
   - Providing patient education on current physical state and pain management with the potential and reasonably attainable pain management goal.
   - Add patients stated pain goal to care board in patient room.

5. Request further intervention orders if pain management is ineffective.

Scope of Assessment/Reassessment

1. **Pain assessments:**
   a. An age and ability-appropriate comprehensive initial pain assessment will be performed for any patient reporting or suspected of having moderate or severe pain. and the comprehensive assessment shall include patients' stated pain goal, pain history (including acute and chronic pain identification and assessment), medication and non-medication pain interventions used at home or in the past.
   b. A routine pain assessment will include time, intensity of pain (level of pain) or behavior scale score, quality of pain (pain type) and location.

   Pain assessment frequency:
   a. Upon admission, every 4 hours when vital signs are taken, or per unit standard requirements for vital sign frequency.

2. **Reassessment of Pain Following Pain Intervention (regardless of intervention method)**

   1. Occurs within a time frame sufficient for the pain intervention to reach effectiveness
   2. Reassessment of pain is demonstrated through documentation of the effectiveness of the intervention (e.g., documenting a response to intervention of pain scale).
   3. It is NOT necessary that the results of such post-intervention reassessment be documented in a concurrent note.
   4. The peak effect of any pharmacologic pain intervention and sedation level can vary significantly from person to person. Factors such as age, weight, metabolism, and the specific medication, route, and dose taken can influence peak times.

Reassessment of pain should fall within the following suggested timeframes:

Intervention	Suggested Re-Assessment timeframe
Non-pharmacologic (e.g., ice)	No longer than 90 minutes
Pharmacologic (e.g., drug or medication by any route)	No longer than 60 minutes

Treatment/Management

1. Pain is managed by pharmacological treatment, non-pharmacological treatment, and interventional procedures.

2. Non-pharmacological treatment may include physical interventions and cognitive behavioral strategies including but not limited to:
   - Repositioning of the patient.
   - Breathing/relaxation techniques.
   - Heat and/or cold compress when available.
   - Cool, quiet, dark room.
   - Ambulation of the patient.
   - Exercise as allowed by physician and tolerated by patient.

3. Consider the cultural aspects of pain management
   - Consider language barriers
   - Identify what cultural differences and potential barriers exist
   - Identify ways to achieve treatment and care outcomes for the patient while at the same time supporting and appreciating the culture.
   - Plan for care with sensitivity to the differences that may present advantages and disadvantages.

4. Consider the patients' health beliefs and practices
   - These provide meaning/cause of illness/health.
   - They may influence expectations about treatment and the healthcare team.
   - They may require consideration of religious/spiritual beliefs and practices, use of traditional healers/practitioners, expectations of practitioners.

Education

Patient education may focus on:

1. The patients right to controlled pain
2. Indication, potential side effects, and perception of effectiveness of pain medication.
3. Concepts behind multimodal pain management and non-pharmacological pain treatment modalities.
4. Discuss use of pain control measures before pain becomes severe
5. Explanation of treatments.

Documentation

1. Document the comprehensive pain assessment upon admission in the electronic medical record.
2. When patient condition allows, determine, and document the patients stated pain goal in the

electronic medical record.

3. Document the routine pain assessment per required frequency in the electronic medical
4. Document the reassessment of the pain score in the medical record.

Discharge

If pain is still present at discharge; pain management will be addressed as part of the discharge instructions.

REFERENCES

1. Cohen, L., Lemanek, K., et al. (2007) Evidence-based Assessment of Pediatric Pain. Journal of Pediatric Psychology, Vol 33 No 9, pp 939-398.

2. Herr, K., Garand, L. (2001) Assessment and Measurement of Pain in Older Adults. Clinical Geriatric Medicine, Vol 17, No 3, pp 457-vi.

3. Jarzyna, D., Pasero, C., et al. (2011) American Society for Pain Management Nursing Guidelines on Monitoring for Opioid-Induced Sedation and Respiratory Depression. Pain Management Nursing, Vol 12, No 3, pp 118-145.

4. The Joint Commission – LD.04.03.13, PC 01.02.07, PC.01.02.01, PI.01. 01.01,

5. Rahu, M., Grap, M. et al. (2015) Validity and Sensitivity of 6 Pain Scales in Critically Ill, Intubated Adults. American Journal of Critical Care, Vol 24, No 6, pp 514-523.

6. Williamson, B., Hoggart, B. (2005) Pain: A Review of Three Commonly Used Pain Rating Scales. Journal of Clinical Nursing, Vol 14, pp 798-804.

APPROVALS

		System	Alameda	AHS/Highland/John George/San Leandro
Department	**Date:**	N/A 4/2026	03/2021	03/2021
Pharmacy and Therapeutics (P&T)	**Date:**	N/A	N/A	N/A
Clinical Practice Council (CPC)	**Date:**	5/2021, 5/2026	N/A	N/A
Medical Executive Committee	**Date:**	5/2021, 5/2026		
Board of Trustees	**Date:**	5/2021, 6/2026	N/A	N/A

Attachment A

Children and adults with limited verbal skills, adult/geriatrics/adolescents with appropriate cognitive and verbal skills will utilize the Modified Wong and Baker Faces/0- 10 Pain Intensity Scale

a. Considerations
   i. Patients are assessed for pain utilizing a modified Wong-Baker Faces Pain Scale superimposed on the 0-10 Pain Intensity Scale.
   ii. This pain scale will be used for patients with impaired cognition and/or communication through observation of facial characteristics or asking the pediatric patient to describe which face compares with how they feel.
   iii. This pain scale will be used to assess a patient's pain level if they display appropriate cognitive and verbal skills.

b. Procedure for children and adults with limited verbal skills
   i. Explain to the patient that each face is for a person who feels happy because he has no pain (hurt) or sad because he has some or a lot of pain.
      - Face #1 is very happy because he doesn't hurt at all (Pain Intensity 0)
      - Face #2 hurts just a little bit (Pain Intensity 2)
      - Face #3 hurts a little more (Pain Intensity 4)
      - Face #4 hurts even more (Pain Intensity 6)
      - Face #5 hurts a whole lot (Pain Intensity 8)
      - Face #6 hurts as much as you can imagine, although you don't have to be crying to feel this bad (Pain Intensity 10)
      - Ask the patient to choose the face that best describes how he or she is feeling.

Key Elements				
Facial grimacing	Writhing	Withdrawal of limb	Moaning	Tearing

c. Procedure for adult/geriatrics/adolescents with appropriate cognitive and verbal skills.
   i. Explain to the patient that the scale ranges from 0=no pain to 5=distressing pain to 10=unbearable pain. Ask the patient to choose the numeric value that best describes how he or she is feeling.
      - Scale/Tool:
        - 1-3 Mild Pain
        - 4-6 Moderate Pain

Attachment C

N-PASS: Neonatal Pain, Agitation, & Sedation Scale			
Assessment Criteria	Normal	Pain / Agitation	
	0	1	2
Cry Irritability	Appropriate crying Not irritable	Irritable or crying at intervals Consolable	High-pitched or silent-continuous cry Inconsolable
Behaviour State	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking Constantly awake or Arouses minimally / no movement (not sedated)
Facial Expression	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
Extremities Tone	Relaxed hands and feet Normal tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense
Vital Signs HR, RR , BP O2Sat	Within baseline or normal for gestational age	↑ 10-20% from baseline SaO_2 76-85% with stimulation – quick ↑	↑ > 20% from baseline $SaO_2 \leq 75\%$ with stimulation – slow ↑ Out of sync with vent

a. Considerations
   i. Neonates
b. Procedure
   i. Using the N-PASS pain scale, evaluate the patient on each of the five key elements.
c. Key elements
   i. Cry irritability
   ii. Behavior state
   iii. Facial expression
   iv. Extremities tone
   v. Vital signs; HR, RR, BP, O2sat
d. Scale Tool
   0 – 1 = No Pain
   2 – 10 = Pain Present

Attachment D
Face, Legs, Activity, Cry, Consolability Scale (FLACC)

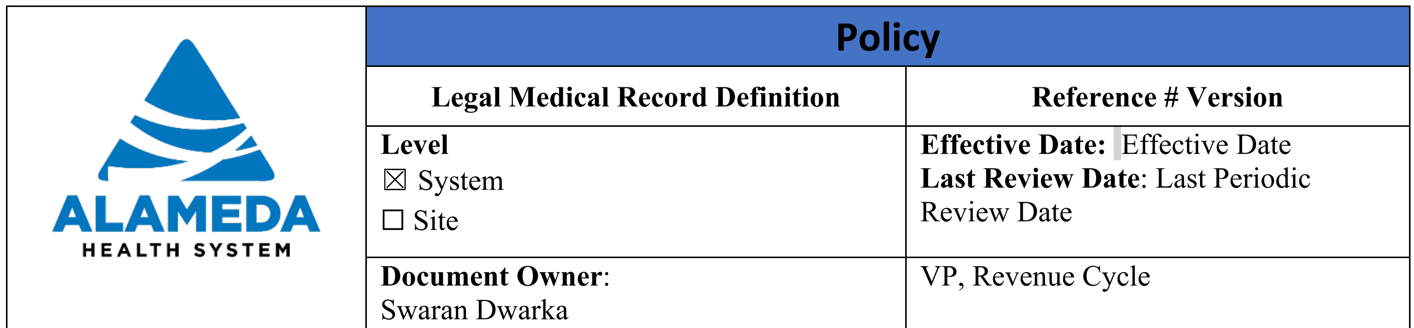
	Scoring		
Categories	**0**	**1**	**2**
Face	No particular expression or smile	Occasional grimace or frown, withdrawn, disinterested	Frequent to constant frown, quivering chin, clenched jaw
Legs	Normal position or relaxed	Uneasy, restless, tense	Kicking or legs drawn up
Activity	Lying quietly, normal position, moves easily	Squirming, shifting back and forth, tense	Arched, rigid, or jerking
Cry	No cry (awake or asleep)	Moans or whimpers; occasional complaint	Crying steadily, screams or sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to; distractible	Difficult to console or comfort

Note: Each of the five categories Face (F), Legs (L), Activity (A), Cry (C), and Consolability (C) is scored from 0-2, which results in a total score between 0 and 10.

a. Considerations
    i. Children up to 3 years of age
b. Procedure
    i. Using the FLACC scale, evaluate the patient on each of the five key elements.
c. Key elements
    i. Face
    ii. Legs
    iii. Activity
    iv. Cry
    v. Consolability
d. Scale Tool
    1-3 Mild Pain
    4-6 Moderate Pain
    7-10 Severe Pain

Attachment E
Critical Care Pain Observation Tool (CPOT)

Indicator	Score	Description
Facial expression	0	Relaxed, neutral *no muscle tension observed*
	1	Tense *Presence of frowning, brow lowering, orbit tightening and levator contraction or any other change (e.g. opening eyes or tearing during nociceptive procedures)*
	2	Grimacing *All previous facial movements plus eyelid tightly closed (the patient may present with mouth open or biting the endotracheal tube)*
Body movements	0	Absence of movements or normal position *Does not move at all (doesn't necessarily mean absence of pain) or normal position (movements not aimed toward the pain site or not made for the purpose of protection)*
	1	Protection *Slow, cautious movements, touching or rubbing the pain site, seeking attention through movements*
	2	Restlessness/Agitation *Pulling tube, attempting to sit up, moving limbs/thrashing, not following commands, striking at staff, trying to climb out of bed*
Compliance with the ventilator (intubated patients)	0	Tolerating ventilator or movement *Alarms not activated, easy ventilation*
	1	Coughing but tolerating *Coughing, alarms may be activated but stop spontaneously*
	2	Fighting ventilator *Asynchrony: blocking ventilation, alarms frequently activated*
Vocalization (extubated patients)	0	Talking in normal tone or no sound
	1	Sighing, moaning
	2	Crying out, sobbing
Muscle tension Evaluation by passive flexion and extension of upper limbs when patient is at rest or evaluation when patient is being turned	0	Relaxed *No resistance to passive movements*
	1	Tense, rigid *Resistance to passive movements*
	2	Very tense or rigid *Strong resistance to passive movements or incapacity to complete them*



Policy	
Legal Medical Record Definition	**Reference # Version**
Level ☒ System ☐ Site	**Effective Date:** Effective Date **Last Review Date**: Last Periodic Review Date
Document Owner: Swaran Dwarka	VP, Revenue Cycle

Purpose
To clearly define the legal medical record for AHS, including which information must be sent to HIM for legal archival.

Scope
This policy applies to all items, locations, departments, processes, and systems within the AHS System involved in Health Information Services. This includes Inpatient, Outpatient, Emergency Room, and Ambulatory Care records.

Definitions
A. Designated Record Set means a group of records maintained by or for AHS that is:

(i) The medical records and billing records about individuals maintained by or for AHS; and

(ii) Used, in whole or in part, by or for AHS to make decisions about individuals.

B. Legal Medical Record (LMR): The official medical record compiling all notes and authenticated documents concerning a patient's care. This is the record provided for follow-up care and in response to billing, audits, quality review, legal requests or research requests when appropriate authorization is provided.

C. Source Data: All original information, data or certified copies of such original information contained in source documents.

D. Source Document: Documents in the medical record, which are either the original document, copies or transcriptions certified after verification as being an exact replication of the original document. When original observations are directly entered into a computer system, the electronic record is the source document.

E. Tagged Image File Format (TIFF): An industry standard file format for bitmapped images, often used to exchange such files between dissimilar computers and by scanners when converting pictures to computer form. The name comes from the specification that describes how to store information in blocks called tags. The format accurately depicts the image of scanned paper and is designed to store a complete image of an original paper document.

Policy
It is the policy of Alameda Health System (AHS) that Health Information Management (HIM) maintain and identify the patient information that must be contained in the legal medical record.

PROCEDURE

1. The LMR will be comprised of hybrid records – paper and electronic documentation, scanned images and transcription system interfaces from various databases and systems used by AHS. The AHS Electronic Medical Record (EMR) will act as the long-term repository for the patient's medical history at AHS.

2. All transcribed documents will be signed either on paper or electronically.

3. Only individuals authorized to do so by Medical Staff Bylaws may make entries into the LMR.

4. Medical records documentation is entered into the chart on paper forms or into the electronic record either by scanning, electronic interface or direct entry.

5. Standardized formats are to be used to document all care.

6. The LMR may include test results, exams and other records from other health care providers when necessary for the evaluation of the patient's subsequent treatment.

7. The LMR may include source data in the absence of documentation or interpretations. When physically required to be stored in a separate location, this information will be given the same level of confidentiality and control as the LMR. Examples of source data include diagnostic films, ECG tracings, treadmill tracings, etc.

8. The minimum content of the LMR shall be:

   a. Identification data including marital status and religion (optional on part of patient);

   b. Dates of admission and discharge;

   c. Legal status regarding behavioral care patients;

   d. Any emergency care provided to the patient prior to arrival;

   e. The record and findings of the patient's assessment to include allergies, past history, family history, present illness and physical exam to include a review of systems;

f. Reason for admission and statement of conclusions or impressions drawn from the medical history and physical exam;

g. Discharge Summary/Note with final diagnosis or diagnostic impression;

h. Treatment Plan;

i. Evidence of known advance directives;

j. Evidence of informed consent for procedures and tests performed for which informed consent is required;

k. Any written or verbal diagnostic and therapeutic orders, procedures and tests performed and their results, if any;

l. Anesthesia records

m. All operative and other invasive procedures performed, using acceptable disease and operative terminology that includes etiology as appropriate;

n. Tissue or surgical pathology reports;

o. Progress notes made by the medical staff and other authorized individuals;

p. All reassessments, when necessary;

q. Clinical observations;

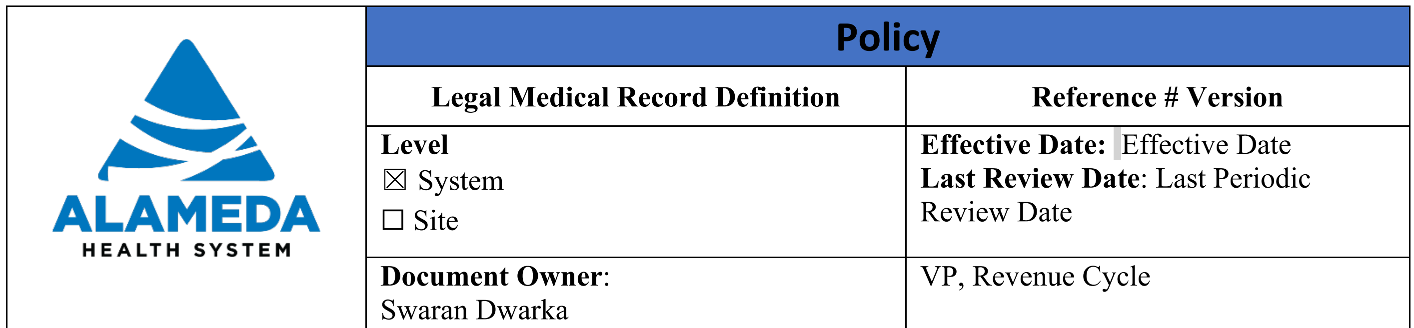
r. Response to care provided;

s. Documentation of restraints, if used, including type of restraint, time of application and removal

t. Consultation reports, when ordered;

u. Every medication ordered or prescribed for an inpatient;

v. Every dose of medication administered and any adverse drug reaction;



w. Each medication dispensed to or prescribed for an ambulatory patient or inpatient at discharge;

x. All relevant diagnoses established during the course of care;

y. Any referrals or communications made to external or internal care providers and to community agencies;

z. Discharge Instructions

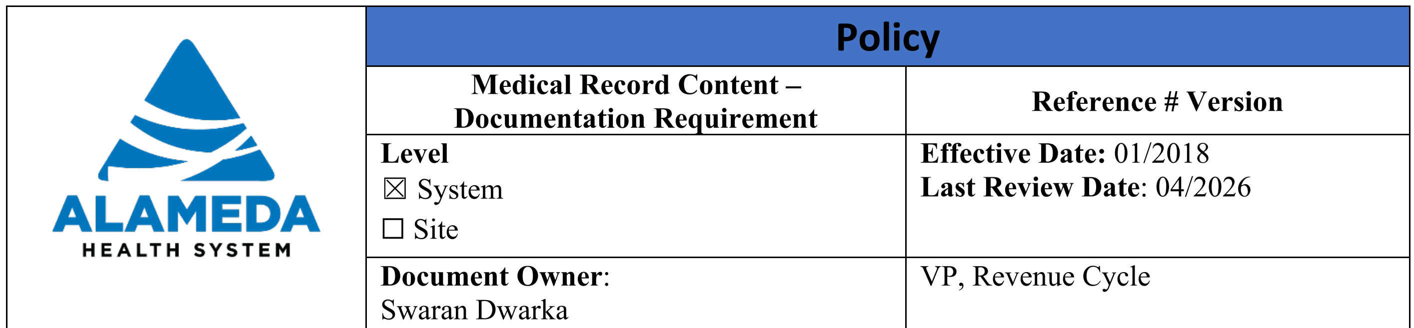
aa. Autopsy findings, if applicable;

bb. Telephone records regarding care, treatment and services;

cc. Email communication between provider and patient regarding care, treatment, and services.

9. The legal medical record contains all final, authenticated reports and is used for patient care, legal, research, audit, and billing purposes. It is the responsibility of each clinical unit to ensure that clinical documentation, created in paper format, is forwarded to HIM within 24 hours after the documentation is generated.

10. Historical paper charts for all AHS facilities is stored in an off-site storage facility per AHS Record Retention Policy.



Policy		
	Medical Record Content – Documentation Requirement	Reference # Version
	Level ☒ System ☐ Site	**Effective Date:** 01/2018 **Last Review Date**: 04/2026
	Document Owner: Swaran Dwarka	VP, Revenue Cycle

POLICY STATEMENT
Alameda Health System maintains a complete and accurate medical record to ensure continuity of patient care and to meet standards set by licensing and accreditation agencies.

PURPOSE
To facilitate patient care; serve as a legal guideline and assist in professional and organizational performance improvement.

SCOPE
This policy applies to all items, locations, departments, processes, and systems within the AHS System involved in Health Information Services. This includes Inpatient, Outpatient, Emergency Room, and Ambulatory Care records.

DEFINITIONS
Complete Record – A record that has all entries, and dictation, timed, dated and signed, within 14 days after discharge.
Policy – A statement of rules and principles to guide decisions and actions; provides guidance and sets expectations for performance.

RESPONSIBILITIES
Director, Health Information Management – Serves as the Document Owner.
Chief Medical Officer – Serves as the Executive Responsible for compliance oversight.

POLICY

I. GUIDELINES

A. General contents of the Inpatient and Outpatient Medical Record, if applicable:

1. The patient's name, address, date of birth, sex, marital status, religion, admitting physician, date and time of admission, date and time of discharge, initial diagnostic impression, name of any legally authorized representative, and name, address and telephone number of person or agency responsible for patient.
2. Name of the patient's admitting physician.
3. The patient's language and communication needs.
4. Emergency care provided to the patient prior to arrival, if any.
5. Documentation and findings of the patient's assessment.
6. History and physical examination.
7. Conclusions or impressions drawn from the medical history and physical examination.
8. The diagnosis, diagnostic impression or condition.
9. The reason for admission or care, treatment and services.

10. The goals of treatment and the treatment plan.
11. Consent forms, when applicable.
12. Evidence of known advance directives.
13. Evidence of informed consent when required.
14. Diagnostic and therapeutic orders include medication, treatment and diet.
15. Diagnostic and therapeutic procedures and test results relevant to the management of the patient's condition including all laboratory tests and X-ray examinations performed.
16. Vital sign sheet.
17. Operative reports include preoperative and postoperative diagnosis, description of findings, technique used, and tissue removed or altered, if surgery was performed.
18. Operative and other invasive procedures performed, using acceptable disease and operative terminology that includes etiology as appropriate.
19. Written record of preoperative and postoperative instructions.
20. Pathological report, if tissue or body fluid was removed.
21. Labor record, if applicable.
22. Delivery record, if applicable.
23. Progress notes made by authorized individuals including current or working diagnosis.
24. Reassessments and plan of care revisions, when indicated.
25. Relevant observations.
26. Response to care, treatment, and services provided.
27. Consultation reports.
28. Anesthesia record including preoperative diagnosis, if anesthesia has been administered.
29. Allergies to food and medicine.
30. Medication ordered or prescribed.
31. Nurses' notes which shall include but not be limited to the following:
    a. Concise and accurate record of nursing care administered.
    b. Records of pertinent observations including psychosocial and physical manifestations as well as incidents and unusual occurrences, and relevant nursing interpretation of such observations.
    c. Name, dosage and time of administration of medications and treatment. Route of administration and site of injection shall be recorded if other than by oral administration.
    d. Record of type of restraint and time of application and removal.
32. Medications dispensed or prescribed on discharge.
33. Every medication order documented as administered or not administered and any adverse drug reaction.
34. All relevant diagnoses/conditions established during the course of care, treatment and services.

35. Documentation of referrals and communications made to external and internal care providers and to community agencies.
36. Conclusions on termination of hospitalization.
37. Discharge instructions to the patient and family including notations of prescriptions written, diet instructions, if applicable, and self-care instructions.
38. Discharge/death summaries, final progress note or transfer summary.
39. Records of communication with the patient regarding care, treatment, i.e., telephone calls or email.
40. Medication Reconciliation.

B. Emergency Room Records

1. Time and means of arrival
2. Whether the patient left against medical advice
3. Pertinent history of illness/injury and physical findings
4. Emergency care provided to the patient prior to arrival
5. Diagnostic and therapeutic orders
6. Clinical observations, including the results of treatment
7. Diagnostic impression
8. Procedures performed
9. Conclusion at the termination of treatment, including final disposition and follow-up care / discharge instructions
10. Medication Reconciliation
11. A copy of any information made available to the practitioner or medical organization providing follow-up care, treatment or services.

C. Ambulatory Care Records

1. Patient Identification
2. Relevant history of present illness or injury and physical findings
3. Diagnostic and therapeutic orders
4. Clinical observations, including the results or treatments
5. Reports or procedures and tests and their results
6. Diagnosis or impressions
7. Patient disposition
8. Referrals, when necessary and appropriate
9. Communication to and from external practitioners or providers
10. For those patients receiving continuing outpatient services, a summary list of all significant diagnoses, procedures, drug allergies and medications, initiated by the third visit and maintained thereafter.

D. Record Completion:

1. A complete record is defined as one that has all entries, and dictation, timed, dated and signed, within 14 days after discharge.

II. DOCUMENTATION REQUIREMENTS

A. History and Physical

1. The history and physical exam shall be completed and present on the medical record within 24 hours after admission.
2. The history and physical shall be completed and present on the medical record prior to any surgical or invasive procedure unless the operating surgeon states, in writing, that delay would constitute a hazard to the patient. If delayed, then the history and physical must be present in the medical record within 24 hours.
3. If the history and physical has been completed within 24 hours prior to admission but not more than 30 days prior to admission, an H&P update note is required. The update must include any significant changes to the documented patient history as well as a statement that the physical exam was repeated and either no changes were identified or list the changes. The alternative short form H&P may be used for the update.
4. A history and physical greater than 30 days old may not be used in the medial record.
5. The dictated history and physical shall contain:
    a. Chief complaint
    b. Details of present illness or condition including, when appropriate, assessment of patient's emotional and behavioral status
    c. Past medical and surgical history
    d. Allergies
    e. Relevant family and social history
    f. Dental review for dental procedures, when appropriate
    g. Podiatric review for podiatric procedures, when appropriate
    h. Mental status
    i. Inventory of body systems
    j. Physical examination should reflect a comprehensive current assessment to include EENT, Heart/lungs, Neck and abdomen, neurological, musculoskeletal and skin. OB/GYN H&P will also require a rectal and pelvic exam, as appropriate.
    k. Diagnostic results, if available
    l. Diagnosis with initial plan of care
6. Observation status requires a full history and physical.
7. H&P Update: The H&P update may be handwritten, electronic or dictated.

Completion of the alternative, short form H&P may be utilized as an update.

8. H&Ps from appropriately privileged Alameda Health System or Allied Staff will be accepted if they meet the above criteria. Copies of history and physical exam from physicians who are not members of the AHS Medical Staff or are not privileged by AHS to perform H&Ps will be accepted only if countersigned by an AHS medical staff member with H&P privileges.
9. The alternative short form H&P may be used for patients admitted to Outpatient Services (OPS) when only conscious sedation, local or no sedation is used. General or Regional anesthesia require a full history and physical.
10. The short form history and physical shall contain:
    a. Chief complaint
    b. Details of present illness or condition
    c. Past medical and surgical history
    d. Allergies
    e. Diagnosis with initial plan of care

B. Consultations

1. A request for consultation shall be documented in the patient's chart.
2. Consultations shall show evidence of a review of the patient's record, pertinent findings on examination of the patient, opinion and recommendations. When operative procedures are involved, the consultation shall be recorded prior to the operation, except in emergency situations, so verified in the record.
3. The consultation may be dictated, electronic or handwritten in the progress notes.

C. Orders

1. Patients shall be admitted / treated only on the order of the attending practitioner. The order must specifically state the level of care. (Inpatient, Observation, OPS)
2. When the level of care changes, the reason must be stated as part of the order. If the level of care is not clear, then the physician will be contacted for clarification.
3. All orders must be dated, timed and signed.
4. Verbal orders will be authenticated within 48 hours for medication.

D. Progress Notes

1. Progress notes shall be recorded at the time of observation and contain sufficient information to permit continuity of care. Progress notes shall be electronic or handwritten at least daily on all patients and shall be signed, dated and timed by the responsible practitioner.

E. Informed Consent

1. Informed consent must be obtained by a physician prior to any invasive and/or operative procedure from each patient or the patient's legally authorized representative. The practitioner shall make an entry in the patient's medical record documenting such consent.

F. Pre and Post Anesthesia Evaluation

1. In the medical record of each patient receiving regional, general, or monitored anesthesia, the Anesthesiologist must document a pre and post anesthetic evaluation.

   The pre- operative evaluation must be performed within 48 hours prior to any inpatient or outpatient surgery or procedure requiring anesthesia service and include:
   a. Review of the medical history, previous anesthetic experiences and drug and allergy history.
   b. Interview and examination of the patient.
   c. Notation of Anesthesia risk
   d. Identification of potential anesthesia problems
   e. Additional pre-anesthesia evaluation, if applicable
   f. Development of the plan for the patient's anesthesia care
   g. Must be dated, timed and signed by a practitioner authorized to provide anesthesia.
2. A post- anesthesia evaluation will be documented no later than 48 hours after surgery or a procedure requiring anesthesia services but not before the patient has recovered from anesthesia. For outpatient, the post-anesthesia evaluation must be completed prior to the patient's discharge. The post-anesthesia evaluation should include:
   a. Respiratory function, including respiratory rate, airway patency and oxygen saturation.
   b. Cardiovascular function, including pulse rate and blood pressure
   c. Mental status
   d. Temperature
   e. Pain
   f. Nausea and vomiting; and
   g. Postoperative hydration
   h. Must be dated, timed and signed by a practitioner authorized to provide anesthesia.

G. Operative Report and Note

1. A complete operative report should be dictated, electronic or handwritten within 24 hours of the procedure and should include:
   a. Name of the surgeon and any assistants

   b. Procedures (s) performed
   c. Preoperative diagnosis
   d. Anesthesia used
   e. Description of the procedure
   f. Findings
   g. Estimated blood loss
   h. Specimens removed
   i. Postoperative Diagnosis

2. A Postoperative Note is entered in the medical record immediately following surgery and should include:
   a. Preoperative diagnosis
   b. Postoperative diagnosis
   c. Procedure (s)
   d. Findings
   e. Surgeon(s)
   f. Estimated blood loss
   g. Complications
   h. Specimen
   i. Date
   j. Time

H. Discharge Summary

1. Discharge summary should be completed at the time of discharge by the responsible staff member and may be handwritten, electronic or dictated.
2. A discharge summary shall be recorded in the medical record of all observation, ambulatory surgery and inpatients.
   a. For observation and ambulatory surgery the Alameda Health System Admission a final Progress may be completed in lieu of a Discharge Summary.
   b. For uncomplicated inpatients hospitalized for less than 48 hours, Alameda Health System Discharge Summary may be completed as a final Progress Note in lieu of a Discharge Summary note. These must include date of admission, date of discharge, admitting diagnosis, final diagnosis, procedures/operations performed, complications, summary narrative, reason for hospitalization, pertinent lab/x-ray/physical findings, treatment and medications, condition on discharge, instructions to patient or family, consultants and the signature and date of the physician.

I. Transfer Summary

1. The transfer summary must be completed before the transfer of the patient. It should also include in addition to the above:
   a. The reason for the transfer
   b. The patient's physical and psychosocial status
   c. A summary of care, treatment and services provided and progress toward goals
   d. Community resources referrals provided to the patient

J. Death Summary

1. In the case of death, the discharge summary is replaced by a death summary stating the same information with a summary of events immediately prior to death, including the cause of death.

L. Autopsies

1. Staff members shall make reasonable efforts to obtain consent for autopsies whenever performance of an autopsy would aid in obtaining a meaningful understanding of the disease process and/or its management.

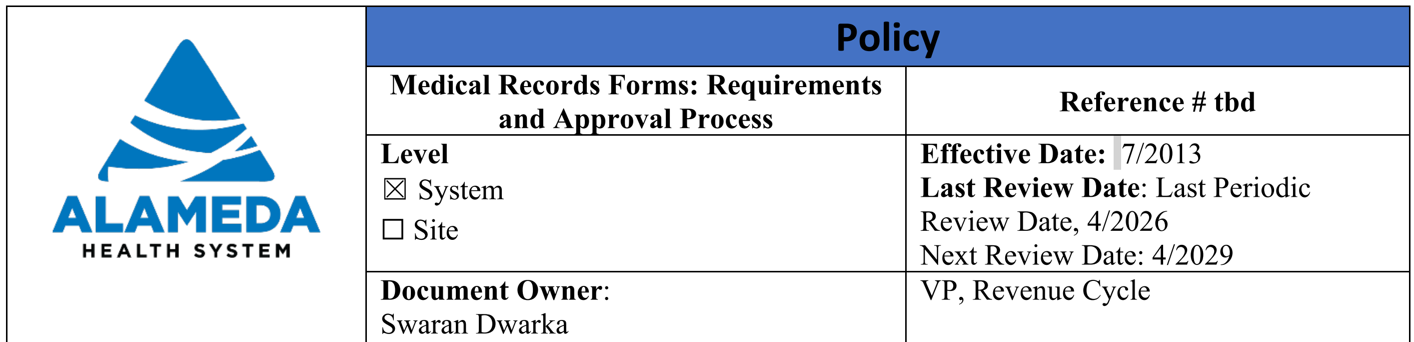
M. Signature Stamp

1. Signature stamps as the sole means of authentication are not authorized for use in the patient's medical record. Printed legible stamps are acceptable to provide interpretation of signatures.

RELATED DOCUMENTS

Alameda Health System and Alameda Hospital Rules & Regulations

REFERENCES



	Policy	
ALAMEDA HEALTH SYSTEM	**Medical Records Forms: Requirements and Approval Process**	**Reference # tbd**
	Level ☒ System ☐ Site	**Effective Date:** 7/2013 **Last Review Date**: Last Periodic Review Date, 4/2026 Next Review Date: 4/2029
	Document Owner: Swaran Dwarka	VP, Revenue Cycle

PURPOSE

To establish and implement procedures for the drafting, approval, issuance, revision, amendment, and control of all clinical forms to prevent duplication of existing forms, promote cost containment and standardization, and advise form development as needed.

SCOPE

This policy applies to all items, locations, departments within the AHS System.

POLICY

The Health Information Management Committee will use the criteria and process outlined in this policy to govern the drafting, approval, issuance, revision, amendment, and control of all clinical forms.

PROCEDURE

Clinical Form Standards

Whenever possible, clinical forms at AHS will contain and adhere to the following standards:

a. Form title
b. Standardized form number, assigned by the HIM department
c. Revision date
d. Approved AHS logo
e. Locations for patient identification and barcode are consistent with the current AHS form template
f. Clinical for contents meet applicable Federal and State regulations as well as, Joint Commission and Core Measure standards
g. Abbreviations are avoided
h. Signature lines - All forms containing a signature line will provide adequate space for the
   care provider's signature, date, and time.
i. Paper size - Standard 8 ½" x 11" paper will be used whenever possible. Forms that fold open and are greater than 8 ½" x 11" must have a page break within the fold of the document.
j. Font – 12-point Arial font is recommended.

Health Information Management Committee

1. The Health Information Management (HIM) Committee's responsibility is to review requests for additions, deletions or changes to clinical forms. New and existing clinical forms are reviewed by the committee for standardization, improvement or elimination.

2. Form requests must be reviewed and approved by the HIM Committee. Consents and Order Sets are routed to their approving committees and then to the HIM department for barcoding and formatting.

3. The VP of Revenue Cycle co-chairs the (HIM) Committee.

4. The HIM Committee is an interdisciplinary committee of the Medical Staff. Membership shall include representation from the following areas:

a. Nursing	e. Safety and Risk Manager/Representative
b. Health Information Management	f. Quality Manager/Representative
c. Information Technology	g. Chief Medical Information Officer
d. Pharmacy	h. AD Hoc Members

5. The HIM Committee will meet at least four times per year

<u>Form Approval/Change Process</u>

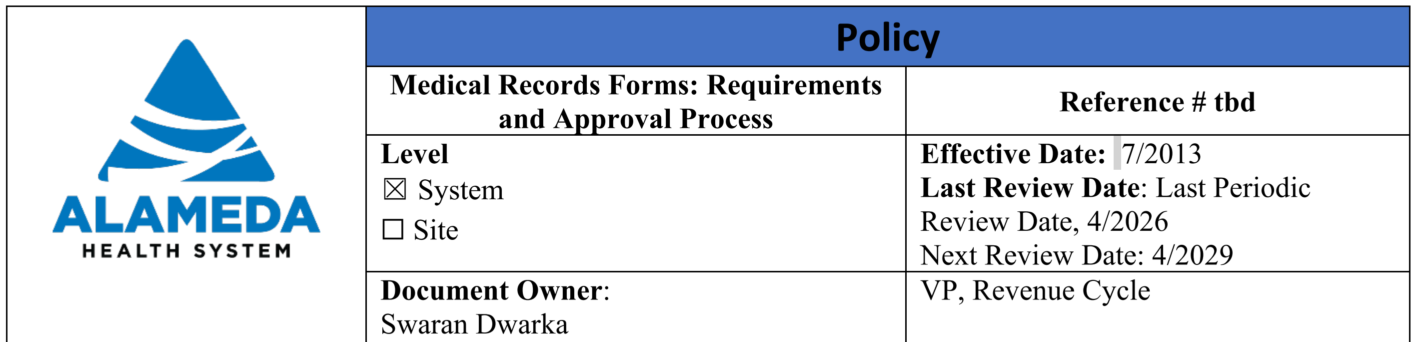
1. The department or "form business owner" requesting the creation of a new form or changes to an existing form must submit their request, in writing, to the Health Information Management Forms Coordinator.

2. Form requests must be received at least two weeks prior to the HIM committee meeting date for inclusion on the HIM Committee agenda.

3. The forms business owner is responsible for obtaining any additional required committee approvals and sign offs prior to prior to their presentation for review by the HIM Committee.

4. Order Sets and Consent forms are routed directly to their approving committees and then to the HIM department for barcoding and formatting.
   a. Order Sets are approved by Pharmacy & Therapeutics (P&T) Committee
   b. Consent forms are reviewed and approved by members of the AHS Risk and Compliance team.

5. The form business owner is required to present a draft of the proposed form or changes for committee review and approval that adheres to established AHS form standards (listed above).



6. The HIM Committee will review all presented forms and move to either approve the form as is or make recommendations for change.
    a. When changes are recommended by the committee, the form business owner will make the necessary revisions and resubmit the revised version electronically to the Health Information Management forms coordinator.

7. Once a form is approved, it will be assigned a standardized form number by the HIM department.

8. The final approved draft will be sent to the form vendor for reproduction.

9. The forms vendor will notify the Health Information Management forms coordinator and form business owner when the final form is generated. HIM will communicate this to the form business owner when needed

10. The HIM department will upload approved forms to the Downtime Forms links on the AHS Intranet for system-wide access.

11. The HIM department is responsible for maintaining records of the following:
    a. Barcoded, hard copy and final electronic version of all forms
    b. Correspondence/special instructions from the form business owner regarding the form
    c. All versions of revised forms
    d. Legal Health Record form inventory includes a spreadsheet of all barcoded forms available for ordering or electronic access in the Downtime Forms links on the AHS Intranet.

12. The form business owner reviews and updates any associated policies or procedures impacted by the implementation of the new or revised form.

13. Prior to form distribution, the form business owner is responsible for contacting the Education department and coordinating inservices for form end-users.

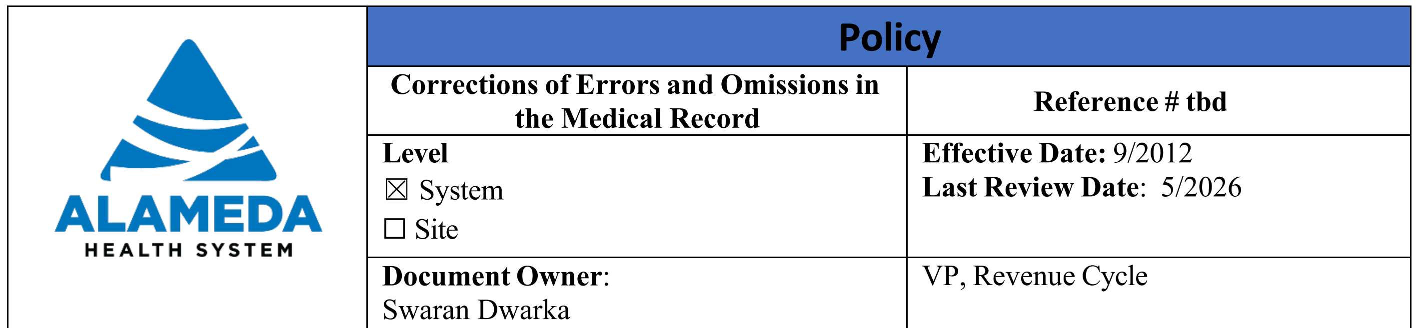
14. Departments will order forms as needed according to ordering procedures established with the form vendor.

REFERENCES

[Mention relevant laws, regulations, or requirements, such as Joint Commission standards. Refer to regulatory organizations, including the Occupational Safety and Health Administration, the National Institute for Occupational Safety and Health, and the American National Standards Institute, that offer guidance on the subject. Include citations of resources used to develop the policy. Cross-reference relevant documents from other organizations.]

ATTACHMENTS

[List attached forms for policy implementation not included in the body of the policy.]



	Policy	
ALAMEDA HEALTH SYSTEM	**Corrections of Errors and Omissions in the Medical Record**	**Reference # tbd**
	Level ☒ System ☐ Site	**Effective Date:** 9/2012 **Last Review Date**: 5/2026
	Document Owner: Swaran Dwarka	VP, Revenue Cycle

PURPOSE

To provide guidelines for corrections in the medical record and to ensure consistency across all disciplines and campuses.

SCOPE

This policy applies to all acute care areas within the AHS System, this includes Inpatient, Outpatient, Emergency Room, and Ambulatory Care records.

POLICY

Errors and omissions which occur on a patient's medical record, including test results which may be placed on the incorrect medical record, shall be corrected as quickly as possible by the person who made the error or omission or a manager in that individual's department.

PROCEDURE

<u>Individuals Authorized to Make Corrections</u>

1. The individual who made the original entry in a medical record is authorized to correct the entry. In instances of absence or unavailability of the individual who made the original entry, corrections may be made by the Attending who saw the patient. If the attending is unavailable, the Department Chair or Department Chief would make the correction.

2. If for any reason compliance with this method of correction is impossible, the matter shall be referred to the Risk Manager.

3. Under no circumstances shall any corrections be made to any entry in a patient's medical record where litigation has been threatened or filed with regard to that patient, except as may be authorized by the Risk Manager.

Correction Procedure:

Paper Documentation:

1. Draw one continuous line through the error.

2. At the end of the correction, write "error", and note the reason for correction.

3. Date, time, and authenticate the correction.

Electronic Entry:

1. Enter the correct information by over-writing the original entry.
2. Amended notes should be re-signed after the correction has been made;
3. Corrections to discrete data will be finalized when the document is closed.

Authentication

Corrections made to documentation in a medical record shall be dated, timed, and authenticated by the individual making the correction.

Paper Documentation: Initials are acceptable for the purpose of authentication, provided full initials are used (middle initial included) and provided the initials are legibly written so they clearly identify a particular employee involved.

Electronic Entry: Corrections to electronic documentation should be made in that part of the chart where the error was made. The EMR system tracks, time-stamps, and authenticates any changes/revisions made in the chart and retains the original entry for historical purposes.

Misfiled Test Results

Paper Documentation

1. Upon discovery of a misfiled test result on the nursing unit, Nursing Manager should review record to determine if care was rendered based on the misfiled report

2. If care was not affected, remove misfile, and file on correct record.

3. If care was affected, misfiled report will remain on the record, assuring a copy is made and routed to appropriate medical record. Draw an X through misfile, and label

"misfiled report, do not remove" across the X.

4. On the misfiled report obliterate all patient identification with a black felt tip marker, date, time and sign.

Electronic Entry

1. Results found to have been erroneously entered directly into a patient's electronic chart should be corrected by the end-user who initially made the entry.

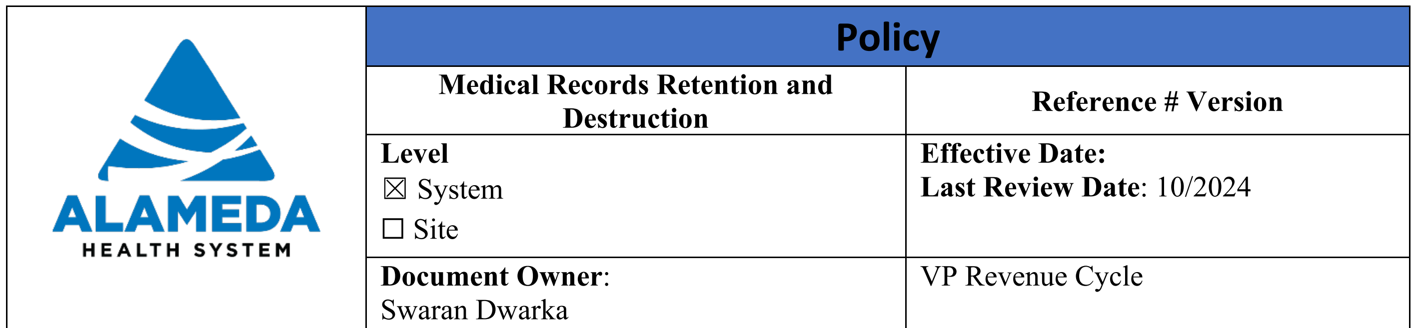
2. Results entered into the wrong chart, or interfaced into the wrong chart via a third-party system, should be referred to the IS Service Center.

Notification of Errors in the Medical Record

1. Upon discovery and correction of an error in the medical record that appears to have impacted patient care (as determined by the person reviewing and correcting the error), Risk Management will be notified immediately by entering a MIDAS Safety Alert.
2. The Nurse Manager shall be responsible for notification to Risk Management, and to any physician, nurse or other caregiver who may have relied upon the original entry to provide care to the patient.
3. The Nurse Manager will document those caregivers who were notified in a dated, timed, and authenticated entry to the medical record.

REFERENCES

ATTACHMENTS



ALAMEDA HEALTH SYSTEM	Policy	
	Medical Records Retention and Destruction	Reference # Version
	Level ☒ System ☐ Site	**Effective Date:** **Last Review Date**: 10/2024
	Document Owner: Swaran Dwarka	VP Revenue Cycle

PURPOSE

1. To establish the retention and destruction requirements for all records, regardless of medium, that contain demographic or medical information about a patient ("medical records").
2. To support good patient care by maintaining all records in an organized, secure manner.
3. To assure regulatory compliance as well as provide a practical framework for records retention.

SCOPE

This policy applies to all items, locations, departments within the AHS System, this includes Inpatient, Outpatient, Emergency Room, and Ambulatory Care records.

POLICY

Alameda Health System will maintain medical records and related documents and data in an orderly manner and for periods of time consistent with legal or regulatory requirements and prudent business practice.

Note: The retention requirements apply to all records whether in hard copy or electronic format and are consistent with California Record Retention Guidelines.

Specific Policies for Retention and Destruction

Medical Records:

1. Adult Medical Record (18 years and over): 15 years from date of patient visit.
2. Medical Record of a Minor (Under 18 years): Until the patient is 28 years of age.
3. Anatomical gift, Death certificates, Birth certificates, labor and delivery and nursery logs: Permanent.
4. Cancer/tumor registry files: Permanent.
5. Operating room logs: Minimum ten years.
6. Test results, tracings and recordings: Although both State and Federal law require the majority of test results to be filed within the medical record, some test records, such as

EKG's, EEG's, EMG's, fetal heart tracings, and video recordings of diagnostic tests are often maintained outside of the chart. All clinically significant portions of these test recordings should be identified and maintained for the life of the corresponding medical record. Clinical Laboratory & Pathology records are maintained in compliance with State and Federal regulations.

Suspension of Retention Schedule and Preservation of Records and Information

1. Any document or information (paper or electronic) that is subject to a known, or reasonably foreseeable, investigation or lawsuit by any outside private party, governmental agency or law enforcement agency, will be subject to a "Preservation hold."

2. The Office of the General Counsel (OGC), or designee, is responsible for initiating and terminating "Preservation holds" and will provide specific direction to affected employees and document custodians.

3. The "Preservation hold" shall suspend the document retention schedules for any and all documents and/or other information that may be relevant to the matter under investigation or in dispute.

4. All documents and information subject to a "Preservation hold" shall be preserved for, at a minimum, the duration of the prevailing retention schedule *and* until the "hold" is terminated.

5. Records subject to a "Preservation hold" shall be identified and tracked within the corresponding records inventory list, both in hard copy and/or electronic format.

6. Any questions regarding "Preservation holds," including whether one should be issued, should be directed to the Office of the General Counsel and AHS Administration.

Storge Location: Record storage need not be on premises but may be at GRM or other approved company.

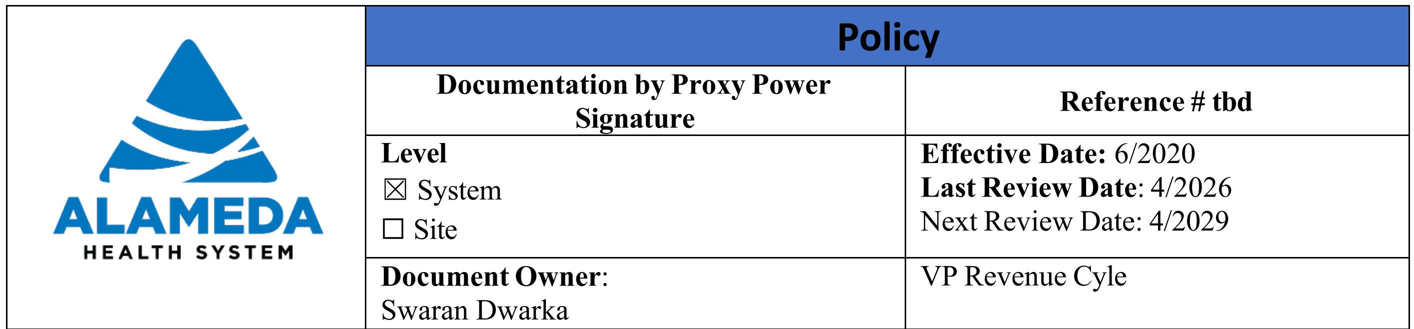
Destruction of Records

1. Medical records shall be destroyed when they have reached the term of their retention schedule unless patient-care, legal or business purposes require an extension of the retention period. No entire medical record shall be destroyed on an individual basis. Any records with protected health information (PHI) must be destroyed in a manner that prevents any compromise of patient privacy. Recommended methods for destruction of any confidential or sensitive business records and all records with patient information follows:

Medium	Recommendation
Paper Records	Shred, pulverize, pulp or provide to an approved bonded document destruction company
Computerized data inter/external hard disk drives/thumb drives.	Reformat drive and overwrite all data (including back-up media), or purge by a bonded vendor.
Computer data/magnetic data.	Reformat after overwriting media and/or magnetically erase (degauss) or pulverize.
CDs - Diskettes	Pulverize
Audio Tapes/Videotapes	Recycle by recording over by the original user, or pulverize the tape and cassette.

2. When medical records are destroyed, the Health Information Management Department will maintain a general accounting (set of dates, inpatient/outpatient) of said records.

REFERENCES



ALAMEDA HEALTH SYSTEM	Policy	
	Documentation by Proxy Power Signature	**Reference # tbd**
	Level ☒ System ☐ Site	**Effective Date:** 6/2020 **Last Review Date**: 4/2026 Next Review Date: 4/2029
	Document Owner: Swaran Dwarka	VP Revenue Cyle

PURPOSE

To define guidelines for when it is appropriate to utilize a proxy power signature to authenticate acute care medical documentation. The physician authenticating an electronic transcribed report takes responsibility for the content of the report.

SCOPE

This policy applies to all acute care areas within the AHS System, this includes Inpatient, Outpatient, Emergency Room, and Ambulatory Care records.

POLICY

When a physician is unable to authenticate their documentation for one of the reasons listed below, The Physician Department Chair and/or Division Chief may contact the HIM department for reassignment of the deficiencies from the unavailable physician to the requesting Department Chair and or Division Chief for completion.

The Department Chair and/or Division Chief is also able to contact HIM for the reassignment of deficiencies so that he or she may provide authentication on behalf of any chief assigned to the medical center.

The proxy accepts responsibility for the content of the original documentation. A proxy only authenticates documentation when a provider is unable to authenticate the document themselves as outlined by this Policy.

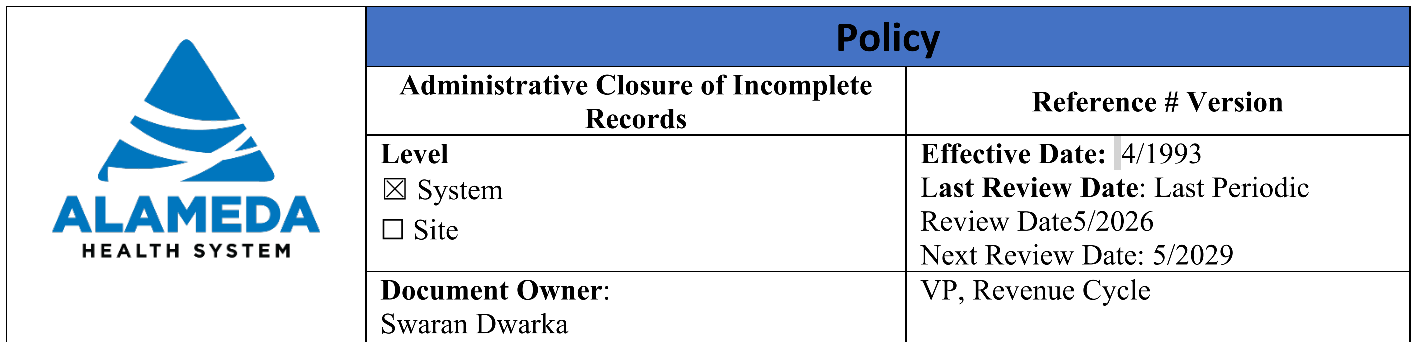
PROCEDURE

Appropriate use of Chief Proxy Power Signature:

1. When the physician is no longer an employee of AHS.
2. When the physician is on an extended leave such as a medical leave of absence, disability, education, and vacation, that exceeds 30 calendar days.

Appropriate use of Chief of Staff Proxy Power Signature:

1. When the physician noted above in items #1 and #2 is a Chief of a Department, the Chief of Staff shall exercise proxy power.



	Policy	
ALAMEDA HEALTH SYSTEM	**Administrative Closure of Incomplete Records**	**Reference # Version**
	Level ☒ System ☐ Site	**Effective Date:** 4/1993 **Last Review Date**: Last Periodic Review Date5/2026 Next Review Date: 5/2029
	Document Owner: Swaran Dwarka	VP, Revenue Cycle

POLICY STATEMENT

A medical record shall ordinarily be considered complete when the required documentation has been filed.

No Medical Staff member is permitted to complete a medical record on a patient unfamiliar to him/her in order to close a medical record that was the responsibility of another staff member unless it meets the requirements set forth by the "Documentation by Proxy Power Signature" policy.

When the Health Information Management Department is unable to obtain signatures and necessary record documentation to complete a medical record, they may utilize administrative closure for the incomplete record.

PURPOSE

To outline the process of and define guidelines for appropriate uses of administrative closure with incomplete records.

SCOPE

This policy applies to all items, locations, departments within the AHS System, this includes Inpatient, Outpatient, Emergency Room, and Ambulatory Care records.

PROCEDURE

1. The Health Information Management Department will make every possible effort to obtain signatures and necessary record documentation on incomplete medical records while the physician is still working at Alameda Health System.

2. The Health Information Management Department will have all the physician's incomplete medical records available for completion.

3. The Health Information Management Department will submit a list of incomplete medical records to the appropriate Medical Staff after a physician has resigned from the Medical Staff.

4. If recommendation is made to administratively close the medical record, the Director of Health Information Management will sign the Administrative Closure of Incomplete Record Form (attachment).

5. When authorizing signature has been obtained, the Health Information Management Department will scan the form in our electronic medical record.

BRAIN DEATH/DEATH BY NEUROLOGIC CRITERIA POLICY

Site	Alameda Health System	**Previous Revision Dates**	3/2011, 9/2017, 6/2018, 1/2022
Effective Date	6/02	**Date Revised**	07/13/2022, 4/2026
		Next Scheduled Review	5/2029
Executive Responsible	CHIEF MEDICAL OFFICER		

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

Scope: Applies to patients who meet clinical criteria for brain death evaluation.

Background:
Brain Death/Death by Neurologic Criteria (BD/DNC) is a medical and legal definition of death. Per the State of California Health and Safety Code, Chapter 3.7, Article 1 (Uniform Determination of
Death Act) Section 7180 (a) "An individual who has sustained either (1) irreversible cessation of circulatory and respiratory functions, or (2) irreversible cessation of all functions of the entire brain, including the brainstem, is dead. A determination of death must be made in accordance with accepted medical standards." Section 7181 states "When an individual is pronounced dead by determining that the individual has sustained an irreversible cessation of all functions of the entire brain, including the brainstem, there shall be independent confirmation by another licensed physician".

Purpose:

The purpose of this document is to define standards for the determination of Brain Death/Death by Neurologic Criteria (BD/DNC) in patients ages 14 and older in accordance with state and federal requirements.

Policy:

1. It is the policy of Alameda Health System (AHS) and the law in the State of California that BD/DNC is death; a patient who is dead by neurologic criteria is both medically and legally dead.

2. Determination of brain death/death by neurologic criteria is a medical assessment and does not require consent from a patient's family or surrogate decision-maker(s). Family or surrogate objections do not prevent the evaluation from proceeding when BD/DNC is clinically indicated and all prerequisites are met, in accordance with institutional policy and applicable state law.

3. The clinical team must make reasonable efforts to inform a patient's family when a BD/DNC evaluation is planned and offer them the opportunity to be present or observe. However, these efforts should not delay BD/DNC determination.

4. Clinicians involved in BD/DNC determination must only consider the interests of their patient. Clinicians should not be directly involved in decision-making around organ donation.

5. Attending clinicians performing BD/DNC examinations must be credentialed members of the hospital's medical staff and adequately trained and competent in the evaluation of BD/DNC in adults, in accordance with local laws and institutional standards. Trainees and advanced practice practitioners may perform the brain death exam as long as an attending physician meeting the above requirements is present, directly supervises the entirety of exam, and attests to the documentation related to the process.

Protocol:

1. Ascertain that the patient has sustained a catastrophic, permanent whole brain injury caused by an identified mechanism that has known potential to progress to BD/DNC through injury to the entire brain, including the brainstem. Confirm that neuroimaging is consistent with the mechanism and severity of injury.
    a. In primary posterior fossa brain injury, ensure that neuroimaging also shows evidence of catastrophic supratentorial injury.

2. Assessment for BD/DNC should be initiated when clinical exam suggests permanent cessation of all functions of the entire brain, including the brainstem.
    a. Clinicians should wait a sufficient amount of time after the brain injury to ensure permanency. This observation period must be based on the pathophysiology of the brain injury leading to the neurologic state of the patient. In patients with hypoxic ischemic brain injury, neurologic function must be observed for at least 24 hours after injury. For those patients treated with targeted temperature management, the observation period must extend at least 24 hours after rewarming to normothermia. During this period, NO sedating drugs can be given and the patient's physiology should be maximally supported.

3. Rule out mimics of brain death:

    a. **Hypothermia:** Core body temperature must be restored and maintained ≥ 36°C. If body temperature has been ≤ 35.5°C, assessment for BD/DNC should only begin after a waiting period of 24 hours after rewarming to ≥ 36°C.

    b. **Hypotension:** In patients ≥ 18 years of age, maintain SBP ≥ 100 mmHg *and* MAP ≥ 75 mmHg. In patients 14-17 years of age, maintain SBP *and* MAP ≥ 5th percentile for age. If a patient's baseline blood pressure varies significantly from their age-based normal range, target an SBP and MAP that approximate baseline for the patient.

    c. Intoxication: Ensure that metabolic derangements, intoxication, and central nervous system (CNS) depressant medications are excluded, adequately corrected, or eliminated prior to evaluating patients for BD/DNC, as clinically appropriate. Specifically:

        1. Ensure that toxicology screening result, if clinically indicated, is negative
        2. Ensure that blood alcohol level, if clinically indicated, is ≤ 80mg/dL
        3. Ensure that serum drug levels for CNS depressant medications, including medications used for sedation in the intensive care unit, are in a subtherapeutic range (if drug levels can be checked and return in a timely manner), or allow five times the drug's half-life to pass (longer when taking renal or hepatic dysfunction, body temperature, body mass index, or age into consideration, requesting pharmacy assistance with these calculations). If the patient has received pentobarbital, the level must be < 5µ/mL or below the laboratory's lower limit of detection before evaluation

for BD/DNC.

4. Exclude severe metabolic, acid-base, or endocrine derangements (Table 1)
5. If previously administered, exclude the effect of pharmacologic paralysis (train-of-four or deep tendon reflexes)

4. Notifications prior to BD/DNC exam
   a. Once the BD/DNC protocol is initiated, the organ procurement agency should be notified.
   b. When possible, the patient's family and/or loved ones should be informed that the evaluation for neurologic death is taking place and invited to observe the exam, if so desired.

5. Perform the BD/DNC Neurologic Examination
   a. **Number of examinations**
      1. **Two** clinicians, meeting the above requirements, must each perform a separate and independent examination for BD/DNC. Whenever possible, one of these physicians should be the treating neurologist or neurosurgeon.
      2. For patients **14 to 17 years of age, a minimum of 12 hours separating the two exams** is required.
   b. **Throughout the BD/DNC Examination:**
      1. Maintain core body temperature ≥ 36°C
      2. Maintain normotension:
         - In patients ≥ 18 years of age, maintain SBP ≥ 100 mmHg *and* MAP ≥ 75 mmHg
         - In patients 14-17 years of age, maintain SBP *and* MAP ≥ 5th percentile for age.
         - If a patient's baseline blood pressure varies significantly from their age-based normal range, target an SBP and MAP that approximate baseline for the patient.

I. Clinical Neurologic Exam

Examination Component	How to Perform the Examination Component	Response Consistent with BD/ DNC	Clinical Considerations
Coma	• Provide maximal external stimulation: call the person by name, apply loud verbal stimuli, and apply noxious stimulation (see motor section)	• No evidence of arousal or awareness to maximal external stimulation (including noxious visual, auditory, and tactile stimulation	Drugs and metabolic derangements may cause reversible coma. Permanency must be established before performing a BD/DNC examination.
Assessment for no spontaneous facial or orofacial movements	• Observe for spontaneous grimace, eye opening, swallowing, chewing, or other brain-mediated movements.	• No spontaneous cranial movement except spinal reflexes (e.g., triple-flexion).	• Myoclonus, seizure activity, or opisthotonos must be recognized and treated/ruled out before BD/DNC evaluation.
Absence of spontaneous respirations	• Observe the chest and abdomen for spontaneous respiratory effort prior to apnea testing. • Confirm stable ventilator settings and absence of	• Absence of spontaneous respirations	• This is a required clinical finding *before* and *during* apnea testing.

	auto-triggering.		
Motor responses of the face & limbs	• Apply noxious stimulation to multiple sites, including: – Nailbed pressure or pressure on bony prominences of all limbs (proximal and distal). – Supraorbital pressure. – TMJ pressure (optional). – Sternal rub (optional, if not contraindicated). – Nasal tickle using a cotton applicator (optional).	• No grimace or purposeful motor responses. • No movement of face or body to noxious stimuli above the foramen magnum. • Noxious stimuli below the foramen magnum may produce spinally mediated reflexes, which are compatible with BD/DNC.	• Ancillary testing is recommended if a person has a pre-existing severe neuromuscular disorder, such as amyotrophic lateral sclerosis or a pre-existing severe sensory neuropathy. • Ancillary testing is not required if a person does not have all 4 limbs. Painful stimulation can still be provided centrally and on the torso as close to the termination of the limb as possible. • Severe facial trauma and swelling may preclude evaluation of facial motor response, so ancillary testing is recommended in this setting. • Spinally mediated reflexes include deep tendon reflexes, plantar reflexes, triple flexion of the legs, toe flexion or extension on plantar stimulation, superficial abdominal reflexes, and blood pressure changes in response to noxious stimulation. Complex motor movements may be observed (Table 2); if no member of the team has sufficient clinical expertise to definitively categorize these movments as spinally-mediated, ancillary testing must be used to exclude cerebral origin of the movement.
Pupillary light reflex	• Dim ambient light to optimize assessment • Shine a bright light (e.g. LED) into each eye and observe for direct and consensual response. • Automated pupillometry may be used as an adjunct; however, automated pupillometers are not validated for use in isolation.	• Ipsilateral and contralateral pupillary response should be absent in both eyes. • Pupils in both eyes should be fixed in a midsize or dilated position.	• Pupils may be round, oval, or irregular. • Constricted pupils (<2 mm) may indicate drug effect but do not independently exclude BD/DNC if there is no light reactivity and intoxication is excluded. • Corneal trauma, ocular

	in BD/DNC.		surgery, or ocular medications may interfere; ancillary testing recommended if pupil evaluation is unreliable. • Any pupillometer-detected reactivity is not compatible with BD/DNC.
Corneal reflex	• Lightly touch the cornea at or near the limbus (iris–cornea border) with a cotton wisp or gauze.	• No eyelid movement, other than the movement caused directly by the examiner's touch.	• In the setting of anophthalmia, severe orbital edema, ocular trauma, prior corneal transplantation, or scleral edema or chemosis, ancillary testing is recommended.
Oculocephalic reflex (OCR)	• Confirm integrity of the cervical spine and skull base, securing the endotracheal tube to prevent accidental dislodgement. • Rotate the head briskly horizontally to both sides. Vertical testing is optional.	• Eyes remain fixed midline with no roving or deviation	• If the OCR cannot be performed, but the OVR is performed bilaterally and there are no extraocular movements, ancillary testing is not required.
Oculovestibular reflex (OVR)	• Confirm external auditory canal patency and intact tympanic membrane. • Elevate head to 30°. • Irrigate the ear canal with ~50 mL of ice water over 20–30 seconds. • Observe for ≥1 minute. • Repeat on the contralateral side after several minutes to allow equilibration.	• No eye deviation toward the irrigated ear; no extraocular movements of any kind.	• Skull base fracture, petrous temporal bone fracture, or severe orbital/scleral edema may make OVR unreliable; ancillary testing is recommended. • If there is anophthalmia, ancillary testing is required.
Gag & cough reflexes	• Stimulate the posterior pharynx with a tongue depressor or rigid suction device to assess gag. • Stimulate the tracheobronchial wall to the level of the carina with deep endotracheal placement of a suction catheter to assess cough	• No gag response • No cough response response	• Injury to vagus or phrenic nerves, high spinal cord injury, or prior airway surgery may confound evaluation; in these cases, ancillary testing is required.

II. Apnea Test

1. Age ≥ 18: At **least one** apnea test after the final BD/DNC neurologic exam.
2. Age 14 to <18: **Two** apnea test must be performed, one after each BD/DNC neurologic exam.
3. The pre-requisites for the clinical exam should continue to be met for the apnea test.
   a. Ensure the patient is not hypercarbia, hypotensive, hypovolemic, or hypothermic
   b. If laboratory studies were done > 4hrs before start of apnea test, repeat ABG, CBC and Chem 10 before the apnea test(s) to reconfirm levels within accepted ranges

4. **Performing the apnea test:**

   a. Determine if the patient has baseline CO2 retention due to pre-existing disease and whether the baseline PaCO2 is known
      - In a patient **without** known baseline CO2 retention, adjust the ventilator to achieve a normal Paco2 (35-45 mm Hg) and pH (7.35-7.45)
      - In a patient with known baseline CO2 retention due to pre-existing disease for whom the baseline PaCO2 is known, adjust the ventilator to achieve baseline pH/ PaCO2
      - In a patient with known baseline CO2 retention due to pre-existing disease for whom the baseline PaCO2 is not known, adjust the ventilator to achieve estimated baseline pH/ PaCO2 (This patient will also require an ancillary test if they do not breathe during the apnea test)
   b. Preoxygenate for at least 10 minutes with 100% FIO2 , aiming for PaO2 > 200 mm Hg
   c. Check ABG to establish baseline pH, PaO2 , PaCO2 within above parameters
   d. Fully disconnect the patient from the ventilator and start timer
   e. Provide apneic oxygenation:
      - Place a catheter inside the endotracheal or tracheostomy tube such that it approximately terminates just above the level of the carina.
      - The catheter diameter should be <70% of the diameter of the endotracheal or tracheostomy tube.
      - Deliver 100% Fio2 at a flow rate of 4-6 L/min.
      - Alternatively, continuous positive airway pressure (CPAP) using 100% Fio2 and the same PEEP the patient required prior to the apnea test can be used.
   f. Monitor closely for respiratory movements for 8-10 minutes: Visual (bare chest and abdomen) and tactile observation of the patient's chest for movement and abdominal musculature for contraction or evidence of spontaneous breathing. If using CPAP, monitor the flow waveforms for a patient-initiated breath.
   g. If no respiratory drive is noted after 8-10 minutes, perform serial ABG's (approximately every 2 minutes) beginning at 8-10 minutes of apnea. If the patient does not have hemodynamic instability or hypoxemia, continue apnea testing until the ABG results are consistent with the following criteria:
      - No respirations or effort occurs, and
      - The arterial pH level is <7.30, and
      - <u>In patients who are known NOT TO HAVE chronic CO2 retention</u>: the PaCO2 level is ≥60 mm Hg AND ≥20 mm Hg above the patient's pre-apnea test baseline level.

- In patients who are KNOWN TO HAVE chronic CO_2 retention, and the baseline $PaCO_2$ is KNOWN: the $PaCO_2$ level is ≥60 mm Hg AND ≥20 mm Hg above the patient's known chronic elevated premorbid baseline level.
- In patients who are SUSPECTED TO HAVE chronic CO_2 retention, but the baseline $PaCO_2$ is UNKNOWN: the $PaCO_2$ level is ≥60 mm Hg AND ≥20 mm Hg above the patient's pre-apnea test level, and an ancillary test is also required.

h. The duration of testing is typically 10-15 minutes but can be carried out for longer if the patient is stable.

i. Terminate the apnea test for:
- Spontaneous respirations or effort
- Hemodynamic instability or hypoxemia :
  SBP ≤100 mm Hg or MAP ≤75 mm Hg in adults, or SBP or MAP ≤5th percentile for age in children, despite titration of vasopressors, inotropes, and/or intravenous fluids.
  Decrease in oxygen saturation below 85%
  Cardiac arrhythmia with hemodynamic instability

5. Unless the test is being aborted due to spontaneous respirations, obtain an ABG before reconnecting the patient to the ventilator if able. If the arterial pH and $PaCO_2$ criteria (as included above) are achieved, the apnea test is consistent with BD/DNC.

6. After resuming mechanical ventilation, transiently increase minute ventilation to achieve normoxia, normocapnea and a normal acid-base status.

7. If the test is aborted but the completion conditions are not met, the apnea test may be repeated for a longer duration if the patient was stable during testing, or an ancillary test may be performed.

III. Ancillary Test (if applicable)

1. Ancillary tests should only be used to assist with BD/DNC determination if the examination or apnea testing cannot be completed or the findings cannot be interpreted adequately. Specific instances include:
   - Inability to correct the listed metabolic derangements, but the neurologic examination(s)/apnea test(s) are consistent with BD/DNC
   - Inability to perform components of the examination because of an underlying medical condition (e.g., fracture of the cervical spine/skull base/orbit, severe facial injury/abnormality, injury to the cervical spine)
   - Inability to interpret whether examination findings such as limb movements are spinally mediated
   - Inability to perform or complete the apnea test because of concern about the risk of cardiopulmonary decompensation

2. Ancillary testing may not be used to avoid performing testable elements of the BD/DNC evaluation.

3. The neurologic examination(s) and apnea test(s) need to be performed to the fullest extent possible and findings must be consistent with BD/DNC *before* ancillary testing is performed. If any findings on the examination(s)/apnea test(s) are consistent with brain-mediated activity, ancillary testing must not be performed because the patient does not meet criteria for BD/DNC.

Acceptable Ancillary Tests:
1. 4-vessel catheter angiography
2. Radionuclide cerebral flow scan
3. Transcranial Doppler ultrasonography (≥ 18 years of age only)

Unacceptable ncillary Tests:
1. CT angiography
2. CT perfusion
3. MR perfusion
4. Electroencephalography

IV. Special Considerations

1. Pregnancy: Pregnancy is not a contraindication to BD/DNC. Any pregnant person with catastrophic, permanent whole brain injury and a clinical examination suggesting permanent cessation of all functions of the entire brain, including the brainstem, should be assessed for BD/DNC. After BD/DNC determination, the clinicians providing care, assisted by clinicians knowledgeable in maternal-fetal medicine, child neurology, and neonatology, as needed, should educate and discuss with surrogate decision-makers the risks and benefits to the fetus of continuing organ support for the deceased parent.

2. Primary Infratentorial/Posterior Fossa Injury: As above, to avoid determining BD/DNC in patients with primary infratentorial/posterior fossa injury and retained supratentorial function, clinicians should ensure that the infratentorial/posterior fossa process has also led to catastrophic, permanent supratentorial injury as demonstrated on a conventional neuroimaging

study before initiating the BD/DNC evaluation.

V. Determination of Death & Documentation

Each examination and apnea test must be documented in the patient's medical record either by, or with an attestation by, an attending physician. Prerequisites for determination of brain death must be included in the documentation.

Time of death:

- If no ancillary test is required, the time of death is the final step of the formal BD/DNC evaluation, namely either: 1) the end of the second neurologic exam consistent with BD/DNC; or 2) the end of the apnea test that is consistent with BD/DNC

- If an ancillary test is required, the ancillary test is the final step of the BD/DNC evaluation, and thus time of death is the time that the attending physician documents in the medical record that ancillary test results are consistent with BD/DNC.

The organ procurement organization must be notified of the time of death. ***No member from the patient care team should coordinate decisions about organ donation with the family.*** If asked about organ donation, members of the care team should indicate that another team handles donation and that team will contact the family at the appropriate time.

VI. Family communication

Patients' family members/loved ones should be invited to observe and ask questions about BD/DNC examinations if they wish.

Per California Health and Safety Code Section 1254.4, if the patient's legally recognized health care decisionmaker, family, or next of kin voices any special religious or cultural practices and concerns of the patient or the patient's family surrounding the issue of BD/DNC, there must be reasonable efforts to accommodate those religious and cultural practices and concerns.

In the event of family request to continue somatic support after the declaration of BD/DNC, a period of brief accommodation should be allowed for the family or next of kin to visit and come to terms with the diagnosis prior to discontinuation of somatic support. If a family wishes for this period of accommodation, they will be allowed a minimum period of 24 hours.

In determining the reasonable period of accommodation the needs of other patients and prospective patients in urgent need of care should be considered.

In the event of a family objection to BD/DNC determination, the care team should consider consulting with Palliative Care, Ethics Committee, and/or Legal.

Supplementary Tables:

Table 1: Metabolic Derangements That May Confound BD/DNC Evaluation	
Metabolic:	
Ammonia	>75 µmol/L
Blood urea nitrogen	>75 mg/dL
Calcium (or ionized calcium)	<7 mg/dL or >11 mg/dL (or <1 mmol/L or >1.3 mmol/L)
Glucose	<70 mg/dL or >300 mg/dL
Magnesium	<1.5 mg/dL or >4 mg/dL
Potassium	<3 mmol/L or >6 mmol/L
Sodium	<130 mmol/L or >160 mmol/L
Acid-Base:	
pH	<7.3 or >7.5
Endocrine:	
Total T4	<3 mg/dL or >30 mg/dL
Free T4	≤0.4 ng/dL or >5 ng/dL

Table 2: Described Spinal Reflexes in BD/DNC	
Decerebrate-type movements	Spontaneous extension of the extremities
Extensor-like posturing	Back arching to the left or right
Eyelid opening	Opening of the eyelids after nipple stimulation
Fasciculation	Twitching of contiguous groups of muscle fibers
Head turning	Intermittent head turning from side to side every 10-30 seconds with or without extension of the upper extremities
Hugging	Flexion of the trunk and movement of the arms in a hugging-like manner
Lazarus sign	Bilateral arm flexion, shoulder adduction, and hand raising to chest, face, or endotracheal tube with dystonic posturing of the fingers
Limb elevation	Raising of limbs off the bed
Myoclonus	Twitching or contraction of a muscle or group of muscles
Plantar response	Plantar flexion
Pronator-extension	Pronation and extension of the upper extremity
Respiratory-like movements	Adduction of both shoulders followed by a slow cough-like movement
Repetitive leg movements	Slight flexion of the leg and foot

Thumbs Up sign	Isolated thumb extension
Triple flexion	Flexion of the thigh, leg, and foot
Undulating toe	Slow flexion then extension of the toes

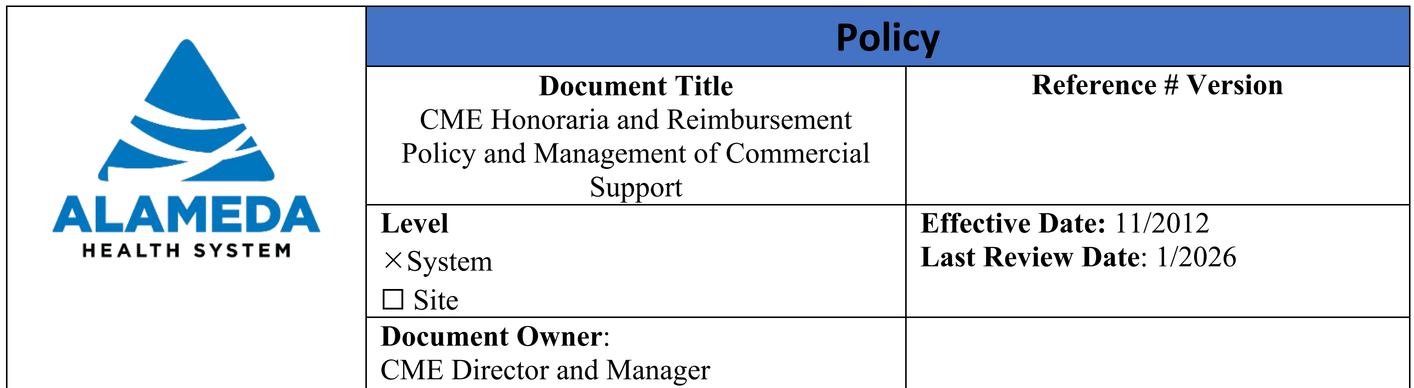
References

- California health and safety Code, section 7181, section 1254.4
- American Academy of Neurology Pediatric and Adult Brain Death/Death by Neurologic Criteria Consensus Guideline. *Neurology* 2023;101:1-21.
- American Academy of Neurology Clinician Guideline Supplement. Update: Determining Brain Death in Adults. *Neurology* 2010;74:1911–1918.
- Sample Brain Death Policy for adaption at an Individual Hospital. Neurocritical Care Society

    The Quality Standards Subcommittee of the American Academy of Neurology. Practice parameters for determining brain death in adults (summary statement). Neurology 1995;45:1012–1014.

Approvals

		System	Alameda	AHS Core
Critical Care Committee	**Date:**		**11/2017**	**4/2018**
Donor Network West	**Date:**	**9/2017**		
Patient Care Leadership Team	**Date:**	**4/2018**		
Clinical Practice Council	**Date:**	**5/2018 7/2022 5/2026**		
Medical Executive Committee	**Date:**	**7/2022 5/2026**		
Board of Trustees	**Date:**	**9/2022 6/2026**		



	Policy	
ALAMEDA HEALTH SYSTEM	**Document Title** CME Honoraria and Reimbursement Policy and Management of Commercial Support	**Reference # Version**
	Level × System ☐ Site	**Effective Date:** 11/2012 **Last Review Date**: 1/2026
	Document Owner: CME Director and Manager	

POLICY STATEMENT

This policy sets parameters for honoraria and expense reimbursements for speakers and presenters (faculty) at AHS Continuing Medical Education (CME) activities and outlines the appropriate management of commercial support in compliance with the *ACCME Standards for Integrity and Independence* (CME Standards)

PURPOSE

The policy for providing honoraria and reimbursement of out-of- pocket expenses for speakers/presenters (faculty) at AHS CME activities and policy for management of commercial support ensures compliance with the CME Standards and that accredited education remains independent and without commercial bias or influence.

SCOPE

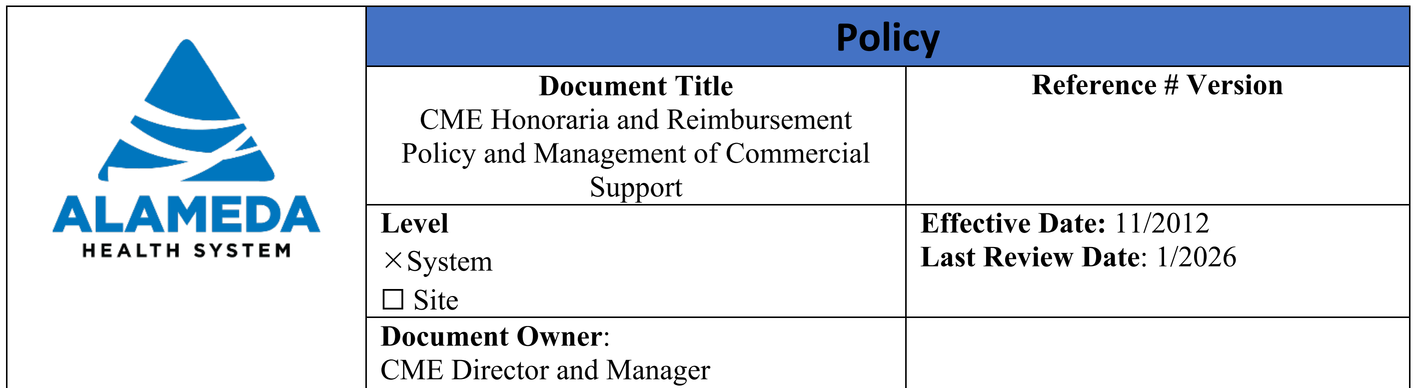
AHS departments conducting or sponsoring CME activities may provide honoraria and/or reimbursement to guest (non-AHS) faculty presenting at AHS CME activities. (Honorarium is not provided to AHS faculty presenting at AHS CME activities) However, not all departments provide honoraria and/or reimbursement to guest faculty, and it is up to each department conducting or sponsoring the CME activity to determine if an honorarium and/or reimbursement will be provided. If a department chooses to provide honoraria and/or reimbursement for guest faculty, it must be approved by the CME department before the activity and provided in alignment with this policy.

If a department is considering commercial support for a CME activity, it must be brought to the attention of the CME Department and then approved by the CME Committee prior to accepting. Commercial support must be managed in alignment with the CME Standards and this policy.

DEFINITIONS

A CME ineligible company (formerly called a commercial interest): is defined as, "*those whose primary business is producing, marketing, selling, re-selling, or distributing healthcare products used by or on patients*" Examples include pharmaceutical and medical device companies. Note: organizations that provide clinical services directly to patients or that provide education to healthcare professionals are not considered ineligible companies unless they are owned or controlled by an ineligible company.

Commercial Support: is defined as financial or in-kind support for a CME activity provided by a CME ineligible company.



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CME activity: An educational activity that awards *AMA PRA Category 1 Credit™* (CME credit) to physicians.

CME Standards: refers to the CME accreditation rules outlined in the Accreditation Council for Continuing Medical Education (ACCME) *Standards for Integrity and Independence in Accredited Continuing Education*

RESPONSIBILITIES

See policy scope and procedures.

POLICY

Honoraria

1. Honoraria may be provided to a speaker/presenter (faculty) of a CME activity in the amount of up to $500 after the completion of the activity. This level may only be exceeded by a vote of the full CME Committee. The maximum honoraria that can be provided is $1000.
2. The exact amount of honoraria must be communicated to the faculty in writing.
3. Payment of honoraria and/or reimbursement will be made directly by AHS.
4. Faculty <u>may not accept</u> direct payments from ineligible companies for presenting at a CME activity.

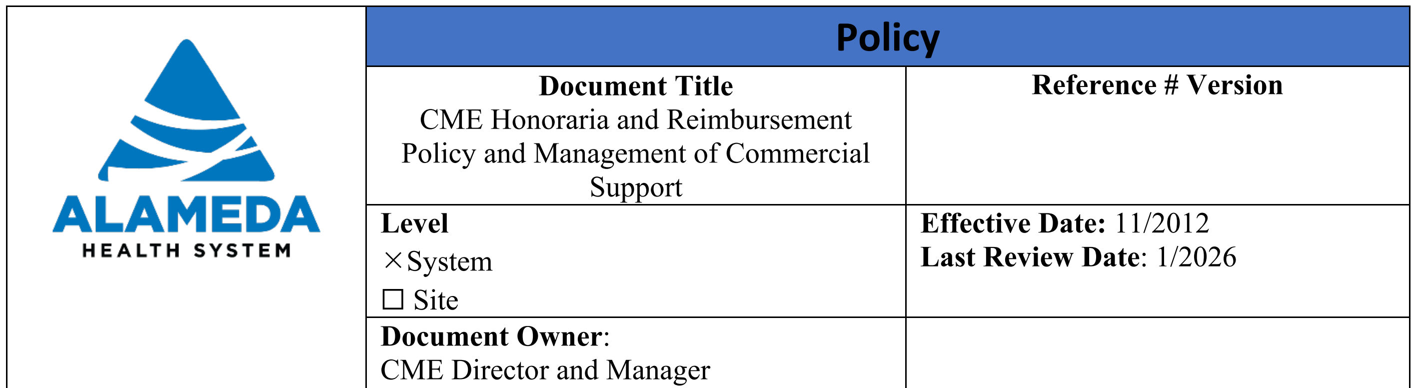
Reimbursement of Expenses

1. Reimbursement for reasonable out-of-pocket expenses may be provided when agreed upon in advance, approved by the CME committee and upon receipt of an itemized expense report.
2. The maximum reimbursement amounts are: $150 per day for lodging and/or travel (limited to coach/economy) and $70 per day for meals (with no single meal more than $40)

Management of Commercial Support in CME

1. **Decision making and disbursement**:

- The CME Committee must vote to approve commercial support before it can be accepted.
- AHS, the accredited CME provider, must make all decisions regarding the receipt and disbursement of the commercial support. Ineligible companies <u>may not pay</u> directly for any of the expenses related to the CME activity.
- <u>AHS may use</u> commercial support to 1) fund honoraria and/or expense reimbursement for faculty (presenters/speakers) at the CME activity or 2) to defray or eliminate the cost for <u>all</u> learners attending the CME activity
- <u>AHS may not use</u> commercial support to pay expenses for individual learners or groups of learners.



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	Document Owner: CME Director and Manager	

2. **Agreement**: The amount, terms, conditions, and purpose of the commercial support must be documented in an agreement between AHS, the accredited CME provider, and the ineligible company providing the support. The agreement must be signed by both AHS and the company prior to the start of the CME activity.
3. **Accountability**: AHS must keep a record of the amount or kind of commercial support received and how it was used, and must produce that accounting, upon request, by the accrediting body or by the ineligible company that provided the commercial support.
4. **Disclosure to learners:** The name of the ineligible company that gave the commercial support, and the nature of the support if it was in-kind, must be disclosed to the learners prior to the CME activity. Disclosure should not include the companies' corporate or product logos, trade names, or product group messages.

Prevent Bias and Marketing in CME

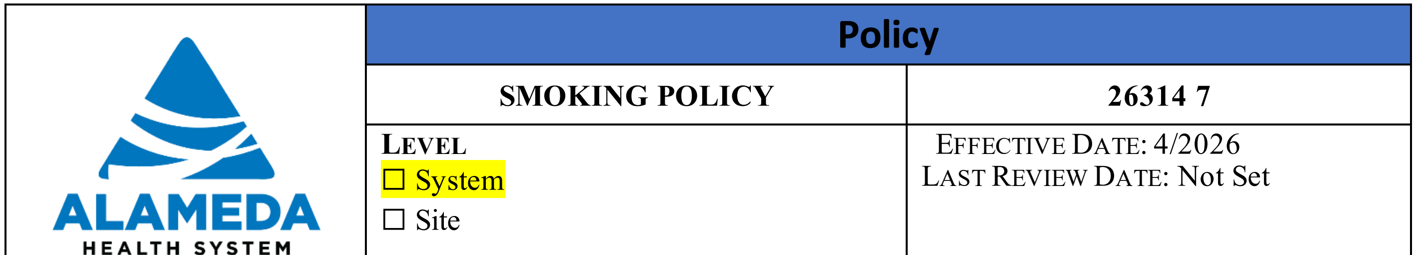
1. All decisions related to planning, topic/faculty selection, delivery, and evaluation of CME activities are made without any influence or involvement from the owners or employees of ineligible companies (with three exceptions described in the ACCME *Standards*).
2. CME must be free of promotion, marketing, or sales. Faculty must not actively promote or sell products or services that serve their professional or financial interests.

REFERENCES

Accreditation Council for Continuing Medical Education (ACCME) *Standards for Integrity and Independence in Accredited Continuing Education*
ACCME STANDARD 2: *Prevent Commercial Bias and Marketing in Accredited Continuing Education*
ACCME STANDARD 4: *Manage Commercial Support Appropriately*

ATTACHMENTS

None



ALAMEDA HEALTH SYSTEM	Policy	
	SMOKING POLICY	26314 7
	LEVEL ☐ System ☐ Site	EFFECTIVE DATE: 4/2026 LAST REVIEW DATE: Not Set

POLICY STATEMENT

The Alameda Health System (AHS) is committed to the promotion of health. Smoking related illnesses (including those related to environmental smoke) comprise the largest proportion of preventable diseases. AHS recognizes that smoking and/or smoke-filled environments are both a health and fire hazard, and that all individuals on the AHS grounds and facilities have a social and/or legal right to a safe, healthy, and comfortable environment. As a health care organization, we have a clear obligation to promote health and discourage tobacco use, and to ensure no one is involuntarily exposed to smoke while in the facilities. This policy is intended to delineate the rights of both smokers and nonsmokers. It applies to employees, contractors, patients, visitors, vendors, and all other people entering the facility.

SCOPE

It is the policy of the Alameda Health System (AHS) that the use of any smoking materials1 is prohibited in all enclosed facilities, covered parking areas and any public entrance areas. This restriction includes patients/resident rooms, work areas, hallways, stairways, employee lounges, cafeterias, private enclosed offices/spaces, restrooms, waiting rooms, auditoriums, elevators, classrooms, meeting rooms, exam rooms, AHS owned vehicles, entrance areas, outside grounds, and parking areas.

Smoking is prohibited within or on the grounds of all campuses of the Alameda Health System with the exception of the designated area at Fairmont Bldg. B.

POSTING AND NOTIFICATION:

1. All major entrances will display signs indicating no smoking and that smoking is prohibited in all areas of the campus.
2. “No Smoking” signs, with the international no-smoking symbol, with letters at least 1inch in height shall be clearly and conspicuously posted at all entrances and other areas where smoking is prohibited. The sign shall include the ordinance number and the telephone number to report violations. These signs will not be posted on the SNF building.
3. All patients will be informed of the policy upon admission to the hospital. Information will also be included in all pre-admission literature.
4. All new employees are informed of the smoking policy and designated areas upon hire via verbal and written communications.
5. Contract staff are informed of the policy and the designated smoking areas by the manager responsible for the contract.

RESPONSIBILITIES

The smoking prohibition applies to inpatients, outpatients, visitors and staff.

1. Inpatients
   a. Inpatients are prohibited from smoking.
   b. All patients admitted to the hospital will be assessed for history of tobacco use by Nursing team.

approval

c. Those patients indicating a history of current tobacco use will be offered smoking cessation education and will be evaluated for appropriate pharmacotherapy, which will be offered if appropriate.

d. This assessment and education about cessation programs and therapies will be documented in the patient's medical record.

2. Visitors/Contractors/Outpatients

a. Visitors, including contractors and vendors, and outpatients shall not smoke on AHS premises.

b. AHS primary care clinic providers will assess outpatients for smoking cessation readiness and if desired, offer pharmacotherapy and smoking cessation education.

3. Staff

a. Employees, physicians, volunteers, trainees and students shall not smoke on campuses.

PROCEDURES

ENFORCEMENT:

1. All executives, directors, managers, supervisors, contractors, employees, physicians and volunteers are responsible for enforcing this policy. This includes educating personnel and visitors to smoking restrictions.
2. Department managers are responsible for ensuring that staff assigned to their respective departments adheres to this policy. Violation of this policy will be grounds for disciplinary action.
3. In the event a staff member observes a violation, s/he should advise the individual of the policy. The staff members should explain the policy with courtesy and avoid engaging in a confrontational exchange.
4. Failure to comply with this policy by anyone should be referred to a manager or supervisor in the area where the violation occurs.
5. Physicians are encouraged to offer alternative therapy for patients who smoke, i.e., nicotine patches, gum, etc., as clinically indicated. For patient/residents who fail to comply with the smoking restrictions, please refer to the policy on "Disruptive and Illegal Behavior" in the Administrative Manual.
6. The Alameda County Sheriff's has the authority to issue citations to anyone found smoking in areas other than designated smoking areas.

PERSONNEL PRACTICES:

1. All current and new employees, volunteers and medical staff will be provided with a copy of this smoking policy or a policy statement upon employment and in all orientation literature.
2. It will not be a practice of AHS to have a hiring preference for non-smokers over smokers. No person or employer will refuse to hire or retaliate in any way against an applicant or employee for exercising the rights afforded by this policy.

approval

3. Abuse or disregard of provisions of this policy will be handled in the same manner as persistent regard of any other hospital policy, i.e., verbal correction, written warning, up to and including suspension and termination.

This policy complies with applicable fire and life safety regulations, including NFPA 101 and NFPA 99 as adopted by CMS and accepted by The Joint Commission. Where applicable, the most stringent code or regulatory requirement shall govern.

approval

Policy	
Scope of Assessment Policy	**Reference # tbd**
Level ☐ System ☐ Site	**Effective Date:** 6/2026

POLICY STATEMENT

PURPOSE

To ensure a qualified rehabilitation therapist designed an age specific and individually based patient treatment plan.

SCOPE

To determine and establish a written treatment plan or plan of care that is based on the prescription of the referring provider and the age specific individual needs of the patient as they present. The assessment of each patient referred to Rehabilitation Services (Physical Therapy, Occupational Therapy and Speech Pathology) will be performed by a qualified licensed/registered therapist and shall include the following:

POLICY

1. The Initial Assessment shall include information gathered by the rehab discipline specific therapist and can include, but would not be limited to, documentation of:
   a. General demographics
   b. Subjective complaints
   c. History of presenting dysfunction
   d. Related Medical/Surgical History to the presenting dysfunction
      i. Social, cultural, religious, psychological/psychiatric conditions, emotional barriers, physical or cognitive limitations, educational level, alcohol/chemical dependency, or personal preferences that can adversely impact functional rehabilitation potential
   e. Review of systems that could relate to the primary dysfunction or have an effect on the rehabilitation potential (e.g., cardiovascular, respiratory, musculoskeletal, etc.)
   f. Patient expectations and goals for therapy/rehabilitation treatment.
   g. Primary medical diagnosis/ICD-10 code, therapist diagnosis (impairment, activity limitations, or participation restrictions)
   h. Muscle test in involved region. PT/OT
   i. Range of motion in involved region. PT/OT
   j. Presence of neurological involvement. If YES; [PT/OT/Speech address items– i - xvi]
      i. Sensory proprioception testing
      ii. Detailed manual muscle testing
      iii. Synergistic pattern assessment
      iv. Gait analysis
      v. Muscle tone assessment
      vi. Perceptual motor assessment
      vii. Vestibular assessment
      viii. Reflex testing ix. Coordination
      x. Visual/perceptual motor skills

xi. Hand dominance xii. Communication Status
xiii. Hearing
xiv. Speech
xv. Language
xvi. Cognitive-Language
xvii. Voice xviii. Modes of Expression

k. Presence of swallowing dysfunction. If YES - SPEECH addresses items
1. Bedside swallowing evaluation ii. Modified Barium Swallow Study

l. Presence of cardiopulmonary dysfunction. If YES – PT/OT
i. Respiratory pattern
ii. Physiological parameters
iii. Medically imposed restrictions
iv. Vital signs n. Pain, including location, objective findings and subjective description by patient. PT/OT

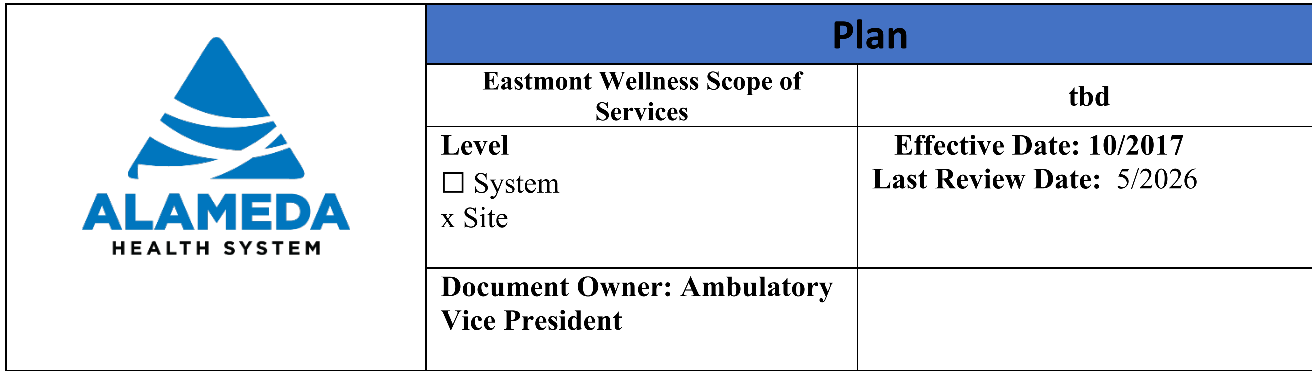
o. Prior functional level.
p. Functional assessment; current dysfunction and problems related to dysfunction.
q. Educational needs of the patient/family/care giver.
r. Proposed treatment plan for rehabilitation.
s. Special procedures anticipated (e.g., referral to another discipline or community resource).
t. Short/Long term goals with projected dates of meeting the goals.
u. Frequency and anticipated duration of treatment.
v. Assisted devices used and/or anticipated.
w. Summary of current clinical condition.
x. Patients' agreement with, and/or understanding of the treatment goals, plan, and duration.
y. Time frame for re-evaluation.
z. Rehabilitation potential/prognosis for restoration of function.
aa. Discharge needs.
bb. Therapist signature and professional designation. Electronic entries will be made with appropriate security and confidential provisions.

2. The therapist will refer to the provider and/or other multi-disciplinary team members the need for further assessment;
   a. For any abnormality previously not reported,
   b. Or for problems which the therapist is untrained to manage, whether by education, experience, or current department/facility services.
   c. Patients who have been identified as having special needs, victims of abuse or neglect, having drug or alcohol dependencies, or displaying behavioral disorders will be referred as per hospital policy to social services for assessment.

3. From the initial assessment the therapist will contribute an analysis of clinical status, the appropriate setting for services, treatment plan, goals and discharge needs.
    a. The therapist will be available to meet and confer regarding acute inpatient care planning and provide documentation in the combined progress note of the medical record.
    b. All assessments will be initiated within 48 hours from receipt of orders.
4. Assessments will be kept in a consistent location so to be available to all disciplines.

REFERENCES

The scope of practice of a physical therapist (PT) is defined in Business and Professions Code Section 2620. The scope of practice of an occupational therapist (OT) is defined in Business and Professions Code Section 2570.2. The scope of practice for speech-language pathologists (SLPs) is defined by the American Speech-Language-Hearing Association (ASHA)



	Plan	
	Eastmont Wellness Scope of Services	**tbd**
	Level ☐ System x Site	**Effective Date: 10/2017** **Last Review Date:** 5/2026
	Document Owner: Ambulatory Vice President	

PURPOSE / OBJECTIVE

The Ambulatory Care Division is a comprehensive network of primary care and specialty care with a supporting network of diagnostic services that provides patients with a full range of health services. Care is provided for patients of all ages. Ambulatory patient care is provided via a multi-disciplinary approach with collaboration among the various support services and providers. Each patient is provided the opportunity to establish an ongoing relationship with a primary care provider and multi-disciplinary team who manage care for that individual, including individual disease management, chronic disease management, preventive health education, screening, and immunizations. Access to specialty care services is arranged through the patient's primary care provider, in consultation with the sub-specialist. Alameda Health System (AHS) provides the patient with care, treatment, and services according to his or her individualized plan of care. The organization communicates with the patient during the provision of care, treatment and services in a manner that meets the patient's oral and written communications needs. Patient assessments are based on need. Phone consultation is available by a registered nurse (who follow approved protocols) and medical provider staff. Comprehensive history and assessment are made for new patients to establish care and develop the provider-patient relationship. Standard screening tools, point of care laboratory tests and clinical assessment by licensed staff are used as indicated for the patient's age, preventive health needs, symptoms, and management of acute and chronic disease. In addition, population health strategies are utilized to manage patients' preventive and chronic care needs.

SCOPE

All Ambulatory departments within Eastmont Wellness Center
Hours of Operation: Monday – Friday, 8am-5pm

Primary Care

1. Adult Medicine
2. Pediatrics
3. Adult and Pediatric Dental
4. Optometry
5. OB/GYN
6. Comprehensive Perinatal Services Program
7. Behavioral Health

8. Psychiatry
9. Health Education/Chronic Care
10. Refugee Screening and Immigration
11. Radiology (plane films, mammogram, ultrasound)
12. Laboratory

Specialty Care

1. Dermatology
2. Ophthalmology
3. Orthopedics
4. Podiatry
5. Rheumatology
6. Endocrinology
7. Urogynecology
8. Pelvic Pain

DEFINITIONS

HEDIS- HEALTHCARE EFFECTIVENESS DATA AND INFORMATION SET
PDSA- PLAN, DO, STUDY, ACT

RESPONSIBILITIES

Administration and Organization
The Ambulatory Division is led by the Associate Chief Medical Officer for Ambulatory with oversight for both medical and administrative direction and performance. The Ambulatory Vice President has administrative and operational lead responsibilities. The ambulatory Directors offer additional system support for their areas of expertise. At the site level, the Medical Director is responsible for implementing the policies established by the Medical Staff of Alameda Health System and assuring quality, safety, and appropriateness of patient care. The Designated clinical operations leader is responsible for the daily operations of the clinic and the implementation of organizational policies and procedures as well as regulatory requirements. The dyad of Medical Director and Designated clinical operations leader collaborate to direct services that align with the Ambulatory Division goals and the needs of the

community. The nursing supervisor(s) direct and develop the nursing staff to ensure coordinated, safe, and quality care is provided to the patients. The Patient Services Supervisors oversee the registration and scheduling staff.

Performance Improvement
The Ambulatory Division sets annual performance and quality goals to ensure continuous improvement to meet the healthcare needs of the community. These goals are based on changes/trends to healthcare delivery and quality improvement for identified clinical metrics comparing performance to community and national standards (ex. HEDIS). Alameda Health System participates in the Quality Incentive Program through State of California Department of Healthcare Services. The AHS quality department and the ambulatory division have staff assigned to support and lead quality improvement. In addition to division goals, individual sites utilize PDSA and LEAN methodologies to improve care.

Appointment Process

Primary Care

Primary Care appointments are scheduled through the Ambulatory Care Call Center. Urgent appointments are available as well as nurse advice during business hours to assess and direct patients to care. Afterhours patients are directed to an on-call medical provider for urgent medical advice. Patients requiring emergent care are directed to a local emergency department and if required, an ambulance is called for patients who are in the clinic.

Specialty Care

Specialty clinics require a referral from an authorized medical provider. The electronic referral system and electronic health record are used to electronically manage referrals from within Alameda Health System and the referring community.

Staffing

The inter-disciplinary healthcare team includes physicians, medical residents, pharmacists, nurse practitioners, physician assistants, nurse midwives, nurses (RNs, LVN's), medical assistants, nutritionists, social workers, outreach workers and registration personnel.

Education and Competency

Each member of the healthcare team holds current licensure/certification in his or her clinical area of expertise, as required. Physician, Physician Assistant and Nurse Practitioner	In accordance with the Medical Staff Bylaws
RN	Current California RN License Current Basic Life Support Certification *Experience and certification in accordance with unit requirement
LVN	Current California LVN License Current BLS Certification IV Certification (Required for specific positions)
Medical Assistants	Completion of a Certified Medical Assistant Program Certification by AAMA, CCBMA, AMT, NCCT/MMCI Current Basic Life Support Certification
LCSW	MSW, Licensed with State of CA
Registered Dietician	Registered with Commission of Dietetic Registration
Clinical Diabetic Educator	National Certification Board of Diabetes Educators certified
Laboratory	Licensed phlebotomist
Certified Nurse midwife	CA Licensed and Certified Nurse Midwife
Licensed RDA	CA licensed Registered Dental Assistant
Certified Ophthalmic Tech	COT Certification
Pharmacist	CA Licensed Pharmacist and PharmD
Pharmacy Technician	CA State licensed pharmacy technician

<u>Primary Care Procedures</u>

Adult Medicine (includes Mobile Health)

1. Joint injections

2. Peak Flow measurement
3. Incision and Drainage
4. Ear irrigation
5. Breathing treatment (nebulizer)
6. Cryotherapy
7. Suture Removal (minor lacerations)
8. Foreign body removal: eye, nose, or ear
9. Local anesthetic techniques including trigger point injections.
10. Carpel tunnel injections
11. Trigger finger injections.

OB/GYN services

1. Biopsy of cervix, vulva, vagina
2. Colposcopy
3. Cryosurgery
4. Endometrial Biopsy
5. Incision and Drainage of abscess
6. Removal of Condylomas
7. Removal and insertion of long-acting reversible contraception
8. OB Ultrasound

Pediatrics

1. Breathing Treatment (Nebulizer)
2. Suture Removal (minor lacerations)
3. Fluoride Varnish
4. Foreign body removal
5. Wart removal
6. Heel sticks phlebotomy for bilirubin draws.
7. Incision and Drainage of abscesses
8. Ear irrigation
9. Venipuncture
10. Urine catheterization
11. Umbilical granuloma chemical cautery

Dental

1. Exam
2. X-rays
3. Cleanings (Periodontics)
4. Deep cleanings (Periodontics)
5. Fillings (restorative dentistry)
6. Root canals

7. Dentures
8. Fixed prosthodontics (Crowns/Bridges)
9. Implant Crowns
10. Partials
11. Extractions (routine & surgical)
12. Fluoride varnish/ Sealants
13. Crown Lengthening (Periodontics)

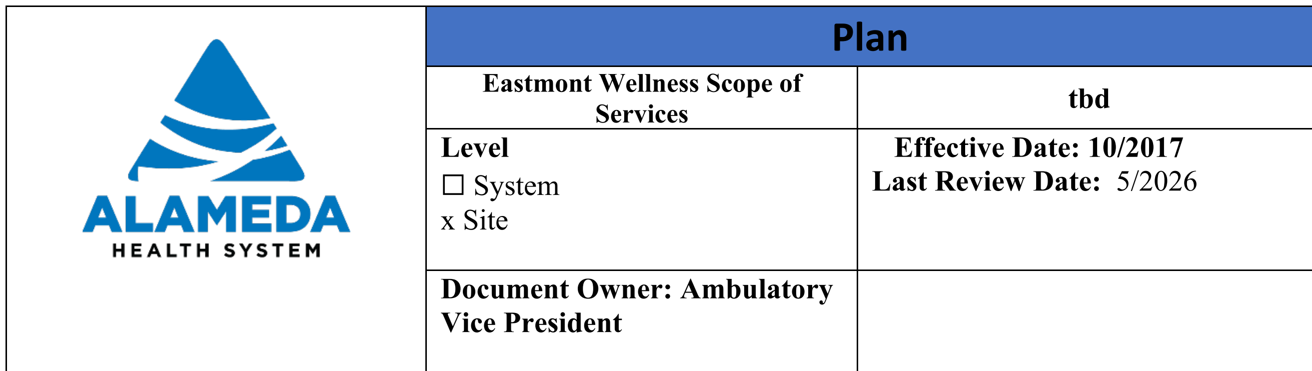
Specialty Clinic Procedures

Dermatology

1. Skin scraping for identification of fungi or parasites.
2. Punch or excision biopsy for diagnosis.
3. Excision of small basal cell or squamous cell carcinoma
4. Injection of keloids and scans with steroids
5. Cautery of benign lesions
6. Liquid Nitrogen therapy to benign and pre-malignant lesions
7. Incision and drainage of abscesses
8. Intralesional steroid injections for alopecia areata and hidradenitis supp
9. Electrodessication and curettage

Orthopedics

1. Superficial wound debridement
2. Arthrocentesis



3. Injections of joints, bursa, tendon sheaths
4. Incision and Drainage

Rheumatology
1. Injections of joints, bursa, tendon sheaths

Optometry
1. Optical Coherence Tomography
2. Complete eye examinations
3. Visual fields testing
4. Refractions

Ophthalmology
1. Suture removal (post-operative)
2. B-Scan of posterior ocular chamber (use of ultrasound Eye scanner)
3. Pan Retinal photocoagulation (use of Argon laser in the prevention of diabetic eye disease)
4. Peripheral laser iridotomy (use of laser in the prevention of or treatment of acute narrow angle glaucoma)
5. Intravitreal injections (used to treat infection or treat exudative age-related macular degeneration)
6. Retinal Cryopexy: Treatment of peripheral retinal tears
7. Chalazion Excision
8. Punctal irrigation
9. Foreign Body removal
10. Cross-linking

Podiatry
1. Application of skin substitute grafts
2. Ulcer debridement
3. Injections of joints, tendon sheath for foot and ankle joints

4. Nerve block
5. Biopsy
6. Suture removal
7. Laceration repair
8. Incision and Drainage
9. Superficial hardware and foreign body removal
10. Trim skin lesion
11. Nail avulsion and Matrixectomy.
12. Cast, brace and splint application and removal.
13. Destruction of benign lesion
14. Nail Care

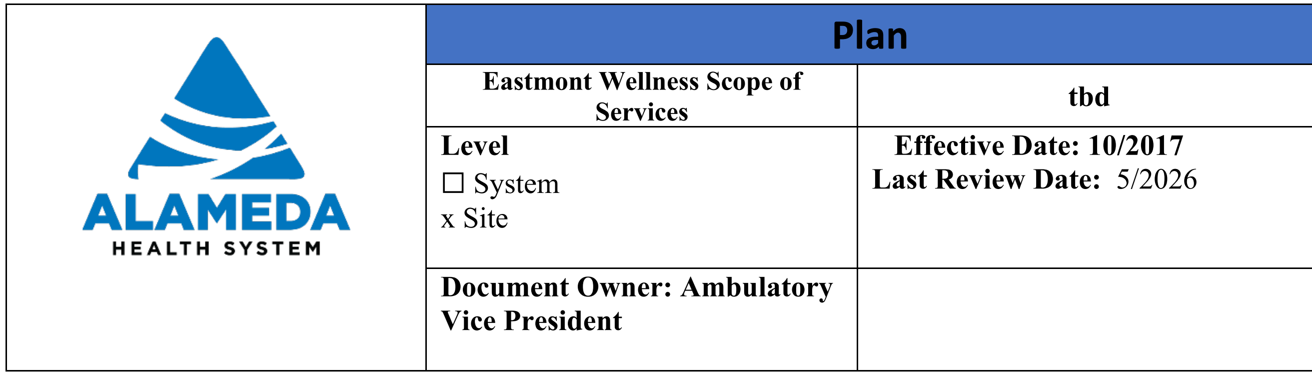
Urogynecology

Conditions treated:

1. Pelvic organ prolapse.
2. Stress urinary incontinence.
3. Overactive bladder
4. Fistulas between pelvic organs
5. Mesh complications
6. Anal incontinence
7. Urethral diverticulum
8. Vaginal/Vulvar mass
9. Vaginal/Vulvar pain
10. Bladder pain syndrome
11. Voiding dysfunction

Procedures:

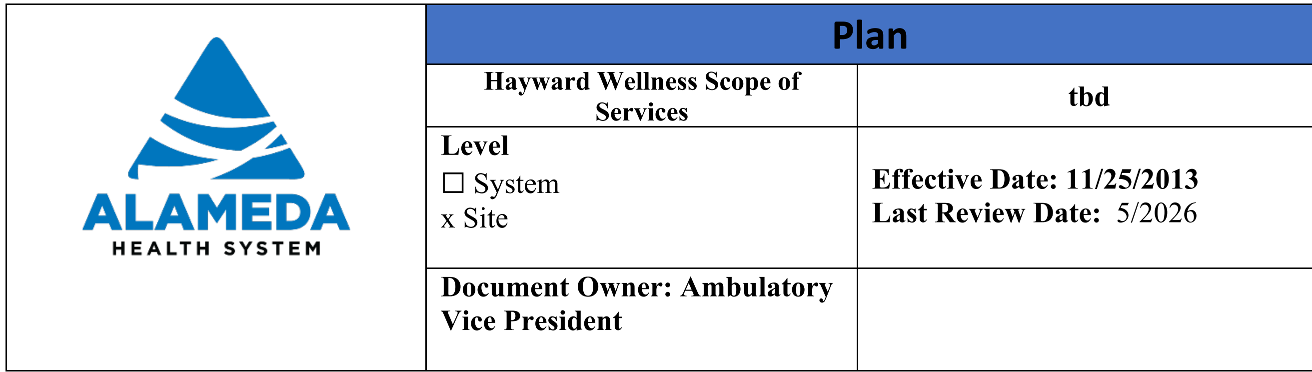
1. Catheterization procedures
2. Voiding trials
3. Cystoscopy
4. Post void residual.
5. Urodynamic testing



ATTACHMENTS
Not Applicable

APPROVAL(S):

Approving Committee / Executive	Date of Approval



	Plan	
	Hayward Wellness Scope of Services	tbd
	Level ☐ System x Site	**Effective Date: 11/25/2013** **Last Review Date:** 5/2026
	Document Owner: Ambulatory Vice President	

PURPOSE / OBJECTIVE

The Ambulatory Care Division is a comprehensive network of primary care and specialty care with a supporting network of diagnostic services that provides patients with a full range of health services. Care is provided for patients of all ages. Ambulatory patient care is provided via a multi-disciplinary approach with collaboration among the various support services and providers. Each patient is provided the opportunity to establish an ongoing relationship with a primary care provider and multi-disciplinary team who manage care for that individual, including individual disease management, chronic disease management, preventive health education, screening, and immunizations. Access to specialty care services is arranged through the patient's primary care provider, in consultation with the sub-specialist. Alameda Health System (AHS) provides the patient with care, treatment, and services according to his or her individualized plan of care. The organization communicates with the patient during the provision of care, treatment and services in a manner that meets the patient's oral and written communications needs. Patient assessments are based on need. Phone consultation is available by a registered nurse (who follow approved protocols) and medical provider staff. Comprehensive history and assessment are made for new patients to establish care and develop the provider-patient relationship. Standard screening tools, point of care laboratory tests and clinical assessment by licensed staff are used as indicated for the patient's age, preventive health needs, symptoms, and management of acute and chronic disease. In addition, population health strategies are utilized to manage patients' preventive and chronic care needs.

SCOPE

All Ambulatory departments within Hayward Wellness Center
Hours of Operation: Monday – Friday, 8am-5pm

Primary Care

1. Adult Medicine
2. Adult Immunology
3. Behavioral Health
4. Integrative Medicine
5. Obstetrics
6. Gynecology
7. Pediatrics

8. Health Education (including Nutrition)
9. Laboratory

Specialty Care

1. Cardiology
2. Dermatology
3. General Surgery
4. Optometry
5. Podiatry
6. Nephrology
7. Rheumatology
8. Pulmonary

Definitions

HEDIS- Healthcare Effectiveness data and information set
PDSA- Plan, DO, Study, Act

Responsibilities

Administration and Organization
The Ambulatory Division is led by the Associate Chief Medical Officer for Ambulatory with oversight for both medical and administrative direction and performance. The Ambulatory Vice President has administrative and operational lead responsibilities. The ambulatory Directors offer additional system support for their areas of expertise. At the site level, the Medical Director is responsible for implementing the policies established by the Medical Staff of Alameda Health System and assuring quality, safety, and appropriateness of patient care. The Practice Manager is responsible for the daily operations of the clinic and the implementation of organizational policies and procedures as well as regulatory requirements. The dyad of Medical Director and Practice Manager collaborate to direct services that align with the Ambulatory Division goals and the needs of the community. The nursing supervisor(s) direct and develop the nursing staff to ensure coordinated, safe, and quality care is provided to the patients. The Patient Services Supervisors oversee the registration and scheduling staff.

Performance Improvement
The Ambulatory Division sets annual performance and quality goals to ensure continuous improvement to meet the healthcare needs of the community. These goals are based on changes/trends to healthcare delivery and quality improvement for identified clinical metrics comparing performance to community and national standards (ex. HEDIS). Alameda Health System participates in the Quality Incentive Program through State of California Department of Healthcare Services. The AHS quality department and the ambulatory division have staff assigned to support and lead quality improvement. In addition to division goals, individual sites utilize PDSA and LEAN methodologies to improve care.

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Primary Care
Primary Care appointments are scheduled through the Ambulatory Care Call Center. Urgent appointments are available as well as nurse advice during business hours to assess and direct patients to care. Afterhours patients are directed to an on-call medical provider for urgent medical advice. Patients requiring emergent care are directed to a local emergency department and if required, an ambulance is called for patients who are in the clinic.

Specialty Care
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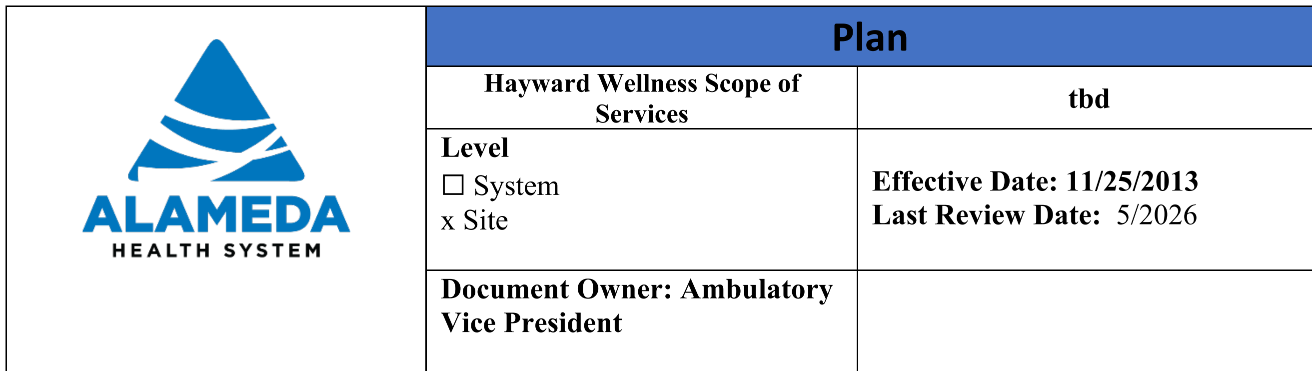
Staffing
The inter-disciplinary healthcare team includes physicians, medical residents, pharmacists, nurse practitioners, physician assistants, nurse midwives, nurses (RNs, LVN's), medical assistants, nutritionists, social workers, outreach workers and registration personnel.

Education and Competency

Each member of the healthcare team holds current licensure/certification in his or her clinical area of expertise, as required. Physician, Physician Assistant and Nurse Practitioner	In accordance with the Medical Staff Bylaws



RN	Current California RN License Current Basic Life Support Certification *Experience and certification in accordance with unit requirement
LVN	Current California LVN License Current BLS Certification IV Certification (Required for specific positions)
Medical Assistants	Completion of a Certified Medical Assistant Program Certification by AAMA, CCBMA, AMT, NCCT/MMCI Current Basic Life Support Certification
LCSW	MSW, Licensed with State of CA
Registered Dietician	Registered with Commission of Dietetic Registration
Clinical Diabetic Educator	National Certification Board of Diabetes Educators certified
Laboratory	Licensed phlebotomist
Certified Nurse midwife	CA Licensed and Certified Nurse Midwife
Licensed RDA	CA licensed Registered Dental Assistant
Certified Ophthalmic Tech	COT Certification
Pharmacist	CA Licensed Pharmacist and PharmD
Pharmacy Technician	CA State licensed pharmacy technician

Primary Care Procedures

Adult Medicine

1. Joint injections
2. Incision and Drainage
3. Ear irrigation
4. Breathing treatment (nebulizer)
5. Joint injections
6. Incision and Drainage
7. Foreign body removal
8. Minor surgical procedures involving nails, skin, subcutaneous tissue.
9. Wound care

10. Skin biopsy and cryotherapy
11. Laceration repair
12. Suture removal
13. Debridement and care of minor superficial burns
14. Treatment of first and/ or second-degree burns
15. Skin tests performance and reading
16. Soft tissue and trigger point injections
17. Musculoskeletal injections
18. Splinting
19. Management of uncomplicated minor closed fractures and dislocations
20. Pap smear and endocervical culture

Women's' services

1. Biopsy of cervix, vulva, vagina
2. Colposcopy
3. Endometrial Biopsy
4. I & D of abscess
5. Removal and insertion of Long-Acting Reversible Contraceptives

Pediatrics

1. Breathing Treatment (Nebulizer)
2. Suture Removal (minor lacerations)
3. Fluoride Varnish
4. Foreign body removal
5. Wart removal
6. Heel sticks phlebotomy for bilirubin draws.
7. Incision and Drainage of abscesses
8. Ear irrigation
9. Venipuncture
10. Urine catheterization
11. Umbilical granuloma chemical cautery

<u>Specialty Clinic Procedures</u>

Dermatology

1. Skin scraping for identification of fungi or parasites.
2. Punch or excision biopsy for diagnosis.
3. Excision of small basal cell or squamous cell carcinoma
4. Injection of keloids and scars with steroids
5. Cautery of benign lesions

6. Liquid Nitrogen therapy to benign and pre-malignant lesions
7. Incision and drainage of abscesses

General Surgery

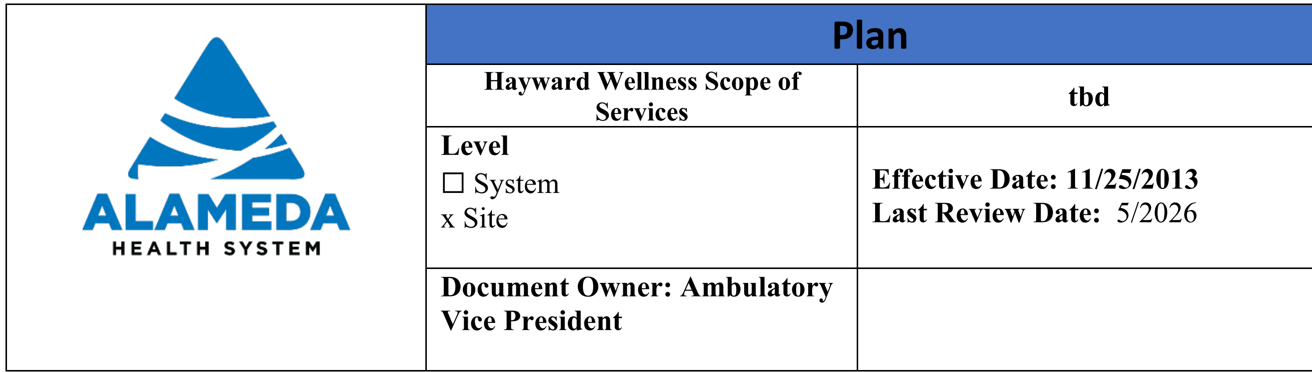
1. Needle aspiration for cytology.
2. Needle/excisional biopsy.
3. Debridement of superficial wounds
4. I & D
5. Foreign body removal
6. Dressing changes
7. Wound Culture

Optometry

1. Optical Coherence Tomography
2. Complete eye examinations
3. Visual fields testing
4. Refractions

Podiatry

1. Application of skin substitute grafts
2. Ulcer debridement
3. Injections of joints, tendon sheath for foot and ankle joints
4. Nerve block
5. Biopsy
6. Suture removal



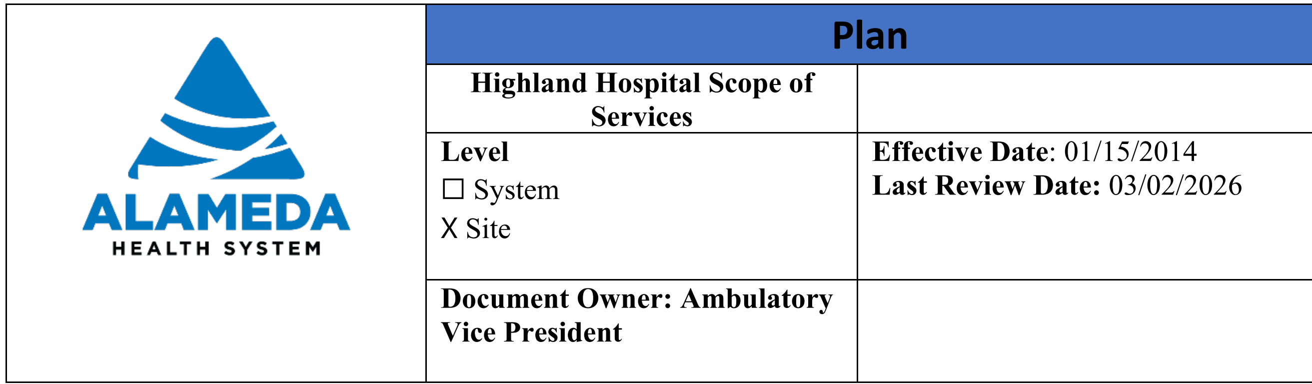
7. Laceration repair
8. Incision and Drainage
9. Superficial hardware and foreign body removal
10. Trim skin lesion
11. Nail avulsion and Matrixectomy.
12. Cast, brace and splint application and removal.
13. Destruction of benign lesion
14. Nail Care

ATTACHMENTS

Not Applicable

APPROVAL(S):

Approving Committee / Executive	Date of Approval



	Plan	
ALAMEDA HEALTH SYSTEM	**Highland Hospital Scope of Services**	
	Level ☐ System X Site	**Effective Date**: 01/15/2014 **Last Review Date:** 03/02/2026
	Document Owner: Ambulatory Vice President	

PURPOSE / OBJECTIVE

The Ambulatory Care Division is a comprehensive network of primary care and specialty care with a supporting network of diagnostic services that provides patients with a full range of health services. Care is provided for patients of all ages. Ambulatory patient care is provided via a multi-disciplinary approach with collaboration among the various support services and providers. Each patient is provided the opportunity to establish an ongoing relationship with a primary care provider and multi-disciplinary team who manage care for that individual, including individual disease management, chronic disease management, preventive health education, screening and immunizations. Access to specialty care services is arranged through the patient's primary care provider, in consultation with the sub-specialist. Alameda Health System (AHS) provides the patient with care, treatment and services according to his or her individualized plan of care. The organization communicates with the patient during the provision of care, treatment and services in a manner that meets the patient's oral and written communications needs.
Patient assessments are based on need. Phone consultation is available by a registered nurse (who follow approved protocols) and medical provider staff. Comprehensive history and assessment is made for new patients to establish care and develop the provider-patient relationship. Standard screening tools, point of care laboratory tests and clinical assessment by licensed staff are used as indicated for the patient's age, preventive health needs, symptoms and management of acute and chronic disease. In addition, population health strategies are utilized to manage patients' preventive and chronic care needs.

SCOPE

All AHD Ambulatory departments within Highland Hospital Campus
Hours of Operation: Monday – Friday, 8am-5pm

Primary Care

1. Adult Medicine
2. Adult Immunology
3. Pediatrics
4. Obstetrics
5. Gynecology

6. Urgent Care
7. Prenatal (Centering) Classes
8. Comprehensive Perinatal Services Program
9. Obstetric Ultrasound
10. Non-Stress Test
11. Behavioral Health
12. Psychiatry
13. Health Education/Chronic Care
16. Anti-coagulation clinic
17. General Dentistry

Specialty Care

1. Cardiology
2. Dermatology
3. Ear, Nose and Throat
4. Endocrine
5. Endoscopy
6. Gastroenterology
7. Hematology/Oncology
8. Infusion
9. Neurology
10. Neurocognitive
11. Neurosurgery
12. Ophthalmology
13. Optometry
14. Oral Surgery
15. Orthopedics
16. Pain
17. Palliative Care
18. Podiatry
19. Pulmonary (Chest)
20. Renal
21. Rheumatology
22. Surgery: Acute, Elective, Trauma

23. Surgery: Breast
24. Surgery: Gynecology
25. Surgery: Minor
26. Surgery: Plastic
27. Surgery: Vascular
28. Urology
29. Wound Healing

DEFINITIONS

HEDIS- Healthcare Effectiveness data and information set
PDSA- Plan, DO, Study, Act

RESPONSIBILITIES

Administration and Organization
The Ambulatory Division is led by the Associate Chief Medical Officer for Ambulatory with oversight for both medical and administrative direction and performance. The Ambulatory Vice President has administrative and operational lead responsibilities. The ambulatory Directors offer additional system support for their areas of expertise. At the site level, the Medical Director is responsible for implementing the policies established by the Medical Staff of Alameda Health System and assuring quality, safety, and appropriateness of patient care. The Practice Manager is responsible for the daily operations of the clinic and the implementation of organizational policies and procedures as well as regulatory requirements. The dyad of Medical Director and Practice Manager collaborate to direct services that align with the Ambulatory Division goals and the needs of the community. The nursing supervisor(s) direct and develop the nursing staff to ensure coordinated, safe, and quality care is provided to the patients. The Patient Services Supervisors oversee the registration and scheduling staff.

Performance Improvement
The Ambulatory Division sets annual performance and quality goals to ensure continuous improvement to meet the healthcare needs of the community. These goals are based on changes/trends to healthcare delivery and quality improvement for identified clinical metrics comparing performance to community and national standards (ex. HEDIS). Alameda Health System participates in the Quality Incentive

Program through State of California Department of Healthcare Services. The AHS quality department and the ambulatory division have staff assigned to support and lead quality improvement. In addition to division goals, individual sites utilize PDSA and LEAN methodologies to improve care.

Appointment Process

Primary Care
Primary Care appointments are scheduled through the Ambulatory Care Call Center. Urgent appointments are available as well as nurse advice during business hours to assess and direct patients to care. Afterhours patients are directed to an on-call medical provider for urgent medical advice. Patients requiring emergent care are directed to a local emergency department and if required, an ambulance is called for patients who are in the clinic.

Urgent Care
The Urgent Care Clinic operates on an appointment and walk in basis. Appointments can be scheduled by phone on the day of the clinic and will be scheduled until all time slots are filled for the day.

Specialty Care
Specialty clinics require a referral from an authorized medical provider. The electronic referral system and electronic health record are used to electronically manage referrals from within Alameda Health System and the referring community.

Staffing
The inter-disciplinary healthcare team of includes physicians, medical residents, medical students, pharmacists, nurse practitioners, physician assistants, nurse midwives, nursing staff (RNs, LVN's), medical assistants, nutritionists, social workers, psychologists, outreach workers and registration personnel.

Education and Competency
Each member of the healthcare team holds current licensure/certification in his or her clinical area of expertise, as required

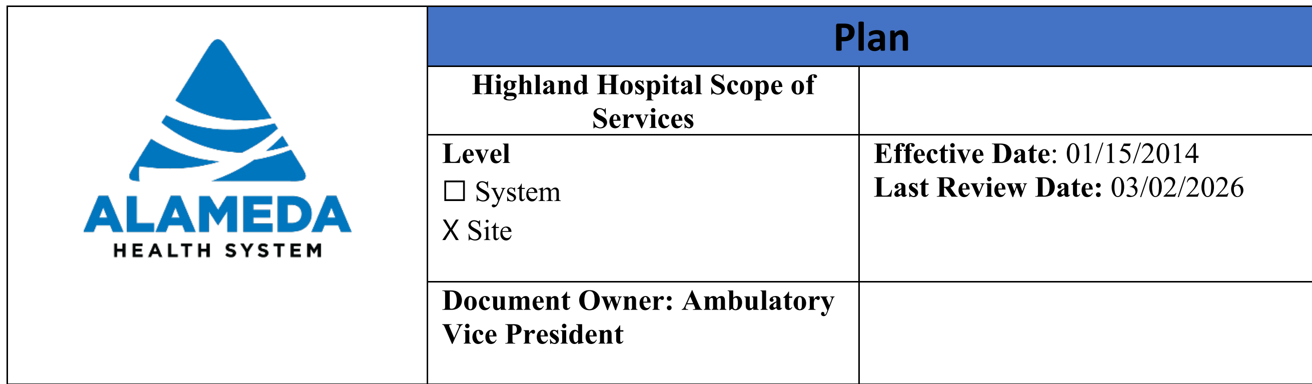
Physician, Physician Assistant and Nurse Practitioner	In accordance with the Medical Staff Bylaws
RN	Current California RN License *Current Basic Life Support Certification* **Experience and certification in accordance with unit requirement*
LVN	Current California LVN License Current BLS Certification IV Certification (Required for specific positions)
Medical Assistants	Completion of a Certified Medical Assistant Program Certification by AAMA, CCBMA, AMT, NCCT/MMCI Current Basic Life Support Certification
LCSW	MSW, Licensed with State of CA
Registered Dietician	Registered with Commission of Dietetic Registration
Clinical Diabetic Educator	National Certification Board of Diabetes Educators certified
Laboratory	Licensed phlebotomist
Certified Nurse midwife	CA Licensed and Certified Nurse Midwife
Licensed RDA	CA licensed Registered Dental Assistant
Certified Ophthalmic Tech	COT Certification
Pharmacist	CA Licensed Pharmacist and PharmD
Pharmacy Technician	CA State licensed pharmacy technician

PROCEDURES:

<u>Primary Care Procedures</u>

Adult Medicine (including Urgent Care)

1. Arthrocentesis and joint injections
2. Peak Flow measurement
3. Incision and Drainage
4. Ear irrigation
5. Breathing treatment (nebulizer)
6. Skin biopsy



7. Post-void residual measurement
8. Fine needle aspiration
9. Foley and Straight Catheter insertion
10. Cryotherapy
11. Foreign body removal: eye, nose or ear
12. Local anesthetic techniques including trigger point injections.
13. Carpel tunnel injections
14. Injection of tendon or ligament
15. Uncomplicated wound closure
16. Cautery of anterior nares
17. Burn debridement
18. Burn treatment (partial thickness)
19. Nail removal
20. Suture removal
21. IUD removal

OB/GYN

1. Biopsy of cervix, vulva, vagina
2. Colposcopy
3. Cryosurgery
4. Endometrial Biopsy
5. Incision and Drainage of abscess
6. Leep Procedures
7. Removal of Condylomas
8. Removal and insertion of Intrauterine Device
9. OB Ultrasound
10. Dilation and Curettage
11. Fetal monitoring / Non-Stress Test
12. Elective Abortion
13. Procedural Sedation
14. Bartholin cyst marsupialization
15. Nexplanon/Implanon insertion and removal

Pediatrics

1. Breathing Treatment (Nebulizer)
2. Suture Removal (minor lacerations)
3. Fluoride Varnish
4. Frenotomy
5. Foreign body removal
6. Wart removal
7. Heel sticks phlebotomy for bilirubin draws
8. Incision and Drainage of abscesses
9. Ear irrigation
10. Venipuncture
11. Urine catheterization
12. Umbilical granuloma chemical cautery

Dental

1. Exam
2. X-rays
3. Cleanings (Periodontics)
4. Deep cleanings (Periodontics)
5. Fillings (restorative dentistry)
6. Root canals
7. Dentures
8. Crowns/Bridges
9. Partials
10. Implant crowns
11. Extractions (routine & surgical)
12. Fluoride varnish/ Sealants
13. Special Needs operating room procedures
14. Apicoectomies (endodontics)
15. Crown Lengthening (Periodontics)

Specialty Clinic Procedures

Dermatology

1. Skin scraping for identification of fungi or parasites
2. Punch or excision biopsy for diagnosis
3. Excision of benign and malignant neoplasms
4. Intralesional injections
5. Cautery of benign lesions
6. Liquid Nitrogen therapy to benign and pre-malignant lesions
7. Incision and drainage of abscesses
8. Botox administration for hyperhidrosis
9. Electrodessication and curettage
10. Deroofing procedures

ENT

1. Control of nasal hemorrhage; nasal packing (simple and complex)
2. Biopsy of lip, cavity, larynx, nose, ear
3. Reduction of nasal fracture
4. Removal of nasal polyps
5. Nasal – pharyngeal laryngoscopy, fiber optic laryngoscopy
6. Intranasal steroid injection
7. Placement of earwicks
8. Auricular hematoma drainage (simple and complex)
9. Removal of impacted cerumen
10. Esophagoscopy with dilatation
11. Laryngoscopy
12. Incision and Drainage
13. Tracheotomy tube changes

14. Voice prosthesis change
15. Foreign body removal ear/nose
16. Peritonsilar abscess drainage
17. Microscopic ear debridement
18. Excision tongue lesion with and without closure
19. Aspiration of mass (cyst, hematoma, seroma or sialocele)
20. Biopsy nasopharynx
21. Biopsy oropharynx
22. Biopsy tongue
23. Ablation turbinates
24. Mass excision inside ear/nose
25. Core biopsy neck mass
26. Rigid nasal endoscopy
27. Eustachian tube balloon dilation
28. Nasal endoscopy
29. External ear endoscopy
30. Excision neck, face, scalp, or ear lesion/mass
31. Auricular abscess management (I&D, aspiration, closure of dead space)
32. Neck abscess drainage
33. Botox injection for management of TMJ, Frey's Syndrome, excess salivation
34. Nasal valve repair
35. Sinus debridement

Hematology/Oncology

1. Bone marrow aspiration and biopsy
2. Therapeutic phlebotomy

Infusion Center

1. Chemotherapy
2. Hydration therapy
3. Blood Transfusions (Blood Products)
4. Parenteral medications including but not limited to
    - Antibiotics

- Biologics
- Immunoglobulin
- Other IV infusions as indicated
- Injections

Minor Surgery

1. Excision of masses less than 4 cm
2. Superficial foreign body removal
3. Biopsy of lesions
4. Skin and soft tissue lesions deemed safely accessible by the faculty surgeon
5. Removal of infusion and dialysis devices

Neurology

1. Lumbar puncture
2. Vagus Nerve Stimulation Therapy
3. Needle electromyography
4. Botox injections
5. Nerve blocks
6. Trigger point injections
7. Braden needle electromyography to EMG/NCS

Neurosurgery

1. Adjustment/Removal of Halo hardware
2. Dressing changes
3. Reprogramming of a programmable cerebrospinal fluid shunt
4. Aspiration of subgaleal fluid
5. Wound closure

Ophthalmology

1. Subconjunctival injections with antibiotics and steroids
2. Incision and drainage chalazion
3. YAG laser
4. Laser iridotomy
5. Laser trabeculoplasty
6. Optical Coherence Tomography
7. Laser retinal photocoagulation
8. Complete eye examinations
9. Visual fields testing
10. Refractions
11. Minor ophthalmic procedures
12. Dilation, probing of nasolacrimal system
13. Retinal photography/Fluorescein Angiography
14. Eye ultrasound
15. Intravitreal injections of anti-VEGF agents, steroids and antibiotics
16. Corneal scraping, foreign body removal, punctal occlusion and botox injections

Oral Surgery

1. Simple and surgical extractions
2. Wisdom teeth removal with sedation
3. Apicoectomy
4. TMJ Therapy and Treatment
5. Dentoalveolar surgery
6. Oral Pathology
7. Osseo integrated implants
8. Prosthetic Surgery
9. Open and close treatment of fracture trauma
10. Sinus Procedures
11. Soft tissue surgery

12. Bone grafting to maxillofacial regions
13. Procedural Moderate Sedation for minor surgery

Orthopedics

1. Hardware removal
2. Alignment/reduction of fractures/dislocations
3. Incision and Drainage
4. Superficial wound debridement
5. Arthrocentesis
6. Minor hand procedures such as trigger finger/carpal tunnel release
7. Injections of joints, bursa, tendon sheaths
8. Cast application and removal
9. Splint application
10. Removal of foreign bodies
11. Excision of wrist ganglion, lesions, distal phalanx
12. Biopsy of lesions

Pain

1. Injections of joints, bursa, tendon sheaths
2. Peripheral nerve blocks
3. Myofascial trigger point injections
4. Botox injections for migraines, blepharospasm, spasticity

Podiatry

1. Consultation and evaluation
2. Application of skin substitute grafts
3. Ulcer debridement
4. Injections of joints, tendon sheath for foot and ankle joints
5. Nerve block
6. Biopsy
7. Suture removal

8. Laceration repair
9. Incision and Drainage
10. Superficial hardware and foreign body removal
11. Trim skin lesion
12. Nail avulsion and Matrixectomy
13. Cast, brace and splint application and removal
14. Destruction of benign lesion
15. Nail Care

Surgery (breast, general, trauma, vascular, plastic)

1. Needle aspiration for cytology
2. Needle/excisional biopsy
3. Debridement of superficial wounds
4. I & D
5. Foreign body removal
6. Dressing changes
7. Wound Culture
8. Tissue Expansion
9. Hemorrhoid banding
10. High Resolution Anoscopy (HRA) and treatment for anal dysplasia

Urology

1. Sounding – dilation of urethra
2. BCG Instillation
3. Bladder irrigation/installation
4. Catheterization procedures
5. Stent removal
6. Voiding trials
7. Cystoscopy
8. Prostatic biopsies

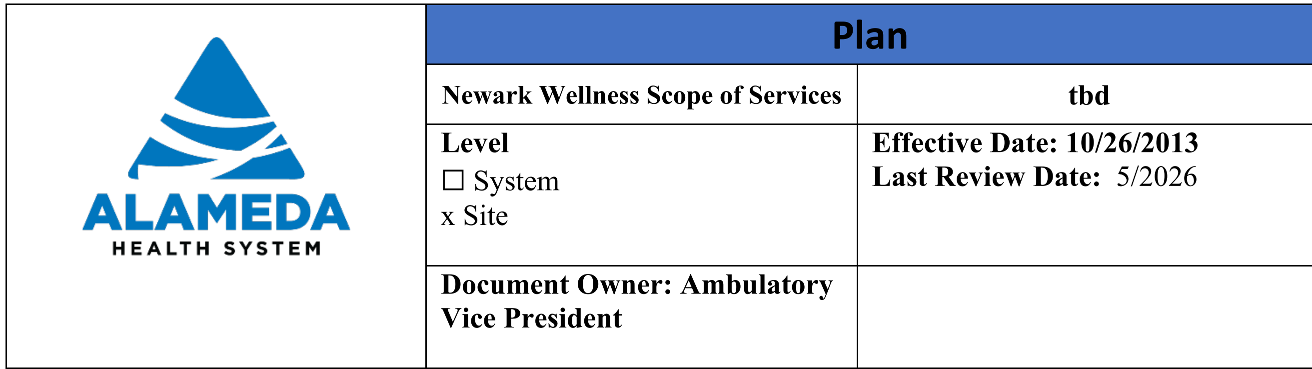
9. Prostate abscess aspiration
10. Gold Seed markers
11. Vasectomy
12. Post void residual
13. Uroflowmetry
14. Scrotal cyst/lesion excisions
15. Penile lesion excisions
16. Complex catheter changes
17. Suprapubic catheter changes
18. Trimix injection
19. Zoladex injection

Wound Healing
1. Debridement
2. Aspiration
3. Dressing changes
4. Injections
5. Lesion Removal

ATTACHMENTS
Not Applicable

APPROVAL(S):

Approving Committee / Executive	Date of Approval



ALAMEDA HEALTH SYSTEM	Plan	
	Newark Wellness Scope of Services	**tbd**
	Level ☐ System x Site	**Effective Date: 10/26/2013** **Last Review Date:** 5/2026
	Document Owner: Ambulatory Vice President	

PURPOSE / OBJECTIVE

The Ambulatory Care Division is a comprehensive network of primary care and specialty care with a supporting network of diagnostic services that provides patients with a full range of health services. Care is provided for patients of all ages. Ambulatory patient care is provided via a multi-disciplinary approach with collaboration among the various support services and providers. Each patient is provided the opportunity to establish an ongoing relationship with a primary care provider and multi-disciplinary team who manage care for that individual, including individual disease management, chronic disease management, preventive health education, screening, and immunizations. Access to specialty care services is arranged through the patient's primary care provider, in consultation with the sub-specialist. Alameda Health System (AHS) provides the patient with care, treatment, and services according to his or her individualized plan of care. The organization communicates with the patient during the provision of care, treatment and services in a manner that meets the patient's oral and written communications needs. Patient assessments are based on need. Phone consultation is available by a registered nurse (who follow approved protocols) and medical provider staff. Comprehensive history and assessment are made for new patients to establish care and develop the provider-patient relationship. Standard screening tools, point of care laboratory tests and clinical assessment by licensed staff are used as indicated for the patient's age, preventive health needs, symptoms, and management of acute and chronic disease. In addition, population health strategies are utilized to manage patients' preventive and chronic care needs.

SCOPE
All Ambulatory departments within Newark Wellness Center
Hours of Operation: Monday – Friday, 8am-5pm

Primary Care

1. Adult
2. Pediatrics
3. Obstetrics
4. Gynecology
5. Behavioral Health

6. Nutrition Education
7. Health Education
8. Laboratory

Specialty Care

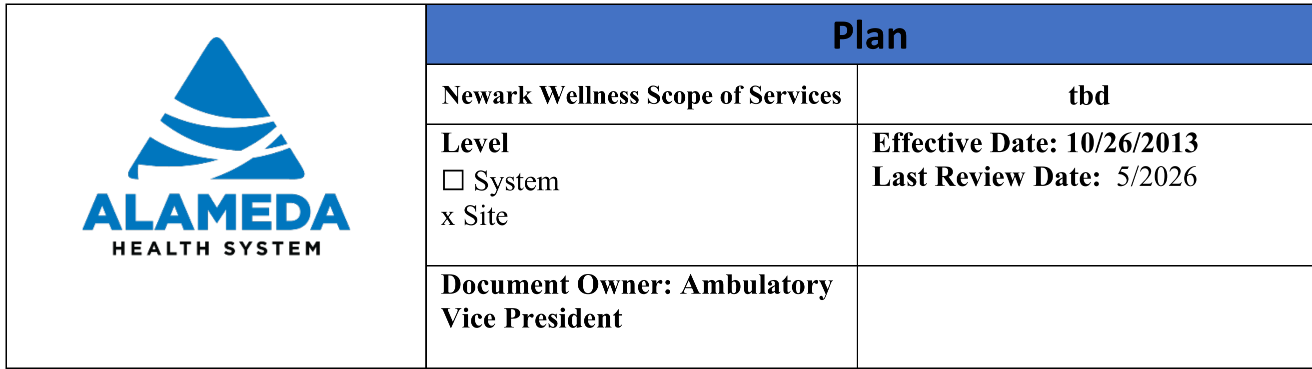
1. Orthopedics
2. Podiatry
3. Mammography
4. Radiology
5. Nephrology

DEFINITIONS

HEDIS- HEALTHCARE EFFECTIVENESS DATA AND INFORMATION SET
PDSA- PLAN, DO, STUDY, ACT

RESPONSIBILITIES

Administration and Organization
The Ambulatory Division is led by the Associate Chief Medical Officer for Ambulatory with oversight for both medical and administrative direction and performance. The Ambulatory Vice President has administrative and operational lead responsibilities. The ambulatory Directors offer additional system support for their areas of expertise. At the site level, the Medical Director is responsible for implementing the policies established by the Medical Staff of Alameda Health System and assuring quality, safety, and appropriateness of patient care. The Practice Manager is responsible for the daily operations of the clinic and the implementation of organizational policies and procedures as well as regulatory requirements. The dyad of Medical Director and Practice Manager collaborate to direct services that align with the Ambulatory Division goals and the needs of the community. The nursing supervisor(s) direct and develop the nursing staff to ensure coordinated, safe, and quality care is provided to the patients. The Patient Services Supervisors oversee the registration and scheduling staff.



Performance Improvement
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Appointment Process

Primary Care

Primary Care appointments are scheduled through the Ambulatory Care Call Center. Urgent appointments are available as well as nurse advice during business hours to assess and direct patients to care. Afterhours patients are directed to an on-call medical provider for urgent medical advice. Patients requiring emergent care are directed to a local emergency department and if required, an ambulance is called for patients who are in the clinic.

Specialty Care

Specialty clinics require a referral from an authorized medical provider. The electronic referral system and electronic health record are used to electronically manage referrals from within Alameda Health System and the referring community.

Staffing

The inter-disciplinary healthcare team includes physicians, medical residents, pharmacists, nurse practitioners, physician assistants, nurse midwives, nurses (RNs, LVN's), medical assistants, nutritionists, social workers, outreach workers and registration personnel.

Education and Competency

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LCSW	MSW, Licensed with State of CA
Registered Dietician	Registered with Commission of Dietetic Registration
Clinical Diabetic Educator	National Certification Board of Diabetes Educators certified
Laboratory	Licensed phlebotomist
Certified Nurse midwife	CA Licensed and Certified Nurse Midwife
Licensed RDA	CA licensed Registered Dental Assistant
Certified Ophthalmic Tech	COT Certification
Pharmacist	CA Licensed Pharmacist and PharmD
Pharmacy Technician	CA State licensed pharmacy technician

Primary Care Procedures

Adult Medicine

1. Joint injections
2. Incision and Drainage
3. Ear irrigation
4. Breathing treatment (nebulizer)
5. Joint injections
6. Incision and Drainage
7. Foreign body removal
8. Minor surgical procedures involving nails, skin, subcutaneous tissue.
9. Wound care
10. Skin biopsy and cryotherapy

11. Laceration repair
12. Suture removal
13. Debridement and care of minor superficial burns
14. Treatment of first and/ or second-degree burns
15. Skin tests performance and reading
16. Soft tissue and trigger point injections
17. Musculoskeletal injections
18. Splinting
19. Management of uncomplicated minor closed fractures and dislocations
20. Pap smear and endocervical culture

Women’s Health Services

1. Biopsy of cervix, vulva, vagina
2. Colposcopy
3. Endometrial Biopsy
4. Removal of condylomas
5. I & D of abscess
6. Removal and insertion of Long-Acting Reversible Contraceptives
7. Cryosurgery

Pediatrics

1. Breathing Treatment (Nebulizer)
2. Suture Removal (minor lacerations)
3. Fluoride Varnish
4. Foreign body removal
5. Wart removal
6. Heel sticks phlebotomy for bilirubin draws.
7. Incision and Drainage of abscesses
8. Ear irrigation
9. Venipuncture
10. Urine catheterization
11. Umbilical granuloma chemical cautery

Specialty Clinic Procedures

Podiatry

1. Application of skin substitute grafts
2. Ulcer debridement
3. Injections of joints, tendon sheath for foot and ankle joints
4. Nerve block
5. Biopsy
6. Suture removal
7. Laceration repair
8. Incision and Drainage
9. Superficial hardware and foreign body removal
10. Trim skin lesion
11. Nail avulsion and Matrixectomy.
12. Cast, brace and splint application and removal.
13. Destruction of benign lesion
14. Nail Care

Orthopedics

1. Superficial wound debridement
2. Arthrocentesis
3. Injections of joints, bursa, tendon sheath

ATTACHMENTS

Not Applicable

APPROVAL(S):

Approving Committee / Executive	Date of Approval

SYSTEM MEDICATION SAMPLES

ALAMEDA HEALTH SYSTEM	Policy	
	Document Title	**Reference # tbd**
	Level X System ☐ Site	**Effective Date:** 6/2026 **Last Review Date**: **4/2026**
	Document Owner: System Medication Safety Officer/System Pharmacy Director	

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

PURPOSE

To provide strict control and quality of all medications used in the hospital and clinics**.**

POLICY

Drug samples for use is not allowed for either patients in the hospital or outpatient clinics at any AHS sites unless specific sample medications for use is reviewed and approved by P&T.

PROCEDURE

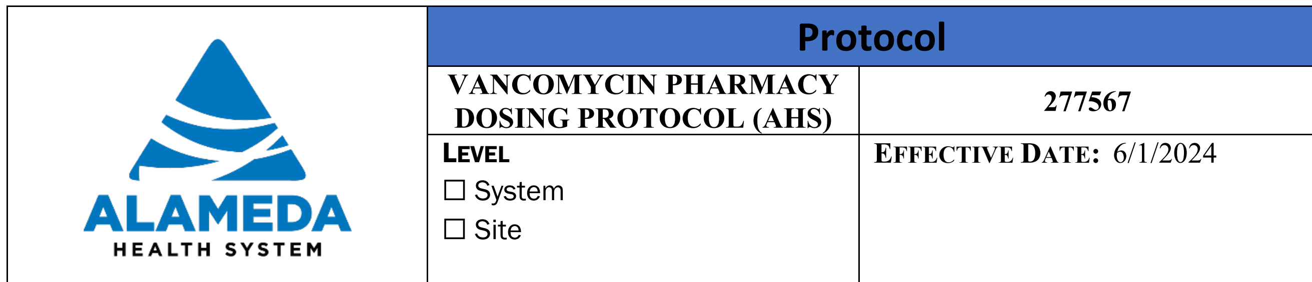
1. All departments and employees of AHS who are offered drug samples by the drug manufacturer sales representatives will not accept such offers unless approved by P&T.
2. Sales representatives will be instructed not to leave any samples at the facility.
3. Only the Emergency Department and Ambulatory Immunology Clinic (AIC) may use drug samples for the purpose of preventing or treating communicable diseases, and only with prior approval from the Pharmacy & Therapeutics (P&T) Committee.

REFERENCES

TJC Medication Management Standards

	System	HH/SLH/JG/FM	Alameda Hospital
Pharmacy Department	Date: 4/2026		
System P&T	Date: 4/2026		
CPC	Date: 5/2026		
Medical Executive Committee (AH & Core)	Date: 5/2026		
BOT	Date: 6/2026		

review



	Protocol	
	VANCOMYCIN PHARMACY DOSING PROTOCOL (AHS)	277567
	LEVEL ☐ System ☐ Site	EFFECTIVE DATE: 6/1/2024

Purpose

To enhance the safe and effective use of vancomycin and to increase antibiotic stewardship for this medication with a pharmacist dosing and monitoring protocol.

Definitions/Equations

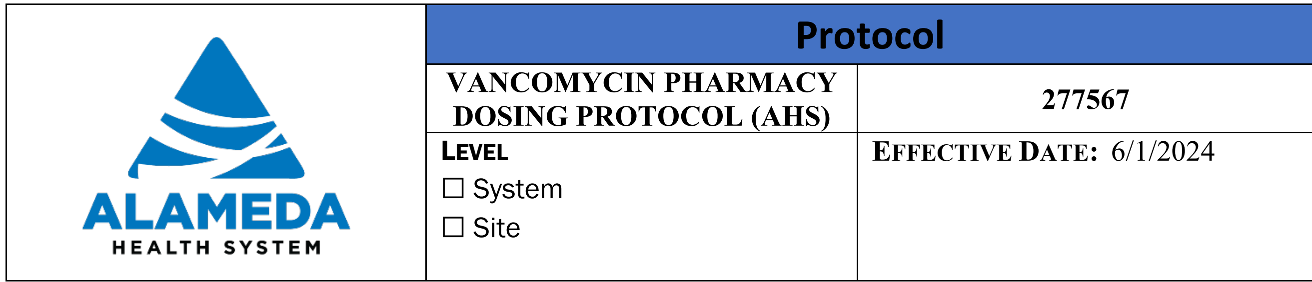
AdjBW	Adjusted body weight = IBW + 0.4(TBW-IBW)
AUC	Area under the curve = TDD/CL_{Va}
AUC:MIC	Ratio of AUC to MIC = AUC/MIC
Modified Cockroft-Gault equation (see number 1, part C).	**$CrCl\ (ml/min) = \frac{(140 - age) \times (IBW^*)}{72 \times SCr}$ (x0.85 if female)** ***If TBW >120% IBW, use AdjBW = IBW + 0.4(TBW-IBW)**
BMP	Basic metabolic panel
CL_{Cr}	Creatinine clearance (mL/min) *Modified Cockroft-Gault equation to be used*
CL_{Va}	Vancomycin clearance (L/h) = CL_{Cr} (mL/min) × 0.045
IBW	Ideal Body Weight(kg) For FEMALES = 45.5 + (2.3 x [height(in) - 60]) For MALES = 50 + (2.3 x [height(in) - 60])
MIC	minimum inhibitory concentration
Scr	serum creatinine
TBW	total body weight (kg)
TDD	Total Daily Dose of vancomycin (mg)
Vd	Vancomycin volume of distribution = 0.7 x TBW

Policy

All adult patients on intravenous vancomycin, excluding pre-op / post-op prophylaxis, open fracture prophylaxis, and Group B *Streptococcus* prophylaxis orders **will be dosed by the pharmacy department.** (*Please direct providers to order vancomycin for surgical prophylaxis using the appropriate surgical prophylaxis orderset(s) in EPIC where dosing & duration values have been pre-populated)*

a. The prescriber will initiate vancomycin therapy by ordering "Vancomycin Dosing per Pharmacy."
b. The pharmacist will use his/her clinical judgment in conjunction with the *Dosing Protocol* when writing orders for vancomycin.
c. Under the vancomycin dosing protocol the pharmacist will have authority to
   i. Order SCr and/or BMP as needed
   ii. Order vancomycin trough and/or random levels as needed
   iii. Adjust vancomycin dosing regimen as needed
   iv. Order MRSA nares screen when indication includes any type of pneumonia to help rule out MRSA pneumonia if no MRSA screen result in the previous 14 days

   These orders will be designated "per vancomycin protocol."
d. If the pharmacist determines that vancomycin cannot be safely and effectively dosed for a particular patient and indication the pharmacist will contact the physician to recommend an alternative agent and/or consultation with the Infectious Disease service.



	Protocol	
	VANCOMYCIN PHARMACY DOSING PROTOCOL (AHS)	277567
	LEVEL ☐ System ☐ Site	EFFECTIVE DATE: 6/1/2024

Dosing Protocol

1. **Pharmacokinetic parameters**
    a. Vancomycin will be dosed to area under the curve : minimum inhibitory concentration (AUC:MIC)
    Exception: Software/network outage. See # **9. Extended Software Outage** below.

Suspected or proven MRSA infections including but not limited to:	AUC:MIC
• **Brain/Epidural Abscess** • **Endocarditis** • **Meningitis** • **Osteomyelitis** • **Pneumonia (pharmacist to order MRSA nares screen if not performed within past 14 days)** • **Prosthetic joint infection** • **Sepsis** • **Cellulitis, Skin and Soft tissue infection** • **Cystitis** • **Neutropenic fever** • **Prophylaxis (i.e. drains, shunts)**	400-600

**Note: these targets are applicable only to adult patients, and only for empiric therapy or directed therapy; MIC should be assumed to be ≤1 mcg/ml unless proven to be greater by broth microdilution (BMD) as they are often overestimated by automated susceptibility testing and E-test*

    b. Total body weight (TBW) will be used for all initial dosing
    c. Vancomycin clearance (CL_{Va}) will be calculated using creatinine clearance. Creatinine Clearance (CL_{Cr}) will be calculated using the Cockroft-Gault equation, whenever appropriate
    d. Doses will preferentially be rounded to the nearest 250 mg increment.

2. **Loading Dose**
    a. ICU and critically ill patients with acute infection and/or with impaired renal function (including dialysis or renal replacement therapy) should receive a loading dose of 20-35 mg/kg (using TBW) to a maximum of 3000mg.
        i. For obese patients (BMI ≥ 30kg/m^2) use a loading dose of 20-25mg/kg (using TBW) to a maximum of 3000mg.
        ii. For dialysis patients see sections **7b-7d below.**
        iii. For pregnant patients see section 7e below

iv. In the event that a first vancomycin dose of less than those recommended above is administered to the patient, the pharmacist will use clinical judgment to adjust dosing, e.g.:
v. Ordering a supplemental dose to achieve a full loading dose.
vi. Retiming subsequent doses to achieve desired steady-state concentrations.

3. **Initial Maintenance Dose**
   a. Initial maintenance dosing will be calculated based on patient-specific pharmacokinetic factors, e.g. Vd, CL_{Va}, targeted vancomycin AUC.
   b. The pharmacokinetic software Precise PK should be used as an approved aid to clinical judgment in creating vancomycin regimens (see Appendix A: Precise PK.).
   c. The initial maintenance dose should not exceed **4500mg / 24 hour period,** unless patient history warrants otherwise. Doses will be rounded to the nearest 250mg.
   d. In patients with severe renal impairment (i.e. CL_{Cr} < 20 ml/min) subsequent dosing status post the loading dose will be based on interpretation of vancomycin levels.

4. **Monitoring**
   a. Serum creatinine levels (SCr) are recommended:
      i. At initiation of the vancomycin maintenance dosing regimen. Loading doses should be administered regardless of serum creatinine availability.
      ii. Every 48-72 hours during vancomycin therapy if not already ordered by prescriber.
      iii. Additionally as deemed appropriate by the pharmacist
   b. Vancomycin levels are recommended for patients who meet one or more of the following criteria:
      i. Receive vancomycin for a suspected or documented infection, not prophylaxis
      ii. Receive dialysis
      iii. Are at heightened risk of nephrotoxicity (i.e. receiving concurrent IV contrast, loop diuretics, NSAIDs, aminoglycosides, amphotericin, cyclosporine, tacrolimus, vasopressors, or chemotherapy)
      iv. Have changing renal status. Significant change in renal function is defined as:
         - Abrupt change in SCr by ≥ 0.3mg/dL (within 48h), or
         - A percentage change in SCr by ≥ 50% from baseline, or
         - A reduction in UOP (documented oliguria of < 0.5mL/kg/h for > 6h)
      v. Have atypical or dynamic Vd (e.g. morbid obesity, burns, dialysis).
   c. Vancomycin levels should be obtained as deemed appropriate per the pharmacist:
      - It is recommended to obtain levels within the first 24-48 hours of therapy, regardless of the number of doses received

- If levels are obtained after only the loading dose, contribution of the loading dose to the actual AUC may vary depending on the magnitude of

ii. Once patient is stable on a regimen; it is recommended to obtain weekly levels thereafter pending patient has stable renal function with an appropriate clinical response.

5. Instructions for drug administration around trough levels:

a. All vancomycin doses should be administered to patients as scheduled.

b. If appropriate, a pharmacist may elect to defer vancomycin administration until a satisfactory vancomycin AUC has been achieved. The choice to hold a vancomycin dose while awaiting a level must be communicated to the responsible nurse through either oral or electronic communication by the pharmacist or the prescriber.

6. Maintenance Dose Adjustment:

a. The pharmacist will assess all vancomycin levels for accuracy and validity, and adjust vancomycin accordingly to achieve intended pharmacokinetic parameters based on pharmacokinetic and clinical interpretation of patient- and lab-data.

b. The pharmacokinetic software Precise PK should be used as an approved aid to clinical judgment in adjusting vancomycin regimens. Round dose to the nearest 250mg.

7. Maintenance Dose Adjustment in Special populations:

a. The "Vancomycin Dosing per Pharmacy" order will remain active on the MAR for the duration of vancomycin therapy for the below patient populations.

b. **Patients on Chronic Intermittent Hemodialysis:**

i. PrecisePk does allow for integration of hemodialysis variables however, will only provide trough and AUC estimation for prior doses. It does not provide dosing recommendations or future trough/AUC estimations. Please use the recommendations below which are in line with the most recent guidelines.

ii. An initial loading dose of 25mg/kg TBW (maximum of 3000mg) should be given to patients on hemodialysis

iii. After the loading dose, a level prior to each hemodialysis session will be obtained (e.g. just prior to dialysis by the hemodialysis nurse). If a level cannot be obtained prior to dialysis, it may be obtained at a minimum of four hours after dialysis (to allow for drug redistribution).

iv. Assume an approximate of 25% drug removal by standard high-flux hemodialysis

v. If the pre-dialysis level is > 20mcg/mL do not give a post-dialysis dose and obtain another random level prior to next dialysis session.

vi. If pre-dialysis level is between 15-20 mcg/mL, consider the suggested maintenance doses post-dialysis below:

Patient's **TBW** ≤ 49kg = 250 mg
Patient's **TBW** = 50-90kg = 500 mg
Patient's **TBW** ≥ 91kg = 750 mg

v. If the next pre-dialysis level is < 15 mcg/mL, add an additional 250mg to current post-dialysis maintenance dose. Obtain another random level prior to next dialysis session.

vi. If level was obtained post dialysis, extrapolate pre-dialysis level by multiplying obtained level by 1.25 and adjust dosing as per above for pre-dialysis levels.

vii. Once patient has had two levels within range on the same regimen and renal function is stable, levels can be drawn at least weekly thereafter.

c. **Patients receiving pulse hemodialysis (not chronic):**

i. Hemodialysis schedule will be followed on a daily basis via: nephrology team, hemodialysis nurse, bedside nurse and/or primary team.

ii. Subsequent dosing status post the loading dose will be based on interpretation of vancomycin levels. A pulse dose should be given once a random vancomycin level falls below the desired the goal.

iii. Refer to chronic hemodialysis section for pulse dose recommendation.

d. **Patients receiving peritoneal dialysis (PD)**

i. Important Notes

- Patients on PD with peritonitis should be treated with intraperitoneal (IP) antimicrobials.
- If administration of IP antimicrobials will delay care OR if patient presenting with signs of systemic infection, IV antimicrobials are appropriate.
- In patients with confirmed peritonitis, transition to IP antimicrobials as soon as possible
- Patients should NOT be receiving the same antimicrobial administered both IV and IP

ii. Intraperitoneal (IP) Vancomycin for PD

- Dose: 25mg/kg IP
- Frequency: every 4-5 days (based on level)
- Monitoring: check level every 2-3 days with a goal of >15. Re-dose when level is ≤15 mcg/mL
- Before re-dosing, contact the renal attending physician to confirm they would like to continue vancomycin and to confirm timing of the next PD session.

iii. Intravenous Vancomycin in patients on PD

- Loading dose: 20-25mg/kg x1

- Maintenance dose: 15-20mg/kg
- Monitoring: check level at 48 hours, re-dose when level ≤15 mcg/mL

e. Pregnant patients
   i. Group B Streptococcus (GBS) prophylaxis
      - Dose: 20mg/kg total body weight q8h (maximum of 2000mg/dose)

8. Storage and Documentation

a. Patient information and dosing history will be securely stored in the Precise PK database located on the cloud server and on the paper or electronic vancomycin daily monitoring sheets used at each facility as needed. Pharmacists will update patient information for monitoring safety and efficacy of vancomycin for the duration of vancomycin therapy.

b. The pharmacist will complete a pharmacokinetic progress note at minimum on initiation of therapy and if the vancomycin regimen is changes. The progress note will be included in the "progress notes" section of the patient chart.

9. Extended Software Outage

a. In the setting of an extended software or network outage, PrecisePK or other pharmacokinetic/pharmacodynamic calculators may not be accessible. In this scenario, vancomycin monitoring should revert back to trough based monitoring/dosing as described in the table below. For new starts, continue to follow the loading dose recommendations in section **2** and use initial maintenance dosing recommendations in tables below.

Vancomycin Maintenance Dose for Software Outage		
Patient weight (kg)	**Trough goal 10-15**	**Trough goal 15-20**
>90	1250mg	1500mg
76-90	1000mg	1250mg
55-75	1000mg	1000mg
45-55	750mg	750mg

Vancomycin Dose Intervals for Software Outage

CrCl	Trough goal 10-15	CrCl	Trough goal 15-20
>65	q12h	>100	q8h
30-65	q24h	66-100	q12h
<30 not on dialysis	Dose by level	30-65	q24h
Dialysis*		<30 not on dialysis	Dose by level
		Dialysis*	

*See **7b. Patients on Chronic Intermittent Hemodialysis**

Vancomycin Dose Adjustments for Software Outage	
Trough goal 10-15	Skin and soft tissue infection, cystitis
Trough goal 15-20	Brain/epidural abscess, endocarditis/bacteremia, meningitis, osteomyelitis, pneumonia, joint infection, neutropenic fever, sepsis
Trough level	Recommended Action
< 10 mcg/mL	If goal is 10-15 mg/L, increase dose by 250 mg If goal is 15-20 mg/L, increase dose frequency by one level (e.g., q24h to q12h)
10 - 15 mcg/mL	If goal is 10 -15 mcg/mL: No change necessary If goal is 15 – 20 mcg/mL: Increase dose by 250 mg
15 - 20 mcg/mL	If goal is 10 -15 mcg/mL: Decrease dose by 250 mg If goal is 15 – 20 mcg/mL: No change necessary
21 - 25 mcg/mL	If goal is 10 -15 mcg/mL: Decrease frequency by one level (e.g., q12h to q24h) If goal is 15 – 20 mcg/mL: Decrease dose by 250 mg

> 25 mcg/mL	Hold dose Use pharmacokinetic equations to estimate when concentration will be <20 mcg/mL to re-start new dosing regimen and/or check a random level and re-dose when concentration is <20 mcg/mL

Protocol Review:
The vancomycin protocol will be assessed annually by pharmacy to ensure optimized dosing and clinical outcomes, and to seek opportunities for improvement.

References:

1. Centers for Disease Control and Prevention. Recommendations for preventing the spread of vancomycin resistance: recommendations of the Hospital Infection Control Practices Advisory Committee (HICPAC). *MMWR Morb Mortal Wkly Rep*. 1995; 44(No. RR-12):1-13.

2. Rybak M, Le J, Lodise T, et al. Therapeutic monitoring of vancomycin for serious methicillin-resistant *Staphylococcus aureus* infections: a revised consensus guideline and review by the American Society of Health-System Pharmacists, the Infectious Diseases Society of America, the Pediatric Infectious Diseases Society, and the Society of Infectious Diseases Pharmacists. *Am J Health Syst Pharm*. 2020; 77 (11):835–64.

3. Ariano RE, Fine A, Sitar DS, Rexrode S, Zelenitsky SA. Adequacy of a vancomycin dosing regimen in patients receiving high-flux hemodialysis. *Am J Kidney Dis*. 2005 Oct;46(4):681-7.

4. Pai AB, Pai MP. Vancomycin dosing in high flux hemodialysis: a limited-sampling algorithm. *Am J Health Syst Pharm*. 2004 Sep 1;61(17):1812-6.

5. Zelenistky, SA et al. Initial vancomycin dosing protocol to achieve therapeutic serum concentrations in patients undergoing hemodialysis. *Clin Infect Dis.* 2012 Aug;55(4):527-33.

6. Brown, M et al. Weight-based loading of vancomycin in patients on hemodialysis. *Clin Infect Dis.* 2011;53(2):164.

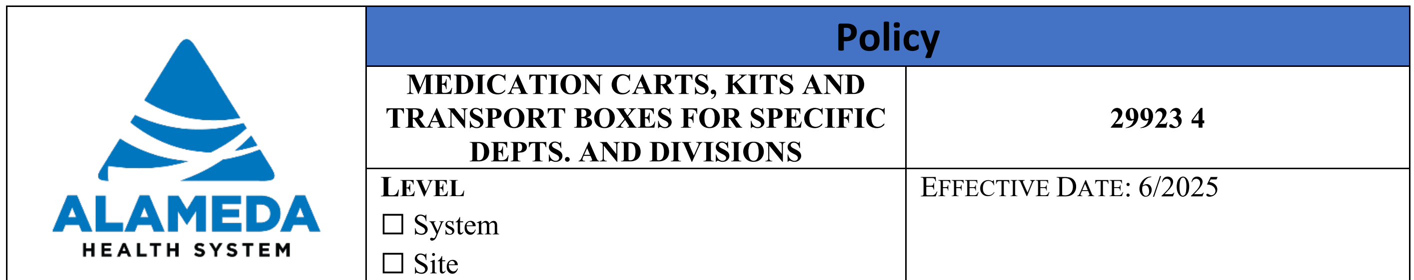
7. Alosaimy S, et al. Vancomycin area under the curve to predict timely clinical response in the treatment of methicillin-resistant *Staphylococcus aureus* complicated skin and soft tissue infections. *Clin Infect Dis*. 2020; Online ahead of print.

8. Chang J, et al. Vancomycin duration therapy. *Clin Infect Dis.* 2020; Online ahead of print.

9. Rybak M, et al. Therapeutic monitoring of vancomycin in adult patients: A consensus review of the American Society of Health-System Pharmacists, the Infectious Diseases Society of America, and the Society of Infectious Diseases Pharmacists. *Am J Health Syst Pharm*. 2009;66(1):82-98

Approvals

		System	AH	HH/SLH
Departmental	**Date:**	4/2026		
System Pharmacy and Therapeutics Committee	**Date:**	4/2026		
Clinical Practice Committee	**Date:**	**5/2026**		
Medical Executive Committee	**Date:**	**5/2026**		
Board of Trustees	**Date:**	**6/2026**		



	Policy	
ALAMEDA HEALTH SYSTEM	MEDICATION CARTS, KITS AND TRANSPORT BOXES FOR SPECIFIC DEPTS. AND DIVISIONS	29923 4
	LEVEL ☐ System ☐ Site	EFFECTIVE DATE: 6/2025

Policy

To provide access and storage to medications in boxes or kits to specific areas where Automated Dispensing Machines (ADM, e.g. Pyxis) are not accessible and/or certain specific drugs are not included in crash carts. These departments/divisions may include however not limited to Allergy Clinic, Anesthesiology, Cardiology, Diagnostics, Oral Surgery, Operating Room, Emergency Department, and Radiology.

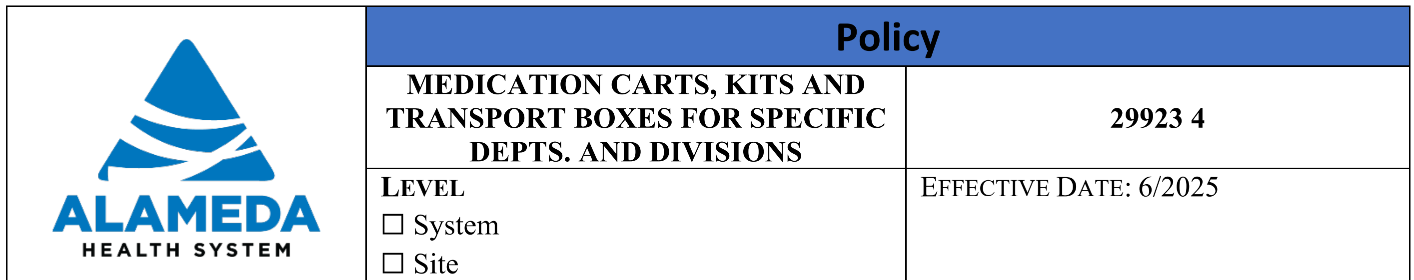
Other medication kits are assembled and put in ADM by pharmacy for the ease of removal under specific situations.

Procedures

A. Preparation
   1. Pharmacy staff fills medications listed in the boxes and kits. Non-medicinal supplies in oral surgery boxes are filled by the Oral Surgery division.
   2. Pharmacy staff records expiration dates of mediations on the content list.
   3. Pharmacy staff who prepares the box or kit will sign and date on the content list.
   4. Pharmacist will check all medications against the content list for correct quantity and expiration.
   5. Pharmacist will sign and date the content list after checking the box or kit.
   6. The signed and dated content list will be put inside the box or kit.
   7. A copy of this content list can be put outside the box or kit. Or a sticker with the name of earliest expired drug and expiration date will be put outside the box or kit. This is to identify when to replace the content of the box or kit.
   8. Pharmacy will put a tamper resistance lock on the checked box or kit to ensure the box or kit is secured before being dispensed.

B. Dispensing
   1. When a box or kit is needed for a procedure by a department/division, the department/division staff will come to pharmacy to pick up the specific box or kit.
   2. Pharmacy staff, before dispensing the box or kit, will make sure the lock is secured and medications are not expired.
   3. Pharmacy staff fills out the dispensing log to indicate when and where the box/kit is dispensed.

C. Storage
   1. Each department/division is responsible for storing the box/kit in an area where direct supervision of its usage is allowed until the procedure is complete.
   2. Anesthesia department, oral surgery division and radiology department will store the boxes/kits in their areas until replacement.
   3. Such storage areas should be easily monitored by the department or division staff to prevent unauthorized usage.



D. Administering and Returning
   1. When a medication is needed, the department staff will break the lock to open the box or kit.
   2. The department/division staff will put the patient addressograph sticker on the content list for subsequent billing by pharmacy.
   3. The department/division staff will return the used box or kit with the patient stamped content list to pharmacy for replacement.
   4. In the situation where the lock is found broken in the department/division, but medications are not used, the box or kit should be returned to pharmacy for checking.

E. Replacement
   1. Pharmacy will follow the procedures under "Preparation" in this policy to replace and refill any medications used in the box or kit that is returned from the department/division.

F. Medication kits stored in Automated Dispensing Machine (ADM, e.g. Pyxis)
   1. These kits are assembled in pharmacy and checked by pharmacist before putting in ADM.
   2. Kits are removed from ADM according to the ADM procedure.
   3. A refill or stock out report will be printed in the pharmacy to prompt for replacement.
   4. Used kits should be placed in the "return to pharmacy" bin for pick up and return to pharmacy.

APPROVALS

		System	Alameda	AHS/Highland/John George/San Leandro
Pharmacy and Therapeutics (P&T)	**Date:**	4/2026		
Clinical Practice Council (CPC)	**Date:**	5/2026		
Medical Executive Committee	**Date:**	5/2026		
Board of Trustees	**Date:**	6/2026		

review

ALL Acute Care Medication Carts and Kits

Department/Divisions	Name of Emergency Box/Kit	Page
Radiology	Radiology Contrast Allergic Reaction Kit	4
Critical Care	RSI kit	5
Employee Health Kit	Adult Anaphylaxis Kit	6
Anesthesia	Anesthesia Support Kit	7

review

Radiology Contrast Allergic Reaction Kit

Medication	Quantity	Expiration
Diphenhydramine Inj. 50 mg/ml 1 ml Vial	1	
Epinephrine Inj. 1 mg/ml (1:1000) 1 ml Vial (in light protection bags)	2	
Methylprednisolone Inj.125 mg Vial	1	

Epinephrine Dosing: Hypersensitivity Reaction (e.g. anaphylaxis):
IM administration in the anterolateral aspect of the middle third of the thigh is preferred in the setting of anaphylaxis. Subcutaneous administration results in slower absorption and is less reliable.

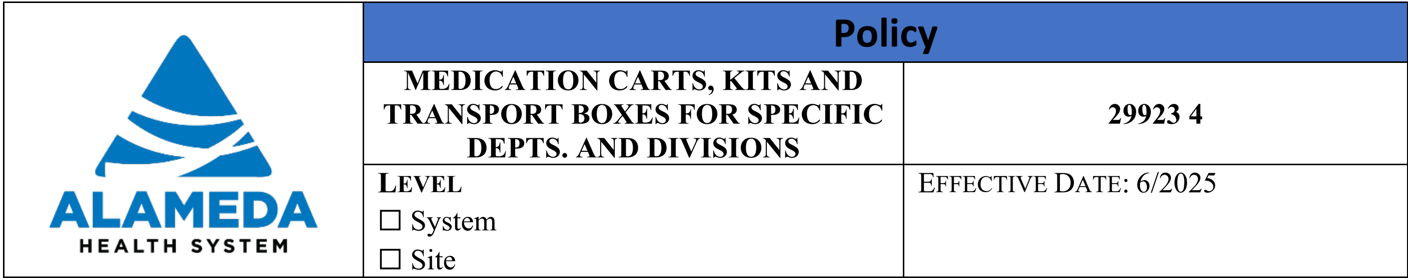
IM (preferred anterior thigh): **Adults:** 0.3 to 0.5 mg (0.3 to 0.5 ml) of 1 mg/ml solution every 5 to 15 minutes. **Peds:** 0.01 mg/kg (Max 0.3 mg) of 1 mg/ml solution (AAAAI [Lieberman 2015]; AHA [Vanden Hoek 2010]; WAO [Kemp 2008])

review

Rapid Sequence Intubation (RSI) Kit

Quantity	Medication	Expiration
1	Etomidate 2 mg/ml vial (total 10 mL)	
1	Rocuronium 10 mg/ml vial (total 10 mL)	
2	Succinylcholine 20 mg/ml inj (total 10 mL)	

review



Employee Health Adult Anaphylaxis Kit

Quantity	**Medication**	**Expiration date**
2	Diphenhydraime 25mg caps	
1	EpiPen 0.3mg/0.3mL prefilled syringe	
1	BD syringe, Leur-lok (1 ml syringe)	
1	BD Eclipse 25G needle	
2	Isopropyl alcohol 70% prep pads	

review

Anesthesia Support Kit

Quantity	Medication	Expiration
1	Ephedrine 50 mg/ml (1 ml) vial/ampule	
1	Etomidate 2 mg/ml (10 ml) vial	
1	Norepinephrine 1 mg/ml (4 ml) ampule	
1	Propofol 10 mg/ml (20 ml) vial	
1	Rocuronium 10 mg/ml (10 ml) vial	
1	Succinylcholine 20 mg/ml (5 ml) syringe	

Back up medications for situations like power outage and Pyxis failure. The kit is stored in a locked box.

review

Wilma Chan Highland Hospital Medication Carts and Kits

Department/Divisions	Name of Emergency Box/Kit	Page
Anesthesiology	• Anesthesia Intubation Kit (to be put in the transport bag)	9
Cardiology	• Cardiac CT Scan/Nuclear Medicine Box • Electrocardiography (EKG) Kit • Heart Alert (STEMI) Kit	10 11 12
Critical Care	• Adult Transport/Code Box • Neonatal Transport Box • Pharmacist code stroke kit • Non-Cytotoxic Vesicant Medication and Fluids Extravasation Kit • Phenylephrine Kit	13 14 15 16 17
Maternal Child Health	• Operation OB – Medication Box • OB Procedural Box	18 19
Oral Surgery	• Oral Surgery Box	20
Heme/Onc	• Hypersensitivity Kit for Infusion Center	21
Emergency Department	• ED Block Cart • ED Code bag	22 23

review

Anesthesia Intubation Kit (to be put in Anesthesia Airway Backpack)

Drug	Quantity	Expiration
Atropine Inj. 0.1 mg/ml 10 ml syringe	1	

Epinephrine Inj. 0.1 mg/ml (1:10,000) 10 ml syringe	1	
Etomidate Inj. 2 mg/ml 10 ml vial	1	
Phenylephrine Inj. 100 mcg/ml 10 ml syringe	1	
Propofol Inj. 10 mg/ml 20 ml vial	2	
Rocuronium Inj. 10 mg/ml 10 ml vial	1	
Succinylcholine Inj. 20 mg/ml 5 ml syringe	1	
Sugammadex 100 mg/ml 5 ml vials	3	

review

Cardiac CT Scan/Nuclear Medicine Box

Drug	Quantity	Expiration
Albuterol Inhaler 90 mcg/puff 8 gm inhaler	1	
Aminophylline Inj. 25mg/ml 10 ml vial	2	
Caffeine inj 60mg/3mL	1	

review

Electrocardiography (EKG) Kit

Medication	Strength	Quantity	Expiration
Atropine inj	1mg/1mL Vial	1	
Diphenhydramine inj.	50 mg/1 ml Vial	1	
Metoprolol inj.	5 mg/5 ml Vial	1	
Nitroglycerin SL tablet	0.4 mg	2 bottles (25 tabs/bottle)	

HEART ALERT (STEMI) Kit

(STEMI = ST-Elevation Myocardial Infarction)

Medication Name	Dose Given	Time	Route	Documented in MAR	Quantity in Kit	Exp. Date	Quantity Used
Atropine Inj 1mg (0.1 mg/ml) 10 ml prefilled syringe				☐	1		
Epinephrine Inj 1mg (1:10,000) 10 ml prefilled syringe				☐	1		
Amiodarone Inj 150mg (50mg/ml) 3 ml vial				☐	2		
Diphenhydramine Inj 50mg/ml 1 ml vial				☐	1		
Nitroglycerin 0.4 mg sublingual tablets				☐	1 bottle		

review

ADULT TRANSPORT/CODE BOX

Generic drug name	Quantity
Atropine 1mg/10mL syringe	1
Dextrose 50% 25g/50mL syringe	1
Dextrose 10% 100mg/mL (250mL bag)	1
Epinephrine 1:10000 1mg/10mL syringe	1
Oral glucose gel 15g	1
Normal saline 10mL flush	3
Angiocath starter kit*	1
Empty syringe 3mL	1
Empty syringe 10mL	3
18 gauge eclipse needle	4
25 gauge eclipse needle for IM inj	1

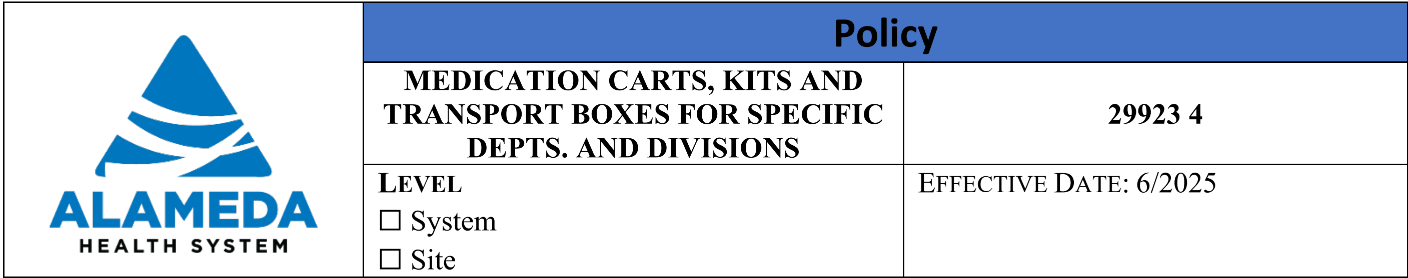
Generic drug name	Quantity
RSI meds grouped together	

Etomidate 2mg/mL (10mL)	1
Rocuronium 10mg/mL (10mL)	2
Succinylcholine 20mg/mL (5 ml) syringe	2
Midazolam 10mg/2mL (Versed)	1
Naloxone 2mg/2mL syr	1

*20G 1 ¼" Catheter x2, 18G 1 ¼" catheter x2, IV starter kit with ChloraPrep (DYND74260) x2

*20G 1 ¼" Catheter x2, 18G 1 ¼" catheter x2, IV starter kit with ChloraPrep (DYND74260) x2

review



Neonatal Transport Box- Pharmacy Section

Pharmacy Section ONLY

Epinephrine 1:10,000 (0.1 mg/mL) 10mL Syringe- 1 ea____ (√)

(Dose of Epinephrine= 0.1 to 0.3 mL/KG of Epinephrine 1:10,000 IV)

review

Pharmacist Code Stroke Kit

Quantity	Medication	Expiration Date
2	30mL syringe	
2	10mL syringe	
5	5mL syringe	
1	BD Alaris Pump Infusion Set (REF 2426-0500)	
6	18G Eclipse Needles	
6	Saline Flush 10mL	
1	Nicardipine 25mg in 100mL (either NS or D5)	
1	Tenecteplase 25mg kit	
1	Labetalol hydrochloride 100mg / 20mL vial	
N/A	Miscellaneous: labels, tapes, and dosing sheet	

review

Non-Cytotoxic Vesicant Medication and Fluids Extravasation Kit

Quantity	Medications	Expiration Dates
2	Phentolamine mesylate for injection 5 mg/vial	
2	Hyaluronidase (Amphadase®) 150 units/ml, 1 ml vial (Hyaluronidase is STORED IN PYXIS REFRIGERATOR)	
2	0.9% Sodium chloride for injection, preservative free, 10 ml	
3	Nitroglycerin Ointment USP, 2% (NITRO-BID®) 1 inch (1 gram) foilpac®	

review

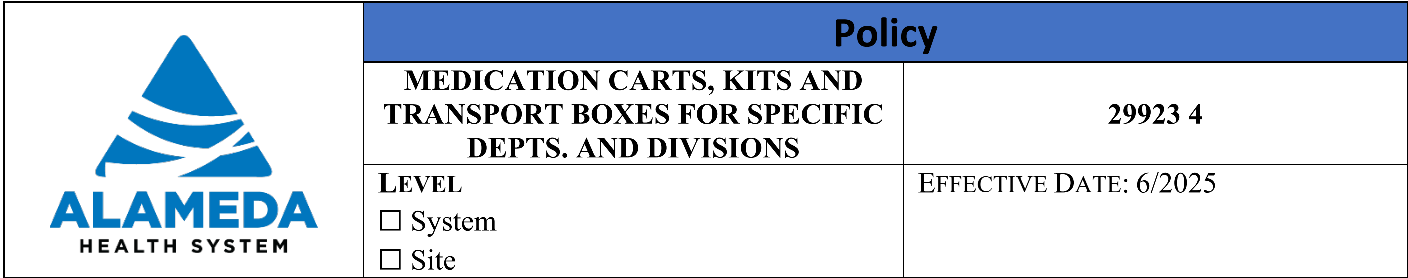
Phenylephrine Kit

To make a phenylephrine 50mg/250mL NS bag: Draw out 50mg = 5mL of phenylephrine from the vial and infuse it into a 250mL bag

Medication	Quantity	Expiration
Phenylephrine 50mg/5mL vial	1	
NS 250mg bag	1	
10mL syringe	1	
18-gauge needle	1	

Beyond Use Date (BUD): Administer within 1 hour of mixing for immediate use.
After starting administration, the bag is good for a total of 24 hours from time of mixing.

review



Operation OB – MEDICATION BOX

Quantity	Drug	Expiration Date
2	Oxytocin (Pitocin) 10 units/ml 1 ml vial	
5	Misoprostol (Cytotec) 100 mcg tablet	

review

OB Procedure Cart

Nursing:
Stamp with patient's name, place in medication box and return to pharmacy

Quantity	Medication	Expiration
2	Calcium gluconate 1g vials	
1	Hydralazine 20mg/mL vial	

1	Labetalol100mg/20mL (5mg/mL) vial	
1	Magnesium sulfate 20g/500mL bag	
2	Magnesium sulfate 50%, 5gm/10mL, 10mL vials	
5	Misoprostol 200mcg tab	
1	Naloxone 2mg/2mL syringe	
1	Nitroglycerin spray 0.4mg/spray	
2	Oxytocin 30 units/500mL bag	
4	Oxytocin 10 units/mL, 1mL vial	
3	Nifedipine 10mg, Immediate Release tabs	
1	Terbutaline1mg/mL vial	
1	Tranexamic Acid 1000mg/10ml	

The following medications are in the **9W** Pyxis Refrigerator under "**OB PPH Emergency Kit**", to access:

- Log in to pyxis
- Hit "remove meds" button
- Hit "kit" button at the bottom of the screen
- Choose the "**OB PPH Emergency Kit**"
- Remove the below meds

Pyxis items in the OB Code Kit	
Quantity	**Medication**
1	Hemabate 250mcg ampule (refrigerator in zip-lock bag)
2	Methergine 0.2mg/mL ampule (refrigerator in zip-lock bag)
5	Misoprostol 200mcg tab

****Diazepam inj** must be **removed separately from Pyxis** when needed

review

Oral Surgery Box

Supplies	Qty.
Alcohol Pads	8
BD 10ml Syringe w/ Luer Lock Tip Blunt Fill Needles	2
BD 5 ml Syringe	3

BD Eclipse 18G x1½" Needles	4
BD Eclipse 3 ml Syringe w/ 21G x1½" Needle	3
CPR Mask	1
Extension Set w/ y-site	1
IV Catheter 18G x1¼"	2
IV Catheter 20G x1¼"	2
IV Catheter 22G x1"	2
IV Start Kit w/Chloral Prep	2
Oxygen Mask	1
Regular IV Set	1

Drugs are replaced by pharmacy. Supplies are replaced by dental dept. oral surgery staff

Drugs	**Qty.**	**Expiration Date**
Albuterol Inhaler	1	
Aspirin 325mg	2	
Atropine Inj. 0.4 mg/ml 1 ml Vial	2	
Dextrose 50% Inj. 0.5 gm/ml 50 ml Syringe	1	
Diphenhydramine Inj. 50 mg/ml 1 ml Vial	1	
Ephedrine Inj. 50 mg/ml 1 ml Ampule w/ Filter needle	1	
Epinephrine 1:1000 Inj. 1 mg/ml 1 ml Ampule (For anaphylaxis: Adults: 0.3 to 0.5 mg (0.3 to 0.5 ml) of 1 mg/ml solution given IM, preferred anterior thigh)	1	
Esmolol 100mg/10ml	1	
Flumazenil Inj. 0.1 mg/ml 5 ml Vial	1	
Hydralazine 20mg/mL (1mL) vial	1	
Labetalol Inj. 5 mg/ml 20 ml vial	1	
Lidocaine Gel 2% 5 ml Tube	1	
Methylprednisolone Inj. 125 mg Vial	1	
Naloxone Inj. 0.4 mg/ml 1 ml Vial	2	
Nitroglycerin SL Tablet 0.4 mg/tab #25 tab Bottle	1	
Normal saline 10ml vial	2	
Normal Saline 250 ml Bag	1	
RSI Kit	1	
Sterile Water Inj. 10 ml Vial	1	

Hypersensitivity Reaction Kit for Infusion Center

Medication	Quantity	Expiration
Diphenhydramine Inj. 50 mg/ml 1 ml Vial	1	

Methylprednisolone Inj.125 mg Vial	1	
Epinephrine 1mg/mL vial (Refer to “MANAGEMENT OF ACUTE ADVERSE REACTIONS (ADR) POLICY: CHEMOTHERAPY/BIOTHERAPY/IMMUNOTHERAPY: policy for dosing)	1	

Famotidine inj. 20 mg/2ml vials are in Pyxis Refrigerator.

- Atropine vial and/or syringe are in the pyxis machine
- Kit will include one 3mL syringe, one 18-gauge needle and one 21-gauge needle.

review

ED Block Cart

Quantity	Medication
Rescue/LAST Treatment	

12	Preferred choice: Intralipid (Fat Emulsion) 20% inj 200 - 250 ml bag with 1.2 micron filter tubing OR 2nd choice: SMOFlipid 20% - 100mL bags x2 with 1.2micron filter tubing + ASRA checklist for treatment of local anesthetic systemic toxicity (LAST) [both original and simplified versions]
2	16 gauge needles
2	50mL syringes

review

ED Code Bag

Generic drug name	Quantity
Atropine 1mg/10mL syringe	1
Dextrose 50% 25g/50mL syringe	1

Dextrose 10% 100mg/mL (250mL bag) **during D50W shortage only**	1
Epinephrine 1:10000 1mg/10mL syringe	1
Etomidate 2mg/mL (10mL)	1
Glucose gel (oral) 15g	1
Midazolam 10mg/2mL (Versed)	1
Naloxone 2mg/2mL syr	1
Rocuronium 10mg/mL (10mL)	2
Succinylcholine 20mg/mL (5 ml) syringe	2
Tenecteplase kit	1
Supplies	**Quantity**
Normal saline 10mL flush	4
Angiocath starter kit*	1
Empty syringe 3mL	2
Empty syringe 10mL	2
18 gauge eclipse needle	4
25 gauge eclipse needle for IM inj	1

review

Alameda Hospital Only Medication Carts and Kits

Department/Divisions	Name of Emergency Box/Kit	Page
Critical Care	• Anaphylaxis Kit • CCU Difficult Airway Cart	25 26
Critical Care/ED	• Kcentra kit • TNKase kit	27 28
Misc.	• Pain Medication Tray	29

review

ANAPHYLAXIS KIT

KEEP AT BEDSIDE FOR PACLITAXEL (TAXOL), L-ASPARAGINASE, PEPASPARAGINE INJECTION

PATIENT NAME
RN NAME

Quantity	Generic Name	Trade Name	Strength	Size	Form
1	Diphenhydramine	Benadryl	50mg/ml	1ml	SDV
1	Epinephrine (1:1000) (For anaphylaxis: Adults: 0.3 to 0.5 mg (0.3 to 0.5 ml) of 1 mg/ml solution given IM, preferred anterior thigh)	Adrenalin	1mg/ml	1ml	Ampule
1	Filter Needle			19G	Needle
1	Methylprednisolone	Solu-Medrol	125mg/2ml	2ml	SDV
1	Albuterol Solution	Proventil	2.5mg/3ml	3ml	SDV
3	Syringe			3ml	Syringe
3	Needle 18G			18G	Needle
3	Alcohol Prep Pad			Each	Pad

RETURN TO PHARMACY AFTER INFUSION.

FIRST EXPIRING DRUG:	EXPIRATION DATE:

TECH/RPH	/

review

CCU Difficult Airway Cart Drug List

Patient Addressograph

Drugs	**Quantity**	**Quantity Used**
Lidocaine 2% Jelly 30ml	2	
Lidocaine 2% 50 ml Multiple Dose Vial	1	
Hurricaine Topical Spray	1	
Phenylephrine Nasal Decongestant Spray	1	

First Drug(s) to Expire:_________________________________ Expiration Date:_________________

Filled/Checked By:______/______ Date:_________________________

***Return entire kit to pharmacy for replacement after each use**

review

Kcentra® Kit Content

(Prothrombin Complex Concentrate, 4 Factor Unactivated)

Item Name	Quantity	Expiration Date
Kcentra Reconstitution Instructions	1	x
Orange "Medication Added" sticker	6	x
60 mL luer lok syringe	2	x
20 mL luer lok syringe	4	x
16 gauge needles	6	x
Empty 100mL IVPB bags	6	
Alcohol swabs	10	x
Kcentra 1000 unit manufacturer box	4	
Kcentra 500 unit manufacturer box	2	

Filled by: _______ Checked by: _______ Date checked: _______

Lock Number: _______________

Date Used: _______________

***Return entire kit to pharmacy for replacement after each use**

review

TNKase® Kit Content

Item Name	Quantity	Expiration Date
TNKase 50mg	1	
AIS bag: dose chart, Orange “Medication Added” sticker, 5cc luer lok syringe, AIS flyer	1	
STEMI bag: dose chart, Orange “Medication Added” sticker, STEMI flyer	1	x

Filled by: _______ Checked by: _______ Date checked: _______

Lock Number: _______________ Kit #: ______

NURSE: Return to Pharmacy when used

NURSE:

Place Patient Hospital Sticker

review

Pain Medications Tray List

Drugs	Exp Date	QTY	QTY Used

Lidocaine 1% P.F. (10 mg/mL) – 5 mL		25	
Lidocaine 2% P.F. (20 mg/mL) – 5 mL		10	
Bupivacaine 0.25% P.F. (2.5 mg/mL) – 10 mL		10	
Dexamethasone P.F. 10 mg/mL – 1 mL		25	
Kenalog (Triamcinolone Acetonide) 40 mg/mL – 1 mL		12	
Bupivacaine 0.5% P.F. (5 mg/mL) – 30 mL		9	
MethylPREDNISolone acetatae injectable suspension (Depo-medrol) 80mg		4	

review

San Leandro Only Medication Carts and Kits

Department/Divisions	Name of Emergency Box/Kit	Page

Cardiology	• Cardiology Drug Kit • Dobutamine Stress Test Kit	31 32
Critical Care	• Rapid Response Kit • Ancillary ICU Code Box • Kcentra Kit • TNKase Kit	33 34 35 36
OR	• OR Eye Medication Tray 1 Drug List • OR Eye Medication Tray 2 Drug List • OR Bleeding Kit	37 38 39
Radiology	• Radiology Emergency Drug (CT-Box)	40
Misc.	• Procedure Room Drug Box	41

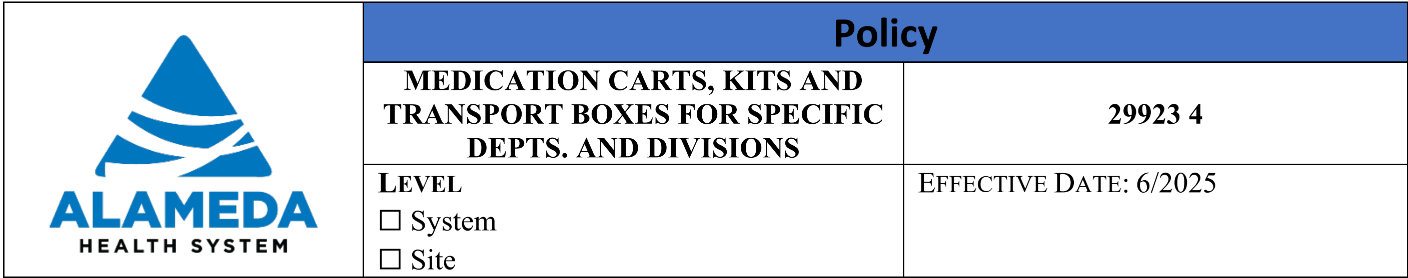
review

Cardiology Drug Kit

Cardiology Drug Kit	Aminophylline 500mg vial	1
Cardiology Drug Kit	Atropine 1mg/10ml	1
Cardiology Drug Kit	Esmolol 100mg/10ml	1
Cardiology Drug Kit	Nitroglycerin 0.4mg tabs	25
Cardiology Drug Kit	Verapamil 5mg/2ml	1
Cardiology Drug Kit	22ga x1.5” safety needle	1
Cardiology Drug Kit	Diltiazem 5mg/ml 10 ml vial	1

review

Dobutamine Stress Test Kit (prepared upon order)



Dobutamine stress test kit (prepared upon order)	Dobutamine 250mg/d50w 250ml
Dobutamine stress test kit (prepared upon order)	d5w 500ml
Dobutamine stress test kit (prepared upon order)	esomolol 100mg/10ml
Dobutamine stress test kit (prepared upon order)	atropine 1mg/10ml inj

review

Rapid Response Kit

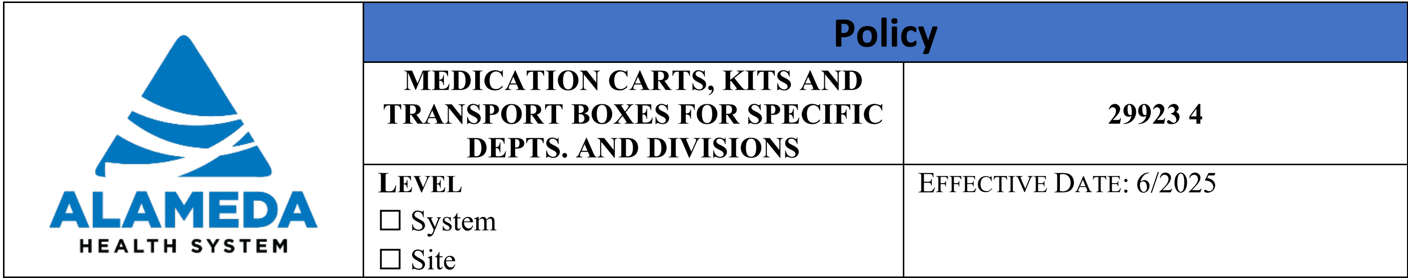
Rapid Response Kit	Ipatroprium/Albuterol 0.5mg/3mg amp	1
Rapid Response Kit	Nitroglycerin 0.4mg	1
Rapid Response Kit	Aspirin 325mg tab	1
Rapid Response Kit	Dextrose 50% 50ml	1
Rapid Response Kit	Naloxone 0.4mg	1
Rapid Response Kit	NS 1000ml IV	1

review

Ancillary ICU Code Box

Ancillary ICU Code Box	Amiodarone 150mg/3ml inj.	3
Ancillary ICU Code Box	Dextrose 5% 100ml bag	1
Ancillary ICU Code Box	Filter - 0.2 Micron	1
Ancillary ICU Code Box	Adenosine 6mg/2ml inj	3
Ancillary ICU Code Box	Atropine 1mg/10ml syringe	3
Ancillary ICU Code Box	Calcium Chloride 10% syringe	1
Ancillary ICU Code Box	Dextrose 50% 50ml syringe	1
Ancillary ICU Code Box	Dopamine 800mg/250ml D5W IV drip	1
Ancillary ICU Code Box	Epinephrine 1mg/10ml syringe	4
Ancillary ICU Code Box	Lidocaine 0.4% 250ml IV drip	1
Ancillary ICU Code Box	Lidocaine 100mg syringe	2
Ancillary ICU Code Box	Magnesium 1gm/2ml vial (Dilute with 9ml NS)	2
Ancillary ICU Code Box	Naloxone 2mg/2ml syringe	2
Ancillary ICU Code Box	Sodium Bicarbonate 8.4% syringe	2
Ancillary ICU Code Box	Sodium chloride flush 10ml syringe	4
Ancillary ICU Code Box	Sterile water 10ml	2
Ancillary ICU Code Box	Vasopressin 20 units/1 ml inj.	2

review



Kcentra® Kit Content

(Prothrombin Complex Concentrate, 4 Factor Unactivated)

Item Name	Quantity	Expiration Date
Kcentra Reconstitution Instructions	1	x
Orange “Medication Added” sticker	6	x
60 mL luer lok syringe	2	x
20 mL luer lok syringe	4	x
16 gauge needles	6	x
Empty 100mL IVPB bags	6	
Alcohol swabs	10	x
Kcentra 1000 unit manufacturer box	4	
Kcentra 500 unit manufacturer box	2	

Filled by: _______ Checked by: _______ Date checked: _______

Lock Number: _______________

Date Used: _______________

review

TNKase® Kit Content

Item Name	Quantity	Expiration Date
TNKase 50mg	1	
AIS bag: dose chart, Orange “Medication Added” sticker, 5cc luer lok syringe, AIS flyer	1	
STEMI bag: dose chart, Orange “Medication Added” sticker, STEMI flyer	1	x

Filled by: _______ Checked by: _______ Date checked: _______

Lock Number: _______________ Kit #: ______

NURSE: Return to Pharmacy when used

NURSE:

Place Patient Hospital Sticker

review

SLH OR Eye Medication Tray 1 Drug List

Drugs	Exp Date	QTY	QTY Used
Cyclopentolate (Cyclogyl) Soln 2% - 2 mL		1	
Cyclopentolate (Cyclogyl) Soln 1% - 2 mL		1	
Tropicamide 1% - 3 mL		1	
Phenylephrine (AK-Dilate) Soln 10% - 5 mL		2	
Sulfacet/Pred (Blephamide) Oint 3.5gm		1	
Gentamicin Soln 5 mL		2	
Gentamicin Oint 3.5 gm		1	
Erythromycin Oint 3.5 gm		2	
Ciprofloxacin (Cipro) Soln 0.3% - 2.5 mL		1	
Neo/Poly B/Dex (Maxitrol) Oint 3.5 gm		10	
Atropine Soln 1% - 2 mL		2	
Epinephrine PF Soln amp 1% - 2 mL		2	
Lidocaine PF Injection amp 1% - 2mL		10	
Cefazolin Injection Vial 1 gm		3	
Sterile Water for Injection SDV 10 mL		3	
Atropine Oint 1% - 3.5 gm		2	
Homatropine Soln 5% - 5 mL		2	
Lidocaine PF Injection 4% - 5 mL		6	
Gentamicin Injection SDV 80 mg/2mL		6	
Dexamethasone Injection SDV 4 mg/mL		8	

review

SLH OR Eye Medication Tray 2 Drug List

Drugs	Exp Date	QTY	QTY Used
Timolol Soln 0.5% - 5 mL		2	
Lidocaine/Epi Injection SDV 2%/1:200K – 20 mL		1	
Tetracaine Sterile Soln 0.5% - 2 mL		2	
Liquifresh PM Oint 3.5 gm		2	
Brinzolamide (Azopt) 1% - 10 mL		6	
Prednisolone (Pred-Forte) Soln 1% - 5 mL		3	
Fluorescein Sodium Ophth Strip 0.6 mg		3	
Lidocaine/Epi Injection SDV 1%/1:100K – 20 mL MDV		1	
Acetylcholine (Miochol-E) Soln – 2mL		3	
Trypan Blue (Vision Blue) Soln Syr 0.06% - 0.5 mL		5	
Pilocarpine Sterile Soln 2% - 15 mL		2	
Tetracaine Soln 0.5% - 15 mL		2	
Bupivacaine 0.75% - 10 mL		6	
Lidocaine Inj MDV 2% - 5 mL		6	
Lidocaine 2% - 50 mL		1	
Tetracaine (TetraVisc) Soln 0.5% - 5 mL		6	
Gatifloxacin (Zymaxid) Soln 0.5% - 2.5 mL		8	

review

OR Bleeding Kit

OR Bleeding Kit	GELFOAM (SIZE 100)	2

OR Bleeding Kit	Recothrom (5000 units)	4
OR Bleeding Kit	HEPARIN (1,000 UNITS/ ML) 10 ML	3
OR Bleeding Kit	HEPARIN (1,000 UNITS/ ML) 30 ML	1
OR Bleeding Kit	Gentamicin (80 MG/ 2 ML) 2 ML	4
OR Bleeding Kit	PROTAMINE (10 MG/ ML) 5 ML	1
OR Bleeding Kit	Visipaque (320mg/ml) 50ml	3
OR Bleeding Kit	30 ML SYRINGE	1
OR Bleeding Kit	18 GA HYPO NEEDLE	1
OR Bleeding Kit	MED LABELS	2

review

Radiology Emergency Drug (CT-box)

Radiology Emergency Drug (CT-Box)	Syringe w/ needle 3ml	3

Radiology Emergency Drug (CT-Box)	Atropine 1mg/ml vial	1
Radiology Emergency Drug (CT-Box)	Benadryl 50mg/ml vial	1
Radiology Emergency Drug (CT-Box)	Epinephrine Inj. 1 mg/ml (1:1000) 1 ml Vial (For anaphylaxis: Adults: 0.3 to 0.5 mg (0.3 to 0.5 ml) of 1 mg/ml solution given IM, preferred anterior thigh)	1
Radiology Emergency Drug (CT-Box)	Ammonia Inhalants	4
Radiology Emergency Drug (CT-Box)	Benadryl 25mg cap	4

review

Procedure Room Drug Box

Procedure Room Drug Box	Fentanyl 100mcg/2ml	8

Procedure Room Drug Box	Midazolam 5mg/5ml	8

review

May 27, 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:** B2

Meeting Date: May 27, 2026

Item Description: Medical Staff Evaluation Forms & Specialty Privilege Forms

COMMITTEE ACTION: Approval of revised Medical Staff Forms

Background:
The Focused Professional Practice Evaluation is a time-limited evaluation process used to assess a provider's clinical competency and performance when privileges are initial granted. This process is also known as "proctoring".

Specialty privilege forms define the scope of procedures and treatments a provider may be granted to perform within our organization. Privilege forms establish the minimum criteria required for provider to qualify.

Medical Staff forms are designed to offer a streamlined, systematic approach to support quality patient care across our facilities (AHS, SLH, AH) as applicable.

Analysis:
The FPPE form is being revised to simplify the user's experience when conducting an evaluation, while maintaining the integrity of the Accreditation Council for Graduate Medical Education (ACGME) six core competencies.

Privilege forms are developed and revised using a standardized, evidence-based process.

Board Action Requested:
Approval of revised FPPE and privilege form revisions for system-wide credentialing and privileging to support patient care at AHS.

Medical Staff Forms for AHS & AH:
- Focused Professional Practice Evaluation (FPPE) Proctoring Single Case Evaluation Form
- Focused Professional Practice Evaluation (FPPE) Proctoring Multiple Case Evaluation Form

Privilege Forms for AHS:
- Certified Registered Nurse Anesthetist

Certified Registered Nurse Anesthetist (CRNA) - AHS

Delineation of Privileges

Applicant's Name:

Instructions:

1. Click the **Request** checkbox to request a group of privileges such as *Core Privileges* or a *Special Privileges*.
2. Uncheck any privileges you do not want to request in that group.
3. Check off any special privileges you want to request.
4. Sign form and submit with any required documentation.

Required Qualifications	
Education/Training	Successful completion of an accredited nurse anesthesia educational program which meets the requirements required for Nurse Anesthetist licensure and certification.
Licensure	Licensed as a registered nurse by the California Board of Registered Nursing. **AND** Certification as a Nurse Anesthetist by the California Board of Registered Nursing.
Certification	Current certification as a Certified Registered Nurse Anesthetist (CRNA) by the National Board of Certification or Recertification of Nurse Anesthetists (NBCRNA).
Clinical Experience (Initial)	Applicant must provide documentation of provision of clinical services (a minimum of 250 cases) representative of the scope and complexity of the privileges requested during the preceding two (2) years (waived for applicants who completed training within the past year).
Clinical Experience (Reappointment)	Applicant must provide documentation of provision of clinical services (33 cases) representative of the scope and complexity of privileges requested during the previous 24 months.
Additional Qualifications	Current ACLS and BLS Certifications **AND** Supervising Physician Agreement **AND** Signed Standardized Procedure

Privileges for the Certified Registered Nurse Anesthetist (CRNA)

Request ☐	***Request all privileges listed below.*** *Uncheck any privileges that you do not want to request.*	Div Chief Rec ☐	Dept Chair Rec ☐
	Cognitive Practice Prerogatives		
☐	Perform a pre-anesthetic assessment	☐	☐
☐	Request lab and diagnostic studies	☐	☐
☐	Administer pre-anesthetic medications	☐	☐
☐	Perform post anesthesia evaluation of the patient	☐	☐
☐	Perform a post anesthesia care and discharge	☐	☐
	Procedural Practice Prerogatives		
☐	Monitored Anesthesia Care	☐	☐
☐	General anesthesia, including inhalational and intravenous anesthesia	☐	☐
☐	Regional anesthesia, including peripheral nerve blocks	☐	☐
☐	Neuraxial anesthesia, including epidurals and subarachnoid nerve blocks	☐	☐
☐	Double Lumen Endotracheal Tube Placement	☐	☐
☐	Endotracheal Intubation	☐	☐
☐	Fiberoptic Endotracheal Intubation	☐	☐
☐	Arterial Lines-Peripheral	☐	☐
☐	Central Venous Lines	☐	☐
☐	Fluid, Electrolyte Management	☐	☐
☐	Laryngeal Mask Airway	☐	☐
☐	Intraosseous line placement	☐	☐
☐	Perianesthesia Monitoring	☐	☐

Focused Professional Practice Evaluation (FPPE)/Routine Initial Proctoring

☐ Retrospective evaluation of a minimum of 5 cases of varied types of anesthesia (general, regional, monitored anesthesia care). Focus of review will be evaluation of patient, formulation and implementation of anesthesia plan documentation.

Acknowledgment of Applicant

I have requested only those privileges for which by education, training, current experience, and demonstrated competency I believe that I am competent to perform and that I wish to exercise at Alameda Health System and I understand that:

A. In exercising any clinical privileges granted, I am constrained by applicable Hospital and Medical Staff policies and rules applicable generally and any applicable to the particular situation.

B. Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of the Medical Staff Bylaws or related documents.

Practitioner's Signature ____________________ Date ____________

Department Chair Recommendation - Privileges

I have reviewed the requested clinical privileges and supporting documentation and make the following recommendation(s):

Privilege	Condition/Modification/Deletion/Explanation

Division Chief Recommendation - FPPE Requirements

Signature of Division Chief/Designee ____________________ Date ____________

Signature of Department Chair/Designee ____________________ Date ____________

Submit

Alameda Hospital

CONFIDENTIAL MEDICAL STAFF PEER REVIEW MATERIAL - Protected by California Evidence Code Sec. 1157

Focused Professional Practice Evaluation (FPPE) / Routine Initial Proctoring Evaluation

Provider: <PractitionerName>

Proctor: <ReviewerName>

Proctoring Encounter Information

Review Type:
- ◯ Concurrent
- ◯ Retrospective

Facility:
- ◯ Alameda Health System (Highland, San Leandro, Fairmont, John George, Wellness Clinics)
- ◯ Alameda Hospital

Procedure/Privilege:			
Encounter Date:		**MRN:**	

Proctoring Encounter Information (***if using cut/paste option, please includes all of the details required above***):

PLEASE EVALUATE THE PROCEDURE/ENCOUNTER CONSIDERING THE APPLICABLE COMPETENCIES BELOW.

Patient Care: Provides care that is compassionate, appropriate, and effective for the promotion of health, prevention of illness, treatment of disease, and care at end of life.

- Complete History & Physical, Pre-operative evaluation
- Problem formulation, impressions, diagnosis
- Use of consultants
- Discharge summary
- Technical performance of procedure(s)
- Complication recognition and management
- Post-procedure care
- Use of equipment

Medical Clinical Knowledge: Demonstrates knowledge of established and evolving biomedical, clinical and social sciences, and the application of this knowledge to patient care and education of others. Includes but not limited to evaluation of the below:

- Quality of operative reports/progress notes
- Pre-Operative diagnosis consistent with findings
- Use of diagnostic services (lab, imaging)

Practice Based Learning: Able to use scientific evidence and methods to investigate, evaluate, and improve patient care practices. Includes but not limited to evaluation of the below:

- Timely clinical response to diagnostic results
- Appropriate use of order sets (VTE assessment, opioids)
- Care consistent with established quality initiatives (CORE Measures, HACs, PSIs)

Interpersonal and Communication Skills: Ability to establish and maintain professional relationship with patients, families, and other members of the healthcare team. Includes but not limited to evaluation of below:

- Hand-off communication
- Use of interpreter services, family conference, palliative care referral

Professionalism: Behaviors that reflect a commitment to continuous professional development, ethical practice, understanding and sensitivity to diversity, and responsible attitude toward patients, profession, and society. Includes but not limited to evaluation of the below:

- Legible, timely, well-organized charting; no unapproved abbreviations
- Consents present, accurate, and signed
- Participation in the time out process

Systems-Based Practice: Demonstrates both an understanding of the contexts and systems in which healthcare is provided and ability to apply this knowledge to improve and optimize patient care. Includes but not limited to evaluation of the below:

- Medication reconciliation
- Appropriate levels of care (Admission, Discharge)
- Procedure performed in appropriate setting

If any of the areas are considered "Not Acceptable", please describe the area(s), along with any intervention or recommendations, in the comment section.

Overall impression of provider's skill and competency.

○ Acceptable
○ Not Acceptable (Comment Required)

Proctor Name: <ReviewerName>

Proctor Signature: <Signature>

CONFIDENTIAL MEDICAL STAFF PEER REVIEW MATERIAL - Protected by California Evidence Code Sec. 1157

Focused Professional Practice Evaluation (FPPE) / Routine Initial Proctoring Evaluation

Provider: <PractitionerName>

Proctor: <ReviewerName>

Proctoring Encounter Information

Review Type:
- ○ Concurrent
- ○ Retrospective

Facility:
- ○ Alameda Health System (Highland, San Leandro, Fairmont, John George, Wellness Clinics)
- ○ Alameda Hospital

Cases Proctored/Reviewed

	Procedure/Encounter	Date	Medical Record Number
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Proctoring Encounter Information ***(if using cut/paste option, all details required above must be included)*:**

PLEASE EVALUATE THE PROCEDURES/ENCOUNTERS CONSIDERING THE APPLICABLE COMPETENCIES BELOW.

Patient Care: Provides care that is compassionate, appropriate, and effective for the promotion of health, prevention of illness, treatment of disease, and care at end of life.

- Complete History & Physical, Pre-operative evaluation
- Problem formulation, impressions, diagnosis
- Use of consultants
- Discharge summary
- Technical performance of procedure(s)
- Complication recognition and management
- Post-procedure care
- Use of equipment

Medical Clinical Knowledge: Demonstrates knowledge of established and evolving biomedical, clinical and social sciences, and the application of this knowledge to patient care and education of others. Includes but not limited to evaluation of the below:

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Practice Based Learning: Able to use scientific evidence and methods to investigate, evaluate, and improve patient care practices. Includes but not limited to evaluation of the below:

- Timely clinical response to diagnostic results
- Appropriate use of order sets (VTE assessment, opioids)
- Care consistent with established quality initiatives (CORE Measures, HACs, PSIs)

Interpersonal and Communication Skills: Ability to establish and maintain professional relationship with patients, families, and other members of the healthcare team. Includes but not limited to evaluation of below:

- Hand-off communication
- Use of interpreter services, family conference, palliative care referral

Professionalism: Behaviors that reflect a commitment to continuous professional development, ethical practice, understanding and sensitivity to diversity, and responsible attitude toward patients, profession, and society. Includes but not limited to evaluation of the below:

- Legible, timely, well-organized charting; no unapproved abbreviations
- Consents present, accurate, and signed
- Participation in the time out process

Systems-Based Practice: Demonstrates both an understanding of the contexts and systems in which healthcare is provided and ability to apply this knowledge to improve and optimize patient care. Includes but not limited to evaluation of the below:

- Medication reconciliation
- Appropriate levels of care (Admission, Discharge)
- Procedure performed in appropriate setting

If any of the areas are considered "Not Acceptable", please describe the area(s), along with any intervention or recommendations, in the comment section.

Overall impression of provider's skill and competency.

○ Acceptable
○ Not Acceptable (Comment Required)

Proctor Name: <ReviewerName>

Proctor Signature: <Signature>

REPORT/DISCUSSION: Medical Staff Reports (Written Report)

Alameda Hospital and Alameda Health System Medical Executive Committee Report to Quality Professional Services Committee of the Board

May 27, 2026

Manasa Kalluri, MD, AH Chief of Staff

Bhrett Lash, MD, AHS Vice Chief of Staff

ALAMEDA HEALTH SYSTEM

Alameda Hospital
Medical Executive Committee Report

- **Patient Experience**
  - FYTD 26 Inpatient Domains: seven (7) of nine (9) metrics are performing above goal
- **Regulatory & Accreditation**
  - TJC Stroke Certification: May 18, 2026
- **Quality of Care & Patient Safety**
  - Quality OKR & KPI Dashboard
    - FYTD No Reported Hospital Acquired Infections
    - Sepsis mortality observed-to- expected rate is performing better than the benchmark target at 0.78.
    - FYTD Sepsis bundle compliance is better than the improvement goal and is approaching the benchmark stretch goal.
- **AH & AHS Combined Medical Staff Committees**
  - Credentials Committee
  - Clinical Practice Council

AHS & AH
Combined Medical Staff Committees

Combined committees provide unified systemwide clinical governance to ensure consistent quality, aligned clinical standards and cohesive medical staffs at Alameda, Highland and San Leandro

Credentials Committee (May 2026)

- Routine credentialing and privileging
- Telemedicine Credentialing by Proxy
- Ongoing Professional Practice Evaluation (OPPE) is factored into reappointment decisions.
- Certified Registered Nurse Anesthetist Privileges (AHS Medical Staff privilege form - revision)

Clinical Practice Council (May 2026)

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

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

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

AHS & AH Credential Committee

Credentials and Privileges

The committee reviewed the credential files of the initial applicants, temporary privileges, and reappointments and recommended approval for Medical Staff membership and clinical privileges as listed. Additional credentialing activity, including leave of absences, completion of proctoring, additional privileges, category/staff status changes, and resignations was also reviewed and approved.

AHS Medical Staff

1 Temporary Privilege Appointment
7 Initial Appointments
43 Reappointments
4 Leave of Absences/6 Returns
3 Completions of FPPE/Proctoring
4 Privilege Modifications
1 Category Change
12 Resignations

AH Medical Staff

3 Initial Appointments
18 Reappointments
2 Leave of Absences returns
1 Completions of FPPE/Proctoring
2 Privilege Modifications
8 Resignations

Credentialing by Proxy (CBP) for Teleneurology and Teleradiology Services:

The committee reviewed and accepted the credentialing files provided by the distant site and recommended approval for Medical Staff clinical privileges as listed.

AHS & AH Medical Staff Credentialing By Proxy

4 Initial Appointment of Privileges
5 Reappointment of Privileges
6 Proctoring Completions
1 Resignation

Clinical Impact and Joint Conference Committees

Open Communication

- Transparency
- Alignment
- Understanding

Clinical Input

- Level 1 Trauma
- Cardiac Arrest Receiving Center
- Stroke Center

Prioritization of Level 1 Trauma Recertification

- Anesthesia
- Vascular
- Geriatrics

MEC Integration in Decisions

- Capital Committee Core Membership

Regulatory and Accreditation

- CMS/CDPH Complaint Validation Survey
  - 4/13/26 through 4/17/26
  - Final report pending plan for correction to address any findings

- Joint Commission Tri-Annual Survey

"Meds to Beds" Program

- In August of 2024, our Emergency Department Community Health Worker (CHW) Program launched a "Meds to Beds" initiative to support patients in care navigation and medication access.
- Multidisciplinary Team: ED physicians, nurses, pharmacy staff, and CHW
- Our "meds to beds" program was designed to address the needs of our most vulnerable patients, bringing their outpatient medications directly to bedside prior to discharge to ensure receipt.

"Meds to Beds" Program Outcomes

- Reduced the pharmacy wastage (or "return to stock" rate) substantially
- Patients receiving a CHW consult are twice as likely to fill their medications
- Enabled complex care patients to safely transition from the ED to venues such as medical respite and substance use programs without an interruption in medication availability.
- Serves as a crucial resource for other aspects of care navigation and supports patient experience in the ED.

ALAMEDA HEALTH SYSTEM

ALAMEDA

HEALTH SYSTEM

CARING, HEALING, TEACHING, SERVING ALL

REPORT/DISCUSSION: Quality Reports

BOT Executive Summary: Quality Report
Ana Torres, Vice President of Quality
May 27, 2026

Key Point 1: The table below summarizes the performance of the metrics on the 2026 FYTD (through March) QPSC OKR report. Six of the ten metrics on the QPSC OKR are performing at goal or better than baseline.

Key Result	Performance		
	Met goal	**≥ Baseline**	**Did not meet goal**
Total Patient Harms			✓
Sepsis Bundle Compliance		✓	
Sepsis Mortality (O/E)		✓	
Readmission, All Cause			✓
Wait for New Appointment – Specialty Clinics			✓
Wait for New Appointment – Primary Clinics			✓
ED Boarding – Community Hospitals		✓	
ED Boarding- Highland Hospital		✓	
HRSN Screening	✓		
Likelihood to Recommend	✓		

HARMS

While the system-wide Total Harms metric will not meet the harm reduction goal, Alameda Hospital and Highland Hospital are on track to meet their FY2026 harm reduction goals.

Most harms occurred in following categories: Hospital Acquired Pressure Injury (HAPI), Behavior Events with Injury, and Falls with Injury. HAPI events are measured at Alameda Hospital, Highland Hospitals and San Leandro Hospital only.
Behavior Events with Injury and Falls with Injury are tracked across the system and include John George and Ambulatory Care settings.

- HAPI
  HAPI mitigation efforts are focused on implementing and sustaining best practices and include conducting skin assessments on admission and turning patients every two hours.
- Falls with Injury
  Fall prevention strategies include proactive toileting during hourly rounding, managing patient expectations regarding call-light usage, and training falls champions on the Bedside Mobility Assessment Tool to support safe patient mobility.
- Behavior Events with Injury
  Behavior event prevention is being addressed through the Workplace Violence Team. Current initiatives include increasing reporting; ensuring implementation of past initiatives; developing a crisis response team and ensuring alignment and compliance with regulatory and accreditation standards.

SEPSIS BUNDLE COMPLIANCE

Sepsis bundle compliance has steadily improved and FYTD performance is one percentage point from the goal.
Alameda Hospital met the goal. Highland and San Leandro Hospitals have not met the goal, but the performance is exceeding baseline performance.

SEPSIS MORTALITY

The sepsis mortality ratio is currently performing at baseline. All sepsis-related deaths are reviewed to determine whether the patient died *from* sepsis or *with* sepsis, and to assess potential preventability. Reviews have identified that incomplete documentation of patient comorbidities may be contributing to a mortality ratio that appears higher than expected.

READMISSIONS

The 30-day All Cause Readmission rate goal was not met. Readmissions is an opportunity for all three acute care hospitals. Readmission reduction efforts are focused on capturing the readmission risk score during interdisciplinary rounds; REACH program's post discharge follow-up within 72 hours; and improving discharge teaching.

WAIT TIME FOR NEW APPOINTMENT – Specialty and Primary

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

ED BOARDING FOR ADMITTED PATIENTS

The ED Boarding times did not meet the goal although performance is exceeding baseline.
ED Boarding is being addressed by the systemwide Throughput Steering Committee. The committee has established five task forces focused on the key drivers of patient throughput: Access, Readmissions, Surge Red, System Bed Capacity, and Length of Stay reduction.
While improvement has been observed, it has been noted that the metric does not capture patients in observation status. As a result, this metric will be adjusted or replaced as part of the FY2027 OKR process.

HEALTH-RELATED SOCIAL NEEDS (HRSN)

The HRSN Screening metric met the goal. Patients that screen positive for one of HRSNs are connected with community services via FindHelp.

LIKELIHOOD TO RECOMMEND:

The Likelihood to Recommend metric met the established goal. This metric measures the Likelihood to Recommend in Acute Care, Emergency Department and Ambulatory Surgery.
The improvement plan focuses on addressing responsiveness of staff, leader rounding, and the discharge communication process which addresses several patient satisfaction domains.
Additional efforts include reinforcing GIFT and standards of behavior with accompanying customer service training.

Key Point 2: The finalized Leapfrog Safety Grades were released in May 2026.

Leapfrog Safety Score

The Spring 2026 Leapfrog Safety Scores were released. The safety grades earned are as follows:

- Alameda Hospital – A
- Highland Hospital - C
- San Leandro Hospital – B

The opportunities for the Spring release were hospital acquired infections and patient experience.

Key Point 3: There was one CMS complaint validation survey in April 2026.

A concurrent 5-day CDPH / CMS Complaint Validation survey occurred at Highland Hospital. The survey concluded on April 17, 2026. April. AHS has not received the Statement of Deficiency.

The Regulatory Team has been focused on licensing projects and survey readiness activities. The Joint Commission survey was expected to occur by April 22, 2026.

FY 2026 QPSC OKR Dashboard

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

Safe Care - Caring, Healing, Teaching All		Performance			Goals		
OBJECTIVES	KEY RESULTS	Mar 2026	FY26 YTD	FY2025 Actual	Improvement	Benchmark	Accountable Leaders
Provide safe care	Total Patient Harms*	23	201	410	204	164	T. Fitzgerald Shaw, L. Laurent
	Bundle Compliance Sepsis Early Management	66.67%	74%	55%	75%	88%	T. Fitzgerald Shaw, L. Laurent
	Sepsis Mortality O/E Ratio	0.99	1.05	1.05	1.00	0.93	T. Fitzgerald Shaw, L. Laurent
Timely, Effective, and Efficient Care							
OBJECTIVES	KEY RESULTS	Mar 2026	FY26 YTD	FY2025 Actual	Improvement	Benchmark	Accountable Leaders
Promote wellbeing	All Cause 30-day readmission rate	12.94%	12.79%	12.26%	11.69%	11.12%	D. Littlepage, A. Wu
Provide accessible care	% of Specialty Clinics with an average of less than or equal to 15 days for New Patients Appointments*	19%		11.76%		80%	T. Amoruwa, P. Mack
	% of Adult Primary Care Clinics with an average of less than or equal to 10 days for New Patients Appointments *	25%		0%		100%	T. Amoruwa, P. Mack
	ED Boarding Time for Admitted Patients Community Hospital	2:47	2:39	3:10	2:12	1:30	T. Fitzgerald Shaw, A.Wu
	ED Boarding Time for Admitted Patients Highland	14:17	10:00	12:57	8:28	4:00	T. Fitzgerald Shaw, A. Wu
Equitable Care							
OBJECTIVES	KEY RESULTS	Mar 2026	FY26 YTD	FY2025 Actual	Improvement	Benchmark	Accountable Leaders
Serving all: Deliver equitable care	Health-related Social Needs Assessment Completed on Inpatients	87.00%	84.00%	64.58%	81.95%	89.40%	T. Fitzgerald Shaw
	% of Inpatients positive for at least 1 Health-related Social Need	30.00%	30.00%	NA			
Patient-Centered Care							
OBJECTIVES	KEY RESULTS	Mar 2026	FY26 YTD	FY2025 Actual	Improvement	Benchmark	Accountable Leaders
Be the most welcoming system to receive care	Likelihood to recommend care composite	73.63%	75.96%	72.54%	73.54%	79.67%	T. Fitzgerald Shaw, A. Ng

Fiscal Year Starts in July 1 and Ends June 30

*Post Acute values to be reported out separately

* AHS' ultimate goal is Zero Hospital Acquired Harm

FY26 YTD is results from July 2025 to FY26YTD

Fiscal Year 2025

OKR Metric Definitions for QPSC

Metric	Definition	GOAL	
		Improvement	Benchmark
Patient Harm	The number of potential health-care acquired patient harms Includes: CLABSI, CAUTI, MRSA BSI, C-Diff, SSI for Acute Med-Surg/Critical Care, and Patient Falls with injuries, Hospital Acquired Pressure Injuries and Behavior Events that result in Injury for all areas (practically, not inclusive of ambulatory)	353 50% gap reduction to the 50th Percentile	293 NHSN 2022 50th Percentile
Bundle Compliance Sepsis Early Management	A set of guidelines that hospitals use to manage patients with severe sepsis or septic shock. The guidelines focus on early recognition and intervention to save lives and limbs. This is an "all-or-nothing" measure, meaning that hospitals must adhere to all elements of the bundle to receive credit. Follows CMS/TJC SEP 1 Definition	CMS National 7/2023-6/2024 75th Percentile	CMS National 7/2023-6/2024 95th Percentile
Sepsis Mortality O/E Ratio	The observed to expected (O:E) sepsis mortality ratio is a comparison of the actual number of sepsis-related deaths in a hospital (observed) to the predicted number of deaths (expected). Performance is considered better than expected if the O:E ratio is less than 1, and worse than expected if the ratio is greater than 1. A lower O:E ratio indicates that more people are surviving conditions that would otherwise be fatal.	NA	1.04 National Mean per Vizient
All-cause 30 day Readmissions Rate	Percentage of inpatient acute med-surg encounters, regardless of payer type, with an unplanned readmission to any AHS facility within 30 days for any cause among encounters for acute care inpatients with a principal discharge diagnosis/procedure for a clinical classification category in the Cardiorespiratory, Cardiovascular, Medicine, Neurology, or Surgery/Gynecology cohort. *Note:* This measure approximates, but likely does not match, the value of the	11.56% 50% gap reduction to the 50th Percentile CMS Hospital Compare	11.12% 50th Percentile CMS Hospital Compare
% of Specialty Clinics with an average of less than or equal to 15 days for New Patients Appointments*	The average of days between when a new patient to AHS requests an appointment with a specialty to the day of appointment. This metric tracks the percentage of clinics that are, on average, less than or equal to 15 business days		80% of clinics have a monthly average equal to or less than 15 business days
% of Adult Primary Care Clinics with an average of less than or equal to 10 days for New Patients Appointments *	The average of days between when a new patient to AHS requests an appointment with a primary care to the day of appointment. This metric tracks the percentage of clinics that are, on average, less than or equal to 10 business days		100% of clinics have a monthly average equal to or less than 10 business days
ED Boarding Time Time in ED from Decision to Admit to Inpatient Bed	Median time from Decision to Admit to departure from the emergency department for admitted patients. Decision to Admit = First Admit Disposition Admit = Time patient admitted to Inpatient Unit	2:20 Community Hospitals: 50% gap closure to pre=pandemic performance	1:30 Community Hospitals: Pre-pandemic Performance 4:00 Highland:
Rate of Inpatients screened for health-related social needs (food, housing, transportation, safety, utilities) ↑	The percentage of inpatient acute medical/surgical admissions where the patient is screened for social determinents of health: food insecurity, housing, transportation, safety and utilites	75% Internal Benchmark: Best Performing Campus rate for FY24	90% Internal Benchmark: Monthly Rate achieve by Best Performing Campus
Rate of patients who reported they would "definitely" recommend AHS	Percentage of patients who would recommend AHS (includes rehab, acute, ambulatory, ED, outpatient surgery, dental, radiology)	78.78% 2% Improvement over FY24 Baseline	79.16% 75th Percentile for Inpatient Med Surg 50th Percentile for all other areas based on Press Ganey National Database

Alameda Hospital FY 2026 Detailed Quality OKR and KPI Dashboard

Vision: Alameda Health System will be recognized as a world-class patient and family centered system of care that promotes wellness, eliminates disparities and optimized the health of our diverse communities.

Safe Care - Caring, Healing, Teaching All			Performance			FY26 Goals	
OBJECTIVES	KEY RESULTS	Detailed KPIs	Mar 2026	FY26 YTD	FY25 Actual	Improvement	Benchmark
Provide safe care	Eliminate Patient Harms	Total Patient Harms	4	21	27	24	14
		CLABSI # Events/SIR	0/NA	0/0	0/0	0/0.317	0/0
		CAUTI # Events/SIR	0/NA	0/0	1/0.56	0/.55	0/.264
		MRSA # Events/SIR	0/NA	0/0	0/0	0/0.658	0/0.335
		C. Difficile # Events/SIR	0/NA	0/0	5/0.75	3/.58	2/.346
		SSI # Events/SIR	0/NA	0/0	1/1.23	1/1.324	0/.849
		Falls with Injury/% Per 1000 Days	1/0.81	6/0.64	10/0.53	9/0.477	3/0.24
		Reportable HAPI #/% per 1000 Discharges	3/11.765	5/2.41	0/0	0/0	0/0
		Behavior Events with Physical Injury	0/0	10/1.06	10/0.76	9/0.684	8/0.608
		HAPI all Stages #/% per 1000 Discharges	10/39.216	36/18.81	50/18.22	45/16.398	40/14.576
		Serious Safety Events (F or Greater)	0	2	0		
	Reduce Mortality from Sepsis	Sepsis Mortality Observed:Expected & Total Deaths	NA	0.78	1.04	1	0.93
		Bundle Compliance Sepsis Early Management	75.00%	83.75%	77.00%	75%	88%
	Embed Critical Behaviors	Hand Hygiene Compliance	92.90%	89.96%	82.62%		95%

Fiscal Year Starts in July 1 and Ends June 30

FY26 YTD is results from July 2025 to Mar 2026

Timely, Effective, and Efficient Care			Performance			FY26 Goals	
OBJECTIVES	KEY RESULTS	Detailed KPIs	Mar 2026	FY26 YTD	FY25 Actual	Improvement	Benchmark
Promote wellbeing	Provide the right care at the right time	All Cause 30-Day Readmission Rate	11.54%	14.84%	14.82%	11.69%	11.12%
Provide accessible care	Minimize Time Spent Waiting for our Patients	ED Boarding Time for Admitted Patients	2:48	2:33	2:55	2:12	1:30
Equitable Care			**Performance**			**FY26 Goals**	
OBJECTIVES	KEY RESULTS	Detailed KPIs	Mar 2026	FY26 YTD	FY25 Actual	Improvement	Benchmark
Serving all: Deliver equitable care	Health-related social needs recognized and addressed	Health-related social needs assessment completed on inpatients	79.00%	76.00%	49.50%	82%	89%
		% of patients that screened positive for at least 1 Health-related social needs	29.00%	25.00%	NA		
Patient-Centered Care			**Performance**			**FY26 Goals**	
OBJECTIVES	KEY RESULTS	Detailed KPIs	Mar 2026	FY26 YTD	FY25 Actual	Improvement	Benchmark
Be the most welcoming system to receive care	Optimize performance regarding patient experience	Likelihood to recommend Acute	44.30%	71.76%	62.99%	63.89%	71.10%
		Likelihood to recommend ED	68.75%	67.23%	64.40%	65.40%	71.60%
		Communication with Nurses	67.85%	74.87%	69.60%	70.60%	79.90%
		Communication with Providers	68.71%	78.75%	75.91%	76.91%	79.20%

Fiscal Year Starts in July 1 and Ends June 30

FY26 YTD is results from July 2025 to Mar 2026

Fiscal Year 2025

OKR Metric Definitions for QPSC

Metric	Definition	GOAL	
		Improvement	Benchmark
Patient Harm	The number of potential health-care acquired patient harms Includes: CLABSI, CAUTI, MRSA BSI, C-Diff, SSI (Colon, C-Section, Gallbaldder, Hysteretomy, Spinal Fusion. Small Bowel)for Acute Med-Surg/Critical Care, and Patient Falls with injuries, Reportable Hospital Acquired Pressure Injuries and Behavior Events that result in Injury for all areas (practically, not inclusive of ambulatory)	HAI equal to or better than 75th percentile Falls, HAPI, Behavior Events 10% reduction	HAI equal to or better than 50th percentile Falls, HAPI, Behavior Events 20% reduction
CLABSI # Events/ SIR	A primary bloodstream infection (that is, there is no apparent infection at another site) that develops in a patient with a central line in place . #: Number of infections that occurred SIR: Standardized Infection Ratio compares the actual number of infections to the predicted number of infections. The predicted number is risk adjusted. Results less 1 are desirable	NHSN National 25th Percentile	NHSN National 10th Percentile
CAUTI # Events/ SIR	an infection of the urinary tract caused by a tube (urinary catheter) that has been placed to drain urine from the bladder. #: Number of infections that occurred SIR: Standardized Infection Ratio compares the actual number of infections to the predicted number of infections. The predicted number is risk adjusted. Results less 1 are desirable	NHSN National 50th Percentile	NHSN National 25th Percentile
MRSA # Events/ SIR	Potential hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA) staph infection that is difficult to treat because of resistance to some antibiotics. #: Number of infections that occurred .Serving as a proxy measure tied to patient days, reflecting the hospital's ability to prevent transmission and invasive infection rather than serving as a confirmed clinical diagnosis. NHSN defines hospital-onset (HO) as the first positive laboratory test for an organism collected on or after hospital day 4 of admission, which reasonably attributes the event to the hospitalization	NHSN National 50th Percentile	NHSN National 25th Percentile
C. Difficile # Events/ SIR	Potential hospital acquired infection that causes diarrhea and colitis (an inflammation of the colon). #: Number of infections that occurred This serves as a proxy for infection risk in the hospital rather than a confirmed diagnosis. Hospital-onset (HO) is defined as the first positive laboratory test for an organism collected on or after hospital day 4 of admission, which reasonably attributes the event to the hospitalization.	NHSN National 75th Percentile	NHSN National 50th Percentile
SSI # Events/ SIR	an infection that occurs after a Colon, C-Section, Gallbaldder, Hysteretomy, Spinal Fusion, Small Bowel surgery in the part of the body where the surgery took place. Excludes superficial infections. Attributed to date of procedure. #: Number of infections that occurred attributed to month procedure performed SIR: Standardized Infection Ratio compares the actual number of infections to the predicted number of infections. The predicted number is risk adjusted. Results less 1 are desirable	NHSN National 75th Percentile	NHSN National 50th Percentile
Falls with Injury/ # % Per 1000 Days	Patient Fall reported via Midas Safety Alert. # of Events / Rate: Number of events divided by number of patient days times 1000	10% improvement as compared to Fiscal Year 2025	NDNQI 25th Percentile
Reportable HAPI #/% per 1000 Discharges	Hospital Acquired Pressure Ulcers Stage 3 or 4 ulcer, acquired after admission to a health facility, excluding progression from Stage 2 to Stage 3 if Stage 2 was recognized upon admissionreported via Midas Safety Alert. This includes deep tissue injuries and unstageable pressure injuries that progress to a stage 3 or 4. # of Events / Rate: Number of events divided by number of patient discharges times 1000	10% improvement as compared to Fiscal Year 2025	20% improvement as compared to Fiscal Year 2025
Behavior Events with Physical Injury	Behavior events that resulted in physicial injury via Midas Safety Alerts # of Events/Rate: Number of events divided by number of patient days times 1000	10% improvement as compared to Fiscal Year 2025	20% improvement as compared to Fiscal Year 2025
HAPI #/ % per 1000 DCs	Hospital Acquired Pressure Ulcers reported via Midas Safety Alert. # of Events / Rate: Number of events divided by number of patient discharges times 1000	10% improvement as compared to Fiscal Year 2025	20% improvement as compared to Fiscal Year 2025
Serious Safety Events (F or Greater)	Midas Safety Alerts where an event occurred that may have contributed to or resulted in temporary harm to any involved parties and required initial or prolonged hospitalization	NA	Zero

Fiscal Year 2025

OKR Metric Definitions for QPSC

Metric	Definition	GOAL	
		Improvement	Benchmark
Sepsis Mortality O/E Ratio	The observed to expected (O:E) sepsis mortality ratio is a comparison of the actual number of sepsis-related deaths in a hospital (observed) to the predicted number of deaths (expected). Performance is considered better than expected if the O:E ratio is less than 1, and worse than expected if the ratio is greater than 1. A lower O:E ratio indicates that more people are surviving conditions that would otherwise be fatal.	Observed Mortality equal to Expected Mortality	Vizient National FY2025 50th Percentile
Bundle Compliance Sepsis Early Management	A set of guidelines that hospitals use to manage patients with severe sepsis or septic shock. The guidelines focus on early recognition and intervention to save lives and limbs. This is an "all-or-nothing" measure, meaning that hospitals must adhere to all elements of the bundle to receive credit. Follows CMS/TJC SEP 1 Definition	CMS National 7/2023-6/2024 75th Percentile	CMS National 7/2023-6/2024 95th Percentile
Hand Hygiene Compliance	Hand hygiene is a leading way to reduce the spread of pathogens in healthcare settings. It includes: Washing hands with soap and water and Using an antiseptic handrub. Hand hygiene compliance is the percentage of times that a person performs hand hygiene when an opportunity arises. It's calculated by dividing the number of hand hygiene actions performed by the total number of opportunities.		The level of adherence crucial for patient safety and preventing healthcare-associated infections.
All-cause 30 day Readmissions Rate	Percentage of inpatient acute med-surg encounters, regardless of payer type, with an unplanned readmission to any AHS facility within 30 days for any cause among encounters for acute care inpatients with a principal discharge diagnosis/procedure for a clinical classification category in the Cardiorespiratory, Cardiovascular, Medicine, Neurology, or Surgery/Gynecology cohort. *Note:* This measure approximates, but likely does not match, the value of the corresponding CMS readmission measure.	50% gap reduction to the 50th Percentile CMS Hospital Compare	50th Percentile CMS Hospital Compare
NTSV Cesarean Section Rate	he NTSV C-section rate is the percentage of live babies born to women in their first pregnancy who meet the following criteria: Born at or after 37 weeks gestation Singleton (no twins or more) In the vertex presentation (no breech or transverse positions)	QIP Target: 10% gap closure between AHS CY2024 performance and 90th Percentile	90th Percentile
ED Boarding Time Time in ED from Decision to Admit to Inpatient Bed	Median time from Decision to Admit to departure from the emergency department for admitted patients. Decision to Admit = First Admit Disposition Admit = Time patient admitted to Inpatient Unit	**Community Hospitals:** 50% gap closure to pre=pandemic performance **Highland:** 50% gap closure to TJC benchmark	**Community Hospitals:** Pre-pandemic Performance **Highland:** TJC guidance for max boarding time
Rate of Inpatients screened for health-related social needs (food, housing, transportation, safety, utilities) ↑	The percentage of inpatient acute medical/surgical and behavioral health admissions where the patient is screened for all 5 social determinents of health: food insecurity, housing, transportation, safety and utilites	10% improvement as compared to Fiscal Year 2025	20% improvement as compared to Fiscal Year 2025
% of patients that screened positive for at least 1 Health-related social needs	The percentage of inpatient acute medical/surgical and behavioral health admissions where the patient screened positive for 1 or more health-related social needs: food insecurity, housing, transportation, safety and utilites	NA - Establishing Baseline	NA-Establishing Baseline
Acute: Rate of patients who reported they would “definitely” recommend AHS	Percentage of discharged inpatients who would recommend AHS	1% improvement as compared to Fiscal Year 2025	**Community Hospitals:** National 50th Percentile **Highland:** National 75th Percentile
Same Day Surgery:Rate of patients who reported they would “definitely” recommend AHS	Percentage of same day surgery patients who would recommend AHS	1% improvement as compared to Fiscal Year 2025	National 50th Percentile
Emergency: Rate of patients who reported they would “definitely” recommend AHS	Percentage of Emergency patients who would recommend AHS	1% improvement as compared to Fiscal Year 2025	National 50th Percentile

Fiscal Year 2025

OKR Metric Definitions for QPSC

Metric	Definition	GOAL	
		Improvement	Benchmark
Communication with Nurses	A domain of HCAHPS which measures patients' perceptions of how well patients feel that their nurses: explained things clearly, listened carefully, and treated the patient with courtesy and respect. Percent of surveyed Inpatient discharges where patient response was highest of the scale	1% improvement as compared to Fiscal Year 2025	National 50th Percentile
Communication with Providers	A domain of HCAHPS which measures patients' perceptions of how well patients feel that their provider(s): explained things clearly, listened carefully, and treated the patient with courtesy and respect. Percent of surveyed Inpatient discharges where patient response was highest of the scale	1% improvement as compared to Fiscal Year 2025	**Community Hospitals:** National 50th Percentile **Highland:** National 90th Percentile

Ambulatory FY 2026 Detailed Quality OKR and KPI Dashboard

Vision: Alameda Health System will be recognized as a world-class patient and family centered system of care that promotes wellness, eliminates disparities and optimized the health of our diverse communities.

Safe Care - Caring, Healing, Teaching All			Performance			FY26 Goals	
OBJECTIVES	KEY RESULTS	Detailed KPIs	Mar 2026	FY26 YTD	FY25 Actual	Improvement	Benchmark
Provide safe care	Eliminate Patient Harms	Total Patient Harms	0	0	1	1	0
		Behavior Events with Physical Injury	0	0	1	1	0
		Serious Safety Events (F or Greater)	0	0	0	1	0
	Embed Critical Behaviors	Hand Hygiene Compliance	90.70%	92.78%	82.84%		95%

Timely, Effective, and Efficient Care			Performance			FY26 Goals	
OBJECTIVES	KEY RESULTS	Detailed KPIs	Mar 2026	FY26 YTD	FY25 Actual	Improvement	Benchmark
Promote wellbeing	Provide the right care at the right time	All Cause 30-Day Readmission Rate	8.88%	12.73%	12.26%	11.56%	11.12%
		MyChart Activation Rate	39.00%	39.00%	27.00%		
	Find and treat conditions early	Breast Cancer Screening	63.00%		59.48%	60.27%	63.48%
		Cervical Cancer Screening	50.71%		46.44%	49.64%	67.46%
		Colorectal Cancer Screening	62.27%		61.68%	57.98%	57.98%
	Achieve the best health outcomes	Glycemic status assessment of patients with diabetes	28.76%		31.16%	29.94%	27.01%
		Controlling High Blood Pressure	64.11%		63.82%	63.86%	72.75%
		Child and Adolescent Well-Care Visits	54.95%		49.99%	49.85%	64.74%

Fiscal Year Starts in July 1 and Ends June 30

FY26 YTD is results from July 2025 to Mar 2026

Timely, Effective, and Efficient Care (continued)			Performance			FY26 Goals	
OBJECTIVES	KEY RESULTS	Detailed KPIs	Mar 2026	FY26 YTD	FY25 Actual	Improvement	Benchmark
	Minimize Time Spent Waiting for our Patients	TNAA Primary Care - Return	19	19	10	10	2
		TNAA Specialty Care -Return	3.5	3.5	7	15	2
		% of Specialty Clinics with an average of less than or equal to 15 days for New Patients Appointments*	19.00%		11.76%		80%
		% of Adult Primary Care Clinics with an average of less than or equal to 10 days for New Patients Appointments *	25.00%		0.00%		100%

Patient-Centered Care			Performance			FY26 Goals	
OBJECTIVES	KEY RESULTS	Detailed KPIs	Mar 2026	FY26 YTD	FY25 Actual	Improvement	Benchmark
Be the most welcoming system to receive care	Optimize performance regarding patient experience	Likelihood to recommend (Dental)	63.10%	66.15%	62.51%	63.51%	79.10%
		Likelihood to recommend (Primary/Specialty)	76.02%	77.56%	73.18%	74.18%	80.00%
		Communication with Care Provider (Primary/Specialty)	75.70%	76.70%	76.48%	77.48%	83.20%

Fiscal Year Starts in July 1 and Ends June 30

*Preliminary Data

FY26 YTD is results from July 2025 to Mar 2026

Fiscal Year 2025

OKR Metric Definitions for QPSC

Metric	Definition	GOAL	
		Improvement	Benchmark
Total Patient Harms	The number of potential health-care acquired patient harms Includes: , Behavior Events that result in Injury	10% reduction compared to FY25 overall	20% reduction compared to FY25 overall
Behavior Events with Physical Injury	Behavior events that resulted in physicial injury via Midas Safety Alerts # of Events/Rate: Number of events divided by number of patient days times 1000	10% reduction compared to FY25 overall	20% reduction compared to FY25 overall
Serious Safety Events (F or Greater)	Risk Events that are given a significance of F or Greater	10% reduction compared to FY25 overall	20% reduction compared to FY25 overall
Hand Hygiene Compliance	Hand hygiene is a leading way to reduce the spread of pathogens in healthcare settings. It includes: Washing hands with soap and water and Using an antiseptic handrub. Hand hygiene compliance is the percentage of times that a person performs hand hygiene when an opportunity arises. It's calculated by dividing the number of hand hygiene actions performed by the total number of opportunities		The level of adherence crucial for patient safety and preventing healthcare-associated infections.
All Cause 30-Day Readmission Rate	Percentage of inpatient acute med-surg encounters, regardless of payer type, with an unplanned readmission to any AHS facility within 30 days for any cause among encounters for acute care inpatients with a principal discharge diagnosis/procedure for a clinical classification category in the Cardiorespiratory, Cardiovascular, Medicine, Neurology, or Surgery/Gynecology cohort. *Note:* This measure approximates, but likely does not match, the value of the corresponding CMS readmission measure.	11.56% 50% gap reduction to the 50th Percentile CMS Hospital Compare	11.12% 50th Percentile CMS Hospital Compare
MyChart Activation Rate	% of patients who have activated MyChart		
Breast Cancer Screening	The percentage of individuals 50–74 years of age who were recommended for routine breast cancer screening and had a mammogram to screen for breast cancer	60.27%	63.48% 90th %tile
Cervical Cancer Screening	The percentage of individuals 21–64 years of age who were recommended for routine cervical cancer screening who were screened for cervical cancer using any of the following criteria: • Individuals 21–64 years of age who were recommended for routine cervical cancer screening and had cervical cytology performed within the last 3 years. • Individuals 30–64 years of age who were recommended for routine cervical cancer screening and had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years. • Individuals 30–64 years of age who were recommended for routine cervical cancer screening and had cervical QIP PY8 Reporting Manual: Primary Care Access and Preventive Care Measures Page 90 of 581 CPT only copyright 2024 American Medical Association. All rights reserved. cytology/high-risk human papillomavirus (hrHPV) co-testing within the last 5 years.	49.64%	67.46% 90th %tile
Colorectal Cancer Screening	Percentage of adults 45-75 years of age who had appropriate screening for colorectal cancer.	57.98%	57.98% 90th %tile
Glycemic status assessment of patients with diabetes	The percentage of individuals 18–75 years of age with diabetes (types 1 and 2) whose most recent glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) was >9.0% during the measurement year	29.94%	27.01% 90th %tile
Controlling High Blood Pressure	percentage of individuals 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90 mm Hg) during the measurement year.	63.86%	72.75% 90th %tile
Child and Adolescent Well-Care Visits	The percentage of individuals who had the following number of well-child visits with a PCP during the last 15 months. The following rates are reported: 1. Well-Child Visits in the First 15 Months. Children who turned 15 months old during the measurement year: Six or more well-child visits. 2. Well-Child Visits for Age 15 Months–30 Months. Children who turned 30 months old during the measurement year: Two or more well-child visits.	49.85%	64.74% 90th %tile
TNAA Primary Care - Return	Median of all third next available appointment for Return patient visit for Primary Care	10	2
TNAA Specialty Care -Return	Median of all third next available appointment for Return patient visit for specialty Care	15	2
% of Specialty Clinics with an average of less than or equal to 15 days for New Patients Appointments*	The average of days between when a new patient to AHS requests an appointment with a specialty to the day of appointment. This metric tracks the percentage of clinics that are, on average, less than or equal to 15 business days		80%
% of Adult Primary Care Clinics with an average of less than or equal to 10 days for New Patients Appointments *	The average of days between when a new patient to AHS requests an appointment with a primary care to the day of appointment. This metric tracks the percentage of clinics that are, on average, less than or equal to 10 business days		100%
Likelihood to recommend (Dental)	Percentage of patients who indicated that they would definitely recommend the clinic Percent of surveyed discharges where patient response was highest of the scale (Top Box Score)	63.51%	79.10%
Likelihood to recommend (Primary/Specialty)	Percentage of patients who indicated that they would definitely recommend the clinic Percent of surveyed discharges where patient response was highest of the scale (Top Box Score)	74.18%	80.00%
Communication with Care Provider (Primary/Specialty)	Percentage of patients who indicated that they would definitely recommend the clinic Percent of surveyed discharges where patient response was highest of the scale (Top Box Score)	77.48%	83.20%

Highland FY 2026 Detailed Quality OKR and KPI Dashboard

Vision: Alameda Health System will be recognized as a world-class patient and family centered system of care that promotes wellness, eliminates disparities and optimized the health of our diverse communities.

Safe Care - Caring, Healing, Teaching All			Performance			FY26 Goals	
OBJECTIVES	KEY RESULTS	Detailed KPIs	Mar 2026	FY26 YTD	FY25 Actual	Improvement	Benchmark
Provide safe care	Eliminate Patient Harms	Total Patient Harms	10	80	136	108	66
		CLABSI # Events/SIR	0/NA	0/0	0/0	2/.317	0/0
		CAUTI # Events/SIR	0/NA	2/0.56	8/0.94	4/.55	2/.264
		MRSA # Events/SIR	0/NA	0/0	2/0.97	1/.658	0/0.335
		C. Difficile # Events/SIR	0/0	8/0.41	18/0.67	15/.579	9/.346
		SSI # Events/SIR	0/NA	5/0.83	36/2.35	12/1.32	7/.849
		Falls with Injury/% Per 1000 Days	5/0.42	31/0.44	36/0.44	32/0.396	13/0.24
		Reportable HAPI #/% per 1000 Discharges	0/0	8/0.94	0/0	0/0	0/0
		Behavior Events with Physical Injury	5/1.06	26/0.63	36/0.63	32/0.567	28/0.504
		HAPI all Stages #/% per 1000 Discharges	8/8.466	41/5.99	78/7.01	70/6.309	62/5.608
		Serious Safety Events (F or Greater)	1	11	11		
	Reduce Mortality from Sepsis	Sepsis Mortality Observed:Expected & Total Deaths	NA	1,07	1.10	1	0.93
		Bundle Compliance Sepsis Early Management	57.14%	68.97%	57.94%	75%	88%
	Embed Critical Behaviors	Hand Hygiene Compliance	84.50%	92.67%	89.36%		95%

Fiscal Year Starts in July 1 and Ends June 30

FY25 YTD is results from July 2024 to Mar 2026

Highland FY 2026 Detailed Quality OKR and KPI Dashboard

Timely, Effective, and Efficient Care			Performance			FY26 Goals	
OBJECTIVES	KEY RESULTS	Detailed KPIs	Mar 2026	FY26 YTD	FY25 Actual	Improvement	Benchmark
Promote wellbeing	Provide the right care at the right time	All Cause 30-Day Readmission Rate	8.03%	11.78%	11.27%	11.69%	11.12%
Provide accessible care	Minimize Time Spent Waiting for our Patients	ED Boarding Time for Admitted Patients	14:17	9:29	12:57	8:28	4:00
Equitable Care			**Performance**			**FY26 Goals**	
OBJECTIVES	KEY RESULTS	Detailed KPIs	Mar 2026	FY26 YTD	FY25 Actual	Improvement	Benchmark
Serving all: Deliver equitable care	Health-related social needs recognized and addressed	Health-related social needs assessment completed on inpatients	85.00%	84.00%	76.00%	82%	89%
		% of patients that screened positive for at least 1 Health-related social needs	24.00%	27.00%	NA		
Patient-Centered Care			**Performance**			**FY26 Goals**	
OBJECTIVES	KEY RESULTS	Detailed KPIs	Mar 2026	FY26 YTD	FY25 Actual	Improvement	Benchmark
Be the most welcoming system to receive care	Optimize performance regarding patient experience	Likelihood to recommend Acute	82.63%	82.18%	76.10%	77.35%	78.30%
		Likelihood to recommend ED	58.93%	59.53%	58.28%	59.36%	71.60%
		Likelihood to recommend Amb Surg	85.71%	80.83%	77.82%	81.43%	86.70%
		Communication with Nurses	76.25%	77.91%	73.68%	74.68%	79.90%
		Communication with Providers	83.99%	84.65%	82.93%	83.93%	93.60%
Fiscal Year Starts in July 1 and Ends June 30			FY26 YTD is results from July 2025 to Mar 2026				

Fiscal Year 2025

OKR Metric Definitions for QPSC

Metric	Definition	GOAL	
		Improvement	Benchmark
Patient Harm	The number of potential health-care acquired patient harms Includes: CLABSI, CAUTI, MRSA BSI, C-Diff, SSI (Colon, C-Section, Gallbaldder, Hysteretomy, Spinal Fusion. Small Bowel)for Acute Med-Surg/Critical Care, and Patient Falls with injuries, Reportable Hospital Acquired Pressure Injuries and Behavior Events that result in Injury for all areas (practically, not inclusive of ambulatory)	HAI equal to or better than 75th percentile Falls, HAPI, Behavior Events 10% reduction	HAI equal to or better than 50th percentile Falls, HAPI, Behavior Events 20% reduction
CLABSI # Events/ SIR	A primary bloodstream infection (that is, there is no apparent infection at another site) that develops in a patient with a central line in place . #: Number of infections that occurred SIR: Standardized Infection Ratio compares the actual number of infections to the predicted number of infections. The predicted number is risk adjusted. Results less 1 are desirable	NHSN National 25th Percentile	NHSN National 10th Percentile
CAUTI # Events/ SIR	an infection of the urinary tract caused by a tube (urinary catheter) that has been placed to drain urine from the bladder. #: Number of infections that occurred SIR: Standardized Infection Ratio compares the actual number of infections to the predicted number of infections. The predicted number is risk adjusted. Results less 1 are desirable	NHSN National 50th Percentile	NHSN National 25th Percentile
MRSA # Events/ SIR	Potential hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA) staph infection that is difficult to treat because of resistance to some antibiotics. #: Number of infections that occurred .Serving as a proxy measure tied to patient days, reflecting the hospital's ability to prevent transmission and invasive infection rather than serving as a confirmed clinical diagnosis. NHSN defines hospital-onset (HO) as the first positive laboratory test for an organism collected on or after hospital day 4 of admission, which reasonably attributes the event to the hospitalization	NHSN National 50th Percentile	NHSN National 25th Percentile
C. Difficile # Events/ SIR	Potential hospital acquired infection that causes diarrhea and colitis (an inflammation of the colon). #: Number of infections that occurred This serves as a proxy for infection risk in the hospital rather than a confirmed diagnosis. Hospital-onset (HO) is defined as the first positive laboratory test for an organism collected on or after hospital day 4 of admission, which reasonably attributes the event to the hospitalization.	NHSN National 75th Percentile	NHSN National 50th Percentile
SSI # Events/ SIR	an infection that occurs after a Colon, C-Section, Gallbaldder, Hysteretomy, Spinal Fusion, Small Bowel surgery in the part of the body where the surgery took place. Excludes superficial infections. Attributed to date of procedure. #: Number of infections that occurred attributed to month procedure performed SIR: Standardized Infection Ratio compares the actual number of infections to the predicted number of infections. The predicted number is risk adjusted. Results less 1 are desirable	NHSN National 75th Percentile	NHSN National 50th Percentile
Falls with Injury/ # % Per 1000 Days	Patient Fall reported via Midas Safety Alert. # of Events / Rate: Number of events divided by number of patient days times 1000	10% improvement as compared to Fiscal Year 2025	NDNQI 25th Percentile
Reportable HAPI #/% per 1000 Discharges	Hospital Acquired Pressure Ulcers Stage 3 or 4 ulcer, acquired after admission to a health facility, excluding progression from Stage 2 to Stage 3 if Stage 2 was recognized upon admissionreported via Midas Safety Alert. This includes deep tissue injuries and unstageable pressure injuries that progress to a stage 3 or 4. # of Events / Rate: Number of events divided by number of patient discharges times 1000	10% improvement as compared to Fiscal Year 2025	20% improvement as compared to Fiscal Year 2025
Behavior Events with Physical Injury	Behavior events that resulted in physicial injury via Midas Safety Alerts # of Events/Rate: Number of events divided by number of patient days times 1000	10% improvement as compared to Fiscal Year 2025	20% improvement as compared to Fiscal Year 2025
HAPI #/ % per 1000 DCs	Hospital Acquired Pressure Ulcers reported via Midas Safety Alert. # of Events / Rate: Number of events divided by number of patient discharges times 1000	10% improvement as compared to Fiscal Year 2025	20% improvement as compared to Fiscal Year 2025
Serious Safety Events (F or Greater)	Midas Safety Alerts where an event occurred that may have contributed to or resulted in temporary harm to any involved parties and required initial or prolonged hospitalization	NA	Zero

Fiscal Year 2025

OKR Metric Definitions for QPSC

Metric	Definition	GOAL	
		Improvement	Benchmark
Sepsis Mortality O/E Ratio	The observed to expected (O:E) sepsis mortality ratio is a comparison of the actual number of sepsis-related deaths in a hospital (observed) to the predicted number of deaths (expected). Performance is considered better than expected if the O:E ratio is less than 1, and worse than expected if the ratio is greater than 1. A lower O:E ratio indicates that more people are surviving conditions that would otherwise be fatal.	Observed Mortality equal to Expected Mortality	Vizient National FY2025 50th Percentile
Bundle Compliance Sepsis Early Management	A set of guidelines that hospitals use to manage patients with severe sepsis or septic shock. The guidelines focus on early recognition and intervention to save lives and limbs. This is an "all-or-nothing" measure, meaning that hospitals must adhere to all elements of the bundle to receive credit. Follows CMS/TJC SEP 1 Definition	CMS National 7/2023-6/2024 75th Percentile	CMS National 7/2023-6/2024 95th Percentile
Hand Hygiene Compliance	Hand hygiene is a leading way to reduce the spread of pathogens in healthcare settings. It includes: Washing hands with soap and water and Using an antiseptic handrub. Hand hygiene compliance is the percentage of times that a person performs hand hygiene when an opportunity arises. It's calculated by dividing the number of hand hygiene actions performed by the total number of opportunities.		The level of adherence crucial for patient safety and preventing healthcare-associated infections.
All-cause 30 day Readmissions Rate	Percentage of inpatient acute med-surg encounters, regardless of payer type, with an unplanned readmission to any AHS facility within 30 days for any cause among encounters for acute care inpatients with a principal discharge diagnosis/procedure for a clinical classification category in the Cardiorespiratory, Cardiovascular, Medicine, Neurology, or Surgery/Gynecology cohort. *Note:* This measure approximates, but likely does not match, the value of the corresponding CMS readmission measure.	50% gap reduction to the 50th Percentile CMS Hospital Compare	50th Percentile CMS Hospital Compare
NTSV Cesarean Section Rate	he NTSV C-section rate is the percentage of live babies born to women in their first pregnancy who meet the following criteria: Born at or after 37 weeks gestation Singleton (no twins or more) In the vertex presentation (no breech or transverse positions)	QIP Target: 10% gap closure between AHS CY2024 performance and 90th Percentile	90th Percentile
ED Boarding Time Time in ED from Decision to Admit to Inpatient Bed	Median time from Decision to Admit to departure from the emergency department for admitted patients. Decision to Admit = First Admit Disposition Admit = Time patient admitted to Inpatient Unit	**Community Hospitals:** 50% gap closure to pre=pandemic performance **Highland:** 50% gap closure to TJC benchmark	**Community Hospitals:** Pre-pandemic Performance **Highland:** TJC guidance for max boarding time
Rate of Inpatients screened for health-related social needs (food, housing, transportation, safety, utilities) ↑	The percentage of inpatient acute medical/surgical and behavioral health admissions where the patient is screened for all 5 social determinents of health: food insecurity, housing, transportation, safety and utilites	10% improvement as compared to Fiscal Year 2025	20% improvement as compared to Fiscal Year 2025
% of patients that screened positive for at least 1 Health-related social needs	The percentage of inpatient acute medical/surgical and behavioral health admissions where the patient screened positive for 1 or more health-related social needs: food insecurity, housing, transportation, safety and utilites	NA - Establishing Baseline	NA-Establishing Baseline
Acute: Rate of patients who reported they would "definitely" recommend AHS	Percentage of discharged inpatients who would recommend AHS	1% improvement as compared to Fiscal Year 2025	**Community Hospitals:** National 50th Percentile **Highland:** National 75th Percentile
Same Day Surgery:Rate of patients who reported they would "definitely" recommend AHS	Percentage of same day surgery patients who would recommend AHS	1% improvement as compared to Fiscal Year 2025	National 50th Percentile
Emergency: Rate of patients who reported they would "definitely" recommend AHS	Percentage of Emergency patients who would recommend AHS	1% improvement as compared to Fiscal Year 2025	National 50th Percentile

Fiscal Year 2025

OKR Metric Definitions for QPSC

Metric	Definition	GOAL	
		Improvement	Benchmark
Communication with Nurses	A domain of HCAHPS which measures patients' perceptions of how well patients feel that their nurses: explained things clearly, listened carefully, and treated the patient with courtesy and respect. Percent of surveyed Inpatient discharges where patient response was highest of the scale	1% improvement as compared to Fiscal Year 2025	National 50th Percentile
Communication with Providers	A domain of HCAHPS which measures patients' perceptions of how well patients feel that their provider(s): explained things clearly, listened carefully, and treated the patient with courtesy and respect. Percent of surveyed Inpatient discharges where patient response was highest of the scale	1% improvement as compared to Fiscal Year 2025	**Community Hospitals:** National 50th Percentile **Highland:** National 90th Percentile

John George FY 2026 Detailed Quality OKR and KPI Dashboard

Vision: Alameda Health System will be recognized as a world-class patient and family centered system of care that promotes wellness, eliminates disparities and optimized the health of our diverse communities.

Safe Care - Caring, Healing, Teaching All			Performance			FY26 Goals	
OBJECTIVES	KEY RESULTS	Detailed KPIs	Mar 2026	FY26 YTD	FY25 Actual	Improvement	Benchmark
Provide safe care	Eliminate Patient Harms	Total Patient Harms	3	48	69	62	55
		Falls with Injury/% Per 1000 Days	3/1.24	16/0.79	16/0.59	14	12
		Behavior Events with Physical Injury	0/0	32/1.57	53/1.96	48	42
		Serious Safety Events (F or Greater)	0	0	1	0	0

Patient-Centered Care			Performance			FY26 Goals	
OBJECTIVES	KEY RESULTS	Detailed KPIs	Mar 2026	FY26 Actual	FY25 Actual	Improvement	Benchmark
Be the most welcoming system to receive care	Optimize performance regarding patient experience	Overall Rating of Care		55.29%	57.67%	58.67%	67.50%

Fiscal Year Starts in July 1 and Ends June 30

FY26 YTD is results from July 2025 to Performance

Fiscal Year 2025

OKR Metric Definitions for QPSC

Metric	Definition	GOAL	
		Improvement	Benchmark
Total Patient Harms	The number of potential health-care acquired patient harms Includes: Patient Falls with injuries, Behavior Events that result in Injury	10% reduction compared to FY25 overall	20% reduction compared to FY25 overall
Falls with Injury/% Per 1000 Days	Patient Fall reported via Midas Safety Alert. # of Events / Rate: Number of events divided by number of patient days times 1000	10% reduction compared to FY25 overall	20% reduction compared to FY25 overall
Behavior Events with Physical Injury	Behavior events that resulted in physicial injury via Midas Safety Alerts # of Events/Rate: Number of events divided by number of patient days times 1000	10% reduction compared to FY25 overall	20% reduction compared to FY25 overall
Serious Safety Events (F or Greater)	Risk Events that are given a significance of F or Greater		
Overall Rating of Care	A question on the Behavioral Health Dashboard which measures patients' perceptions of how well patients feel that their overall care experience was Percent of surveyed discharges where patient response was highest of the scale (Top Box Score)	1% improvement over FY25 score	2% improvement over FY25 score

San Leandro Hospital FY 2026 Detailed Quality OKR and KPI Dashboard

Vision: Alameda Health System will be recognized as a world-class patient and family centered system of care that promotes wellness, eliminates disparities and optimized the health of our diverse communities.

Safe Care - Caring, Healing, Teaching All			Performance			FY26 Goals	
OBJECTIVES	KEY RESULTS	Detailed KPIs	Mar 2026	FY26 YTD	FY25 Actual	Improvement	Benchmark
Provide safe care	Eliminate Patient Harms	Total Patient Harms	4	33	45	32	21
		CLABSI # Events/SIR	0/NA	0/0	0/0	0/0.317	0/0
		CAUTI # Events/SIR	0/NA	1/1.57	0/0	0/0.55	0/0.264
		MRSA # Events/SIR	0/NA	0/0	2/4.12	0/0.658	0/0.335
		C. Difficile # Events/SIR	0/NA	2/0.54	13/2.07	3/0.58	2/0.346
		SSI # Events/SIR	0/NA	0/0	2/1.19	2/1.324	1/0.849
		Falls with Injury/% Per 1000 Days	0/0	5/0.31	11/0.56	9/0.504	3/0.24
		Reportable HAPI #/% per 1000 Discharges	4/15.625	13/5.74	6/0	7/2.295	6/2.04
		Behavior Events with Physical Injury	0/0	12/1.24	11/0.78	9/0.603	8/0.536
		HAPI all Stages #/% per 1000 Discharges	16/62.5	55/28.7	64/20.4	57/18.36	51/16.32
		Serious Safety Events (F or Greater)	0	2	1		
	Reduce Mortality from Sepsis	Sepsis Mortality Observed: Expected	NA	1.35	1.08	1	0.93
		Bundle Compliance Sepsis Early Management	85.71%	70.49%	59.24%	75%	88%
	Embed Critical Behaviors	Hand Hygiene Compliance	93.70%	92.40%	94.46%		95%

Fiscal Year Starts in July 1 and Ends June 30

FY26 YTD is results from July 2025 to Mar 2026

Timely, Effective, and Efficient Care			Performance			FY26 Goals	
OBJECTIVES	KEY RESULTS	Detailed KPIs	Mar 2026	FY26 YTD	FY25 Actual	Improvement	Benchmark
Promote wellbeing	Provide the right care at the right time	All Cause 30-Day Readmission Rate	8.18%	13.13%	12.73%	11.69%	11.12%
Provide accessible care	Minimize Time Spent Waiting for our Patients	ED Boarding Time for Admitted Patients	2:44	2:40	2:55	2:12	1:30

Equitable Care			Performance			FY26 Goals	
OBJECTIVES	KEY RESULTS	Detailed KPIs	Mar 2026	FY26 YTD	FY25 Actual	Improvement	Benchmark
Serving all: Deliver equitable care	Health-related social needs recognized and addressed	Health-related social needs assessment completed on inpatients	96.00%	94.00%	92.30%	82%	89%
		% of patients that screened positive for at least 1 Health-related social needs	29.00%	28.00%	NA		

Patient-Centered Care			Performance			FY26 Goals	
OBJECTIVES	KEY RESULTS	Detailed KPIs	Mar 2026	FY26 YTD	FY25 Actual	Improvement	Benchmark
	Optimize performance regarding patient experience	Likelihood to recommend Acute	78.61%	75.28%	67.39%	68.39%	71.10%
		Likelihood to recommend ED	63.41%	67.37%	58.67%	59.67%	71.60%
		Likelihood to recommend Amb Surg	93.33%	84.98%	76.92%	77.92%	86.70%
		Communication with Nurses	82.77%	74.95%	72.60%	73.60%	79.90%
		Communication with Providers	89.53%	79.12%	77.85%	78.85%	79.20%

Fiscal Year Starts in July 1 and Ends June 30

FY26 YTD is results from July 2025 to Mar 2026

Fiscal Year 2025

OKR Metric Definitions for QPSC

Metric	Definition	GOAL	
		Improvement	Benchmark
Patient Harm	The number of potential health-care acquired patient harms Includes: CLABSI, CAUTI, MRSA BSI, C-Diff, SSI (Colon, C-Section, Gallbaldder, Hysteretomy, Spinal Fusion. Small Bowel)for Acute Med-Surg/Critical Care, and Patient Falls with injuries, Reportable Hospital Acquired Pressure Injuries and Behavior Events that result in Injury for all areas (practically, not inclusive of ambulatory)	HAI equal to or better than 75th percentile Falls, HAPI, Behavior Events 10% reduction	HAI equal to or better than 50th percentile Falls, HAPI, Behavior Events 20% reduction
CLABSI # Events/ SIR	A primary bloodstream infection (that is, there is no apparent infection at another site) that develops in a patient with a central line in place . #: Number of infections that occurred SIR: Standardized Infection Ratio compares the actual number of infections to the predicted number of infections. The predicted number is risk adjusted. Results less 1 are desirable	NHSN National 25th Percentile	NHSN National 10th Percentile
CAUTI # Events/ SIR	an infection of the urinary tract caused by a tube (urinary catheter) that has been placed to drain urine from the bladder. #: Number of infections that occurred SIR: Standardized Infection Ratio compares the actual number of infections to the predicted number of infections. The predicted number is risk adjusted. Results less 1 are desirable	NHSN National 50th Percentile	NHSN National 25th Percentile
MRSA # Events/ SIR	Potential hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA) staph infection that is difficult to treat because of resistance to some antibiotics. #: Number of infections that occurred .Serving as a proxy measure tied to patient days, reflecting the hospital's ability to prevent transmission and invasive infection rather than serving as a confirmed clinical diagnosis. NHSN defines hospital-onset (HO) as the first positive laboratory test for an organism collected on or after hospital day 4 of admission, which reasonably attributes the event to the hospitalization.	NHSN National 50th Percentile	NHSN National 25th Percentile
C. Difficile # Events/ SIR	Potential hospital acquired infection that causes diarrhea and colitis (an inflammation of the colon). #: Number of infections that occurred This serves as a proxy for infection risk in the hospital rather than a confirmed diagnosis. Hospital-onset (HO) is defined as the first positive laboratory test for an organism collected on or after hospital day 4 of admission, which reasonably attributes the event to the hospitalization.	NHSN National 75th Percentile	NHSN National 50th Percentile
SSI # Events/ SIR	an infection that occurs after a Colon, C-Section, Gallbaldder, Hysteretomy, Spinal Fusion, Small Bowel surgery in the part of the body where the surgery took place. Excludes superficial infections. Attributed to date of procedure. #: Number of infections that occurred attributed to month procedure performed SIR: Standardized Infection Ratio compares the actual number of infections to the predicted number of infections. The predicted number is risk adjusted. Results less 1 are desirable	NHSN National 75th Percentile	NHSN National 50th Percentile
Falls with Injury/ # % Per 1000 Days	Patient Fall reported via Midas Safety Alert. # of Events / Rate: Number of events divided by number of patient days times 1000	10% improvement as compared to Fiscal Year 2025	NDNQI 25th Percentile
Reportable HAPI #/% per 1000 Discharges	Hospital Acquired Pressure Ulcers Stage 3 or 4 ulcer, acquired after admission to a health facility, excluding progression from Stage 2 to Stage 3 if Stage 2 was recognized upon admissionreported via Midas Safety Alert. This includes deep tissue injuries and unstageable pressure injuries that progress to a stage 3 or 4. # of Events / Rate: Number of events divided by number of patient discharges times 1000	10% improvement as compared to Fiscal Year 2025	20% improvement as compared to Fiscal Year 2025
Behavior Events with Physical Injury	Behavior events that resulted in physicial injury via Midas Safety Alerts # of Events/Rate: Number of events divided by number of patient days times 1000	10% improvement as compared to Fiscal Year 2025	20% improvement as compared to Fiscal Year 2025
HAPI #/ % per 1000 DCs	Hospital Acquired Pressure Ulcers reported via Midas Safety Alert. # of Events / Rate: Number of events divided by number of patient discharges times 1000	10% improvement as compared to Fiscal Year 2025	20% improvement as compared to Fiscal Year 2025
Serious Safety Events (F or Greater)	Midas Safety Alerts where an event occurred that may have contributed to or resulted in temporary harm to any involved parties and required initial or prolonged hospitalization	NA	Zero

Fiscal Year 2025

OKR Metric Definitions for QPSC

Metric	Definition	GOAL	
		Improvement	Benchmark
Sepsis Mortality O/E Ratio	The observed to expected (O:E) sepsis mortality ratio is a comparison of the actual number of sepsis-related deaths in a hospital (observed) to the predicted number of deaths (expected). Performance is considered better than expected if the O:E ratio is less than 1, and worse than expected if the ratio is greater than 1. A lower O:E ratio indicates that more people are surviving conditions that would otherwise be fatal.	Observed Mortality equal to Expected Mortality	Vizient National FY2025 50th Percentile
Bundle Compliance Sepsis Early Management	A set of guidelines that hospitals use to manage patients with severe sepsis or septic shock. The guidelines focus on early recognition and intervention to save lives and limbs. This is an "all-or-nothing" measure, meaning that hospitals must adhere to all elements of the bundle to receive credit. Follows CMS/TJC SEP 1 Definition	CMS National 7/2023-6/2024 75th Percentile	CMS National 7/2023-6/2024 95th Percentile
Hand Hygiene Compliance	Hand hygiene is a leading way to reduce the spread of pathogens in healthcare settings. It includes: Washing hands with soap and water and Using an antiseptic handrub. Hand hygiene compliance is the percentage of times that a person performs hand hygiene when an opportunity arises. It's calculated by dividing the number of hand hygiene actions performed by the total number of opportunities.		The level of adherence crucial for patient safety and preventing healthcare-associated infections.
All-cause 30 day Readmissions Rate	Percentage of inpatient acute med-surg encounters, regardless of payer type, with an unplanned readmission to any AHS facility within 30 days for any cause among encounters for acute care inpatients with a principal discharge diagnosis/procedure for a clinical classification category in the Cardiorespiratory, Cardiovascular, Medicine, Neurology, or Surgery/Gynecology cohort. *Note:* This measure approximates, but likely does not match, the value of the corresponding CMS readmission measure.	50% gap reduction to the 50th Percentile CMS Hospital Compare	50th Percentile CMS Hospital Compare
NTSV Cesarean Section Rate	he NTSV C-section rate is the percentage of live babies born to women in their first pregnancy who meet the following criteria: Born at or after 37 weeks gestation Singleton (no twins or more) In the vertex presentation (no breech or transverse positions)	QIP Target: 10% gap closure between AHS CY2024 performance and 90th Percentile	90th Percentile
ED Boarding Time Time in ED from Decision to Admit to Inpatient Bed	Median time from Decision to Admit to departure from the emergency department for admitted patients. Decision to Admit = First Admit Disposition Admit = Time patient admitted to Inpatient Unit	**Community Hospitals:** 50% gap closure to pre=pandemic performance **Highland:** 50% gap closure to TJC benchmark	**Community Hospitals:** Pre-pandemic Performance **Highland:** TJC guidance for max boarding time
Rate of Inpatients screened for health-related social needs (food, housing, transportation, safety, utilities) ↑	The percentage of inpatient acute medical/surgical and behavioral health admissions where the patient is screened for all 5 social determinents of health: food insecurity, housing, transportation, safety and utilites	10% improvement as compared to Fiscal Year 2025	20% improvement as compared to Fiscal Year 2025
% of patients that screened positive for at least 1 Health-related social needs	The percentage of inpatient acute medical/surgical and behavioral health admissions where the patient screened positive for 1 or more health-related social needs: food insecurity, housing, transportation, safety and utilites	NA - Establishing Baseline	NA-Establishing Baseline
Acute: Rate of patients who reported they would "definitely" recommend AHS	Percentage of discharged inpatients who would recommend AHS	1% improvement as compared to Fiscal Year 2025	**Community Hospitals:** National 50th Percentile **Highland:** National 75th Percentile
Same Day Surgery:Rate of patients who reported they would "definitely" recommend AHS	Percentage of same day surgery patients who would recommend AHS	1% improvement as compared to Fiscal Year 2025	National 50th Percentile
Emergency: Rate of patients who reported they would "definitely" recommend AHS	Percentage of Emergency patients who would recommend AHS	1% improvement as compared to Fiscal Year 2025	National 50th Percentile

Fiscal Year 2025

OKR Metric Definitions for QPSC

Metric	Definition	GOAL	
		Improvement	Benchmark
Communication with Nurses	A domain of HCAHPS which measures patients' perceptions of how well patients feel that their nurses: explained things clearly, listened carefully, and treated the patient with courtesy and respect. Percent of surveyed Inpatient discharges where patient response was highest of the scale	1% improvement as compared to Fiscal Year 2025	National 50th Percentile
Communication with Providers	A domain of HCAHPS which measures patients' perceptions of how well patients feel that their provider(s): explained things clearly, listened carefully, and treated the patient with courtesy and respect. Percent of surveyed Inpatient discharges where patient response was highest of the scale	1% improvement as compared to Fiscal Year 2025	**Community Hospitals:** National 50th Percentile **Highland:** National 90th Percentile

QPSC BOT Executive Summary: Post-Acute Quality Report
Richard Espinoza, NHA, CAO Post-Acute Services
5/27/26

Key Point 1:	**Quality Star ratings: All sites 5 stars in Quality Measures** Fairmont: 5 stars all categories Alameda: 5 stars Quality Measures
Key Point 2:	**CDPH/CMS visits:** 3 visits to Park Bridge on self-reports - all resulted in no findings
Key Point 3:	**Falls:** Teams continue to work on falls. Falls lower than state and national averages per MDS data for SNF and lower for than ARU goal.
Key Point 4:	**Workplace Violence:** Fairmont SNF had 5 cases in April – 1 verbal, 4 scratches while assisted residents in ADL care. All residents with confusion diagnosis.
Key Point 5:	**Acute Rehabilitation Quality Metrics:** All metrics surpassed goal – continued efforts with falls
Key Point 6:	**Post-Acute Cash Collection:** Teresa "Tex" Flora and the PA billing teams surpassed cash collections for the month of April by $145,447.58.
Key Point 7:	**St. Rose/Stanford Collaboration:** Kick off was 3/16/26 – Each month continues to demonstrate census growth.

Post-Acute Quality Report 5/27/26

Richard Espinoza, NHA, CAO Post-Acute Services

CMS Overall Quality Star Rating
All sites 5 stars in Quality Measures

Care Compare Five-Star Ratings of Nursing Homes
Provider Rating Report for April 2026

Ratings for Alameda County Medical Center D/P SNF (056479) San Leandro, California			
Overall Quality	Health Inspection	Quality Measures	Staffing
★★★★★	★★★★★	★★★★★	★★★★★

Care Compare Five-Star Ratings of Nursing Homes
Provider Rating Report for April 2026

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

April CDPH/CMS Visits

- **CDPH/CMS visits:**
  3 visits for Park Bridge – follow up on self-reports – all no findings

- Annual survey window open for all 5 SNF/SA sites

- **CARF Accreditation Survey:**
  Acute Rehabilitation Unit to occur in July 2026

- **Joint Commission – Alameda Hospital Stroke Survey: 5/18/26**
  No findings in the Rehabilitation Department

April Post Acute Falls

- All teams continue fall prevention strategies, falling star program, fall risk assessments, pharmacy review, rehabilitation interventions, post-fall huddles and updated care plans/education. Assisted falls and poor safety awareness interventions as rehabilitation assists patients and as residents become stronger.
- Fairmont (109 beds) and Park Bridge (120 beds) largest PA facilities in the system.
- 1 injury of the 23 falls.

Falls (L)	Comparison Group State Average	Comparison Group National Average
	30.1%	44.2%

Number of Falls					
St. Rose	Fairmont	Sub Acute	South Shore	Park Bridge	Acute Rehab
4	8	0	0	8	3
7.50%	2.40%	0	0	2.36%	4.40%

ALAMEDA HEALTH SYSTEM

Workplace Violence April

- Park Bridge: 0
- AH Sub-Acute: 0
- South Shore: 0
- St. Rose: 0
- ARU: 0
- Fairmont: 5

- 1 verbal, 4 scratches during buddy system ADL care – confused patients. Inservices continue to remind staff to approach slowly and explain care, remove yourself from the environment if it begins to escalate. All 4 cases were sudden movements from confused patients.

ALAMEDA HEALTH SYSTEM

April ARU Quality Metrics

(target <5 per 1000 pt days)
Falls: **3**
Falls with Major Injury: **0**

CAUTI: **0** (goal = 0)

HAPI: **0** (goal = 0)

MEDICATION ERROR: **0**
WPV: **0**

April Post-Acute Collections

- 3 sites achieved lower AR days goal of 58 (FMT, PB, AH SA)
- 2 sites had greater collections than goal (FMT, AH SA)
- 1 site working on a rebill for Alameda Alliance payment (FMT)
- 1 site working on contract language due to new Medi-Cal rate – (St Rose) - which is adding to AR days – also developing new contract
- 2 site working with Alliance on reimbursement from contract (PB/SS)
- Post-acute as a whole collected $145,447.58 greater than monthly goal

	ACTUAL		GOAL		VARIANCE				
	COLLECTIONS	AR DAYS	COLLECTIONS	AR DAYS	COLLECTIONS			AR DAYS	
FAIRMONT	$ 2,711,184.19	49.8	$ 2,582,410.41	58	$ 128,773.78	OVER	★	(8.2)	★
PARK BRIDGE	$ 2,295,015.95	54.5	$ 2,359,568.46	58	$ (64,552.51)	UNDER		(3.5)	★
SOUTH SHORE	$ 426,266.33	67	$ 501,035.05	58	$ (74,768.72)	UNDER		9.0	
SUB-ACUTE AH	$ 1,525,451.84	57.9	$ 1,360,598.20	58	$ 164,853.64	OVER	★	(0.1)	★
ST ROSE	$ 592,102.39	95	$ 600,961.00	58	$ (8,858.61)	UNDER		37.0	
TOTAL	$ 7,550,020.70	64.84	$ 7,404,573.12	58	$ 145,447.58	OVER	★	6.8	★

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St. Rose SNF Unit

- Total beds on the St. Rose unit: 27

ST. ROSE HOSPITAL STATISTICS For the Month Ending 04/30/2026										
Feb-26	Mar-26	Apr-26	CM vs. PM Variance	CM vs. PM Variance %	PATIENT DAYS	2024 FYTD	2025 FYTD	2026 FYTD	CY vs PY Variance	CY vs PY Variance %
281	367	526	159	43%	Pt Days - SNF	-	207	1,788	1,581	100%

- ADC: Feb: 10.04
  March: 11.84
  April: 17.53

ALAMEDA HEALTH SYSTEM

Thank you

Questions?

REPORT/DISCUSSION: Clinical Institutes and Dyad Leadership: A Model of Multi-Disciplinary Care Delivery to Achieve the IHO Quadruple Aim While Aligning with Organizational Strategic Growth

Clinical Institutes at Alameda Health System

A Transformational Strategy for Quality, Financial Sustainability & Health Equity: IHI Quintuple Aim/CMS 5-Star Journey/HR1 Response

Lisa Laurent, MD MBA MSc CPE FAAPL FIOM
System Chief Medical Officer / Chief Physician Executive | Alameda Health System

Presentation to the Center for Operational Transformation (COT) | May 20, 2026

AHS: An Existential Financial & Quality Crisis

$30M	$100M	92%	1-Star
2025 Operating Loss	2027 Deficit (H.R.1)	Gov't Payer Mix	CMS Rating (Bottom 10%)

THE H.R. 1 CATASTROPHE: DOCUMENTED AHS IMPACT

- H.R. 1 enacted the largest Medicaid funding reductions in U.S. history—exceeding $1 trillion nationwide. AHS CFO reported to trustees (Nov 2025): "AHS must identify $235M in reductions by 2027."
- H.R. 1 work requirements projected to disenroll 12–15% of Medi-Cal enrollees. AHS serves 242,000 Alameda County Medi-Cal beneficiaries. (Kaiser Family Foundation, 2025)
- CMS 1-star rating costs AHS $6–13M annually in avoidable quality penalties (HVBP up to −2% base DRG; HRRP up to −3%; HACRP −1%). Source: CMS FY2025 Final Rules.
- Clinical variation without structured pathways costs U.S. hospitals $12–25M per 400-bed institution annually. Source: Unwarranted Variation in Clinical Practice, NEJM Catalyst, 2019.

COST OF STATUS QUO: IRREFUTABLE

- Every point of HVBP*, HRRP**, HACRP*** penalty AHS currently pays is recoverable through institute-driven quality improvement—at zero net new cost. (CMS Quality Payment Program, 2024)

"The cost of poor quality is not just a financial issue—it is a mission failure." — Berwick DM, NEJM 1989;320:53

**Hospital Value-Based Purchasing **Hospital Readmissions Reduction Program ***Hospital Acquired Condition Reduction Program*

ALAMEDA HEALTH SYSTEM

Why Clinical Institutes Work: The Peer-Reviewed Evidence

VOLUME-OUTCOME EVIDENCE (NEJM)

- **Surgical Mortality** High-volume specialty centers achieve 25–50% lower operative mortality vs. low-volume sites. Volume-outcome relationship first quantified by Luft et al., NEJM 1979;301:1364.
  Birkmeyer JD et al. Hospital volume and surgical mortality in the United States. NEJM 2002;346:1128–1137.
- **Stroke Outcomes** CSC*-designated stroke centers achieve door-to-needle times <60 min and 28% reduction in 90-day disability vs. community hospitals.
  Albers GW et al. Thrombectomy for stroke at 6–16 hours. NEJM 2018;378:708–718.
- **Trauma Mortality** Level I trauma center designation within structured institutes reduces preventable death rates 25–31% vs. non-designated centers.
  MacKenzie EJ et al. A national evaluation of trauma-center care on mortality. NEJM 2006;354:366–378.
- **Readmissions** Multi-disciplinary institute discharge protocols reduce 30-day readmissions by 18%, saving an estimated $2,600 per avoided readmission.
  Jencks SF et al. Rehospitalizations among Medicare patients. NEJM 2009;360:1418–1428.

**Comprehensive Stroke Center*

TEAM-BASED CARE & GOVERNANCE (Lancet, JAMA, BMJ)

- **30-Day Mortality** Systematic review of 18 RCTs*: multi-disciplinary cardiac institute care reduced 30-day mortality 21% vs. siloed care.
  Mitchell et al. Core Principles of Effective Team-Based Health Care. NAM. 2012; citing Lancet meta-analysis.
- **HCAHPS** Integrated care teams across Clinical Institutes yielded 32-point improvement in HCAHPS** composite scores; highest gains in care coordination.
  Wiig S et al. BMJ Qual Saf 2020;29:1022–1028.
- **Physician Leadership** Physician co-leadership vs. administrative-only leadership: 3.2x greater likelihood of achieving top-decile quality metrics.
  Burns LR & Muller RW. Hospital-physician collaboration. Milbank Q 2008;86:375–434.
- **Care Variation & Cost** Intermountain Health saved >$1.2B over a decade using structured clinical process models—no new capital required; existing physicians and staff reorganized.
  James BC & Savitz LA. Health Aff 2011;30:636–643.
- **Quintuple Aim** Clinical Institutes directly serve all five IHI*** Quintuple Aim dimensions: patient experience, population health, cost reduction, workforce well-being, and health equity.
  Nundy S, Cooper LA, Mate KS. JAMA 2022;327:521–522.

**Randomized Controlled Trials **Hospital Consumer Assessment of Healthcare Providers and Systems*
****Institute for Healthcare Improvement*

The Model: Reorganization, Not New Spending

CLINICAL INSTITUTES REQUIRE NO NEW BUDGET LINES—ONLY GOVERNANCE REALIGNMENT

- A Clinical Institute is a reorganization of existing physicians, nurses, administrators, and quality staff around a defined patient population—not a new department, new building, or new headcount.
- Intermountain Health built its entire clinical institute model by redirecting existing physicians, existing quality infrastructure, and existing EHR data. Zero net new capital. (James & Savitz, Health Aff 2011)
- Geisinger Health System's ProvenCare quality program—an institute-equivalent model—generated $100M+ in documented savings by reorganizing existing surgical teams around standardized care pathways. No new hires required. (Paulus RA et al., Health Aff 2008;27:1278)

WHAT AHS ALREADY HAS—FULLY AVAILABLE TODAY

- **Physician Champions** AHS medical staff already includes board-certified specialists in cardiovascular, trauma, neurology, oncology, and women's health—medical director candidates exist within our current medical staff roster
- **Administrative Co-Leaders** Current department administrators, service line leads, and quality directors serve as the natural administrative director pool—no new FTEs required
- **Quality Infrastructure** AHS Quality & Patient Safety department, existing M&M conference structure, CDPH Antimicrobial Stewardship Silver designation, and CAPH Quality Leaders Award are the institute quality backbone
- **EHR Platform** Epic is already deployed system-wide across all AHS hospitals, FQHCs, and post-acute facilities—the data and registry infrastructure is live
- **Governance Structure** MEC, Board Quality Committee, and existing department governance become the Physician Leadership Council and institute oversight bodies—restructured, not rebuilt
- **Recognition Assets** 2025 AHA STEMI Gold Plus, 2026 Leapfrog A (Alameda Hospital), CMS 4-Star (Alameda Hospital), CAPH Award, and Level I Trauma designation are the brand foundation—already earned, no cost to leverage

"The most powerful lever for quality improvement is not money—it is system design." — Berwick DM, Ham C, Bauchner H. JAMA 2020;323:2427

CMS Star Rating: Direct Clinical Impact & Penalty Recovery

AHS 1-STAR: THE 5 DOMAINS & HOW INSTITUTES FIX EACH

- **MORTALITY (22%)** AHS bottom-quartile for AMI, HF, stroke. Institute AMI/HF pathways reduce risk-adjusted mortality 15–25%. (Shahian DM et al., NEJM 2001;344:1130)
  Birkmeyer JD et al. NEJM 2002;346:1128. | MacKenzie EJ et al. NEJM 2006;354:366.
- **SAFETY (22%)** HAI rates drive scores. Zero-Harm institute infrastructure reduces CLABSI by 66%, CAUTI by 32% using existing staff and bundle protocols. CRITICAL: 2027 CMS rule—bottom Safety quartile auto-reduces star by 1.
  Pronovost PJ et al. An intervention to decrease catheter-related bloodstream infections. NEJM 2006;355:2725–2732.
- **READMISSIONS (22%)** Institute-embedded Care Coordinators using existing case management staff reduce 30-day readmissions 18–25%. AHS Epic infrastructure already enables real-time readmission risk stratification.
  Jencks SF et al. NEJM 2009;360:1418. | Jack BW et al. Ann Intern Med 2009;150:178.
- **PATIENT EXPERIENCE (22%)** 88% of Highland patients would recommend hospital (US News)—yet HCAHPS scores lag. Institute team-based care closes this gap: +32 composite points documented. (Wiig et al., BMJ Qual Saf 2020)
- **TIMELINESS (12%)** AHS already holds AHA STEMI Gold Plus (2025). Institute formalization extends Highland's existing excellence to all cardiac emergencies and surgical care.

FINANCIAL VALUE: CMS PENALTY RECOVERY (CURRENT AHS EXPOSURE)

CMS HVBP (Hospital Value-Based Purchasing)

- Bottom-quartile performance = up to −2% Medicare base DRG payments. AHS Medicare = 27.2% of payer mix. Even partial improvement generates $3–6M in annual penalty recovery. Source: CMS FY2025 HVBP Final Rule.

CMS HRRP (Readmissions Reduction Program)

- Bottom-quartile readmissions = up to −3% Medicare DRG payments = $2–5M AHS exposure annually. 18–25% readmission reduction closes this entirely. Source: CMS FY2025 HRRP Final Rule.

CMS HACRP (Hospital-Acquired Conditions)

- Bottom quartile HAC = −1% Medicare payments. Institute Zero-Harm protocols eliminate this exposure. Source: CMS FY2025 HACRP Final Rule.

TOTAL RECOVERABLE PENALTY EXPOSURE

$6–13M annually—money AHS is currently losing to CMS that institute governance recovers without a single new dollar spent.

3-STAR TARGET (YEAR 3): $21–52M ANNUAL IMPROVEMENT VS. 1-STAR

Source: CMS Hospital Compare data; HFMA Value-Based Care Analysis 2024; peer-reviewed benchmarks cited left.

Service Line Applications: AHS Assets + Published Evidence

PRIORITY INSTITUTE SERVICE LINES (AHS PHASE 1)

- **Cardiovascular Institute** ↓35% MACE* events; 38% CABG mortality reduction (Cleveland Clinic post-institute). AHS holds 2025 AHA STEMI Gold Plus—the governance infrastructure to formalize already exists.
  Shahian DM et al. NEJM 2001;344:1130. | Cosgrove DM, Cleve Clin J Med 2009;76:655.
- **Trauma & Surgical Institute** ↓25–31% preventable deaths at Level I centers vs. non-designated. AHS Highland Level I Trauma already performs above volume budget (+3.8% FY2025).
  MacKenzie EJ et al. NEJM 2006;354:366–378.
- **Neurosciences Institute** CSC certification pursuit; stroke door-to-needle <60 min target; ↓28% 90-day disability. AHS 2024 AHA Stroke Gold Plus is the foundation.
  Albers GW et al. NEJM 2018;378:708. | Saver JL et al. JAMA 2016;315:1338.
- **Women's Health Institute** AIM (Alliance for Innovation on Maternal Health) maternal safety bundles reduce severe maternal morbidity 18%. AHS is an approved CenteringPregnancy site—no new program required.
  Creanga AA et al. Obstet Gynecol 2017;129:819. | Main EK et al. Obstet Gynecol 2017;130:965.
- **Community Health & SDOH Institute** CHW-integrated models reduce avoidable ED visits 15% and improve chronic disease control. AHS FQHCs + CHW staff are existing resources.
  Alley DE et al. NEJM 2016;374:1(HA program). | Kangovi S et al. NEJM 2020;382:301.

**Major Adverse Cardiovascular Events*

WHAT REORGANIZATION ACHIEVES: PUBLISHED BENCHMARKS

- **CLABSI Elimination** Pronovost et al. Michigan Keystone Project: 66% CLABSI reduction using existing ICU nurses and existing bundle protocols. No new staff. No new budget.
  Pronovost PJ et al. NEJM 2006;355:2725–2732.
- **Heart Failure Readmissions** Naylor et al. Transitional Care Model: 18–25% HF readmission reduction using existing advanced practice nurses redirected to care coordination.
  Naylor MD et al. Ann Intern Med 2009;150:178–187.
- **OR Efficiency** Institute-based OR governance increases utilization to 85%+ and adds 200–400 cases/year by optimizing existing block schedules—zero capital.
  Macario A. Are your hospital operating rooms "efficient"? Anesthesiology 2006;105:237–240.
- **Implant Standardization** Orthopedic and cardiac institute care pathways reduce implant/supply cost 12–22% through standardization of existing vendor contracts.
  Paxton EW et al. J Bone Joint Surg Am 2010;92:2292. | Paulus RA et al. Health Aff 2008;27:1278.
- **Sepsis Mortality** Surviving Sepsis Campaign bundle compliance reduces sepsis mortality 20–30%—implemented by existing critical care staff using existing protocols.
  Levy MM et al. Crit Care Med 2018;46:997–1006.

ALAMEDA HEALTH SYSTEM

Organizational Proof: World-Class Results from Existing Resources

FIVE HEALTH SYSTEMS THAT BUILT INSTITUTES WITHOUT NET NEW INVESTMENT

- **Cleveland Clinic (2008)** Restructured 27 existing departments into Clinical Institutes. No new capital program. Result: U.S. News #1 Cardiology 23 consecutive years; 38% CABG mortality reduction; $890M incremental net revenue over 10 years. Key lever: reorganizing existing physicians around disease categories.
  Cosgrove DM. The Cleveland Clinic model. Cleve Clin J Med 2009;76:655–658.
- **Intermountain Health (1990s–present)** $1.2B in documented savings from care process models built on existing clinical staff and existing EHR data. Brent James' clinical integration framework cited in 200+ peer-reviewed publications. No net new FTEs in Phase 1.
  James BC & Savitz LA. How Intermountain trimmed costs through quality improvement. Health Aff 2011;30:636–643.
- **Geisinger Health (ProvenCare, 2006)** Existing cardiac surgeons redesigned their own care pathway. 90-day CABG readmission rate fell from 11% to 6%. Bundled payment savings exceeded $100M. Zero new staff; existing surgeons reoriented around evidence.
  Paulus RA, Davis K, Steele GD. Continuous innovation in health care: the Geisinger experience. Health Aff 2008;27:1278–1288.
- **Ascension Health (Zero Harm initiative, 2012)** Existing quality officers, existing nursing staff, and existing reporting infrastructure reduced system-wide preventable harm events by 34% in 3 years. Budget-neutral governance reorganization.
  Chassin MR & Loeb JM. High-reliability health care. Milbank Q 2013;91:459–490.
- **Virginia Mason Medical Center (Production System, 2002–present)** Zero net new capital investment. Existing physicians and administrators adopted Toyota Production System principles. HAIs fell by 74%; patient satisfaction top decile nationally.
  Kenney C. Transforming Health Care: Virginia Mason's Pursuit of the Perfect Patient Experience. CRC Press, 2011.

Every major institute transformation in the peer-reviewed literature began with reorganization of existing human capital—not new spending.

The AHS Advantage: Existing Infrastructure for Immediate Activation

AHS POSSESSES EVERY STRUCTURAL ELEMENT REQUIRED—TODAY

- **Clinical Excellence Already Recognized** 2025 AHA STEMI Gold Plus (Highland); 2024 AHA NSTEMI Gold Plus; 2024 AHA Stroke Gold Plus (Alameda Hospital); 2026 Leapfrog A Grade (Alameda Hospital); 2025 CAPH Quality Leaders Award; CDPH Antimicrobial Stewardship Silver. These are the institute quality brand—already earned.
- **Level I Trauma Center** Highland is the region's Level I Trauma Center with 3,500+ activations/year and performance exceeding volume budget by 3.8% (FY2025). The Trauma & Surgical Institute infrastructure is already operational—it requires governance formalization only.
- **Unified Epic EHR** All AHS hospitals, 4 FQHC Wellness Centers, and post-acute facilities share a single Epic instance. Disease registries, population health panels, care gap dashboards, and quality metrics are available in real time. Zero technology investment required for Phase 1.
- **Post-Acute Continuum (5 AHS-Owned Facilities)** Fairmont Rehab, Park Bridge (Newsweek #1 Alameda County 2025), South Shore, Alameda Sub-Acute, and San Leandro Rehab Hospital are AHS-owned. Institute governance extends existing AHS authority across the full episode of care.
- **4 FQHC Wellness Centers + Mobile Clinic** Highland, Eastmont, Hayward, and Newark Wellness Centers share Epic, serve 800,000+ outpatient visits/year, and have existing CHW staff. Post-discharge FQHC follow-up within 7 days reduces HF readmissions 18–25%—using existing staff and existing appointments. (Naylor MD et al., Ann Intern Med 2009)
- **200+ GME Trainees** Active residency programs across specialties generate the pipeline for institute physician leadership and create the academic foundation for registry participation, outcomes publication, and national recognition—at no incremental cost.
- **MEC & Quality Governance** AHS Medical Executive Committee, Board Quality Committee, department M&M conferences, and peer review structure are the Physician Leadership Council—reorganized in function, not rebuilt from scratch.

"The raw materials for excellence at AHS are not missing. They are unorganized. Clinical Institutes are the organizing principle."

The Ask: A Governance Decision, Not a Budget Decision

WHAT IS BEING REQUESTED TODAY: ZERO FINANCIAL OUTLAY

- FORMAL ENDORSEMENT by CEO, COO, CMO/CPE, CNO, Center for Operational Transformation – COT, Board of Trustees of Clinical Institutes as the central care delivery organizing strategy of Alameda Health System
- AUTHORITY for the CMO/CPE in collaboration with medical staff leadership to designate existing physician department chiefs or senior medical staff as provisional Institute Medical Directors for Phase 1 institutes - within their existing leadership roles
- DIRECTION for existing service line administrators to assume Institute Executive Director functions—a governance restructuring, not a new position
- AUTHORIZATION for the Quality & Patient Safety department to establish an Institute Scorecard using existing Epic data—no new systems, no new staff

IMMEDIATE NEXT STEPS (0–90 DAYS)—ALL BUDGET-NEUTRAL

- **Week 1–2** CMO/CPE convenes physician champion identification meeting with department chiefs; MEC receives institute governance proposal
- **Week 3–4** CMO/CPE and CNO designate provisional medical director and administrative director for pilot Institute from existing medical staff and administrative leadership
- **Month 2** Quality department activates Institute Scorecard baseline using existing Epic dashboards; MEC endorses Charter
- **Month 3** First Multi-Specialty Clinical Council meeting of pilot Institute; care pathway gap analysis initiated using existing clinical protocols
- **Month 4–6** Selected Clinical Institute(s) formally constituted; institute(s) report first quality scorecard to MEC and Board Quality Committee

SUCCESS AT 18 MONTHS (EVIDENCE-BASED TARGETS)

- Clinical Institute(s) fully operational; statistically significant improvement in pre-determined desired clinical outcomes demonstrated
- CMS Safety domain: CLABSI/CAUTI bundle compliance documented; trajectory toward 2027 safety-floor protection
- First quality scorecard with race/ethnicity-stratified outcomes published to MEC and Board

"The question before this body is not whether AHS can afford Clinical Institutes. The question is whether AHS can survive without them."

Thank you

REPORT/DISCUSSION: Evaluation of System Programs, Services, and Operations

No Written Materials

Agenda Item E, Evaluation of System Programs, Services, and Operations

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.

WRITTEN REPORT: Regulatory Affairs Report

May
2026

Regulatory Affairs QPSC Report

- OPEN Session

Nilda Perez – System Director of Regulatory Affairs
ALAMEDA HEALTH SYSTEM

I. Regulatory Events Summary – OPEN Session

A. Site Visits and Complaints

1. The California Department of Public Health (CDPH) survey team completed their five-day combined CDPH/ Centers for Medicare & Medicaid Services (CMS) complaint validation survey at Highland Hospital. The activities consisted of documentation review, review of staff human resources files, staff and physician interviews, and a tour of the Emergency Department, Special Processing Department, and the Operating Room.

   Final determination of deficiency will be done by the CMS Regional Office. AHS is awaiting the CMS statement of deficiencies.

B. AHS Licensing Projects

1. Fairmont Hospital – Outpatient Rehabilitation Services Space Program Flex application submitted to CDPH for approval. If granted, this will increase patient treatment space and expand access to services.
2. Alameda Hospital – Outpatient Occupational Therapy Services Program Flex application submitted to CDPH for approval. If granted, this will increase patient treatment space and expand access to services.
3. Marina Wellness Outpatient Clinic – Licensing application was approved by Central Applications Branch in January 2026. The Licensing survey will be performed (date to be scheduled) by CDPH Licensing and Certification office for approval of outpatient services addition to the Alameda Hospital license.

C. Joint Commission Activity

1. Joint Commission Triennial Survey anticipated imminently.

D. Continuous Survey Readiness Activities

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

ADDENDUM: QPSC Acronyms

Abbreviation	Term	Why is this important?
		Agencies - Federal/State/Private
CMS	Centers for Medicare & Medicaid Services	The federal agency that provides health coverage through Medicare, and Medicaid. Serves as regulatory body enforcing federal healthcare las, regulations and standards
CDPH	California Department of Public Health	CDPH is the licensing body for hospitals.
DHCS	California's Department of Health Care Services	the state's primary agency managing Medi-Cal (California's Medicaid)
TJC	The Joint Commission	Private health policy agency promoting quality and safety. Triannual hospital accreditation offers financial/regulatory advantages (like Medicare/Medicaid eligibility)
CDC	Centers for Disease Control and Prevention	National public health agency of the United States. Developed and manages NHSN (see below)
NHSN	National Healthcare Safety Network	The nation's most widely used healthcare-associated infection (HAI) tracking system. AHS is require to report HAIs to NHSN under Federal and State Requirements
HCAI	the Department of Health Care Access and Information	A California state agency (formerly OSHPD) that ensures safe hospitals, collects healthcare data, helps with financial assistance, and improves access to care.
CAL/OSHA	The California division of Occupational Safety and Health (DOSH)	State agency that protects and improves the health and safety of working men and women in California
AHRQ	Agency for Healthcare Research and Quality	leading federal agency within the U.S. Department of Health and Human Services (HHS) producing evidence, developing tools, and supporting research to make care more accessible, equitable, and affordable.
		Federal Regulatory and Public Reporting Programs
IQR OQR IPFQR	Inpatient Quality Reporting Outpatient Quality Reporting (Hospital Based) Inpatient Psychiatric Facility Quality Reporting	CMS pay-for- reporting programs intended to empower patient choice and promote quality and safety improvement. All required metrics can be used in the public reporting and penalty and incentive programs below
VBP	Value Based Purchasing	A CMS program that rewards top performing hospitals(50th percentile and above) with incentive payments while penalizing bottom performing hospital based on the quality of care provided in the inpatient setting. Measurement includes four domains: Clinical Outcomes (condition specific mortality and complications), HCAHPS, Safety (HAIs + Sepsis), and Efficiency and Cost
HRRP	Hospital Readmission Reduction Program	A CMS program that aims to reduce avoidable hospital readmissions for specific conditions. Hospitals with higher than expected readmissions are penalized.
HAC	Hospital Acquired Conditions	A CMS program that penalized hospitals in the worst-performing quartile with respect to performance on PSI-90 and HAIs
Hospital Quality Star Rating	CMS Hospital Star Rating	Summarizes a variety of measures across 5 areas of quality into a single star rating for each hospital. Includes mortality, safety, readmission, patient experience, and timely and effective care

Abbreviation	Term	Why is this important?
HCAHPS Star Rating	CMS Hospital Patient experience Star Rating	CMS' summary star rating scores hospitals on a one-to-five-star scale based on the 10 publicly reported measures in the HCAHPS survey, which assesses patient experiences.
		State and Private Public Reporting Programs
Safety Grade	Leapfrog Hospital Safety Grade	Independent Private group that uses CMS Publicly reported data as well as voluntary submissions to calculate a rating focused exclusively on hospital safety
QIP	Quality Incentive Program	a managed care directed payment program tying payments to a set of 40 metrics aligned with California's Department of health Comprehensive Quality Strategy and Managed Care Accountability Set. Primarily focused on ambulatory care with some cross over in inpatient and behavioral health
		Metrics used in Required and Public Reporting
HAIs	Hospital Acquired Infections	HAIs refer to CLABSI, CAUTI, Colon and Abdominal Hysterectomy, MRSA bacteremia, C. diff. tracked in NHSN and included in VBP, HAC, Star Rating, and Leapfrog public reporting
PSI	Patient Safety Indicators	AHRQ developed a set of measures to track potentially avoidable safety events (identified via claims) that represent opportunities for improvement.
PSI-90	Patient Safety Indicator Composite Measure	This measure summarizes patient safety across multiple indicators into a single metric. Includes: rates of Pressure Ulcer, Iatrogenic Pneumothorax, In Hospital Fall-Associated Fracture, Postoperative Hemorrhage or Hematoma, Postoperative Acute Kidney Injury Requiring Dialysis, Postoperative Respiratory Failure, Perioperative Pulmonary Embolism or Deep Vein Thrombosis, Postoperative Sepsis, Postoperative Wound Dehiscence, Abdominopelvic Accidental Puncture/Laceration
CLABSI	Central line associated bloodstream infection	An HAI that is associated with increased complications, longer hospital stays and increased risk of death
CAUTI	Catheter associated urinary tract infection	An HAI that is associated with increased complications, longer hospital stays and increased risk of death
C.Diff	Clostridium dificile	An HAI that is a common cause of infectious diarrhea in hospitals and can lead to serious illness, death and outbreaks.
MRSA Bacteremia	Methicillin-resistant Staphylococcus aureus bacteremia	An HAI that can lead to increased complication, longer hospital stays and can cause outbreaks.
SSI	Surgical site infection	An HAI that can lead to complications, longer recovery, longer hospital stays and readmissions.
HAPI	Hospital-acquired pressure injury	HAPIs negatively impact patients' quality of life and recovery due to pain, infection and other complications. HAPIs are categorized into four stages. Stages three and four are reportable to CDPH.
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems Survey	After Inpatient discharge surveying of patient satisfaction and quality of care as seen through the patient's perspective. Includes assessment of communication (Nurses, Physicians and Medications), responsiveness of Staff, clean/quiet, discharge information , overall rating/recommend hospital
HRSN	Health Related Social Needs	HRSN refers to the factors that affect an individual's well-being and health outcomes. At AHS the HRSN includes food, housing, transportation, safety and utilities insecurity.
TNAA	Third Next Available Appointment	TNAA measures patient access. The TNAA measures how soon a patient can get an appointment that is not due to a cancellation or working patients into the schedule.

Abbreviation	Term	Why is this important?
O/E	Observed to Expected Ratio	The O/E is a ratio that measures AHS performance to the expected risk adjusted performance. Typically an O/E of one is acceptable however there are metrics where the national benchmark is less than one.
Internal Committee and Processes		
MEC	Medical Executive Committee	The governing body for a hospital's medical staff, acting as a crucial link between physicians, administration, and the governing board. Oversees credentialing, quality improvement, policy enforcement, and professional conduct
QSC	Quality Steering Committee	This AHS internal committee that oversees quality and performance improvement processes
PSC	Patient Safety Committee	The PSC oversees patient safety processes such as RCAs, regulatory findings, and other patient safety practices.
IPCC	Infection Prevention and Control Committee	The IPCC oversees, develops, and implements policies to stop infections in healthcare settings
RCA	Root Cause Analysis	A process for identifying system issues that led or could potentially lead to harm. RCAs are conducted for all events where serious harm has occurred or operations were significantly impacted
OKR	Objective and Key Results	OKR is the dashboard used to measure the quality pillar of the strategic plan.

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PSI	Patient Safety Indicator
QSC	Quality Steering Committee
OKR	Objective Key Result
TNAA	Third Next Available Appointment
PSC	Patient Safety Committee
RCA	Root Cause Analysis
CDPH	California Department of Public Health
HAC	Hospital Acquired Conditions
VBP	Value Based Purchasing
QIP	Quality Incentive Program
HRRP	Hospital Readmission Reduction Program

PSI-90	Patient Safety Indicator Subset
HAIs	Hospital Acquired Infections
HRSN	Health Related Social Needs
O/E	Observed to Expected Ratio

Why is this important?

CLABSIs are hospital-acquired infections that are associated with increased complications, longer hospital stays and increased risk of death

CAUTIs are hospital-acquired infections that are associated with increased complications, longer hospital stays and increased risk of death

C. diff is a common cause of infectious diarrhea in hospitals and can lead to serious illness, death and outbreaks.

MRSA bacteremia can lead to increased complication, longer hospital stays and can cause outbreaks.

SSIs can lead to complications, longer recovery, longer hospital stays and readmissions.

HAPIs negatively impact patients' quality of life and recovery due to pain, infection and other complications. HAPIs are categorized into four stages. Stages three and four are reportable to CDPH.

HCAHPS are a measure of patient satisfaction and quality of care as seen through the patient's perspective.

AHRQ developed the PSI as a measure of potentially avoidable safety events that represent opportunities for improvement.

This committee oversees quality and performance improvement processes

OKR is the dashboard used to measure the quality pillar of the strategic plan.

TNAA measures patient access. The TNAA measures how soon a patient can get an appointment that is not due to a cancellation or working patients into the schedule.

The PSC oversees patient safety processes such as RCAs, regulatory findings, and other patient safety practices.

A process for identifying system issues that led or could potentially lead to harm. RCAs are conducted for all events where serious harm has occurred or operations were signifgantly impacted

CDPH is the licensing body for hospitals.

HAC Reduction Program is a CMS program that penalized hospitals in the worst-performing quartile with respect to performance on PSI-90 and HAIs

The Hospital VBP is a CMS program that rewards hospitals with incentive payments based on the quality of care provided in the inpatient setting. The VBP includes four domains: Clinical Outcomes (condition specific mortality and complications), HCAHPS, Safety (HAIs + Sepsis), and Efficiency and Cost

The HRRP is a CMS program that aims to reduce avoidable hospital readmissions for specific conditions. Hospitals with higher than expected readmissions are penalized.

PSI-90 is a subset of the AHRQ PSIs. This measure summarizes patient safety across multiple indicators into a single metric. PSI-90 includes: rates of Pressure Ulcer, , Iatrogenic Pneumothorax, In Hospital Fall-Associated Fracture, Postoperative Hemorrhage or Hematoma, Postoperative Acute Kidney Injury Requiring Dialysis, Postoperative Respiratory Failure, Perioperative Pulmonary Embolism or Deep Vein Thrombosis, Postoperative Sepsis, Postoperative Wound Dehiscence, Abdominopelvic Accidental Puncture/Laceration

HAIs refer to CLABSI, CAUTI, Colon and Abdominal Hysterectomy, MRSA bacteremia, C. diff.

HRSN refers to the factors that affect an individual's well-being and health outcomes. At AHS the HRSN includes food, housing, transportation, safety and utilities insecurity.

The O/E is a ratio that measures AHS performance to the expected performance. Typically an O/E of one is acceptable however there are metrics where the national benchmark is less than one.