BOARD OF TRUSTEES MEETING

WEDNESDAY, JUNE 10, 2026
5:00pm to 9:00pm

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

LOCATION:

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

ZOOM Meeting Link:[1]
https://alamedahealthsystem.zoom.us/j/9361457125?pwd=4JnAmhDnBaLqY4GWf4PQBwp3w0Puy2.1&omn=81267662342
Meeting ID: 936 145 7125
Meeting Password: 20200513

One tap mobile
+14086380968,,9361457125# or
+13462487799,,9361457125#

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

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

MEMBERS

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

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

BOARD OF TRUSTEES MEETING AGENDA

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

Public Comment Instructions
If you wish to address the Board or Committee regarding an item on the agenda or in their purview, please communicate your intent with the Clerk of the Board prior to or at the beginning of the meeting. Time limitations shall be at the discretion of the Chair. Signups for public comment will close 10 minutes after public comment begins.

OPEN SESSION / ROLL CALL

PUBLIC COMMENT

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

B. MEDICAL STAFF REPORTS

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

C. COMMITTEE AND TRUSTEE REPORTS

C1. Human Resources Committee: May 20, 2026
Donna Linton, Chair

C2. Quality Professional Services Committee: May 27, 2026
Lilavati Indulkar, MD, Trustee

C3. Finance Committee: June 3, 2026
Alan Fox, Trustee

D. CONSENT AGENDA: ACTION

D1. Approval of the Minutes of the May 13, 2026, Board of Trustees Meeting.

D2. 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

D3. Contracts

D3a. Renewal agreement with East Bay Foundation for Graduate Medical Education for provision of surgical residency services. The term of this agreement is effective July 1, 2026 through June 30, 2027. The estimated impact of this agreement is $3,823,379.
Lisa Laurent MD, Chief Medical Officer and Chief Physician Executive

D3b. Renewal agreement with Healogics, LLC dba Accelecare Wound Centers, LLC for the management and staffing of the Creedon Advanced Wound Care Center. The term of this agreement is effective July 1, 2026 through June 30, 2029. The estimated impact of this agreement is $1,552,000.
Mark Fratzke, Chief Operating Officer

D3c. Renewal agreement with CDW, LLC for provision of Microsoft software and cloud licensing services. The term of this agreement is effective July 1, 2026 through June 30, 2029. The estimated impact of this agreement is $6,758,367.
Christine Yang, Chief Information Officer

D3d. New agreement with The CSI Companies, Inc. for provision of staff augmentation services to assist with the Epic implementation at Saint Rose Hospital. The term of this agreement is June 5, 2026 through February 28, 2027. The estimated impact of this agreement is $3,100,000.
Chris Adams, Chief Administrative Officer (Saint Rose Hospital) and Christine Yang, Chief Information Officer (Alameda Health System Liaison)

D4. Resolution Approving 401(h) Account, Pursuant to Section 31592

END OF CONSENT AGENDA

ACTION/DISCUSSION

E. ACTION/DISCUSSION: FY 2027 Budget
Kim Miranda, Chief Financial Officer

F. DISCUSSION: Board Calendar and Tracking
David Sayen, President

G. STAFF REPORTS (Written)

G1. Chief Financial Officer Report, May Financial Report
Kimberly Miranda, Chief Financial Officer

CLOSED SESSION

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

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

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

(Reconvene to Open Session)

General Counsel Report on Action Taken in Closed Session

TRUSTEE COMMENTS

ADJOURNMENT

Our Mission
Caring, Healing, Teaching, Serving All

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

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

Meeting Procedures

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

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

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

Disability Access

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

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

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

CEO REPORT

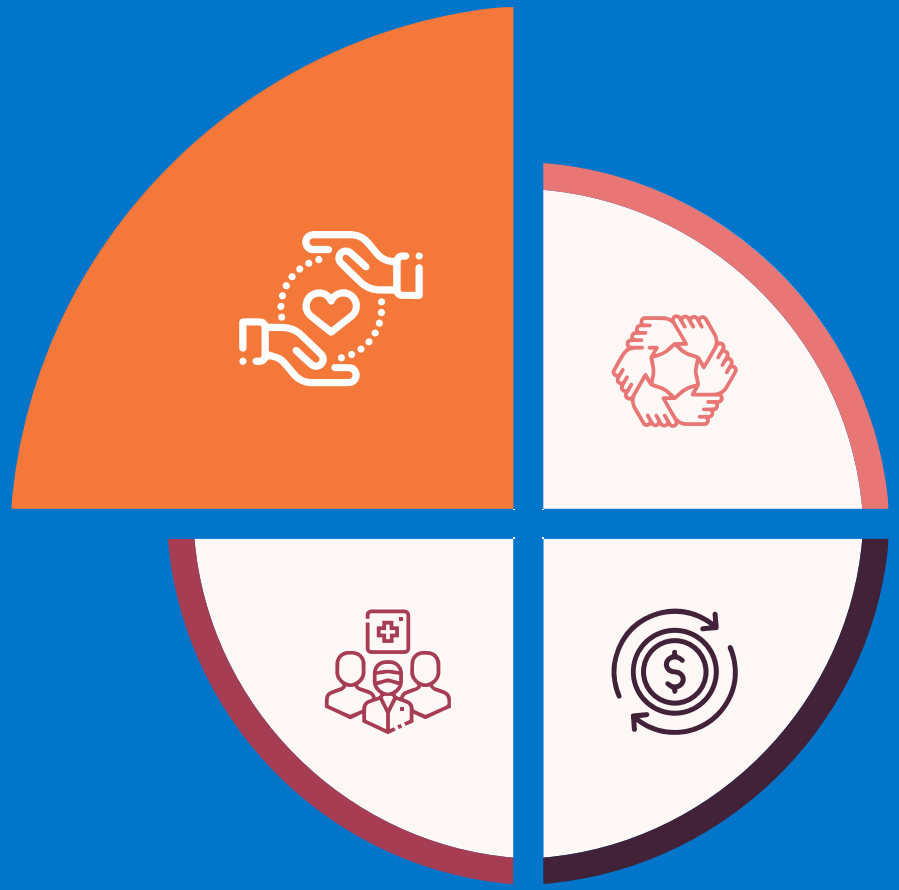
AHS CEO Board Report

James Jackson
6/10/2026
Board of Trustee Meeting

AHS Pillars

Quality Care

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

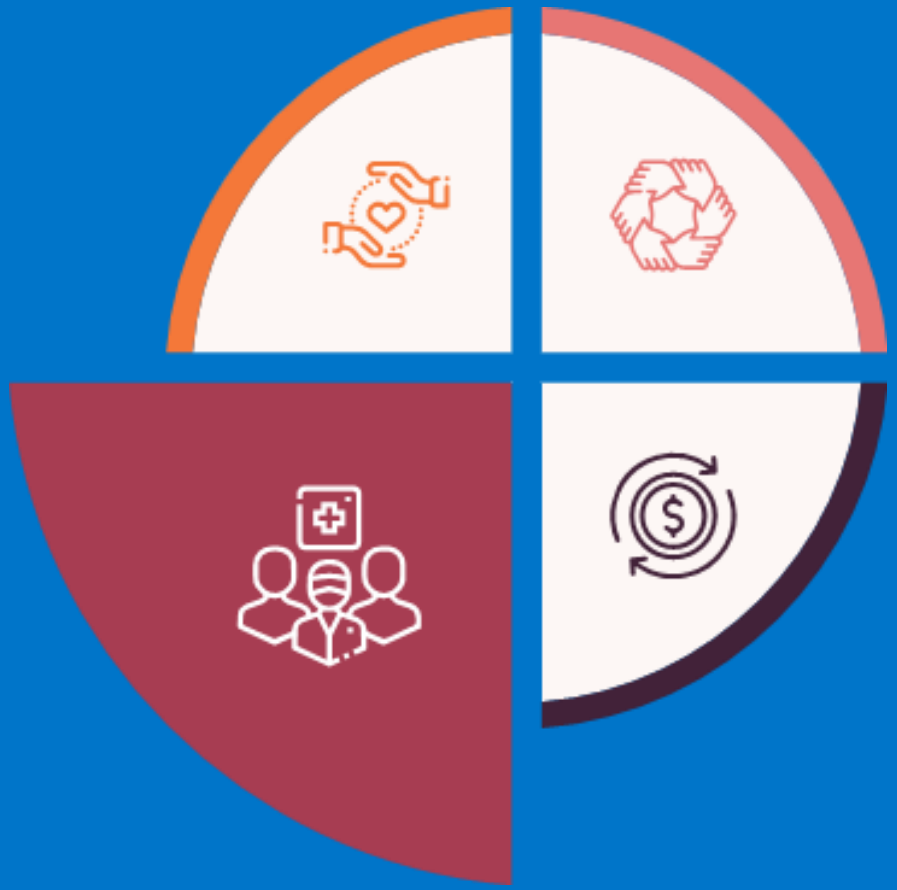


Leapfrog Computerized Physician Order Entry (CPOE)

- I am pleased to share that Alameda Health System completed the Leapfrog CPOE (Computerized Physician Order Entry) Evaluation on May 15, 2026, across Alameda, Highland, and San Leandro Hospitals. This national assessment measures how effectively our Epic system and clinical decision support prevent serious medication-related harm through testing clinical scenarios within our AHS Epic environment. Physician representatives from each hospital participated in the testing.
- All three hospitals achieved the highest level of performance, **“Full Demonstration of National Safety Standard for Decision Support,”** confirming our ability to reliably intercept high-risk medication scenarios and reflecting strong governance and coordinated execution across teams.
- CPOE performance contributes to the medication safety domain of the Leapfrog Hospital Safety Grade and reinforces our overall safety infrastructure. These results provide external validation of our EHR as a patient safety tool and underscore our continued commitment to delivering safe, high-quality care while identifying opportunities for ongoing optimization.

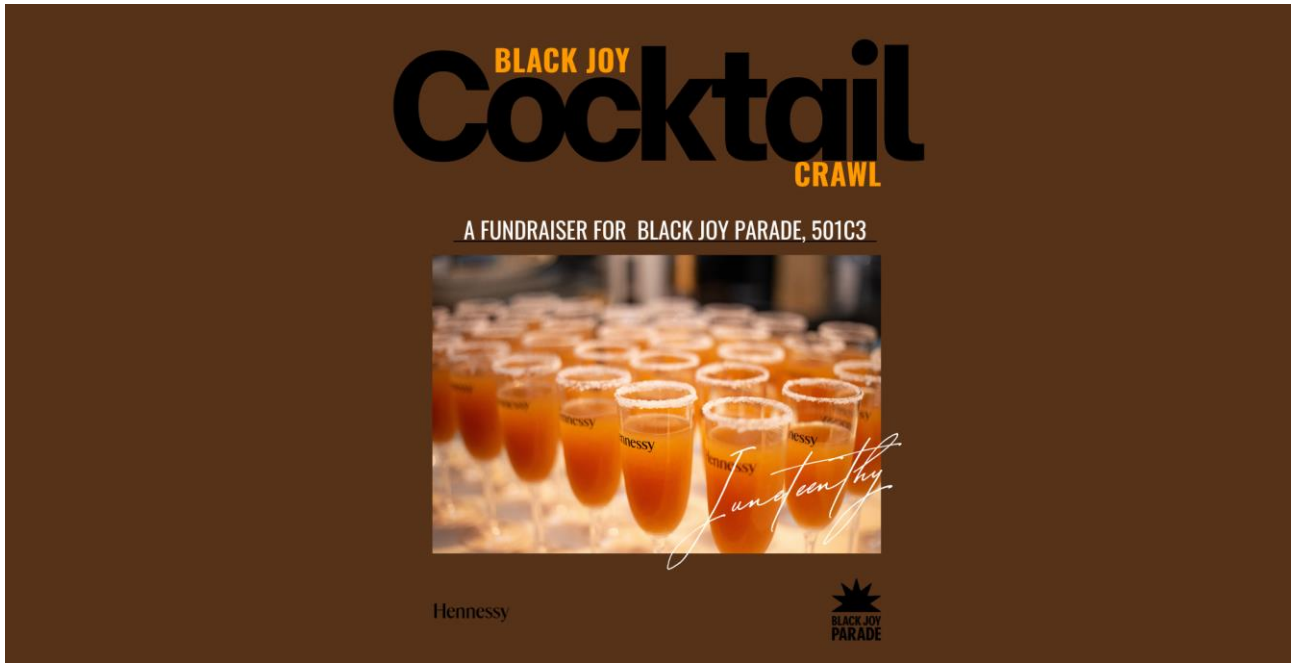
AHS Pillars

Staff & Physician Experience



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

Black Joy Parade Sponsored – Your ticket helps keep Black Joy moving



Black Joy Parade has always been about more than one day.

It's about creating spaces where Black culture is seen, Black creativity is centered, and our community can gather safely, belong fully, and be celebrated boldly.

That's why we're inviting you to join us for the **Hennessy Black Joy Cocktail Crawl** on **Thursday, June 18 at 6:30pm**.

This fundraiser brings together four Black-owned Oakland hotspots, Hennessy cocktails crafted by Black mixologists, and a room full of people who believe in celebrating Black joy out loud.

Your ticket includes one cocktail at each stop, light bites at the end, and a direct way to support Black Joy Parade's year-round work.

This is the kind of night that's better with your people. **Grab your ticket, then text the friend who's always down for a good cause and a good cocktail.**

Hope to see ya'll there!

A note from

JAMES E. T. JACKSON, CEO

Honoring Pride Month 2026

June is Pride Month, when we celebrate the LGBTQIA+ community and honor its remarkable history, resilience, and contributions. At the Alameda Health System, it is also an opportunity to reaffirm our commitment to cultivating a culture of inclusion and belonging where everyone can succeed, regardless of sexual orientation, gender identity or gender expression.

Pride Month reminds us that health care is about more than treating illness. It is about ensuring that every person feels safe, respected, valued and seen when they walk through our doors. Our commitment to equity and compassionate care extends to every patient, every family member and every member of our workforce.

Despite ongoing national challenges, there are still many meaningful developments and milestones to celebrate this Pride Month. California continues to lead the nation in advancing protections, visibility and support for LGBTQIA+ communities. Here in Alameda County, local leaders and community organizations are reaffirming their commitment to inclusion, belonging and the wellbeing of LGBTQIA+ residents through Pride celebrations, youth programming, public recognition and community partnerships.

These efforts matter. They send a powerful message that everyone deserves dignity, safety and access to care and opportunity.

At Alameda Health System, we are proud to stand with our LGBTQIA+ patients, staff, providers, learners and community members. We recognize the important role health care organizations play in fostering trust, improving health outcomes and creating spaces where people can show up fully as themselves.

To help celebrate Pride Month across our campuses and virtual spaces, we have created special Pride-themed Zoom backgrounds for staff to use throughout June. We invite you to join us in celebrating the diversity, strength and contributions of the LGBTQIA+ community.

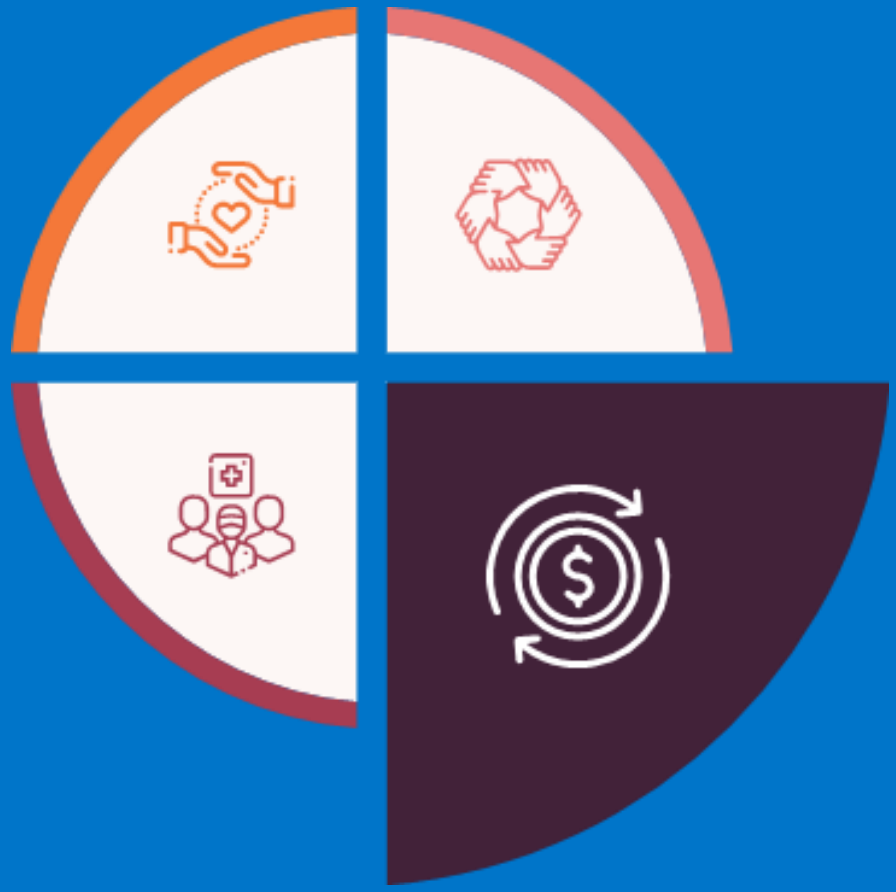
Thank you for all you do to help make Alameda Health System a place of healing, inclusion and belonging for all.

With gratitude,

James

AHS Pillars

Sustainability



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

HealthPATH – Host a Summer Intern – Shana June Yu

Internship Details:

Duration: June 8, 2026 – July 31, 2026, Mondays through Fridays, 35-40 hours per week (*includes a one-week HealthPATH internship orientation and additional professional development sessions*)

Cost: Fully covered by HealthPATH for summer 2026

Selection Process: Department leads will interview candidates vetted by HealthPATH to select the intern that best fits their department's needs. The following is the candidate selection timeline:

February 2026: All candidates complete a preliminary interview with HealthPATH team.

March 2026: Department leaders will interview 3-4 candidates for consideration.

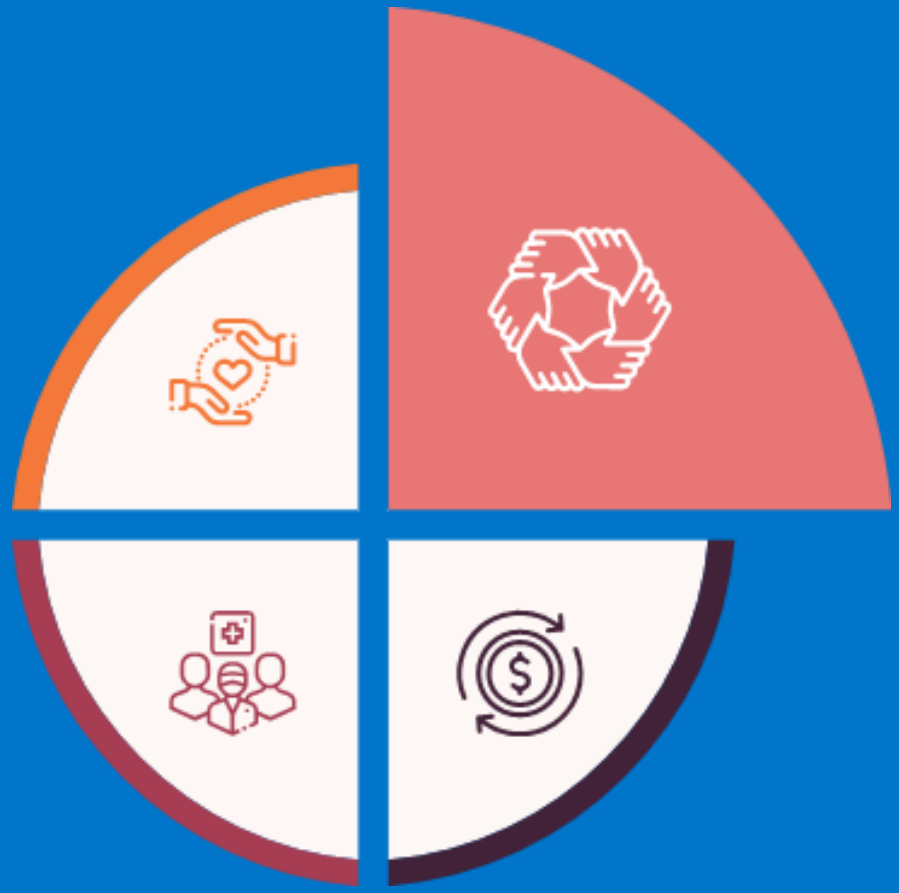
April 2026: Final offers made by the recommendation of the hosting department.

April/May 2026: Candidates onboarded through HR.

June 2026: Start of internship.

Community Connection

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



Let's spruce up our neighborhood!

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

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

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

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

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

Clean-up will be canceled if it rains.

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


ALAMEDA
HEALTH SYSTEM

ALAMEDA HEALTH SYSTEM

Questions

James Jackson
6/10/2026
Board of Trustee Meeting

MEDICAL STAFF REPORTS

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

June 10, 2026

Manasa Kalluri, MD, AH Chief of Staff

Berenice Perez, MD, AHS Chief of Staff

Alameda Hospital
Medical Executive Committee Report

- **Patient Experience**
  - FYTD 26 Inpatient Domains
    - Seven (7) of the nine (9) metrics are performing above goal

- **Quality and Safety Metrics**
  - 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.

Medical Staff Committees

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

AHS & AH Credentials Committee (May 2026)

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

Clinical Practice Council (May 2026)

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

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

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

Annual Department Reports

DEPARTMENT OF AMBULATORY AND PREVENTIVE MEDICINE

AHS AND AH DEPARTMENT OF SURGERY

Alameda Health System
Department of Ambulatory and Preventive Medicine
Report to
Medical Executive Committee

Dr. Srilekha Puranam, MD

June 3, 2026

Eastmont Wellness Center

Hayward Wellness Center

Newark Wellness Center

Urgent Care

ALAMEDA HEALTH SYSTEM

Department of Ambulatory and Preventive Medicine Report

Strengths

- **Provider Dedication & Mission-Driven Care**

Exceptional providers across all four sites — clinically skilled, mission-driven, consistently going above and beyond. Strong leadership-provider teamwork at all sites. Caring, flexible providers and ancillary staff. Minimal provider turnover.

- **Innovation: AI Tools & Technology & IS Partnership**

AI Nabla Scribe (Ambient Scribe) deployed across ambulatory. AI Chart Insights pilot. Telehealth check in workflows revised. On-the-fly encounter – work in progress, Direct scheduling - pilot at Eastmont.

- **Care Gap Coverage & Quality Improvement**

Active care gap closures across all sites. Patient satisfaction increasing. New patient waitlist at Hayward now zero. Actively driving P4P and PRIME QIP metrics — generating significant quality incentive revenue for AHS.

Department of Ambulatory and Preventive Medicine Report

Strengths – Community Advocacy & Clinical Programs

• Food as Medicine — Sweena Burroughs NP presented at CA Primary Care Association

• Screening for food insecurity (R4H) and linkage to resources

• Group Medical Visits (GMV) — OSW Behavioral Pharmacy, Hayward

• Menopause Work Group — multidisciplinary women's health support

• INSPIRED Trial (UCSF) — BP self-monitoring & HTN workflow standardization

Statewide Recognition

Sweena Burroughs NP — CA Primary Care Association speaker: Food as Medicine.

DHCS / SNI Quality Awards

Top Performer Award + SNI Quality Leader Award for Breast Cancer Screening Equity. 10+ measures above 90th %ile.

PRIME QIP – Measures Close to Target (2026)

Glycemic Status Latinx/AA (5-10 gap)
Tobacco Cessation (3 gap)
Depression Follow-Up (9 gap)

Department of Ambulatory and Preventive Medicine Report

Strengths – QIP Quality Metric Performance & Financial Impact | FY2021–2026

Alliance P4P: $1.75M per metric above 90th percentile · AAFH P4P: 75% of system-wide payment attributed to ambulatory/primary care

FY2021	FY2022	FY2023	FY2024	FY2025 ★
2 metrics >90th %ile	5 metrics >90th %ile	7 metrics >90th %ile	9 metrics >90th %ile	10 metrics >90th %ile
$6,000,000	$9,000,000	$10,500,000	$12,000,000	$15,750,000

FY2025 Total Achievement

$15,750,000

10 metrics above 90th percentile
★ DHCS Top Performer Award
★ SNI Quality Leader Award (Breast Cancer Screening Equity)
+ Overperformance: 5.5 additional metrics ($1.75M each)

Metric	FY26 Rate	Target	Status
BMI/Wt Assessment	95.53%	91%	✓ >90th
Colorectal Cancer Screening	72.44%	69.07%	✓ >90th
Depression Screening	85%+	85%	✓ At target
Controlling High BP	64.11%	72.75%	↯ 51 gap
Glycemic Status DM	28.76%	29.94%	↯ Close
Cervical Cancer Screening	50.71%	—	↑ Trending

Department of Ambulatory and Preventive Medicine Report

Strengths – Quality Improvement | Primary Care Adult Medicine (FY26 YTD through March 2026)

✓ AT TARGET — Primary Care Adult Medicine

Depression Screening (PHQ-9) · HIV Screening · Chlamydia Screening · BMI/Weight Assessment (Adult) · Colorectal Cancer Screening (62.3%) · Controlling High BP (64.1%) · Glycemic Status DM Overall (28.8%)

CLOSE TO TARGET / IMPROVING

Controlling High BP — 64.1% (FY26 YTD) vs 63.82% FY25 actual ↑ Target: 72.75%
Glycemic Control DM — 28.8% FY26 YTD vs 29.94% FY25 | Depression Follow-Up PHQ-9: close to target, +9 gap
Glycemic Status Latinx: 5-patient gap

✗ BELOW TARGET / FOCUS AREAS

Influenza (Adult Immunizations) — 560-patient gap | Cervical Cancer Screening — 178-patient gap (trend ↑)
Breast Cancer Screening: 63.0% FY26 vs 60.27% FY25 ↑ | MyChart Activation: 39% FY26 YTD vs 27% FY25 ↑

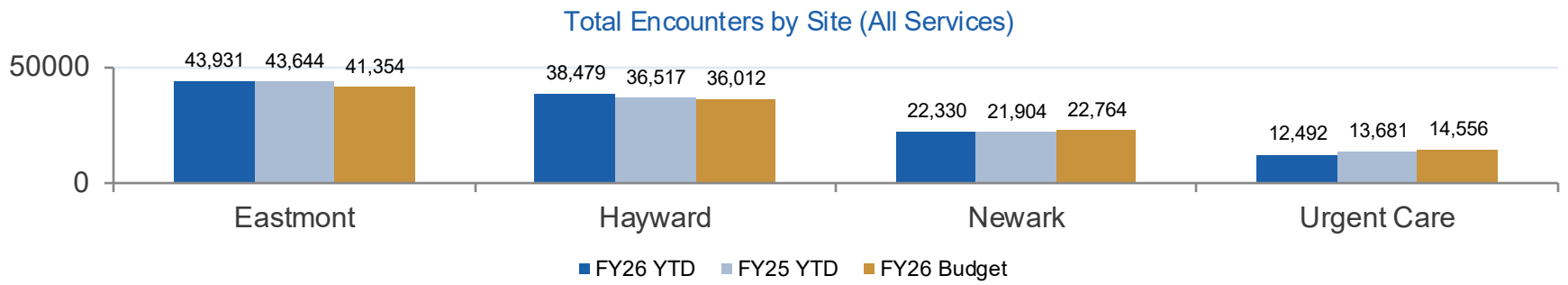
ACCESS METRICS — Primary Care Sites (March 2026)

Site	Wait Days (Mar 26)	TNAA Status
Eastmont	35 days	↑ High — template/staffing
Hayward	19 days	Improved
Newark	0 days	✓ At target

7

Department of Ambulatory and Preventive Medicine Report

Ambulatory Visit Volumes — FY2026 YTD vs FY2025 | Jul 2025 – Apr 2026 (10 months)



Site	FY26 YTD	FY25 YTD	vs Prior Yr	vs Budget
Eastmont (all)	43,931	43,644	+0.7%	+6.2% ✓
Hayward (all)	38,479	36,517	+5.4%	+6.9% ✓
Newark (all)	22,330	21,904	+1.9%	-1.9%
Urgent Care	12,492	13,681	-8.7%	-14.2% ↓
TOTAL	**117,232**	**117,746**	-0.4%	-0.9%

★ *Urgent Care volume decline: long-term provider transitioned to SAN; replacement approved & recruiting ·*

Department of Ambulatory and Preventive Medicine Report

Staff Experience — SCORE Survey: Burnout | Mar 2026 | Physicians & APPs

† Burnout items reflect % negative (burned out) — higher percentile = fewer burned-out staff = better

Newark Primary Care

Item	% Pos	Pctile†	Trend
Job frustration	60%	99th†	↑ 10%
Working too hard	20%	68th†	↑ 20%
Burnout climate	--	--†	

✓ Strength: 99th %ile — Job frustration
(fewer frustrated than 99% of peers)

Opportunity: None in burnout domain
See Teamwork & Safety Climate

Eastmont Primary Care

Item	% Pos	Pctile†	Trend
Burnout climate	40%	7th†	↓ 33%
Working too hard	40%	29th†	↑ 4%
Job frustration	60%	29th†	↓ 4%
Fatigued (mornings)	40%	35th†	↓ 15%
Burned out	40%	38th†	↓ 15%

Opportunity: All 5 items 26th–38th %ile
All trending ↓ year-over-year

i Low response rate: 55% non-respondents may feel worse

Hayward Wellness Primary Care

Item	% Pos	Pctile†	Trend
Working too hard	27%	10th†	↓ 9%
Fatigue (mornings)	55%	25th†	0%
Burned out	46%	44th†	↑ 18%
Job frustration	46%	35th†	0%
Burnout climate	64%	52nd†	↑ 28%

✓ Strength: Safety climate & teamwork strong
(99th %ile disagreement resolution)

Opportunity: 10th %ile — Workload burnout
25th %ile — Morning fatigue

i Cohesive team stretched thin, not broken culture

6B

Department of Ambulatory and Preventive Medicine Report

Weaknesses / Challenges

Recruitment & Staffing Gaps
– Eastmont: open position >1 year, 2 failed offers; open 0.8 FTE MD + 1 SAN APP
– Hayward: 1 open 0.1 SAN MD · Newark: 1 open 0.8 FTE MD
– Urgent Care: 1.0 FTE physician vacancy actively recruiting; nurse leadership transition in progress
– Providers on extended leaves straining capacity; no reliable SAN pool for sick-call coverage

Access & Schedule Issues
– Eastmont waitlist: avg 32 days ; scheduling constraints limit available appointment slots
– MyChart scheduling live at EWC (March 2026) but low uptake; only EWC offering online scheduling in Adult Medicine

SWOT Summary

Department of Ambulatory and Preventive Medicine · AHS · 2026 · Primary Care Focus

S Strengths

- Provider dedication & mission-driven care
- Care gap coverage & pt satisfaction ↑
- AI Nabla Scribe, Chart Insights
- Telehealth pilot, direct scheduling
- UC: nimble, expanded hours, system support
- INSPIRED / HTN & LTBI standardization
- Food as Medicine, Menopause WG
- Epic Campaigns live — QI momentum

W Weaknesses

- Hard to recruit — Eastmont vacancy >1 year
- In-basket management unsupported
- Template/MyChart access issues
- UC: 1.0 FTE vacancy + nurse leadership transition
- QI infrastructure reduced by RIF
- No reliable SAN pool for coverage

O Opportunities

- FQHC rate reassessment
- CDI note template & billing standardization
- In-basket & waitlist/backfill workflows
- UC: scope expansion (IVF, lab, pharmacist-chronic care)
- MyChart & open-access scheduling rollout
- Population health / MediCal coverage monitoring
- Chronic disease mgmt & assigned/unseen pts
- LTBI & HTN nursing workflow standards
- Depression follow-up / IBH collaboration

T Threats

- Big Beautiful Bill — Medicaid/FQHC funding cuts
- Burnout climate
- UC: patients w/o PCP straining urgent care scope
- HR1: QIP funding impact 2028; Medi-Cal drops now
- Immigration fear + vaccine hesitancy widening gaps
- AAH closure / provider shortage pipeline
- Dept. future (independent vs. merger) — uncertainty

ALAMEDA HEALTH SYSTEM

Department of Surgery Report 2026

65/108

Surgery Divisions:

Dental
General Surgery
Neurosurgery
Ophthalmology
Optometry
Otolaryngology
OMFS
Plastics
SICU
Trauma
Urology
Vascular

68/108

Level 1 Trauma Center

Site Survey Spring 2027

AMERICAN COLLEGE OF SURGEONS
Verified Trauma Center

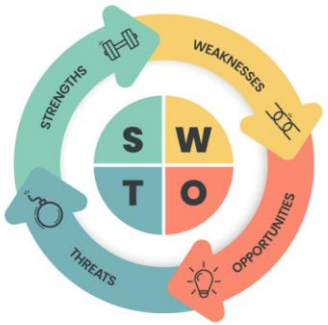
69/108

General Surgery Residency

Fully accredited – 10 year cycle

Dr Emily Miraflor
Program Director

72/108



GPR Dental Residency

Passed accreditation site survey with no reporting requirements

Dr Anchita Venkatesh
Program Director

70/108

OMFS Residency

Passed accreditation site survey with no reporting requirements.
Next site survey in summer, 2026.

Dr Akshay Govind
Program Director

71/108

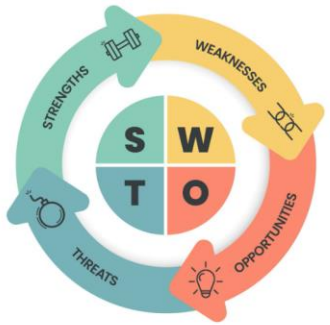
ALAMEDA HEALTH SYSTEM

Incomplete coverage for all surgical subspecialties at all 3 sites.

74/108

Incomplete coverage for Vascular Surgery at HGH.

75/108



Level 1 Trauma Center

2026 Survey Year

1) Vascular Surgery
2) Plastic Surgery
3) Anesthesia

AMERICAN COLLEGE OF SURGEONS
Verified Trauma Center

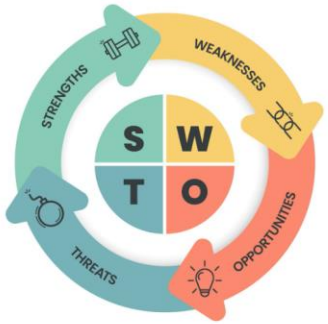
79/108

1) Financial Environment

2) Loss of talent

80/108

ALAMEDA HEALTH SYSTEM



1) Surgical Robot

2) Cancer Center

77/108

Graduate Medical Education Report

Pamela Simms-Mackey, MD, FAAP
DIO/Chief of Graduate Medical Education & Chair of Pediatrics

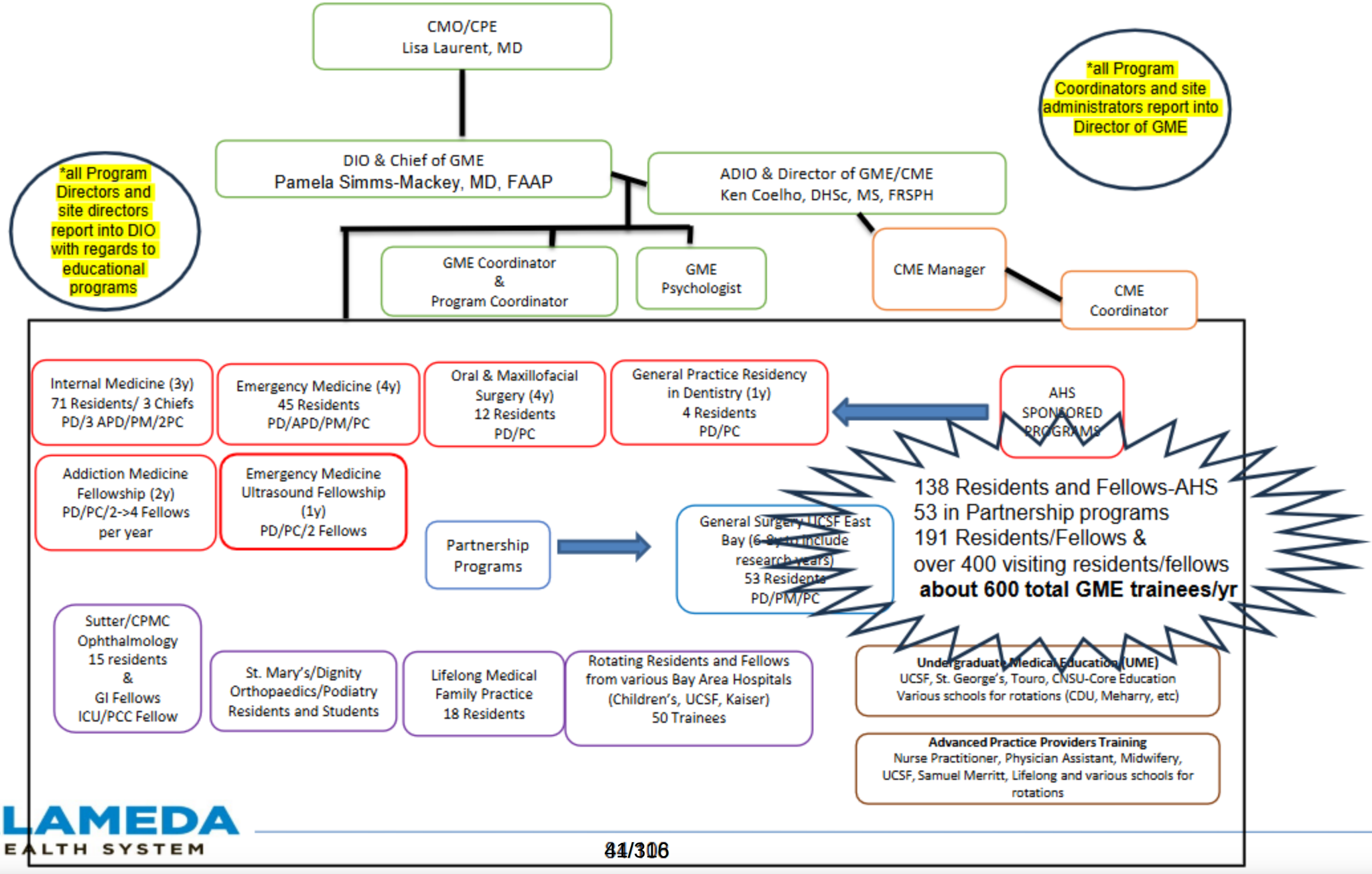
Ken Coelho, DHSc, FRSPH
Assoc. DIO/Director of Graduate and Continuing Medical Education

Nathan Calloway (last day June 4)
Institutional GME Coordinator, Graduate Medical Education

Graduate Medical Education Department Mission

The Graduate Medical Education Department at Alameda Health System-Highland Hospital provides oversight and support for our training programs to recruit clinicians who reflect our world today and provide the highest quality education and training in delivering care to underserved areas and working to eliminate healthcare disparities, while creating a learning environment committed to the institutional mission of Caring, Healing, Teaching, Serving ALL.

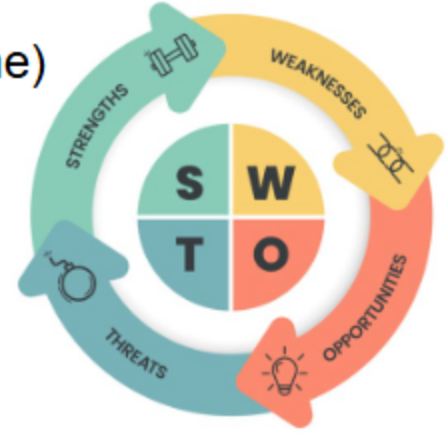
Graduate Medical Education Organizational Chart



Graduate Medical Education Committee Report

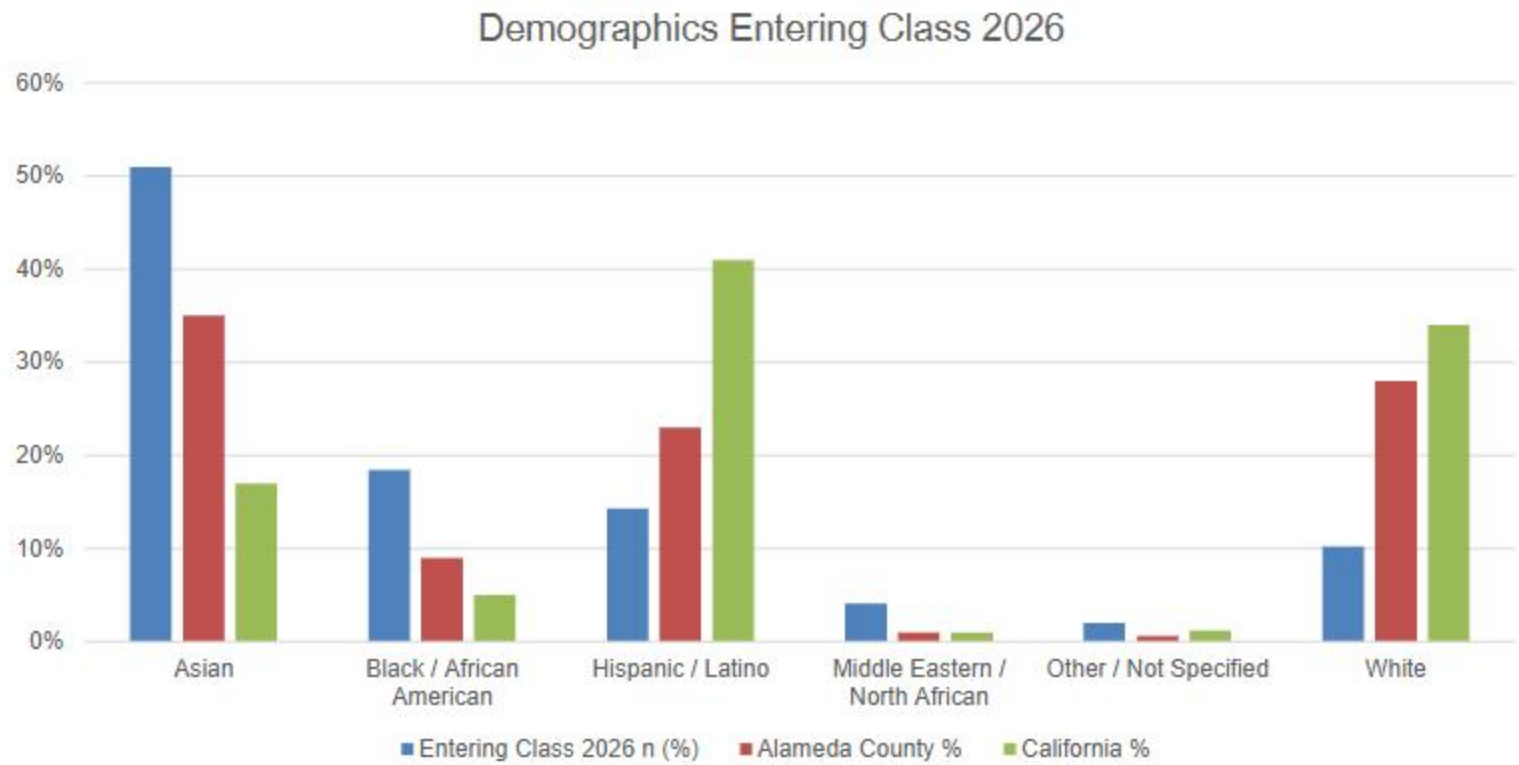
Strengths

- All programs “continued accreditation”-ACGME and CODA citation free
- Addiction Medicine successful 1st site visit Sept 2025
  - Grant to expand to 4 residents.
- Diverse trainees and wealth of clinical opportunities
- Excellence in scholarship activity
  - Research, Publications, QI work, Presentations at National Conferences, Award winners
- Sharing of knowledge across programs
- Robust educational curriculum with respect to eliminating healthcare disparities and preparation for careers working with underserved populations.
- Institutional Support & Well being (GME Psychologist, National Academy of Medicine)
- Graduates-pipeline to medical staff, competitive fellowships and/or employment
- Obtaining CalMedForce and Song Brown Grants annually
  - (cumulative over $20,000,000)



Graduate Medical Education Report

Strengths



ALAMEDA HEALTH SYSTEM

June 2026

AHS MEDICAL STAFF NEWS

Clinical Impact Committee

The AHS Medical Staff Clinical Impact Committee (CIC) provides consultative clinical input on how staffing changes may affect patient care delivery and safety. The CIC is not a decision-making body. It is comprised of three medical staff members and Executive Leadership and reviews proposals that expand, reduce, or otherwise impact care delivery.

The CIC reports to the Medical Executive Committee and the Board of Trustees (BOT). This approach supports our shared commitment to patient safety, regulatory compliance, and collaborative governance.

For questions, please contact your Department Chair or Division Chief.

Medical Staff Leadership and Finance Collaboration

As an action item from the adhoc Board of Supervisors Committee, we are pleased to share that AHS Finance Team is collaborating with Department Chairs to identify improvement opportunities. Areas of focus may include revenue capture, coding and billing optimization, and revenue enhancement initiatives. These meetings will occur over the next few weeks. If you have suggestions, please contact Dr. Subramanian or your Department Chair.

Department of Emergency Medicine Quality Improvement Initiative

The Emergency Department developed a Community Health Worker (CHW) program in August 2024 with the goal of supporting patients in care navigation, particularly in regard to medication access. Many Highland ED patients cannot access the medications prescribed after an Emergency visit, for logistical or financial reasons. Our multidisciplinary team (comprised of ED physicians, nurses, pharmacy staff, and CHW Tasha Thibodeaux) developed a "meds to beds" program to address the needs of our most vulnerable patients, bringing their outpatient medications directly to bedside prior to discharge to ensure receipt. Tasha now instructs health coaches in this practice as they train to become Community Health Workers themselves. CHW intervention has reduced the pharmacy wastage (or "return to stock" rate) substantially; patients receiving a CHW consult are twice as likely as other patients to fill their medications. The Meds to Beds program has 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. The CHW program also serves as a crucial resource for other aspects of care navigation and supports patient experience in the ED.

WELCOMING NEW PROVIDERS ACROSS OUR SYSTEM

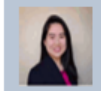
Hank Sun, MD
Anesthesiology, Perioperative and Pain Medicine Department

Jeffrey Lewis, MD
Anesthesiology, Perioperative and Pain Medicine Department

Natasha Thrower, MD
Psychiatry Department

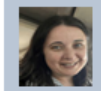
Kevin La, MD
Medicine Department Internal Medicine

Gabriela Drago-Spencer, MD
Medicine Department Cardiology



Victoria Liew, DPM
Orthopaedic Surgery Department Podiatry

Nirvana Kundu, MD
Anesthesiology, Perioperative and Pain Medicine Department



Karine Hajyan, DO
Obstetrics, Midwifery and Gynecology Department

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

Medical Staff Collaboration Updates

Clinical Impact Committee

- Comprised of three medical staff members and Executive Leadership
- Provides consultative clinical input on how operational decisions may impact patient care delivery and safety
- CIC is not a decision-making body
- Reports to Medical Executive Committee and the Board of Trustees (BOT)
- Fosters a commitment to collaborative governance in the delivery of patient care

Medical Staff Leadership and Finance Collaboration

- Action item from the adhoc Board of Supervisors Committee
- Finance Team is collaborating with Department Chairs to identify financial opportunities
- Areas of focus may include revenue capture, coding and billing optimization, and revenue enhancement initiatives

Ensuring Medication Access at ED Discharge Improves Outcomes

- **Access Gap**: Many HGH ED patients leave without medications after their ED visit
- **Solution**: 'Meds to Beds' delivers medications prior to discharge
- **Multidisciplinary team**: ED physicians, nurses, pharmacists, and Tasha Thibodeaux, CHW
- **Workforce development**: CHW model used to train health coaches
- **Impact**: 2X higher fill rates, reduced pharmacy waste, safter care transitions and improved patient experience.

ALAMEDA HEALTH SYSTEM

CARING, HEALING, TEACHING, SERVING ALL

COMMITTEE AND TRUSTEE REPORTS

No Written Materials

Agenda Item C Committee Reports

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

CONSENT AGENDA: ACTION

ALAMEDA HEALTH SYSTEM

BOARD OF TRUSTEES MEETING

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

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

LOCATION:

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

MEMBERS

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

BOARD OF TRUSTEES MEETING MINUTES

THE MEETING WAS CALLED TO ORDER AT 5:02 pm

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

ABSENT: Nely Obligacion

PUBLIC COMMENT:

Shane Ruiz spoke regarding how the union, SEIU, supports the Board granting economic authority to the bargaining team thus giving them the authority to offer a fair and just contract.

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

Trustee Fox asked if the state-directed payment reductions were part of HR1. Ms. Rodriguez said they were. The state-directed payments sounded like they came from the state. But it was a federal mechanism to draw down federal funding. AHS will put up a non-federal share in place of the state to draw down federal funding. It's a state-directed payment because it's directed from the federal government to the states. It wasn't telling the states to do something different; it was saying that the rate was going to be lower for this population. Trustee Fox

confirmed this was where the state requested payment and the feds matched it. Ms. Rodriguez confirmed. It would not go away, but it would be reduced. It is a direct impact to public hospitals because we put up the non-federal share.

Trustee Sblendorio asked if the 'existing structural deficit' would really stay $1.5B as shown on the 2025-2032 cumulative impact slide. Ms. Rodriguez said it was kind of a proxy. It could increase, but that was the proxy for the gap.

Trustee Sblendorio asked if there were some systems that were more underwater than others. Ms. Rodriguez said there were some systems that had no support from their counties at all. They were the ones that tended to struggle the most with the difference. She would have to go back confirm details with their finance team though.

Trustee Fox asked if she knew of any systems or counties that are looking to private, not-for-profit hospital organizations to bridge some of the gap. Ms. Rodriguez said she wasn't aware of any doing that right now. Though, it has happened in the past. Trustee Fox asked if she had heard of any of that happening at a service level. For example, having a Kaiser or Sutter take over a program that was shut down. Ms. Rodriguez said that hasn't happened yet with the exception of gender affirming care where they have partnered with institutions that do not rely on federal funding.

Trustee Sblendorio asked if she had details on what systems have begun implementing cuts and if AHS leadership was aware of which systems have done this. Ms. Rodriguez said Santa Clara and San Francisco both have public information available regarding their cuts. She was aware of other organizations that were actively working on plans for cuts.

Trustee Sblendorio asked if the CAPH was going to catalog the services systems were cutting so others can learn other ways to provide the services. Ms. Rodriguez said they had not so far. They were trying to catalog, for advocacy purposes, the story of what happens in terms of patients. They have been supporting system in terms of the work they were doing on cost effectiveness and efficiency. She would be happy to talk with the Board as they see more of this to understand what would be useful. Mr. Jackson said they definitely had the one-on-one conversations. He appreciated the suggestion of cataloging the issues and said he would be happy to bring that to the CAPH Board at their upcoming meeting.

Trustee Sayen said he didn't understand how the impact slide related to the total spend. Ms. Rodriguez said state-directed payments, for example, for some systems was between 10 and 20% of their entire Medi-Cal revenue that is being cut from the state-directed payments.

Trustee Sblendorio said it would also be helpful to understand where 1.8M who could lose coverage would end up. Ms. Rodriguez said those were the kinds of numbers they are building over time.

Trustee Linton said as counties start holding budget discussions there would be a lot more public information. The UCs would be a slightly different source of information. Ms. Rodriguez agreed. The UCs were looking at cuts to grants and such.

Trustee Fox asked if there were discussions with other public health consortiums across the country. Ms. Rodriguez said they had very strong relationships with organizations in other states. Particularly some of the red states that depend on things like state-directed payments and they were a better face of advocacy than California can be in Washington DC.

Trustee Indulkar asked where the Measure A tax sat compared to Santa Clara and Contra Costa. Ms. Rodriguez said she'd bring that information back. Trustee Indulkar said she was wondering if there would be an appetite to increase Measure A after the elections. Ms. Dong said the surveys conducted so far indicated that there was not an appetite to increase taxes.

Trustee Indulkar said this was forcing us to redefine what a safety net is. She was curious about how other counties were approaching this and if there were learnings we could gain from this and if there could be collaboration with for profit organizations. Ms. Rodriguez said she would give that more thought. Everyone spoke about core services, but that was defined differently in different communities.

Trustee Sblendorio said he heard about a six-month moratorium on Medicare. He asked if there was more information on that. Ms. Rodriguez said they announced a six-month moratorium on adding new home health providers to Medicare. They also announced that CMS would be withholding some funding from California. There were not a lot of specifics, but the assumption is that they are concerned that California was providing coverage to the UIS (Unsatisfactory Immigration Status) population.

Trustee Garrett asked for high level summary on the 1115 waiver. Ms. Rodiguez said the biggest impact would be the loss of the global payment program, which was where the Medicaid DSH (Disproportionate Share Hospital Program) dollars flowed. The question would be how much of the DHS dollars would be drawn down.

Trustee Sayen asked what the State was proposing to do about the waiver. Ms. Rodriguez said because the Global Payment Program was focused on outpatient care, it aligned with a lot of the current administration's goals around preventative care and such. So the program has been reframed as a Make America Healthy Again program to speak to the preventative care, as well as what it has been doing.

B. CEO REPORT

James E.T. Jackson, Chief Executive Officer

Trustee Sayen said Leapfrog and CMS seemed redundant. Mr. Jackson said that was a fair point. AHS did not submit data to Leapfrog for a long time. It became difficult to ignore the bad grads we received as a result. The decision was made a while ago to participate in part because a lot of the work required by Leapfrog was already being done and it just needed to be submitted.

Trustee Linton said she was thrilled about the St. Rose Epic roll out but was curious about the cost and how it was financed. Mr. Fratzke said it was about $6.5M and it was financed with money from Stanford and from the fund Stanford advanced us as the skilled nursing school.

Trustee Indulkar asked if all the note documentation would be Epic and visible by docs at Highland and St. Rose. Mr. Ip said yes. Patients had one medical record. The notes would be shared. The financing would be separated out.

C. MEDICAL STAFF REPORTS

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

D. COMMITTEE AND TRUSTEE REPORTS

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

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

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

E. CONSENT AGENDA: ACTION

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

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

E2. Recommendation to the Board of Trustees for approval of the AHS Medical Staff Policies and Procedures listed below:

AHS and AH Medical Staff:

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

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

E3. Recommendation to the Board of Trustees for approval of the AHS Medical Staff Policies and Procedures listed below:

AHS Medical Staff:

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

AHS and AH Medical Staff:

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

E4. Contracts

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

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

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

ACTION: A motion was made and seconded to approve the consent agenda. A roll call was taken, and the motion passed.
AYES: Trustees Alan Fox, Greg Garrett, Lilavati Indulkar, MD, Donna Linton, Nicholas Moss, MD, Rachel Richman, David Sayen, and Sblend Sblendorio
NAYS: None
ABSTENTION: None

END OF CONSENT AGENDA

ACTION/DISCUSSION

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

Trustee Sayen asked what will happen when they present a budget to the Supervisors with a hole in it. Mr. Jackson said they will not take anything to the Supervisors without coming this Board first. They will take a snapshot to the Health Committee. But it will not be final, because this Board will not have approved it yet.

Trustee Sayen said he wasn't sure how they would approve a budget that was not balanced. Mr. Jackson said they were going to keep working to get to a balanced budget.

Trustee Fox said it sounded like the only program being cut was IOP. He asked if they were not able to balance the budget through all the pruning, would they get to the point where they would have to consider program cuts and how would that decision be made.

Trustee Sayen said a program with a negative margin still had some income attached. It would be a bigger group of programs than they discussed a few months ago.

Trustee Fox said they don't necessarily need to be negative, but some don't make enough money to cover the variable expenses.

Trustee Garrett said Beilenson Hearings were listed as a possibility on the Expense Improvement Tactics slide. It was listed because leadership understood if they did not reach budget goals, future program and service cuts would need to be made. Additionally, all service lines lose money because Medi-Cal reimbursement rates were so low.

Trustee Fox said they knew every location lost money, but not every service line loses a significant amount of money. They would have to go to where the individual services that were not mission critical and determine which of those were losing money. Mr. Fratzke said they were getting close to maximizing their revenue, in terms of capturing it all. However, 75% of their expense was labor. Programs and RIFs were going to have to be on the table still. Additionally, the further they push past July 1st, the more it gets prorated into FY27, making the gravity of the cuts greater to try to meet the deficit.

Trustee Garrett said delaying RIFs will create larger RIFs or program cuts, which would also lead to RIFs down the road.

Trustee Linton said the time frame was short. They had one Finance Committee meeting prior to June 8. She asked if that should be a joint meeting of the full Board and Finance Committee and if they would have identified the layoffs or program closures related to the $7.5 to $20M. Mr. Fratzke said he would ask the Board how they want staff to proceed in terms of programs. They could have a special meeting to review the information. Or they could come on June 3rd.

Trustee Linton said she also understood that Capital was not budgeted it. Ms. Miranda said they had to have cash flow to pay for capital. They did not yet know how much money they'd have to spend. Mr. Fratzke said they had around $11M of capital in progress that they might be able to carry over. But there were going to be some very difficult decisions that will need to be made. Trustee Linton said that would be risky as well, as they've had presentations on the aging of equipment and they should have a number in the budget.

Trustee Linton said she understood that Capital was not yet budgeted. Ms. Miranda said they had to have cash flow to pay for capital There was work happening to prioritize it, but they don't know how much money they'll have. Mr. Fratzke said they probably have $11M in capital in progress in one department, which may be all we should carry over. There may be some real tough decisions that will have to be made. Trustee Linton said that would be risky as well. They've had presentations about aging equipment and the compromises it makes for quality of care. She said as challenging as it was, they should have a number in there for capital. Mr. Fratzke said they will bring $30M of capital forward. It'll be in three buckets: Strategy, replacement, and carryover. We will pick and choose from that based on how we do with the budget.

Trustee Linton said they were going to need some meetings between now and the 29th when they had to have the report ready for the Health Committee.

Trustee Fox said alternatively they just post what they are seeing today on the 29th. It was where they were now. Mr. Jackson said he proposed they give them a snapshot of where they were. It was not going to be a final budget.

Trustee Linton said that if they don't show them the impact of this, they might be missing an opportunity. Mr. Jackson said he was fully committed to ensuring they understood the impact. Trustee Linton said then they still need a meeting to determine what would be cut, how many people, and all of that, so they understood what was at risk as they moved into their budget hearings.

Trustee Fox said another conversation with the Supervisors on the 8th, should be the withholding at John George going back to 2023. That was the capital budget right there. When you look at what they've risked there was also risk to physician retention if our equipment could not compete with other systems.

Trustee Linton asked if our contract with the County covered all of John George or were there gaps as in previous years. Ms. Miranda said the County gives AHS the funding they received from the State. There was no way for AHS to recover denials, and there was no additional funding to cover the costs. The entity financials were projecting they would lose $21M. Trustee Linton asked if they would ask for additional money to cover that cost.

Trustee Garrett asked if it was part of the Ad Hoc committee's meeting that they would provide data on denials so they could be resolved by AHS. Ms. Miranda said the County has not been able to provide data on denials.

Trustee Linton said they needed to identify the gap in IOP as well. AHS needed to understand if it would go to a community program or if the County would support that program as well.

Trustee Garrett said that at the last Ad Hoc meeting it was said that there was so much revenue being lost because they weren't documenting correctly. It was important to note that the revenue improvement tactics were addressing this and at most would raise $3M. It was not the answer to a $100M gap.

Trustee Linton asked if QPSC could be forum to discuss services that could be cut.

Trustee Sayen said if they were going to show a snapshot in the red, they also needed to include some suggestions for how to remedy it.

Trustee Moss asked what triggered Beilenson. Mr. Azzi said reductions in force of closures of programs. Trustee Moss said they could propose closing programs without Beilenson. Mr. Azizi agreed.

Trustee Sayen said so the snapshot could come with ideas on how to remedy without triggering Beilenson. Mr. Fratzke said staff can draft a proposal for the Board. They would not have time to vet it with the entire organization, so they needed to be clear that none of it was a final decision.

Trustee Garrett asked that the proposal quantify the impact on services, not just the savings that would accrue.

Trustee Richman said they had been talking about building partnerships with other institutions to accommodate services. She did not see how they could work out any of that by July 20th. She didn't understand the time frame for doing that. Mr. Fratzke said part of the analysis could be identifying who they should partner with. That would take longer. It's going to be more about what should be eliminated. Trustee Richman asked where the July 20 date was coming from.

Trustee Linton said the July 20 date probably comes from the fact the Supervisors take recess in August. If there was going to be a Beilenson Hearing, they would have to catch them in July. Otherwise, it won't happen until probably mid to late September.

Trustee Richman understood that. But she didn't understand why they needed to wait until July 20. They needed to give themselves time to negotiate mitigations.

Trustee Linton said the 20th would be for the hearing. Notice would have to be given six weeks prior to that.

Trustee Fox said if they were looking at getting nonprofits in the county to pick up some programs it would take the better part of a year to approve any of it.

Trustee Sblendorio said the budget was for the year, it didn't mean the cuts all happen on July 1. Any cuts that required a Beilenson could happen over the year.

Trustee Sayen said it may be more realistic to ask for financial contributions than for them to take over a program.

Trustee Indulkar said she was trying to work out what the different pathways were. One was to meet and make tough decisions almost immediately to prevent us from being more and more in debt as the year goes on. But they learned from the past RIF how expansive it was in terms of delivery of patient care. If they were going to be making those decisions it couldn't be just coming up with things. They would make the same mistakes they did last year. She wanted to be thoughtful on how to proceed because the other option was this was a gamble. If they could be more thoughtful knowing that we were going to get in bigger debt as they move forward. The question was the timing of it. They realized it might be inevitable given information they didn't have.

Trustee Sayen said they didn't have a way to go further in debt. They would not be able to make payroll. He understood the suggestion was to come back at QPSC and have the Board look at what pieces could financially make that work and prioritize the least bad. They could then go to the Health Committee with their ideas of the ways to fill the gap. Then the Health Committee, who may have access to other resources, would weigh in. It is going to be hard. But it was going to be harder in years to come. The executive team would bring their ideas to the Board at QPSC.

Trustee Fox said it was going to get exponentially worse through 2032. It would seem like instead of repeating this same thing a year from now when they have to cut more programs than they might have to this year, he wasn't sure how to synthesize the whole thing. He thought they should let the Supervisors know this is what we need to do for 27 and 28, but it was going to be two or three times that to survive into 2032.

Trustee Richman wondered to what extent they needed to specify what the cuts were. Last time they took a lot of heat. They needed vetting with the medical staff, with labor, and heads up to the Supervisors. In trying to rebuild relationships, they needed to figure out more methodical approach. Mr. Fratzke said he wished they had the time to do that. And if that was the direction they were given, they would be done with the first quarter of 27 before they were done.

Trustee Moss said if they were going to do that, they should remember that subsequent years were going to be worse. They could make bigger cuts that took longer but that were prorated.

Trustee Linton said if they were able to put something together on the fourth Wednesday, which would frame information going to the ad hoc committee, which communicates the cuts they were looking at without concessions and without revenue. They will not be able to say they did not know, like they did last year. It would add a level of seriousness

Trustee Sayen said it sounded like they wanted to look at this on the last Wednesday of this month and have staff bring some suggestions about what this snapshot will look like. Either

snapshot A, which is basically what they saw tonight, or snapshot B which would be painful reductions. Hopefully some things will come out of the ad hoc.

Trustee Fox said the source of the capital funding needed to be the withheld funds from John George. They are not paying us enough money for John George to make it break even, then they are withholding 20% of their inadequate reimbursements, going back three or four years.

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

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

Trustee Linton asked what the Board of Supervisors were saying about their plans if the legislation passed. Ms. Dong said they have not communicated that.

Trustee Garrett asked about the delegation of duties. Ms. Dong said it meant that the Supervisors could designate the executive team to execute daily operations. Mr Azizi said there would be certain boards, such as the Quality Profession Services Committee, that would have to remain. So the Trustees would take on some of the sub committee roles if the governing body was the Board of Supervisors.

Trustee Richman asked if it was also the case that the closer we are pulled to them the more vulnerable they are to having to take on our debt. Ms. Dong said yes. The analysis of the bill included strong advice to not be perceived as too much of one organization with the County as then it would be the same debt ratio requirements, spending requirements, etc. Mr. Azizi said that all employes would remain AHS employees. The organizations would be completely separate, but there would be a governing body if the most restrictive would be the County taking over the governing body role.

Trustee Sayen asked if there was anything in this legislation that would help with the financial situation. Mr. Azizi said if the governing board was the county they would have to pass the budget.

Trustee Linton asked if AHS was a co-sponsor. Ms. Dong said she understood we could co-sponsor if they wanted to, but they were not currently.

Trustee Sayen asked if co-sponsoring the bill could give AHS some potential influence over the bill. Ms. Dong said it would.

Trustee Indulkar said her concern was that there were so many decisions as a health system that had to be made from the healthcare perspective. She asked how that would translate to the Supervisors having the bandwidth or the understanding to make these decisions from an isolated perspective. Ms. Dong said the language in this legislation was permissive not prescriptive. It would allow them to make these changes, not require them to.

Trustee Indulkar asked how they advocate for them to not have the pendulum swing all the way back to the Supervisors. Trustee Sayen said the Trustees could speak with the Supervisors who appointed them.

Trustee Sayen asked what the local legislators thought. Ms. Dong said she didn't thing the entire delegation was on the bill, if that was any help.

Trustee Linton asked if there should be some institutional guidance before individual Trustees communicated with the Supervisors.

I. DISCUSSION: Board Calendar and Tracking

J. STAFF REPORTS (Written)

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

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

Mr. Azizi announced that the Board would go into closed session to discuss the items on the agenda.

Trustee Indulkar recused herself from the closed session as a member of SEIU.

CLOSED SESSION

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

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

(Reconvene to Open Session)

General Counsel Report on Action Taken in Closed Session

Mr. Azizi said the Board met in closed session and took no reportable action.

TRUSTEE COMMENTS

ADJOURNMENT: 10:10pm

	Policy	
ALAMEDA HEALTH SYSTEM	**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.

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	
ALAMEDA HEALTH SYSTEM	**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.

ALAMEDA HEALTH SYSTEM	Policy	
	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.

ALAMEDA HEALTH SYSTEM

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	
	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.

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 may not accept 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 may not pay directly for any of the expenses related to the CME activity.
- AHS may use 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 all learners attending the CME activity
- AHS may not use commercial support to pay expenses for individual learners or groups of learners.

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.

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.

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.

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

Primary Care Procedures

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

	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	

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
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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.

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

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

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 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	
	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
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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:

Primary Care Procedures

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	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)

	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

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

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

	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	

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

ALAMEDA HEALTH SYSTEM

SYSTEM MEDICATION SAMPLES

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		

ALAMEDA HEALTH SYSTEM	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).	$$CrCl\ (ml/min) = \frac{(140 - age) \times (IBW^*)}{72 \times SCr}\ (\times 0.85 \text{ if female})$$ *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.

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**		

ALAMEDA HEALTH SYSTEM	Policy	
	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		

ALL Acute Care Medication Carts and Kits

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])

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)	

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	

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.

Wilma Chan Highland Hospital Medication Carts and Kits

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	

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	

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		

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

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)

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	

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®	

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.

Operation OB – MEDICATION BOX

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

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

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.

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

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

Alameda Hospital Only Medication Carts and Kits

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 / **

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**

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: _____

PATIENT HOSPITAL LABEL STICKER

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

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

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	

San Leandro Only Medication Carts and Kits

Department/Divisions	Name of Emergency Box/Kit	Page

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

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

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

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

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: _____

PATIENT HOSPITAL LABEL STICKER

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

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	

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	

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

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

Procedure Room Drug Box

Procedure Room Drug Box	Fentanyl 100mcg/2ml	8

Procedure Room Drug Box	Midazolam 5mg/5ml	8

ALAMEDA HEALTH SYSTEM	Policy	
	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

	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

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:

Appendix A

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

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.

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

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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.

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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	
ALAMEDA HEALTH SYSTEM	**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

ALAMEDA HEALTH SYSTEM	Policy	
	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

Form Approval/Change Process

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	
	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

Individuals Authorized to Make Corrections

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			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

Contract Approvals
June 2026

1) Renewal agreement with East Bay Foundation for Graduate Medical Education for provision of surgical residency services. The term of this agreement is effective July 1, 2026 through June 30, 2027. The estimated impact of this agreement is $3,823,379.
Lisa Laurent MD, Chief Medical Officer and Chief Physician Executive

2) Renewal agreement with Healogics, LLC dba Accelecare Wound Centers, LLC for the management and staffing of the Creedon Advanced Wound Care Center. The term of this agreement is effective July 1, 2026 through June 30, 2029. The estimated impact of this agreement is $1,552,000.
Mark Fratzke, Chief Operating Officer

Contract Approvals
June 2026

3) **Renewal agreement with CDW, LLC for provision of Microsoft software and cloud licensing services. The term of this agreement is effective July 1, 2026 through June 30, 2029. The estimated impact of this agreement is $6,758,367.**

Christine Yang, Chief Information Officer

4) **New agreement with The CSI Companies, Inc. for provision of staff augmentation services to assist with the Epic implementation at Saint Rose Hospital. The term of this agreement is June 5, 2026 through February 28, 2027. The estimated impact of this agreement is $3,100,000.**

Chris Adams, Chief Administrative Officer (Saint Rose Hospital) and Christine Yang, Chief Administrative Officer (Alameda Health System)

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

Contractor/ Vendor Name:	East Bay Foundation for Graduate Medical Education ("EBFGME")
Description:	EBFGME is a non-profit corporation that administers the East Bay Residency Program for surgical residents under the UCSF School of Medicine. The residents from EBFGME have been participating in clinical rotations at Alameda Health System's ("AHS") Wilma Chan Highland Hospital ("WCHGH") since 1989, as well as at Kaiser Permanente (various locations within the East Bay), San Francisco VA Medical Center and Children's Hospital. All participating hospitals make a financial commitment to EBFGME for the purpose of sharing certain costs and expenses proportionally to hospital participation, including resident salaries and benefits (salary portion) as well as expenses incurred by EBFGME in the administration of resident salaries, benefits and recruitment activities (administration portion). Hospital financial commitment is calculated based on the number and experience of the residents assigned to the hospital for the salary portion and the percentage of students assigned to the hospital for the administration portion. The EBFGME program will place a total of 55 residents across all participating hospitals during FY 27 comprising 39 continuing residents and 16 new residents. Of the 55 surgical residents in the program for the upcoming year, 29 have been assigned to the Accreditation Council of Graduate Medical Education ("ACGME") accredited Surgical Department Residency Training Program at WCHGH accounting for 52% of the residents in the EBFGME program. The residents range from those in their first through fifth years of residency ("Program Years I through V, often abbreviated PGY I, II, etc.") and will provide the following services: • Inpatient and Outpatient Duty Hours (where "Duty Hours" include all clinical and academic activities related to the residency requirements) • Administrative Duties related to patient care • On-Call Duty Hours Supervision of the residents and oversight of the Surgical Department Residency Training Program is performed by the UCSF East Bay Faculty Surgeons, under the UCSF Professional Services Agreements for Trauma, Surgery and Neurosurgery. The structure of the Renewal Amendment with EBFGME remains unchanged over the prior term. Our proposed total financial obligation will increase by 9.3% over current rates due to the following changes: 1) 9% overall increase in residents' salaries due to EBFGME's Board of Directors approval of a cost-of-living increase. 3) 2.2% average increase in benefits allocation, including housing stipend and addition of a flexible spending account. 3) 12.6% increase in the cost of the share of the administrative budget for which AHS is responsible. • AHS administrative budget allocation increase reflects the following: 1. 7% increase in salaries for personnel

<table>
<tr><td></td><td>2. No increase in total cost in supplies, printing and equipment reflecting increased utilization and inflation.
3. 31% increase in cost of support services, including CPA/audit, legal, and payroll fees.</td></tr>
<tr><td>Contract Type and Term:</td><td>Renewal Amendment
Term: 07/01/2026 – 06/30/2027 (12 months)</td></tr>
<tr><td>Termination Clause:</td><td>Without Cause Termination: This contract automatically renews for an additional one-year period if either party fails to give the other party written notice to terminate prior to November 1, 2026.</td></tr>
<tr><td>Total Spend with Vendor:</td><td>
<table>
<tr><th>Description</th><th>Board Approval</th><th>Total</th></tr>
<tr><td>Amendment (07/01/2026 – 06/30/2027)</td><td>Approval Requested</td><td>$3,823,379</td></tr>
</table>
</td></tr>
<tr><td>Estimated Cost Savings:</td><td>There is no cost savings associated with this renewal amendment.</td></tr>
<tr><td>Fiscal Implications:</td><td>AHS is financially responsible for residents' rotations at AHS facilities. Based on the number of assigned residents in FY 27 in conjunction with recent run rates reflecting time at AHS facilities (excluding non-AHS rotations), we are projecting actual expenditures over the course of the proposed amendment to be $3,823,379 with a budget variance in the amount of $528,752. A reconciliation process ensures that we only pay for services rendered at AHS facilities during the agreement term.</td></tr>
<tr><td>Reasons for Recommendation:</td><td>EBFGME has a proven track-record of providing high quality and reliable resident physicians that enhance AHS' ability to provide vital services to the community while simultaneously furthering our teaching mission.</td></tr>
<tr><td>Impacted Facilities:</td><td>
<table>
<tr><th>AHS</th><th>JGPH</th><th>Highland</th><th>Fairmont</th><th>San Leandro</th><th>Alameda</th><th>Clinic(s)</th></tr>
<tr><td></td><td></td><td>X</td><td></td><td>X</td><td>X</td><td></td></tr>
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</td></tr>
<tr><td>Coordination with Medical Staff:</td><td>The proposed renewal amendment was reviewed by AHS' Chief Medical Officer.</td></tr>
<tr><td>Administrative Review:</td><td>Primary: Director, Graduate Medical Education
Secondary: Designated Institutional Officer</td></tr>
<tr><td>Prior BOT Review/Action:</td><td>In May 2025, the Board approved an amendment for a 12-month renewal.</td></tr>
<tr><td>Executive Sponsor:</td><td>Chief Medical Officer</td></tr>
</table>

Contractor/Vendor Name:	Healogics, LLC dba Accelecare Wound Centers, LLC ("Accelecare")
Description:	The Creedon Advanced Wound Care Center ("Creedon") serves as the Alameda Health System ("AHS") facility providing state-of-the-art technologies and techniques in management of slow- and non-healing wounds. Wound care management deploys on-going specialized interventions and treatments ("Therapies") designed to help healthy tissues combat infection, promote wound healing, and prevent skin breakdown. Therapies are used to treat a variety of widespread and potentially serious conditions including diabetic, traumatic and non-healing surgical wounds which if left untreated can delay recovery and in extreme cases result in more serious negative outcomes (i.e. diabetic foot ulcer requiring amputation, etc.). A key technology utilized in provision of Therapies is Hyperbaric Oxygen Therapy (HBOT) which increases the patient's blood oxygen concentration which in turn supports and accelerates the natural healing process. Given the specialized equipment and therapeutic techniques required, AHS has partnered with Accelecare in providing a county wound management clinic seeing both AHS and community patients. Accelecare has demonstrated experience and capacity with over 20 years delivering care to over 300,000 patients annually. Per terms of this management services agreement ("Agreement"), Accelecare provides the equipment, staffs the department director, and provides comprehensive administrative support and management services, including the following – • Managing daily operations • Scheduling • Credentialing and licensure • Train AHS staff and physician • Support development of department budget • Billing collection services AHS supplies all other department staff and consumables (i.e. oxygen and other medical supplies). The Creedon clinic is located in leased office space at the Marina Wellness Center and sees ~ 40 patients daily for chronic wound care. Given the prevalence of diabetes in the community as well as our role providing trauma and complex acute care services for the Alameda County area, it is anticipated that service utilization and volumes at Creedon will continue to rise. In light of the preceding, AHS leadership is requesting Board approval to enter a renewal agreement ("Renewal") for a term of 3-years with no change in services.
Contract Type and Term:	Renewal Agreement for a fixed term of 3 additional years, July 1, 2026 through June 30, 2029.
Termination Clause:	Early termination without cause by providing ninety (90) days' prior written notice to the other Party.

<table>
<tr><td>Total Spend with Vendor:</td><td>
<table>
<tr><th>Description</th><th>Board Approval</th><th>Total</th></tr>
<tr><td>Renewal Agreement
(7/01/2026 – 6/30/2029</td><td></td><td>$1,552,000</td></tr>
<tr><td>Total Estimated Spend:</td><td></td><td>$1,552,000</td></tr>
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<tr><td>Estimated Cost Savings:</td><td>Costs are composed of a fixed management services fee (“Fixed Fee”) and pass-through for the salary and benefits cost of the department director position (“Pass Through”). Accelecare has agreed to carry over the Fixed Fee from the current Agreement without increase for the duration of the proposed 3-year Renewal term. The Pass Through will continue on terms established under the current Agreement allowing for a 3.5% annual escalator reflective of annual salary increases and cost of benefits adjustment. Total cost increase for the 3-year Renewal term as compared to the current Agreement is $115,983 reflecting a 8.1% increase for total spend.</td></tr>
<tr><td>Fiscal Implications:</td><td>Creedon generates direct revenue for AHS through its billing services. 2025 net revenue was $3,688,188 with a resulting contribution margin of $650,000.</td></tr>
<tr><td>Reasons for Recommendation:</td><td>Effective and efficient wound care management reduces the burden on the healthcare system to provide increasingly invasive care, such as amputations, as wounds become more complicated. There is also a reduction in the social burden of wound treatment including the inability to work, mental health, and treatment of recurring infections. Accelecare is an established provider of wound care management services having partnerships similar to AHS throughout the Bay Area, including Stanford Health Care, Sutter Health, John Muir Medical Center, and El Camino Hospital. The proposed Renewal agreement will continue the work of providing needed services to the community, at reasonable cost and the ability to generate net positive revenue.</td></tr>
<tr><td>Impacted Facilities:</td><td>
<table>
<tr><th>JGPH</th><th>Highland</th><th>Fairmont</th><th>San Leandro</th><th>Alameda</th><th>Clinic(s)</th></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td>Creedon Advanced Wound Care</td></tr>
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</td></tr>
<tr><td>Coordination with Medical Staff:</td><td>Reviewed with AHS Associate Chief Medical Officer for Ambulatory Services.</td></tr>
<tr><td>Epic Coordination:</td><td>Currently, Accelecare generates its own medical record that is input into Epic manually.</td></tr>
<tr><td>Administrative Review:</td><td>Primary: CAO & VP Patient Care Services – Outpatient</td></tr>
<tr><td>Prior BOT Review/Action:</td><td>June 2023 Renewal - Approved</td></tr>
<tr><td>Executive Sponsor</td><td>Chief Operating Officer</td></tr>
</table>

Contractor/Vendor Name:	CDW, LLC ("CDW")
Description:	Alameda Health System ("AHS") utilizes the Microsoft ("MS") Enterprise Agreement ("EA") program to license and support its core business productivity, collaboration, security, and cloud-based technology services used across the organization. These services include Microsoft 365, Exchange, Teams, Visio, Power BI, and various Microsoft server products that support critical administrative, operational, and clinical functions for more than 7,000 users across AHS. Under the proposed agreement, Microsoft will maintain 99.9% or greater uptime for all licensed Microsoft 365 cloud services, in accordance with the Microsoft Service Level Agreement, measured monthly throughout the term of the EA. To renew and maintain these services, AHS contracts with an authorized Microsoft reseller. AHS is proposing to renew its Microsoft EA through CDW Corporation ("CDW"), which will continue serving as the intermediary between AHS and Microsoft for licensing, billing, and administrative support. The proposed renewal agreement is a 3-year renewal of AHS' existing Microsoft EA and includes the continuation of core Microsoft software and cloud service licenses currently utilized throughout the organization. In addition, the renewal incorporates the following enhancements to support evolving operational and automation needs: • Increase in Microsoft Copilot licenses from 30 to 40 licenses • Addition of 20 Microsoft Power Automate Premium licenses The proposed agreement has a total contract value of approximately $6.76 million over a 3-year term, with payments structured in equal annual installments of approximately $2.25 million per year. The current Microsoft EA expires on June 30, 2026. Execution of this Microsoft EA is critical to ensure uninterrupted access to essential Microsoft services.

Contract Type and Term:	Renewal Agreement Term of Contract: July 1, 2026 – June 30, 2029
Termination Clause:	Early termination is available in the event of a breach of contract.
Total Spend with Vendor:	<table><tr><th>Description</th><th>Board Approval</th><th>Total</th></tr><tr><td>**CDW** **7/01/2026 – 06/30/2029**</td><td>**Approval Requested**</td><td>**$6,758,367**</td></tr></table>
Estimated Cost Savings:	AHS successfully negotiated fixed pricing for all 3-years of the agreement, with no annual cost escalators during Years 2 and 3. Total cost increase limited to $465K over proposed 3-year term compared to current agreement, reflective of average 8% rate increase compared to current agreement. Maintaining equal annual payments throughout the

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<tr><td></td><td>contract term provides budget stability and avoids additional costs that would otherwise result from year-over-year price increases, including reducing our exposure to the significant market rate increases in infrastructure pricing due to AI demand.</td></tr>
<tr><td>Fiscal Implications:</td><td>The requested amount was included in the approved FY27 budget, and any additional costs will be included in future budgets.</td></tr>
<tr><td>Reasons for Recommendation:</td><td>CDW is a licensed reseller for Microsoft products and has been a reliable source of software licenses and hardware.</td></tr>
<tr><td>Impacted Facilities:</td><td><table>
<tr><th>AHS</th><th>JGPH</th><th>Highland</th><th>Fairmont</th><th>San Leandro</th><th>Alameda</th><th>Clinic(s)</th></tr>
<tr><td>X</td><td>X</td><td>X</td><td>X</td><td>X</td><td>X</td><td>X</td></tr>
</table></td></tr>
<tr><td>Administrative Review:</td><td>Primary: Chief Technology Officer
Secondary: Chief Information Officer</td></tr>
<tr><td>Prior BOT Review/Action:</td><td>N/A</td></tr>
<tr><td>Executive Sponsor:</td><td>Chief Information Officer</td></tr>
</table>

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<tr><td>Contractor/ Vendor Name:</td><td>The CSI Companies, Inc.</td></tr>
<tr><td>Description:</td><td>St. Rose Hospital (“SRH”) in conjunction with Alameda Health System (“AHS”) leadership, has made the decision to implement Epic, along with AHS’ other clinical systems, at SRH as part of AHS’ Community Connect Program. SRH seeks to enter into a contract with The CSI Companies, Inc. (“CSI”) under which CSI would provide staff augmentation for the Epic project. CSI will provide analysts to do build work or backfill AHS staff that will support the project. CSI will also provide staffing for training, technical dress rehearsal, and at-elbow support during go-live.

AHS has utilized CSI, and CSI is familiar with AHS’ Epic system and other clinical systems. This familiarity will help expedite the project at SRH.

St. Rose proposes to enter into a Master Services Agreement with CSI and enter into one or more Statements of Work which will define the scope of services and the costs of such services including staffing commitments. Th expected staffing is as follows:

• 14.5 Epic Analysts to support the Epic build.
• 7 Credentialled Epic Trainers with 1 Training Oversight Manager
• 1 Team Lead and 2 Testers for the Technical Dress Rehearsal
• 1 Activation Project Manager, 2 Command Center Managers, 20 Activation Support personnel for the Go-Live phase.

The implementation of Epic will support efforts to increase utilization of SRH by community physicians and Stanford Health Care affiliated physicians.</td></tr>
<tr><td>Contract Type and Term:</td><td>New Contract – Master Services Agreement between SRH and CSI.
1. The Master Services Agreement has a term of 1 year commencing on June 15, 2026.
2. The term of Statement of Work No. 1 is June 5, 2026 through February 28, 2027.</td></tr>
<tr><td>Termination Clause:</td><td>SRH may terminate the Master Services Agreement without cause on thirty (30) days’ written notice.</td></tr>
<tr><td>Total Spend with Vendor:</td><td><table><tr><th>Description</th><th>Board Approval</th><th>Total</th></tr><tr><td>Total Estimated Spend:</td><td>Approval Requested</td><td>$3,100,000</td></tr></table></td></tr>
<tr><td>Estimated Cost Savings:</td><td>N/A</td></tr>
<tr><td>Fiscal Implications:</td><td>Funds have been identified and allocated for the Epic project and the spend with CSI is included in this allocation. Stanford Health Care has also agreed to provide financial support for the project in the form of a grant.</td></tr>
</table>

Reasons for Recommendation:	In order to implement Epic, SRH requires support from CSI to appropriately staff the project and also allow AHS staff with specific expertise to support the project. CSI is familiar with AHS' Epic systems and other clinical systems, and this familiarity will improve the efficiency of the implementation at SRH. The implementation of Epic will support efforts to increase utilization of SRH by community physicians and Stanford Health Care affiliated physicians.
Administrative Review:	Primary: SRH Chief Administrative Officer Secondary: SRH Manager of Information Technology
Prior BOT Review/Action:	None.
Executive Sponsor:	Chris Adams, SRH Chief Administrative Officer AHS Liaison – Christine Yang, AHS Chief Information Officer

ALAMEDA HEALTH SYSTEM

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

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

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

24	Fisher Scientific Company LLC dba Fisher Healthcare	$6,600,000	4/1/2026	3/31/2029	FC - 3-4-26 BOT Approved 3-11-26	Laboratory supplies		Chief Operating Officer
25	Hill-Rom Company, Inc.	$1,430,000	3/12/2026	3/11/2027	FC - 3-4-26 BOT Approved 3-11-26	Replacement nurse call system for SNFs		Chief Operating Officer
26	Hyland Software, Inc.	$2,599,491	5/1/2026	4/30/2029	FC - 4-1-26 BOT Approved 4-8-26	Provision of enterprise content management services		Chief Information Officer
27	Mission Linen Supply	$13,325,000	5/1/2026	4/30/2029	FC - 4-1-26 BOT Approved 4-8-26	Provision of linen rental and laundry services.		Chief Operating Officer
28	Contra Costa Pathology Associates	$2,700,000	5/20/2026	5/19/2029	FC - 5-6-26 BOT Approved 5-13-26	Provision of anatomic pathology and histology laboratory services		Chief Operating Officer
29	Quest Diagnostics	$25,619,650	6/1/2026	5/31/2033	FC - 5-6-26 BOT Approved 5-13-26	Provision of reference laboratory services		Chief Operating Officer
	Total Amount for FY 26 year to date	$587,828,817						

ALAMEDA
HEALTH SYSTEM

1411 East 31 st Street
Oakland, CA 94602

MEMORANDUM

TO: Board of Trustees

FROM: Jetrenee Chapman, Chief Human Resources Officer

DATE: June 10, 2026

SUBJECT: **Agenda Item:**
Meeting Date: June 10, 2026
Item Description: Approval of a Resolution Approving 401(h) Account Pursuant to Section 31592

BOARD ACTION: Approve Resolution.

Background: Alameda Health System (AHS) provides non-vested Retiree Health Benefits (RHB) to eligible retirees on a non-taxable basis. An account has been established under Internal Revenue Code Section 401(h) from which RHBs are paid. The account is funded by contributions from AHS to ACERA specifically for RHBs. Annually, upon determination of the amount needed to fund RHBs for the next year, ACERA requests authorization from the governing boards of its member employers permitting the transfer of contributions to the 401(h) account.

Purpose/Analysis: Attached to this memorandum is a draft resolution that would authorize ACERA to take this action. It is accompanied by a letter from the ACERA Fiscal Services Officer, to the CEO, dated May 21, 2026, explaining the transfer process and the required contributions. This letter is supported by a report from ACERA's actuary detailing the calculation of the 401(h) contribution. Contributions used for RHBs are held by ACERA in a Supplemental Retiree Benefit Reserve (SRBR) pending authorization for transfer to the 401(h) account. The transfer of assets from the SRBR is governed by section 5.5 of the County Employee Retirement Law of 1937. The effect of the resolution is simply to continue to allow our retired employees to receive their medical, dental and vision insurance on a tax-free basis. Failure of AHS to approve the resolution would immediately cause our retired employees' health and welfare benefits to be taxed on the ACERA contribution amounts. This transfer is balanced each year and AHS' financial liability is not increased in any manner.

Prior Review/Action: AHS Board of Trustees review and approval of similar resolutions in the past is an annual exchange between ACERA and AHS, along with every other employer participating in the ACERA retirement plan.

Board Action Requested: Staff recommends the Board adopt the attached resolution authorizing transfer of assets from ACERA Account (Supplemental Retiree Benefits Reserve (SRBR) to IRC (h) Sub Account**.**

Fiscal Impact: There is no new/added fiscal impact. The contribution for RHB is a reallocation or prior contribution to ACERA that have been included in the operating budget.

Budgeted/Authorization: This cost is included in the Budget for FY 2026/2027

Estimated Cost Savings: None, directly to AHS, however, AHS Retirees will be entitled to receive favorable tax treatment for earned health care benefits.

Strategic Plan Pillar: Workforce

ALAMEDA COUNTY EMPLOYEES' RETIREMENT ASSOCIATION

475 14th Street, Suite 1000, Oakland, CA 94612 800/838-1932 510/628-3000 fax: 510/268-9574 www.acera.org

May 21, 2026

James Jackson
Chief Executive Director
Alameda Health System
1411 East 31st Street
Oakland, CA 94602

Re: Authorization for 2026-2027 IRC § 401(h) Sub-Account

Dear Mr. Jackson:

In fiscal year 2007-2008, the Alameda County Medical Center (ACMC), now known as Alameda Health System (AHS), authorized the creation ofan Internal Revenue Code (IRC) Section 401(h) sub-account under the Alameda County Employees' Retirement Association's (ACERA) overall 401(h) Account in order to provide non-vested Retiree Health Benefits (RHBs) to eligible retirees on a non-taxable basis. If AHS intends to continue with this practice in the upcoming fiscal year, it is time to initiate the process to authorize the contributions to AHS's IRC § 401(h) sub-account.

The 401(h) sub-account is based on the following criteria:

1. The account is funded by the contributions made directly by AHS to ACERA for the sole purpose of providing RHBs to retirees,
2. AHS specifies that these contributions are for the sole purpose of providing RHBs to retirees,
3. The contributions are separately accounted for by ACERA, and
4. The contributions are used by ACERA solely for RHBs.

In accordance with the County Employees Retirement Law of 1937 (CERL), ACERA holds assets in an account called the Supplemental Retiree Benefit Reserve (SRBR), which may be used only to provide benefits to retirees and their beneficiaries as determined by the Board of Retirement. In accordance with § 31592.4 of the CERL, ACERA may transfer amounts from the SRBR to the Employer Advance Reserve account and treat these transfers as if they were contributions made by AHS to fund health benefits, as long as AHS makes equal contributions directly to ACERA's 401(h) Account. AHS does not have an obligation to pay for health benefits for retirees since they are non-vested. Refer to the 401(h) Agreement signed in October 2007.

Included with this letter are the following documents that will assist you with the authorization process, if so desired.

1. A letter from ACERA's actuary setting forth the required contributions for the 401(h) Account for fiscal year 2026-2027 (Exhibit A).
2. A schedule showing the summary of the 401(h) contributions by Participating Employer for fiscal year 2026-2027 (Exhibit B).
3. A proposed resolution for your governing body to authorize contributions to a 401(h) Account (Exhibit C).

Exhibit A is a letter from ACERA's Actuary, Segal Consulting, which estimates the fiscal year 2026-2027 funding requirements of the 401(h) Account from all employers is $71,154,000.00. This estimate includes projected health premium subsidy increases of 3.625% for medical, 6.20% for Medicare Part B, 5.00% for dental, and 3.00% for vision. An additional 10% subsidy is included to provide a margin for unexpected retirements (e.g., if the employer grants Golden Handshake benefits or other increased benefits). Effective July 1, 2011 administrative expenses for health benefits are also included.[1]

Exhibit Bis the schedule of the 401(h) Contributions Summary by Participating Employer for the Fiscal Year 2026-2027. This schedule shows that AHS's net 401(h) contribution amount is $9,099,500.00. This result was obtained by multiplying the percentage of AHS retirees eligible for retirement benefits, 14.45%, by the total required contribution amount of $71,154,000.00 and adjusting it by the estimated balance of $1,182,252.94 that is remaining in AHS's 401(h) sub-account as of June 30, 2026.

Beginning with pay period 26-14, AHS should allocate $349,981.00 ofyour total contribution amount per pay period toward your 401(h) contributions if your intent is to provide non-vested tax-free health benefits to retirees. There is no net financial impact to AHS because ACERA contributes an equal amount from the SRBR to the Employer Advance Reserve account.

In order to ensure uniform tax compliance in the resolutions passed by the various Participating Employers, we have enclosed a proposed resolution which appears as Exhibit C. This resolution authorizes AHS to contribute $9,099,500.00 to your 40 l(h) sub-account for fiscal year 2026-2027. ACERA appreciates that AHS may require additional language in the resolution, but we request that you include the language provided that relates to the authorization and funding of the 401(h) sub-account. If you wish to change the resolution in anyway, including adding to it, ACERA must review the changes before they are adopted to ensure that they comply with federal law that governs the 401(h) Account and your sub-account. We believe that this language addresses and ensures compliance with the CERL statutory issues, the agreed upon funding mechanism and IRC § 401(h) tax code requirements. Once the resolution has been passed, please send me a copy for our files.

Authorization to fund AHS's 401(h) sub-account must becompleted by June 30, 2026. If this date poses a problem, or if you have any questions about any of the material contained in this packet, please contact ACERA for further clarification.

Sincerely,

Assistant Chief Executive Officer

Attachment:
Memo from Segal
401(h) Contributions needed for County and Special Districts FY 2026-2027
Proposed Resolution

l This is required to comply with tax qualification requirements per ACERA's Tax Counsel.

cc: David Nelsen, Chief Executive Officer, ACERA
Carlos Barrios, Assistant ChiefExecutive Officer, ACERA
Jeffrey Rieger, Chief Counsel, ACERA
Cynthia Enriquez, Senior Retirement Plan Administrator, Alameda Health System
Catherine Kozul, Director, Total Rewards, Alameda Health System
Marylou Lestro-Mayo, Payroll Manager,Alameda Health System

180 Howard Street
Suite 1100
San Francisco, CA 94105-6147
segalco.com

April 13, 2026

Lisa Johnson
Assistant Chief Executive Officer
Alameda County Employees' Retirement Association
475 14th Street, Suite 1000
Oakland, CA 94612-1916

Re: 401(h) Contributions for the 2026–2027 Fiscal Year

Dear Lisa:

Pursuant to the Association's request, we have estimated the 401(h) contributions for the 2026–2027 fiscal year.

Results and analysis

We project that, for the 2026–2027 fiscal year, the Association will need $71,154,000 to provide medical benefit subsidies from the 401(h) account. The process used to determine the actual biweekly contribution amounts is discussed on page 2. Please note that as previously directed by ACERA, in developing the estimated 401(h) contribution amount, we have included the expenses related to the administration of health benefits for retirees.

The 401(h) funding requirement is developed as follows:

Component	Amount
1. Total monthly premium subsidy paid by ACERA to all health benefit plan providers during the month of February 2026, projected to June 2026 by the Association (for comparison purposes only).	$4,827,000[1]
2. Annualized premium subsidy as of February 2026, projected to June 2026 (for comparison purposes only).	$57,924,000

[1] Last year, the total monthly premium subsidy paid by ACERA to all health benefit plan providers for February 2025 and projected to June 2025 by the Association was $4,381,000, or $52,572,000 annualized. There is an increase in the projected monthly premium subsidy amount from last year to this year primarily as a result of an increase in the medical, Medicare Part B, and dental premium subsidies from 2025 to 2026.

	Component	Amount
3.	Best estimate of annualized premium subsidy required for 2026–2027 (based on actual payouts from July 2025 through February 2026 and estimated payouts from March 2026 through June 2026 provided by ACERA). Following the Association's current practice, we have assumed that the Retirement Board will increase the Monthly Medical Allowance at the rate equal to one-half of the lowest medical trend assumption for the non-Medicare and Medicare Advantage plans. We have assumed that the Medicare Part B, dental and vision subsidies will increase at the full rate of the trend assumption for those plans for calendar year 2026 (as assumed in the December 31, 2024 SRBR valuation). The assumed increases in the subsidy calculation are 3.625%[2] for medical, 6.20% for Medicare Part B, 5.00% for dental, and 3.00% for vision.	$62,412,000
4.	Increase of 10% in Item 3 to provide a margin for unexpected retirements rounded to nearest $1,000.	$6,241,000
5.	Administrative expenses for health benefits, rounded to nearest $1,000.	$2,501,000[3]
6.	**Sum of Items 3, 4, and 5.**	**$71,154,000**

Important assumptions regarding anticipated change in health premium subsidy

Except for the projected health premium subsidy increases described above, we have not assumed any other changes in the level of subsidy from 2025–2026 to 2026–2027. Our estimate may need to be revised if the Retirement Board later decides to amend the level of benefits.

During the April 2026 Retirees Committee meeting, the Board approved action item #2, which increases the maximum Monthly Medical Allowance (MMA) for Medicare Eligible Retiree Individual Plans to Coincide with Group Plans starting January 1, 2027. Based on Scenarios 2 and 3 of our letter dated April 1, 2026, we estimated this change will increase the calendar year 2027 benefits by between $0.88 to $3.28 million.[4] Accordingly, the impact on the 2026–2027 fiscal year benefit expenses is estimated to be between $0.44 to $1.64 million dollars. As shown in the table above, a 10% adjustment is already included in the estimate to provide margin for unexpected retirements. The 10% margin could be increased to 12% to account for the potential impact of the MMA increase for Medicare Eligible Retiree Individual Plans under the more conservative assumptions in Scenario 3. However, based on the plan's recent benefit costs, we believe the current margin of $6.2 million based on a 10% load provides sufficient conservatism for the purposes of this letter.

[2] This is based on 50% of the 7.25% trend assumption used to project the increase for Medicare Advantage plans from calendar year 2026 to calendar year 2027, as described in the assumptions section of the December 31, 2024 SRBR sufficiency valuation. The medical trend assumptions in our letter dated March 11, 2026, recommended for the December 31, 2025 sufficiency valuation, will be applied in the 401(h) contribution estimate for the 2027–2028 fiscal year.

[3] As part of the determination of the 401(h) contributions for the 2025–2026 fiscal year, we followed the directions from the Association (as provided in the past) to use the actual 2024 calendar year expense as a proxy for the 2025–2026 fiscal year expense. We have maintained this procedure and have used the actual 2025 calendar year expense as a proxy for the 2026–2027 fiscal year expense.

[4] The $3.28 million impact in Scenario 3 included conservative migration assumptions, which would shift the overall Medicare distribution from 72% Group & 28% Exchange to 55% Group & 45% Exchange.

401(h) contributions

The actual required contributions for the 2026–2027 fiscal year should be determined by subtracting the June 30, 2026 balance in the 401(h) account from the $71,154,000. We understand that this net amount will be contributed to the 401(h) account on a biweekly basis by the employers and the Association will transfer a like amount from the Supplemental Retirees Benefit Reserve (SRBR) to the Employer Advance Reserve.

As instructed by the Association, we have provided a breakdown of the 401(h) expense by employer in the following table. We understand that the breakdown has been compiled by the Association as of February 2026, based on the number of retirees eligible for retirement benefits.[5]

Employer	Percentage of 401(h) Contributions
Alameda County[6]	78.06%
Health System	14.45%
Superior Court	5.85%
Livermore Area Recreation and Park District	0.76%
Housing Authority	0.65%
First 5	0.23%
Total	**100.00%**

Under IRC Section 401(h), medical benefits must be “incidental” to the retirement benefits under a plan. Section 401(h) indicates that medical benefits will be considered “incidental” if the contributions for medical benefits are less than 25% of the total contributions under the plan (excluding unfunded actuarial accrued liability (UAAL) payments). We believe that the transfer from the SRBR should be treated as an offset to the UAAL contribution requirement (to the extent that the net UAAL payment after the offset is still positive), which means that in a given year the medical contributions can be up to 25% of the total Normal Cost contributions.

[5] The Alameda Local Agency Formation Commission (LAFCO) has become an independent participating employer of ACERA effective January 1, 2026. Based on the breakdown compiled by the Association, LAFCO does not have any retirees eligible for retirement benefits.

[6] As in years past, retirees from the Office of Education and the Alameda County Fire Department are included in the County’s percentage by ACERA.

In the following table, we demonstrate that the value of the medical benefits is in compliance with the above requirement. Please note that as the Retirement Board has not yet adopted the contribution rates for the December 31, 2025 pension funding valuation, we have continued to apply the average employer and employee contribution rates calculated in the last valuation, that is, as of December 31, 2024, to the payroll calculated in that valuation, increased by 3.00% to reflect one year of projected payroll growth.

Source of Contributions	Estimated Amount ($ millions)
Employee Normal Cost (based on an aggregate member rate of 9.84% calculated in the December 31, 2024 valuation and an estimated payroll of $1,465 million)	$144.1
Employer Normal Cost (based on aggregate employer normal cost rate of 10.68% calculated in the December 31, 2024 valuation and an estimated payroll of $1,465 million)	$156.5
Recommended 401(h) Medical Contributions	$71.2
Total Normal Cost and Recommended 401(h) Medical Contributions	$371.8
Ratio of 401(h) Contributions to the Total Normal Cost Contributions and Recommended 401(h) Medical Contributions	19.1%[7]

These calculations were prepared under our supervision. Except as noted above, the calculations are based on the December 31, 2024 actuarial pension funding valuation results including the membership data and the non-health care cost trend actuarial assumptions on which that valuation was based, and the health care cost trend assumptions in the December 31, 2024 SRBR sufficiency valuation.

This document has been prepared for the exclusive use and benefit of the client, based upon information provided by you and your other service providers or otherwise made available to Segal at the time this document was created. Segal makes no representation or warranty as to the accuracy of any forward-looking statements and does not guarantee any particular outcome or result. This document should only be copied, reproduced, or shared with other parties in its entirety as necessary for the proper administration of ACERA. This document does not constitute legal, tax or investment advice or create or imply a fiduciary relationship. You are encouraged to discuss any issues raised with your legal, tax and other advisors before taking, or refraining from taking, any action.

[7] This ratio was 18.5% as provided in our 401(h) contributions letter for the 2025–2026 fiscal year. This ratio would increase to 19.4% if the margin load of 10% was changed to 12%.

We are members of the American Academy of Actuaries and we meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion herein.

Please let us know if you have any questions.

Sincerely,

Mehdi Riazi, FSA, MAAA, FCA, EA
Vice President and Actuary

Daniel Siblik, ASA, MAAA, FCA, EA
Vice President and Actuary

Eva Yum, FSA, MAAA, EA
Vice President and Actuary

/elf

cc: Carlos Barrios
Rhea Donida

401(h) Contributions needed for County and Special Districts - For the Fiscal Year 2026-27

Employer	Percentage of 401(h) Contribution	Paid Interval	Actuarial 401(h) Account Balance Required for FY 2026-27	Est. 401(h) Balance as of 6/30/2026	FY 2026-27 Required 401(h) Contribution Amount	FY 2026-27 Per Pay Period 401(h) Payment	Monthly Payment 2 PP	Jul.'26 & Dec'26 3 PP	Required Adm. Allocation 2026-27 Total	Monthly Adm.Allocation
									$ 2,501,000.00	
Alameda County	**78.06%**	Bi-Weekly (26 PP)	$ 55,542,812.40	$ 6,569,097.79	$ 48,973,715.00	$ 1,883,604.42	$ 3,767,208.84	$ 5,650,813.26	$ 1,952,281.00	$ 162,690.00
AHS	**14.45%**	Bi-Weekly (26 PP)	10,281,753.00	1,182,252.94	$ 9,099,500.00	$ 349,981.00	$ 699,962.00	$ 1,049,943.00	$ 361,395.00	$ 30,116.00
Superior Court	**5.85%**	Bi-Weekly (26 PP)	4,162,509.00	469,077.56	$ 3,693,431.00	$ 142,055.00	$ 284,110.00	$ 426,165.00	$ 146,309.00	$ 12,192.35
Livermore Area Recreation & Park District	**0.76%**	Bi-Weekly (26 PP)	540,770.40	61,299.39	$ 479,471.00	$ 18,441.00	$ 36,882.00	$ 55,323.00	$ 19,007.00	$ 1,584.00
Housing Authority	**0.65%**	Bi-Weekly (26 PP)	462,501.00	54,804.71	$ 407,696.00	$ 15,681.00	$ 31,362.00	$ 47,043.00	$ 16,256.00	$ 1,355.00
First 5	**0.23%**	Bi-Weekly (26 PP)	163,654.20	17,254.60	$ 146,400.00	$ 5,631.00	$ 11,262.00	$ 16,893.00	$ 5,752.00	$ 479.35
Total	***100.00%***		***$ 71,154,000.00***	***$ 8,353,786.99***	***$ 62,800,213.00***	***$ 2,415,393.42***	***$ 4,830,786.84***	***$ 7,246,180.26***	***$ 2,501,000.00***	***$ 208,416.70***

Per SEGAL letter dated April 13, 2026 required amount **$ 71,154,000.00**

** Please see attached payment schedule.

Prepared by: Hema - 4/23/2026

Reviewed by: Hermella - 4/22/2026

ALAMEDA
HEALTH SYSTEM

EXHIBIT C

BOARD OF TRUSTEES

RESOLUTION NO. 2026-002

APPROVING 401(H) ACCOUNT PURSUANT TO SECTION 31592

WHEREAS, in 1996, the Alameda County Employees' Retirement Association ("ACERA") Board of Retirement informed the Board of Supervisors that by adoption of Resolution No. 96-111, the Board of Retirement had established a health benefits account intended to satisfy the requirements of Internal Revenue Code ("IRC") Section 401(h) and the regulations thereunder ("401(h) Account") in order to provide non-vested, tax-free health benefits to eligible County and Participating employer retirees (collectively, the "Retirees"); and

WHEREAS, in 1996, this Board of Supervisors adopted Resolution No. R-96-634, which provided that ACERA could offer such non-taxable benefits if the County designated a portion of its contribution to ACERA for a fiscal year as a contribution to the 401(h) Account, and

WHEREAS, under Section 31592.4 and Article 5.5 of the County Employees' Retirement Law of 1937 ("CERL"), assets in the Supplemental Retiree Benefit Reserve ("SRBR") at the end of a fiscal year of ACERA may, in the immediately succeeding fiscal year, be transferred to the Employer Advance Reserve account of the Participating Employers, and treated as a contribution to ACERA by the County and as applicable by other Participating Employers to the extent that in the immediately succeeding fiscal year the County and other Participating Employers make contributions to ACERA's 401(h) Account in order to pay for retiree health benefits; and

WHEREAS, Section 31592.4 and Article 5.5 of the CERL thus permit the Participating Employers to contribute to a 401(h) Account and pay for retiree health benefits for a fiscal year without increasing the Alameda Health System's total contributions to ACERA for that fiscal year; and

WHEREAS, commencing with the 1996-1997 fiscal year, and for each fiscal year thereafter, the County has directed that a specified portion of its fiscal year contribution to ACERA for that year be contributed to the 401(h) Account; and

WHEREAS, in 2007 Alameda County Medical Center ("ACMC"), now known as Alameda Health System ("AHS"), authorized ACERA to establish and manage a 401(h) sub-account on its behalf to provide tax free health benefits for its retirees.

NOW THEREFORE, IT IS RESOLVED AS FOLLOWS:

1. In fiscal year July 1, 2026 – June 30, 2027, AHS shall contribute to ACERA $9,099,500.00 to be used only for the payment of retiree health benefits. This contribution shall be made on the terms and conditions set forth in the Agreement between ACMC (now knows as AHS) and ACERA concerning such contributions, executed on October 15, 2007.

2. This contribution shall be designated, in writing, as being only for AHS's IRC§ 401(h) Account and such designation shall be made at the time of the contribution.

3. Such contribution is contingent on the Board of Retirement immediately transferring, in accordance with Government Code § 31592.4, an amount equal to such contribution from ACERA's SRBR account to AHS's Advance Reserve account. Such amount shall be treated as a contribution for pension and therefore shall be applied to reduce the pension contribution otherwise required by AHS for the fiscal year beginning July 1, 2026.

4. No party, including any existing or future AHS employee, retiree, spouse or dependent, shall have any vested rights, contractual rights or other rights in or to any retiree health benefits or payment or subsidy for any such benefits nor shall any such person or ACERA have any such rights to have AHS contribute towards paying or subsidizing the cost of any retiree health benefits provided by ACERA under the 401(h) Account or otherwise. AHS may modify or terminate, at any time and without any limitation, its decision to contribute to AHS's 401(h) Account. This modification or termination may occur even if it may affect any employee first hired prior to the date of such modification, any person who retired prior to such date, and/or any person who became a spouse or dependent of an employee or retiree prior to such date.

5. All contributions by AHS to its 401(h) sub-account shall be governed by requirements of the IRC and all administrative and other applicable rules established by ACERA governing such sub-account and ACERA's 401(h) Account.

THE FOREGOING Resolution was presented this 10th day of June 2026, to wit:

I hereby certify under penalty of perjury that the President of the Board of Trustees was duly authorized to execute this document on behalf of Alameda Health System by majority of vote of the Board on June 10, 2026 and that a copy has been delivered to the President.

ATTEST:

_____
Ronna Jojola Gonsalves
Clerk of the Board of Trustees

Date:_____

APPROVED AS TO FORM:

_____ _____
Ahmad Azizi Date
General Counsel

THE FOREGOING Resolution was **PASSED** and **ADOPTED** by the Alameda Health System Board of Trustees this 10th day of June, to wit:

_____
David Sayen
President, Board of Trustees
Alameda Health System

ACTION/DISCUSSION: FY 2027 Budget

ALAMEDA HEALTH SYSTEM

FY 27 Preliminary Budget Update
Finance Committee

Kimberly Miranda
Grace Mesina
John Minot-Scwhartz
June 3, 2026

HR 1 & Other State Impact

HR 1 and Federal Impacts in FY2027 Budget (est. 6/2/2026)

Revenue category	Budget Year Revenue Impact vs. No HR 1 / Federal Actions	Notes
Emergency Medi-Cal Matching Rate (FMAP)	($9.0M)	For emergency services for subset of UIS population, FMAP will drop from 90% to 50% on 10/1/2026
Rate-Range Reduction	($4.1M)	Reduction to enrollment under HR 1 creates small reductions to rate-range, directly tied to Medi-Cal beneficiary count in Alameda County
EPP Ceiling	($1.2M)	HR 1 will significantly cut Enhanced Payment Program from 1/1/2028, but before then it also prevents EPP from growing by the normal medical inflation trend factor
Expiration of 1115 Waiver and GPP Funds	($3.5M)	HHS expected **not** to renew Federal 1115 waiver creating Global Payment Program after it expires 12/31/2026, remove extra SNCP waiver-based funds for 2nd half of budget year (while majority remains as Medicaid DSH)

Total: ($17.8M), of which ($8.8M) is in supplementals. Note this does not include changes in utilization which are reflected by holding utilization constant from CY 2025 and applying no trend

Update on Projected Enrollment Loss

- ***CalHHS revised estimates released May 2026 show more delayed HR 1 impact than previously estimated due to state implementation choices, but Alliance enrollment continues to drop in line with prior estimates (UIS)***

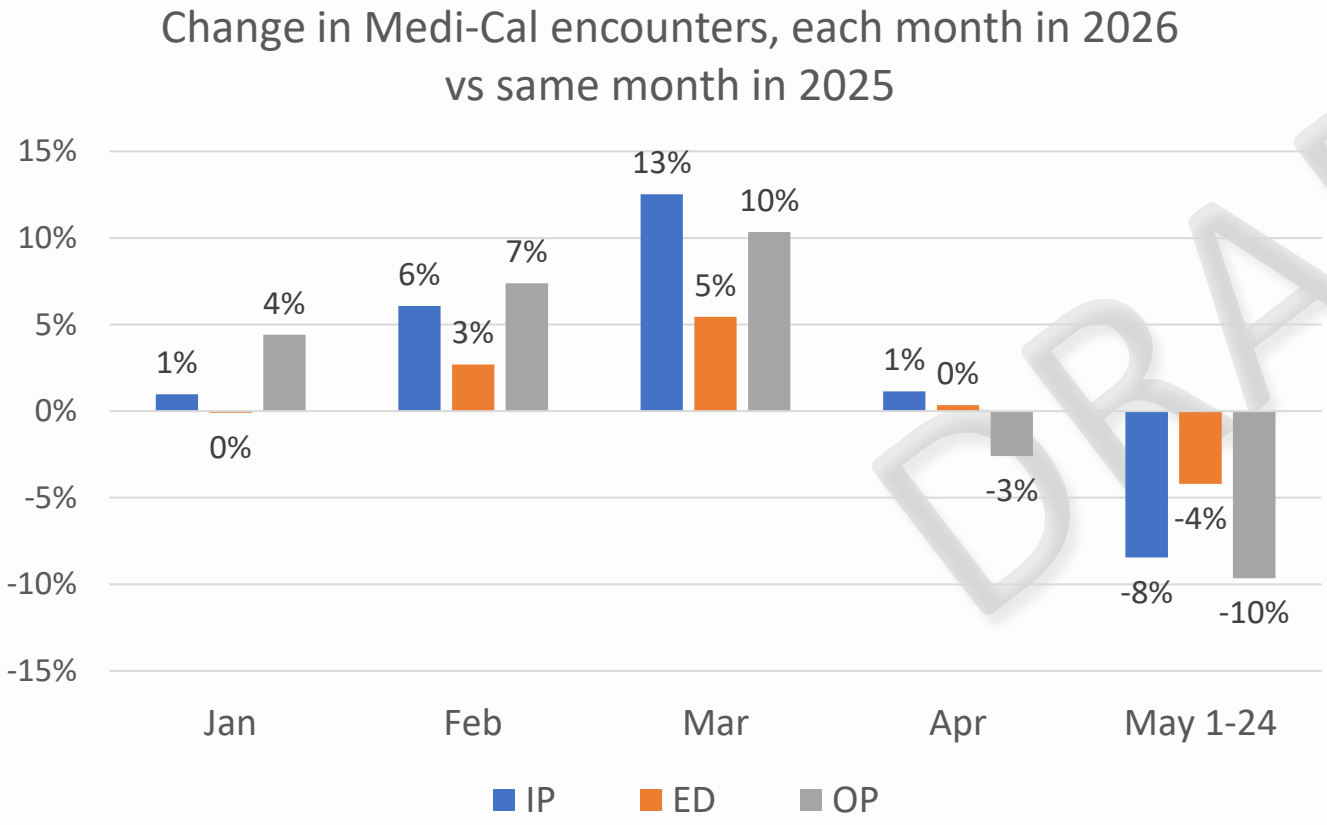
Number of people losing coverage **statewide** under HR 1 provisions (and % of Medi-Cal est.)

	Loss timeframe	State ests. released Jan. 2026	State ests. released May 2026
HR 1: Community engagement / work requirements	By Jun 2027	233,000 (1.6%)	43,000 (0.3%)
	By Jun 2028	1.4 million (9.8%)	1.1 million (7.7%)
HR 1: Six-month redeterminations	By Jun 2027	289,000 (2%)	0
	By Jun 2029	400,000 (2.8%)	278,600 (1.9%)
HR 1: Refugees, other legal immigrants from full-scope to Emergency-Only Medi-Cal	Oct. 2026 (all at once)	200,000 (1.4%)	200,000 (1.4%)

- Meanwhile at county level, Alameda Alliance has already lost **22,577 members** from Dec. 2025 to Apr. 2026, or **6% drop**, corresponding closely to monthly loss estimates from UIS freeze. Continued through Dec. would be 17%

Evolved thinking on HR 1 Patient Revenue Projections

Even while Alliance lost 6% of total enrollment due to UIS freeze (4% by March 1), AHS Medi-Cal utilization still seems not to be changing with any clear relationship to that loss



With ambiguous enrollment to utilization linkage, using lower factors to connect enrollment to revenue loss in later years

- Lower ratio to translate Medi-Cal enrollment loss to Medi-Cal utilization, so lesser impact on Medi-Cal revenues
  - Supplemental revenue impacts stay massive
- Estimates assume that only 25% of the Medi-Cal drop reduces direct costs, with individuals forgoing care entirely
  - E.g. remaining 75% of Medi-Cal drop becomes uncompensated care in HPAC or Self-Pay
- If the drop in partial month of May becomes a trend, we may increase the ratio based on that experience

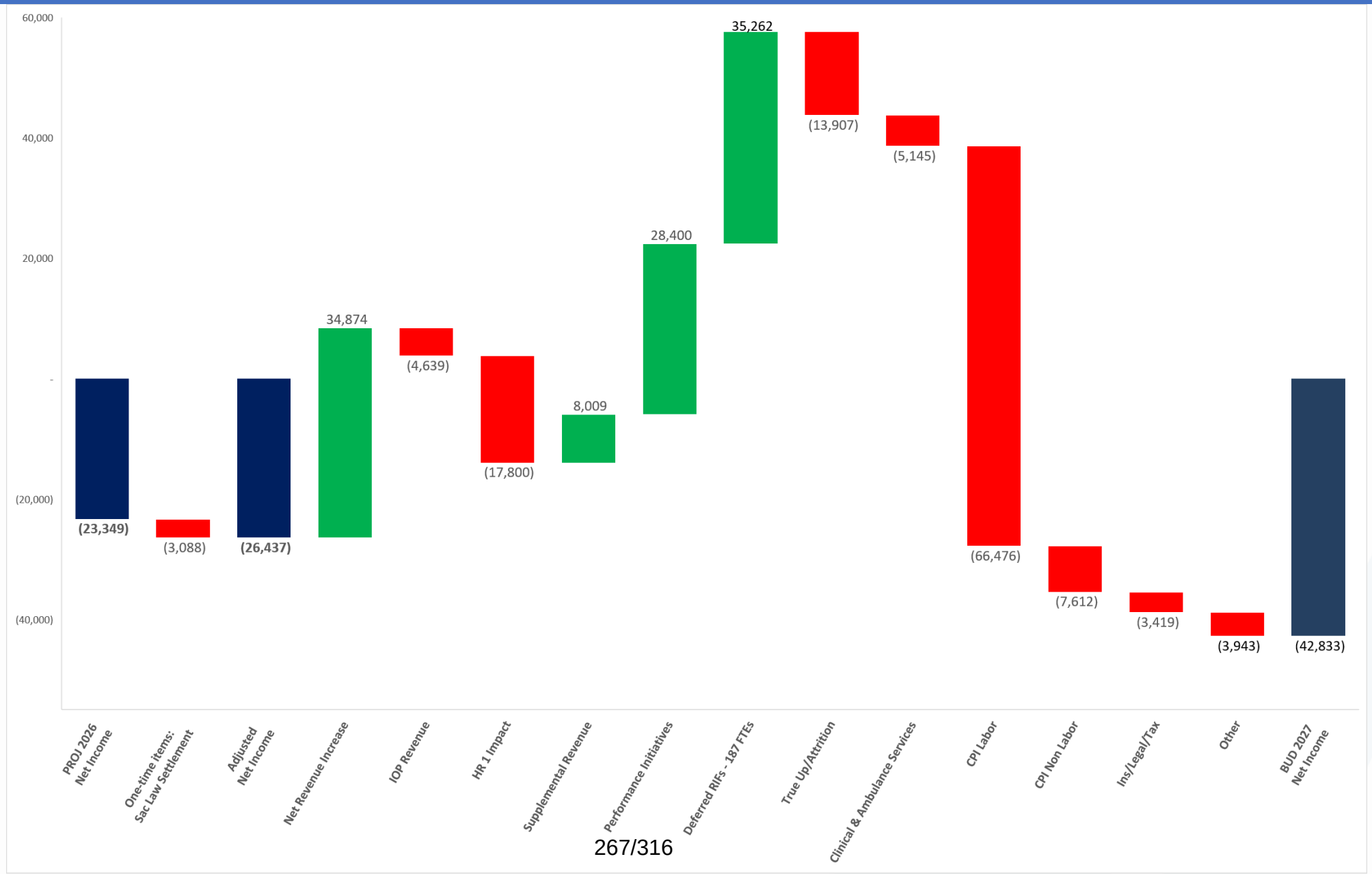
Full HR 1 and Other Impacts on Income Statement through FY2028-2029 (est. 6/2/2026)

Description	FY 2026-27	FY 2027-28	FY 2028-29
HR 1 impact to net patient revenue, less direct costs savings	(projected as flat utilization)	($2.5M)	($3.8M)
State UIS changes' impact to net patient revenue, less direct costs savings	(projected as flat utilization)	($6.1M)	($6.1M)
Emergency Medicaid FMAP reduction (HR 1)	($9.0M)	($12.0M)	($12.0M)
HR 1/federal impact on supplementals (GPP, EPP, QIP, rate-range, etc.)*	($8.8M)	($46.4M)	($63.9M)
Total impact	($17.8M)	($67m) (±10%)	($86M) (±10%)

** Vs. counterfactual without HR 1 or other federal cuts, not vs. FY26*

Budget 2027

Net Income Roll Forward / Reconciliation



ALAMEDA HEALTH SYSTEM

Preliminary Budget as of 5/29/2026

(in thousands)	Actual 2025	Projection 2026	Budget 2027	Variance Proj2026 vs Budget 2027	% Variance (Proj2026 vs Budget 2027)
Operating Revenue ----------					
Net Patient Revenue	$ 942,426	$ 968,067	$ 993,039	$ 24,972	2.6%
Capitation Revenue	55,600	53,236	53,601	365	0.7%
Other Government Programs	563,927	546,753	545,962	(791)	-0.1%
Other Revenues	63,966	70,863	70,109	(754)	-1.1%
Total Revenue - All Sources	**$ 1,625,920**	**$ 1,638,920**	**$ 1,662,711**	**$ 23,791**	**1.5%**
Collection %	***19.6%***	***19.0%***	***19.4%***	***0.4%***	
Operating Expenses ----------					
Salaries & Wages	$ 675,936	$ 731,450	$ 749,448	$ 17,998	2.5%
Salaries & Wages (Providers)	150,009	153,385	164,350	10,966	7.1%
Registry	52,211	37,062	35,019	(2,042)	-5.5%
Physician Contract Services	41,338	45,564	40,134	(5,430)	-11.9%
Employee Benefits (Taxes, Ins)	196,870	207,199	218,956	11,757	5.7%
Retirement	96,797	102,092	103,424	1,331	1.3%
Total Labor Expenses	**$ 1,213,161**	**$ 1,276,752**	**$ 1,311,331**	**$ 34,579**	**2.7%**
Purchased Services	$ 105,279	$ 103,560	$ 105,154	$ 1,594	1.5%
Materials and Supplies	154,414	165,160	166,365	1,204	0.7%
Facilities	41,248	43,895	44,597	701	1.6%
Depreciation & Amortization	37,542	29,047	30,031	984	3.4%
General and Administration	53,335	40,077	44,216	4,139	10.3%
Total Non-Labor Expenses	**$ 391,817**	**$ 381,740**	**$ 390,362**	**$ 8,623**	**2.3%**
Total Operating Expenses	**$ 1,604,978**	**$ 1,658,491**	**$ 1,701,693**	**$ 43,201**	**2.6%**
Operating Income (Loss)	***$ 20,941***	***$ (19,572)***	***$ (38,982)***	***$ (19,410)***	**99.2%**

ALAMEDA HEALTH SYSTEM

Preliminary Budget

(in thousands)	Actual 2025	Projection 2026	Budget 2027	Variance Proj2026 vs Budget 2027	% Variance (Proj2026 vs Budget 2027)
Non-Operating Activity ----------					
Interest Income (Expense)	$ 2,899	$ (3,777)	$ (3,860)	$ (83)	2.2%
Other nonoperating Revenue	(253)	0	8	8	100.0%
Total Non Operating Activity	**$ 3,152**	**$ (3,777)**	**$ (3,852)**	**$ (91)**	**2.0%**
Net Income (Loss)	**$ 17,790**	**$ (23,349)**	**$ (42,833)**	**$ (19,318)**	**83.4%**
EBIDA Adjustments					
Interest Income (Expense)	$ 2,899	$ 3,777	$ 3,860	$ 83	2.2%
Depreciation & Amortization	37,542	29,047	30,031	984	3.4%
Amortization (GASB-68, GASB-75)*	160	-	-	-	
Total EBIDA Adjustments	**$ 40,601**	**$ 32,824**	**$ 33,891**	**$ 1,067**	**3.3%**
EBIDA	**$ 58,390**	**$ 9,475**	**$ (8,943)**	**$ (18,251)**	**-194.4%**
Operating Margin	1.3%	-1.2%	-2.3%	-1.2%	
EBIDA %	3.6%	0.6%	-0.5%	-1.1%	
FTEs	**5,166**	**5,135**	**5,024**	**(111)**	**-2.2%**
Salaries per FTE (incl Registry)	**$ 169,975**	**$ 179,522**	**$ 188,857**	**$ 9,335**	**5.2%**
Adjusted Patient Days	**189,632**	**190,450**	**185,114**	**(5,336)**	**-2.8%**

- *Projection 2026 reflects YTD FY2026 April Actual, with April MTD for May & June, adjusted for holidays*

Performance Improvement Initiatives *Included in the Budget*

Performance Improvement Initiatives - Revenues

In Thousands

- ***$100M Together Initiatives***
- ***These are stretch goals <u>included</u> in the FY2027 Budget***

#	Name	Description	Metric	Responsible	Category	FY2027 Budget
1	Charge Capture Optimization - Non FQHC	• Improve Charge Capture • Clinical Documentation Improvement.	Charge per case increase by 0.5% Baseline Mar 2026: $5,889 Budget FY2027: $6,131 Reimb %: 11.9%	Shari Johnson	Revenue	$ 1,000
2	Ambulatory Access & Revenue Improvement	• Improve Patient Access •Redesign Scheduling Templates •Implmenet On-the-Fly Encounters	Additional 5,877 Visits improvement x FQHC rates	Dr. Mack/Shari Johnson	Revenue	2,145
3	Charge Capture - Professional Inpatient Rounding	• Inpatient Visit Rounding - Trauma	Trauma related PB Inpatient Visits increase by 6,498 at $37.,80 reimb per visit	Shari Johnson	Revenue	246
4	Accounts Receivables	• Payer Settlements (AR reduction) Gross Revenues of $43.0M with failure rate of 30%, net revenue at 19%, for and estimated at $5.7M, less $1.7M in legal fees for total net collection of $4.0M. Settlement may take a few years.	Legal Action - Managed Medicare & Managed Medi-Cal Payors less Less fees	Shari Johnson	Revenue	250
5	Alameda Alliance	• Fee Increase proposed during AdHoc process pending receipt of Contract Amendment	Non FQ Net Patient Revenue Medi-Cal Managed	Kimberly Miranda	Revenue	1,874

Performance Improvement Initiative - Expenses

In Thousands

- ***$100M Together Initiatives***
- ***These are stretch goals <u>included</u> in the FY2027 Budget***

#	Name	Description	Metric	Responsible	Category	FY2027 Budget
6	OT Reduction	• Reduce OT by 15%	Reduction in OT $ by 15% Baseline: 5.6% Target: 5.0%	Dr. Laurent/Terrance FS	Expense	3,429
7	Contract Management	• Identify savings through engagement with Guidehouse	Contract Expense	Ahmad Azizi	Expense	4,818
8	SC Cost Downs	• Supply Chain Cost Down, changing GPO	Non Pharmaceutical Supplies per Adjusted Patient Days	Doug Johnson	Expense	2,500
9	Meal Breaks	• Reduce Missed Meal & Breaks Penalties	Missed Meals/Missed Breaks Amount	Dr. Laurent/Terrance FS	Expense	725
10	FY26 Reduction in Force	Implement pending Reduction in Force - 183 FTEs Actual RIF is less due to atttrition in this population	FTEs	AHS Leadership	Expense	35,262
11	Non Labor Budget Cuts	3.0% Non Labor Savings from Department Leaders	Department Expense Reduction	AHS Leadership	Expense	8,800
12	Decrease in Opportunity Days	2.5% Improvement(1,743 days) of decrease in Patient Days(Lower ALOS by 0.1)	Decrease in Opportunity Days x $1500 per day	Dr. Andrea Wu/Salma Adin	Expense	2,614
			Grand Total			**$ 63,662**

Cash Flow & NNB Debt Projection

FY2027 Preliminary Budget
EBITA Roll-forward and Reconciliation

	FORECAST 2026	BUDGET 2027	PROJECTED 2028	PROJECTED 2029
Estimated Net Income (Loss) before HR1		(24,706)	(42,506)	(110,716)
HR 1 impact, current estimate		(17,800)	(67,000)	(86,000)
Supplemental impact			22,237	52,597
DP-NF SNF (program ended FY27)		-	(23,447)	-
Adjusted net income (loss)		(42,506)	(110,716)	(144,119)
EBIDA adjustments		33,891	33,891	33,891
Earning Before Interest, Depreciation and Amortization (EBIDA)	**$ 9,475**	**$ (8,615)**	**$ (76,825)**	**$ (110,228)**

- Current preliminary budget with net income loss $42.5M. AHS has not achieved a balanced budget.
- Future years in the table reflect the FY2027 preliminary budget with the exception of supplemental revenue and HR 1 impacts. There are no operational changes (i.e. *salary and FTE changes, program changes/closures, inflation, or potential HR 1 relief).*
- Long range strategic plan is under development, which will include a financial plan for future years.

FY 2027 Preliminary Budget
NNB Debt Projection

	FORECAST 2026	BUDGET 2027	PROJECTED 2028	PROJECTED 2029
Earning Before Interest, Depreciation and Amortization (EBIDA)	**$ 9,475**	**$ (8,615)**	**$ (76,825)**	**$ (110,228)**
Supplemental Program Timing				
GPP	105,156	89,529	81,151	80,945
HPAC Amendment	-	19,636	-	-
AB85 Realignment	(41,505)	-	(53,658)	-
EPP	58,145	114,733	84,833	84,833
QIP	74,304	110,658	113,684	113,684
Other programs	289,250	248,613	238,021	240,187
Total supplemental program cash	485,350	583,169	464,031	519,649
Supplemental program revenue (included in EBIDA)	546,753	545,962	498,628	487,066
Net Supplemental Cash Flow	**(61,403)**	**37,207**	**(34,597)**	**32,583**
Other Balance Sheet timing	3,578	(5,338)	(5,010)	(5,010)
AHSF support	-	725	725	725
Jaber support	169	169	169	169
Other Activity	**3,747**	**(4,444)**	**(4,116)**	**(4,116)**
Other arrangements (leases, software)	(9,235)	(8,850)	(8,850)	(8,850)
Capital Projects	(20,694)	(20,600)	(20,600)	(20,600)
Capital Outlay	**(29,929)**	**(29,450)**	**(29,450)**	**(29,450)**
Cash Surplus/(Deficit)	**(78,110)**	**(5,302)**	**(144,988)**	**(111,211)**
NNB, Beginning Balance	26,949	(51,161)	(56,463)	(201,451)
NNB, Ending Balance	**(51,161)**	**(56,463)**	**(201,451)**	**(312,662)**
NNB Limit at June 30th	100,000	100,000	85,000	80,000
Under (Over) NNB Limit	48,839	43,537	(116,451)	(232,662)

- As a reminder, AHS operates utilizing a line of credit with the County called the Net Negative Balance (NNB).
- The schedule reflects additional detail for the supplemental cash flows versus accrued revenue reflecting the significant swings in cash and the impact on the NNB.
- Additional funding may be required for St. Rose due the IGT delay and the cost of the Epic implementation.
- NNB agreement reverting back to original schedule in FY2028. AHS is expected to be out of compliance at 6/30/28.

Summary of Entity Financial Statements

First step towards service line development

Summary of Entity Financial Statements

In Thousands	PROJ 2026		BUDGET 2027	
	Contribution Margin	FTEs	Contribution Margin	FTEs
Alameda	6,565	633	1,443	630
Fairmont	(23,127)	294	(18,351)	272
FQ Clinic	(9,958)	501	1,519	520
Highland	(6,261)	1,946	(54,537)	1,924
John George	(26,454)	386	(21,286)	382
Professional Services	0	67	0	0
San Leandro	134	499	(1,549)	504
System Overhead	(291,456)	809	(297,433)	791
Total	**(350,558)**	**5,135**	**(390,195)**	**5,024**
Measure A	**148,245**		**148,000**	
QIP	**77,624**		**113,684**	
GPP	**105,117**		**89,529**	
Non-Operating Activity	**(3,777)**		**(3,852)**	
Net Income	**(23,349)**		**(42,833)**	

- **Alameda:** Revenues include $14.0M in DP-SNF funding, which is scheduled to end after FY2027. Other Governmental Revenues increase by $2.0M primarily due to Hospital Fee and SNF Supplemental. Expenses increased by $7.1M compared to FY2026, primarily due to salary COLA adjustments offset by facilities maintenance performance initiatives.
- **Fairmont:** Revenues include $9.4M in DP-SNF funding, with FY2027 representing the final year of this funding. The closure of the IOP program reduced FTEs and resulted in lower net expenses.
- **FQHC Clinics:** Revenues increased by $24.6M due to higher HGH rates resulting from the settlement and increased EWC rates from the scope-of-service change. These revenue gains were partially offset by $15.4.7M in increased salary COLA and provider-related expenses. FTEs increase is due to reclassing of physician FTEs from Professional Services.
- **Highland:** Net revenue decreased by $13.7M. Other governmental revenues decreased by $22.4M, primarily due to reductions in AB915, Medi-Cal Managed Care revenue and DHCS Physician funding. Expenses increased by $11.1 primary driven by salary COLA.
- **John George:** Revenue is ($10.M) higher than FY2026 contract timing differences offset by salary COLA ($5.6M)
- **San Leandro:** Expenses increased by $1.2M compared to FY2026, primarily driven by salary COLA adjustments.
- **System Overhead:** Expenses increased due to higher Insurance and Legal costs ($3.9 million) and increased depreciation and amortization expense ($1.6 million).

Budget Calendar

Tasks	Responsibility	Target Due Date
Complete department reviews; Incorporate adjustments in Strata Preparation of Preliminary Budget Update for FC and BOT	Department Leaders / Finance Department	4/27 - 5/25/2026
Preliminary Budget Status Update for Executive Operations Team	Chief Financial Officer	5/26/2026
Preliminary Budget Status Update to the Finance Committee	Chief Financial Officer	6/3/2026 Post 5/29/2026
AdHoc Committee Meeting	Executive Leadership	6/3/2026
Preliminary Budget Status Update to Board of Supervisors: Health Committee	Chief Financial Officer	6/8/2026
Preliminary Budget Status Update the Co-Applicant Board (CAB)	Chief Financial Officer	6/9/2026 Post 6/2/2026
Preliminary Budget Status Update to the Board of Trustees	Chief Financial Officer	6/10/2026 Post 6/5/2026
Incorporate Performance Improvement (PI) Initiatives	Budget Oversight Committee / Adhoc Committee / Finance	6/16/2026
Vetting and finalizing Preliminary Capital Budget	Capital Committee	6/18/2026
Finance Committee & Board of Trustees Approval 278/316	Finance Committee & Board of Trustees	TBD

Key Budget Assumptions

Key Budget Assumptions

Baseline is based on CY2025

Volumes

- In light of HR 1 and expected and unknown utilization changes, volumes and charges are slightly lower and consistent with current trends; overall adjusted patient days decreased 0.2%
- Performance Initiatives: Decrease Opportunity Days ($2.6M)

Revenues

- Increase in pricing (chargemaster) 3%
- Net revenue rate increases
  - Commercial based on contracts $2.2M
  - Government Payors $6.3M
- Behavioral Health Contract at current rate of $81.2M
- FQHC rate increases at HGH ($453) and EWC ($479 Rate) of $24.6M
- Performance Initiatives: Clinic Patient Access($2.1M); Charge Capture($1.2M) and Alameda Alliance Contract($1.9M)
- Deferred RIF Impact for IOP closure reduction of revenue ($4.6M)

Key Budget Assumptions

Labor Expenses

- Budgeted FTEs based on:
  - Variable FTEs: determined by current labor standard based on CY2025 volumes
  - Fixed FTEs: hired as of February 1, 2026; excludes vacancies
  - SEIU Physicians FTEs: hired as of February 1, 2026
  - Registry FTEs: at run rate adjusted for hired employees
- Labor COLA - Consistent with union contracts, includes registry and UNREP at $49.0M
- Deferred RIF Impact reduction ($25.7M)
- Performance Initiatives: OT Reduction($3.4M); Missed Meal Breaks ($0.7M), FY26 RIF ($35.2M)

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

Key Budget Assumptions

Non-Labor

- Non labor overall increase is 2.3%
  - Utilities CPI: Electricity 3%; Gas 9%; Water 7%
  - Supplies: 2.4% effective 1/1/27
  - Drugs CPI: 3.6 to 3.9% effective 1/1/27
  - Purchased Services, IT, Repairs & Maintenance at CY2025
- Donation to St. Rose at $9.5M, consistent with current year
- Performance Initiatives: Supply Chain Costs ($2.5M), Contract Management ($4.8M), Non-Labor Savings ($8.8M)

Foundation

- AHS subsidy to Foundation total operating cost is $5.2M
- Foundation will contribute $2.2M towards AHS operations ($1.5M) and Capital budget ($0.7M)
- Grant revenue is $8.3M

Capital

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

APPENDIX

Budget Goals & Guiding Principles

Preliminary Budget Framework

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

External and Financial Drivers

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

Sustainable Continuous Improvement

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

Volumes

	ACTUAL2025	PROJ 2026 Aor	BUDGET 2027	Var to PROJ 2026 Apr	% to PROJ 2026 Apr
Campus: AHS ALL CAMPUS					
Total Adjusted Patient Days	189,632	190,450	185,114	(5,336)	*-2.8%*
Total Adjusted Discharges	30,725	31,971	31,653	(318)	*-1.0%*
Physician wRVU	1,671,512	1,714,128	1,623,746	(90,382)	*-5.3%*
FQHC & Other Clinic Visits	411,554	431,744	400,996	(30,748)	*-7.1%*
GENERAL ACUTE					
Patient Days	76,737	74,131	71,217	(2,914)	*-3.9%*
Discharges	14,554	14,774	14,681	(93)	*-0.6%*
ALOS: Average Length of Stay	*5.3*	*5.0*	*4.9*	*-0.2*	*-3.3%*
Occupancy %	*70.5%*	*68.2%*	*65.5%*	*-2.7%*	
CMI	1.6340	*1.6190*	*1.6190*	-	*0.0%*
Observation Days	7,772	8,960	8,917	(43)	*-0.5%*
Emergency Visits	109,570	112,644	111,797	(850)	*-0.8%*
Trauma Cases	3,659	3,637	3,602	(40)	*-1.0%*
Surgeries	8,480	8,026	7,979	(47)	*-0.6%*
Deliveries	1,541	1,659	1,555	(104)	*-6.3%*
PSYCH					
Patient Days	23,788	24,003	24,093	90	*0.4%*
Discharges	2,473	2,483	2,420	(63)	*-2.5%*
ALOS: Average Length of Stay	*9.6*	*9.7*	*10.0*	*0.3*	*3.0%*
PES Equivalent Days	8,392	7,983	8,342	359	*4.5%*
Occupancy %	81.5%	82.2%	82.5%	*0.3%*	

- ***Note: Budget 2027 is based on CY2025 (same store) due to HR 1 impact***
- ***Budget 2027 excludes IOP visits (33,453) due to Deferred RIFs and includes 5,877 additional clinic visits for ambulatory access and revenue improvement (initiative)***

Volumes

	ACTUAL2025	PROJ 2026 Aor	BUDGET 2027	Var to PROJ 2026 Apr	% to PROJ 2026 Apr
REHAB					
Patient Days	8,360	8,324	8,402	78	*0.9%*
Discharges	615	614	633	19	*3.1%*
ALOS: Average Length of Stay	*13.6*	*13.6*	*13.3*	*(0.3)*	*-2.1%*
Occupancy %	*81.8%*	*81.4%*	*82.2%*	*0.8%*	
SNF					
SNF Patient Days	100,381	100,819	100,957	138	*0.1%*
Average Daily Census	275.0	276.2	276.6	0	*0.1%*
Occupancy %	*94.8%*	*95.2%*	*95.4%*	*0.1%*	
Bed Holds	1,072	957	960	3	*0.3%*
Payor Mix					
Insurance %	7.5%	6.7%	6.5%	-0.2%	
Medi-Cal %	56.2%	59.6%	59.9%	0.3%	
Medicare %	34.7%	29.5%	29.4%	-0.1%	
Other Govt %	1.2%	1.5%	1.6%	0.1%	
Self-Pay %	0.5%	2.8%	2.7%	-0.2%	
Total Payor Mix %	100.0%	100.0%	100.0%	0.0%	

Other Government Revenues

In Thousands

Programs	Actual FY25	Projected FY26	Budget FY27	Cash Flow FY27	Cash Flow FY28	Cash Flow FY29	Comments
Global Payment Program (GPP)	$ 139,537	$ 105,117	$ 89,529	$ 89,529	$ 81,151	$ 80,945	GPP reduction reflects loss of SNCP portion due to expiration of federal waiver 12/31/2026 (renewal submission has presupposed loss of that portion). Most likely remainder amount will revert to being Medicaid DSH, which is available under federal statute without requiring federal approvals, but does require traditional cost-based claiming excluding non-hospital facilities.
Old Waiver	1,000	-	-	-	-	-	
Medi-Cal Waiver	***$ 140,537***	***105,117***	***89,529***	***$ 89,529***	***$ 81,151***	***$ 80,945***	
Measure A	$ 146,177	148,245	148,000	$ 148,000	$ 148,000	$ 148,000	Based on sales tax increment approved by county voters (one-half cent).
AHD Parcel Tax	4,049	4,795	4,320	4,320	4,320	4,320	Tax per property parcel in City of Alameda.
Measure A & Parcel Tax	***$ 150,226***	***153,040***	***152,320***	***$ 152,320***	***$ 152,320***	***$ 152,320***	
FEMA FUNDING	$ 5,830	$ 223	$ -				Approved claims from FEMA for COVID relief.
Covid Funding	***$ 5,830***	***223***	***-***	***$ -***	***$ -***	***$ -***	

Other Government Revenues

In Thousands

Programs	Actual FY25	Projected FY26	Budget FY27	Cash Flow FY27	Cash Flow FY28	Cash Flow FY29	Comments
HPAC Amendment	$ 50,125	$ -	$ 19,636	$ 19,636	$ -	$ -	Originally $0 until Gov.'s May Revision to budget projected lower giveback than FY26, implying $19M paid during FY27. All will be reserved away for likely FY30 payback in Redirection line below
AB85 Redirection Reserve	(42,093)	0	(19,636)	4,789	(53,658)	-	True-up of FY24 received during FY27 estimating a small amount regained (we received no HPAC Amendment during FY24); then true-up of FY25 during FY28 estimating almost all received will be paid back (we received full HPAC Amendment during FY25); FY27 interim $19M reserved in FY27, transferred back to state in FY30
Medi-Cal SNF Cost Settlement	382	(1,965)	420	(1,659)	420	417	Decreases started Jan 2023 and deepened as virtually all Medi-Cal FFS SNF service moved to Medi-Cal Managed Care where this supplemental is unavailable; HR1 results in small cuts FY27; payback in FY27 reflects FY22 final reconciliation hitting FY27 cash (not yet calculated but likely similar to FY21)
PNPP (Physician SPA)	3,450	11,340	1,733	1,733	1,784	4,755	Reflects adjustment to closer to what is being actually received in cash, since CMS has never started paying the ACA portion and the audits that would allow this payout have no schedule to restart, so even if we are technically owed it we do not have any immediate prospect of getting it.
Rate-Range IGT (RR)	42,592	55,956	41,765	45,831	45,297	44,735	Actual 2024 amounts trended forward, with HR1 reduction est.; higher cash in FY27 reflects payout of CY2025 with less reduction, but 5% reserve added
Enhanced Payment Program (EPP)	68,131	83,085	84,833	114,733	84,833	84,833	Like last year, budget incorporates 25% increase 2024 (seen in payment cycle Spring 2026) followed by 48% increase 2025, plus reduction reflecting some of the new new money being tied to Cost, Efficiency, Productivity, and Access Program (CEPA) which we may not earn 100%; reduction from FY26 budget reflects slightly lower utilization than projected; cash is higher only because EPP payment acceleration will pay us for 18 months during the year on a one-time basis, whereas budget amount is the lower amount earned for services in the year. HR1 cuts will not kick in until 1/1/2028, & will not be seen in cash until fall 2029, FY30.
Quality Incentive Program (QIP)	82,504	77,624	113,684	110,658	113,684	113,684	CMS approved 70% increase to overall program starting CY2025, grandfathered thereafter; 100% of CY2024 assumed earned, 90% of CY2025 and onward; constant distribution. Settlement typically 2 years after year earned. This increase was not reflected in FY26 budget as it would not be in cash for some time, but CY 2025 is expected to be paid out in full during FY 2027 so the full increase is assumed. Under HR1, like EPP, cuts will kick in from 1/1/2028 and cash will affected starting fall 2029 (FY30)

Other Government Revenues

In Thousands

Programs	Actual FY25	Projected FY26	Budget FY27	Cash Flow FY27	Cash Flow FY28	Cash Flow FY29	Comments
Hospital Fee	7,129	7,440	3,670	3,670	3,670	3,670	Direct grant portion only. 50% reduction for FY26, FY27, and onward reflects that under new HR1-related constraints, entire HQAF from 1/1/2025 may significantly reduce, and related to that, hospital community may reduce public hospital portion of it. Negative for projected FY26 assumes reductions to CY 2025 and first half of CY 2026 otherwise being
Medi-Cal Graduate Medical Education (GME)	18,191	14,199	17,307	16,492	17,276	17,203	Some HR1 cuts assumed due to lower Medi-Cal utilization, otherwise has relatively stabilized
AB915	6,535	8,737	9,075	8,812	9,075	8,908	Trending based on 3% cost trend, 1% revenue trend, known FMAP changes, and some drop for state-only transition out of FFS, and small HR1 cuts due to lower Medi-Cal utilization.
DPNF Pass Through	19,281	23,775	23,447	23,447	-	-	3-year limited-time program, calendar 2023-2025. Little transparency on amounts paid before they are actually paid. Amount received for CY2024 in Dec 2025 was about $2M less than expected in budget. FY27 amount is final year of program to be paid during FY27.
Prop 56	(830)	262	260	260	260	260	State tobacco tax revenue spent on Medi-Cal enhancements. Amount is subject to change.
County EMS	395	395	395	395	395	395	Same amount each year.
County Trauma	5,266	5,266	5,266	5,266	5,266	5,266	Funded through Measure C (parcel tax for trauma services approved 1997). Same amount each year.
CalAim ECM (Enhanced Care Mgmt)	1,383	1,048	1,048	1,048	1,048	1,048	Patient care funding for Enhanced Care Management services, a Medi-Cal managed care benefit created under CalAim for patients approved as eligible by Alameda Alliance. Reimbursement is only provided if Medi-Cal managed care member is eligible for services in a month, received ECM services from AHS in that month and AHS submits appropriate documentation and billing.
Other (P4P, BHCS)	4,892	1,210	1,210	1,210	1,210	1,210	P4P
Supplemental Programs	***$ 267,333***	***$ 288,373***	***$ 304,113***	***$ 356,320***	***$ 230,561***	***$ 286,384***	
Total Other Government Programs	***$ 563,927***	***$ 546,753***	***$ 545,962***	***$ 598,169***	***$ 464,032***	***$ 519,649***	

Financial Statement by Entity- Budget 2027

In Thousands	ALAMEDA	FAIRMONT	FQ CLINIC	HIGHLAND	JOHN GEORGE	SAN LEANDRO	SYSTEM OVERHEAD	Grand Total
Operating Revenue ----------								
Net Patient Revenue	128,961	30,488	136,706	468,632	96,645	131,608	-	993,039
Capitation Revenue	2,213	388	17,383	25,991	-	7,625	-	53,601
Other Government Programs	38,208	10,484	1,022	115,981	-	29,053	0	194,749
Other Revenues	1,075	676	1,532	64,767	742	1,317	-	70,109
Total Revenue - All Sources	**170,457**	**42,036**	**156,643**	**675,371**	**97,387**	**169,604**	**0**	**1,311,498**
Projected 2026 Total Revenue	*168,410*	*40,588*	*129,593*	*712,276*	*86,759*	*170,084*	*223*	*1,307,933*
Collection %	***16.0%***	***23.0%***	***59.6%***	***16.8%***	***30.1%***	***15.9%***		***19.4%***
Projected 2026 Collection %	*15.8%*	*18.7%*	*48.3%*	*17.4%*	*28.2%*	*16.1%*		*19.0%*
Operating Expenses ----------								
Salaries & Benefits	130,188	48,751	91,350	446,846	90,284	117,661	181,327	1,106,407
Purchased Services	7,416	2,342	1,410	33,872	3,723	6,074	50,318	105,154
Contracted and Provider	8,796	1,376	49,310	100,449	20,273	23,823	896	204,924
Materials and Supplies	11,354	4,278	7,169	124,373	1,835	16,469	886	166,365
Facilities	6,076	3,092	1,904	17,801	2,193	3,670	9,861	44,597
Depreciation	4,721	449	3,789	4,522	323	3,234	12,992	30,031
General & Administration	462	99	190	2,045	42	223	41,154	44,216
Total Operating Expenses	**169,014**	**60,388**	**155,123**	**729,908**	**118,673**	**171,153**	**297,433**	**1,701,693**
Projected 2026 Total Operating Expenses	*161,845*	*63,715*	*139,551*	*718,538*	*113,213*	*169,950*	*291,679*	*1,658,491*
Contribution Margin	**1,443**	**(18,351)**	**1,519**	**(54,537)**	**(21,286)**	**(1,549)**	**(297,433)**	**(390,195)**
Projected 2026 Contribution Margin	*6,565*	*(23,127)*	*(9,958)*	*(6,261)*	*(26,454)*	*134*	*(291,456)*	*(350,558)*
Var Contribution Margin	**(5,122)**	**4,776**	**11,477**	**(48,275)**	**5,167**	**(1,683)**	**(5,977)**	**(39,637)**

Alameda Hospital by Service Line - Budget 2027

In Thousands	Acute	SNF and Subacute	Wound Care & Marina Specialty	Direct Facility Shared Services	Grand Total
Operating Revenue ----------					
Net Patient Revenue	78,061	45,603	5,297	0	128,961
Capitation Revenue	1,539	647	27	0	2,213
Other Government Programs	21,881	15,732	595	0	38,208
Other Revenues	481	275	39	279	1,075
Total Revenue - All Sources	**101,962**	**62,257**	**5,959**	**279**	**170,457**
Projected 2026 Total Revenue	*106,458*	*56,848*	*4,726*	*379*	*168,410*
Collection %	***13.8%***	***20.9%***	***20.0%***		***16.0%***
Projected 2026 Collection %	*14.1%*	*20.6%*	*16.8%*	*0.0%*	*15.8%*
Operating Expenses ----------					
Salaries & Benefits	64,289	41,366	2,982	21,552	130,188
Purchased Services	1,736	1,652	575	3,452	7,416
Contracted and Provider	6,269	761	1,766	0	8,796
Materials and Supplies	6,010	2,807	891	1,646	11,354
Facilities	332	81	169	5,494	6,076
Depreciation	423	1,033	405	2,861	4,721
General & Administration	53	50	13	346	462
Total Operating Expenses	**79,112**	**47,751**	**6,800**	**35,351**	**169,014**
Projected 2026 Total Operating Expenses	*78,327*	*42,459*	*6,125*	*34,935*	*161,845*
Contribution Margin	**22,850**	**14,506**	**(841)**	**(35,072)**	**1,443**
Projected 2026 Contribution Margin	*28,131*	*14,389*	*(1,399)*	*(34,556)*	*6,565*

Fairmont Hospital by Service Line - Budget 2027

In Thousands	OP Rehab	SNF	Direct Facility Shared Services	Grand Total
Operating Revenue ----------				
Net Patient Revenue	1,334	29,154	0	30,488
Capitation Revenue	295	93	0	388
Other Government Programs	76	10,020	381	10,484
Other Revenues	38	238	401	676
Total Revenue - All Sources	**1,743**	**39,505**	**782**	**42,036**
Projected 2026 Total Revenue	*1,465*	*37,533*	*(1,197)*	*37,800*
Collection %	***10.8%***	***24.3%***		***23.0%***
Projected 2026 Collection %	*9.3%*	*22.8%*		*18.7%*
Operating Expenses ----------				
Salaries & Benefits	5,384	28,853	14,514	48,751
Purchased Services	14	392	1,935	2,342
Contracted and Provider	0	1,376	0	1,376
Materials and Supplies	215	1,692	2,372	4,278
Facilities	5	47	3,041	3,092
Depreciation	8	90	352	449
General & Administration	3	25	71	99
Total Operating Expenses	**5,628**	**32,476**	**22,284**	**60,388**
Projected 2026 Total Operating Expenses	*5,525*	*31,354*	*21,823*	*58,702*
Contribution Margin	**(3,885)**	**7,029**	**(21,502)**	**(18,351)**
Projected 2026 Contribution Margin	*(4,059)*	*6,178*	*(23,020)*	*(20,902)*

FQ Clinic by Service Line - Budget 2027

In Thousands	Eastmont	Highland	Hayward	Newark	Direct Facility Shared Services	Grand Total
Operating Revenue ----------						
Gross Revenues	60,119	128,690	26,042	14,482	0	229,332
Deductions	22,211	53,038	11,444	5,933	0	92,627
Net Patient Revenue	37,908	75,652	14,598	8,549	0	136,706
Capitation Revenue	4,819	6,019	3,928	2,618	0	17,383
Other Government Programs	317	575	81	49	0	1,022
Other Revenues	911	423	101	57	40	1,532
Total Revenue - All Sources	**43,954**	**82,668**	**18,707**	**11,272**	**40**	**156,643**
Projected 2026 Total Revenue	*43,198*	*59,827*	*16,083*	*10,262*	*223*	*129,593*
Collection %	***63.1%***	***58.8%***	***56.1%***	***59.0%***		***59.6%***
Projected 2026 Collection %	*56.3%*	*42.2%*	*53.9%*	*56.2%*		*48.3%*
Operating Expenses ----------						
Salaries & Benefits	19,664	45,333	8,654	5,186	12,513	91,350
Purchased Services	343	91	430	334	213	1,410
Contracted and Provider	9,552	32,673	4,549	2,536	0	49,310
Materials and Supplies	3,262	1,946	1,288	625	49	7,169
Facilities	950	165	627	127	35	1,904
Depreciation	2,794	287	615	93	0	3,789
General & Administration	60	80	21	8	21	190
Total Operating Expenses	**36,624**	**80,576**	**16,185**	**8,908**	**12,830**	**155,123**
Projected 2026 Total Operating Expenses	*37,170*	*71,291*	*16,041*	*8,867*	*6,182*	*139,551*
Contribution Margin	**7,330**	**2,093**	**2,522**	**2,364**	**(12,790)**	**1,519**
Projected 2026 Contribution Margin	*6,027*	*(11,464)*	*42*	*1,395*	*(5,959)*	*(9,958)*

John George Psychiatric by Service Line - Budget 2027

In Thousands	Total
Operating Revenue ----------	
Net Patient Revenue	96,645
Capitation Revenue	0
Other Government Programs	0
Other Revenues	742
Total Revenue - All Sources	**97,387**
Projected 2026 Total Revenue	*86,759*
Collection %	***30.1%***
Projected 2026 Collection %	*28.2%*
Operating Expenses ----------	
Salaries & Benefits	90,284
Purchased Services	3,723
Contracted and Provider	20,273
Materials and Supplies	1,835
Facilities	2,193
Depreciation	323
General & Administration	42
Total Operating Expenses	**118,673**
Projected 2026 Total Operating Expenses	*113,213*
Contribution Margin	**(21,286)**
Projected 2026 Contribution Margin	*(26,454)*

Highland Hospital by Service Line - Budget 2027

In Thousands	Total
Operating Revenue ----------	
Net Patient Revenue	468,632
Capitation Revenue	25,991
Other Government Programs	115,981
Other Revenues	64,767
Total Revenue - All Sources	**675,371**
Projected 2026 Total Revenue	*711,082*
Collection %	***16.8%***
Projected 2026 Collection %	*17.4%*
Operating Expenses ----------	
Salaries & Benefits	446,846
Purchased Services	33,872
Contracted and Provider	100,449
Materials and Supplies	124,373
Facilities	17,801
Depreciation	4,522
General & Administration	2,045
Total Operating Expenses	**729,908**
Projected 2026 Total Operating Expenses	*715,851*
Contribution Margin	**(54,537)**
Projected 2026 Contribution Margin	*(4,769)*

San Leandro Hospital by Service Line - Budget 2027

In Thousands	Acute	Rehab	Direct Facility Shared Services	Grand Total
Operating Revenue ----------				
Net Patient Revenue	99,219	32,389	0	131,608
Capitation Revenue	7,481	145	0	7,625
Other Government Programs	26,643	2,411	0	29,053
Other Revenues	735	152	431	1,317
Total Revenue - All Sources	**134,078**	**35,096**	**431**	**169,604**
Projected 2026 Total Revenue	*134,654*	*35,049*	*380*	*170,084*
Collection %	***13.4%***	***36.5%***		***15.9%***
Projected 2026 Collection %	*13.7%*	*37.2%*		*16.1%*
Operating Expenses ----------				
Salaries & Benefits	80,407	21,194	16,061	117,661
Purchased Services	1,842	1,212	3,020	6,074
Contracted and Provider	22,237	1,586	0	23,823
Materials and Supplies	14,827	283	1,359	16,469
Facilities	207	1	3,462	3,670
Depreciation	1,724	100	1,409	3,234
General & Administration	128	2	94	223
Total Operating Expenses	**121,371**	**24,378**	**25,405**	**171,153**
Projected 2026 Total Operating Expenses	*120,582*	*22,350*	*27,018*	*169,950*
Contribution Margin	**12,707**	**10,718**	**(24,974)**	**(1,549)**
Projected 2026 Contribution Margin	*14,072*	*12,699*	*(26,637)*	*134*

STAFF REPORTS (Written)

ALAMEDA HEALTH SYSTEM

April 2026 Financial Report

Kimberly Miranda, Chief Financial Officer
Finance Committee
June 3, 2026

April 2026 Financial Report
Finance Dashboard

April-2026

	Metric	FY2026 Goal YTD	Actual YTD	YTD	Trend Lines
Volume					
	Total Adjusted Discharges	26,899	27,067		
	Total Adjusted Patient Days	304,617	309,199		
Revenue Cycle					
	Collection Ratio	19.5%	19.0%		
	Cash as % of Net Revenue	100.0%	104.1%		
	Gross Days in Patient Receivables	62.0	65.2		
Labor					
	Productivity %	100.0%	108.5%		
	Registry as % of Total FTEs	4.2%	3.5%		
	Overtime % excl Company 30	4.5%	5.7%		
	Total FTEs	5,130	5,159		
	FTE per Adjusted Discharge	0.19	0.19		
	*Labor Cost/FTE w/o GASB	$242,799	$246,702		
Profitability					
	Total Cost per Adjusted Discharge	$49,966	$50,669		
	Total Cost per Adjusted Patient Days	$4,412	$4,435		
	Net Income	$5,095	($10,813)		
	EBIDA Margin	2.5%	1.2%		
	NNB (Net Negative Balance)	<$95M	$42,401		
	Net Position	>$0	-$72,443		
Capital					
	Capital Spent	$24,853	$16,143		
	% of Capital Spent		65.0%		

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

April 2026 Financial Report
Volume Highlights – Part 1

	April 2026				FY2026 Year-To-Date				FY2025 Year-To-Date		
	Actual	Budget	Var	% Var	Actual	Budget	Var	% Var	Actual	Var	% Var
Campus: AHS ALL CAMPUS											
Total Adjusted Patient Days	30,749	30,912	-163	-0.5%	309,199	304,617	4,583	1.5%	303,726	5,473	1.8%
Total Adjusted Discharges	2,657	2,704	-47	-1.7%	27,067	26,899	168	0.6%	26,045	1,022	3.9%
Physician wRVU	159,504	121,823	37,681	30.9%	1,395,119	1,187,668	207,451	17.5%	1,433,836	-38,718	-2.7%
FQHC & Other Clinic Visits	38,821	37,768	1,053	2.8%	365,005	365,443	-438	-0.1%	344,815	20,190	5.9%
GENERAL ACUTE											
Patient Days	6,423	6,226	197	3.2%	61,285	64,319	-3,034	-4.7%	64,529	-3,244	-5.0%
Discharges	1,226	1,203	23	1.9%	12,322	12,473	-151	-1.2%	12,224	98	0.8%
Average Length of Stay	5.2	5.2	-0.1	-1.2%	5.0	5.2	0.2	3.5%	5.3	0.3	5.8%
Occupancy %	72%	70%	2%		68%	71%	-3%	-4.7%	71%	-4%	
CMI	1.636	1.553	0.082	5.3%	1.623	1.565	0.058	3.7%	1.638	-0.015	-0.9%
Emergency Visits	9,155	9,134	21	0.2%	94,334	91,365	2,969	3.2%	91,109	3,225	3.5%
Trauma Cases	284	259	25	9.7%	3,069	2,960	109	3.7%	3,030	39	1.3%
Observation Equivalent Days	728	595	132	22.2%	7,504	6,576	928	14.1%	6,391	1,113	17.4%
Surgeries	653	714	-61	-8.5%	6,720	6,725	-5	-0.1%	7,193	-473	-6.6%
Deliveries	153	117	36	30.9%	1,353	1,377	-24	-1.7%	1,316	37	2.8%
PSYCH											
Psych Patient Days	1,983	2,152	-169	-7.8%	20,037	19,998	39	0.2%	19,660	377	1.9%
Psych Discharges	206	239	-33	-13.8%	2,071	2,229	-158	-7.1%	2,061	10	0.5%
Occupancy %	83%	90%	-7%		82%	82%	0%	0.2%	81%	2%	
PES Equivalent Days	598	697	-99	-14.3%	6,788	6,625	163	2.5%	6,829	-41	-0.6%

April 2026 Financial Report
Volume Highlights – Part 2

Campus: AHS ALL CAMPUS	April 2026				FY2026 Year-To-Date				FY2025 Year-To-Date		
	Actual	Budget	Var	% Var	Actual	Budget	Var	% Var	Actual	Var	% Var
REHAB											
Rehab Patient Days	669	726	-57	-7.8%	6,986	7,353	-367	-5.0%	7,032	-46	-0.7%
Rehab Discharges	50	55	-5	-8.9%	514	556	-42	-7.6%	519	-5	-1.0%
Average Length of Stay	13.4	13.2	-0.2	-1.2%	13.6	13.2	-0.4	-2.8%	13.5	0	-0.3%
Occupancy %	80%	86%	0%		82%	86%	0%	0.0%	83%	0%	
SNF WITH SUB-ACUTE											
SNF Patient Days	8,282	8,270	12	0.1%	84,255	83,803	452	0.5%	83,573	682	0.8%
Average Daily Census	276.1	275.7	0.4	0.1%	277.2	275.7	1.5	0.5%	274.9	2.2	0.8%
Occupancy %	95%	95%	0%		96%	95%	0%	0.0%	95%	0%	
Bed Holds	117	70	47	66.2%	887	794	93	11.7%	847	40	4.7%
PAYOR MIX											
Insurance %	7.07%	5.61%	1.46%		6.82%	6.94%	-0.13%		6.84%	-0.02%	
Medi-Cal %	59.42%	61.46%	-2.04%		59.57%	60.52%	-0.95%		60.53%	-0.95%	
Medicare %	28.48%	27.91%	0.56%		29.21%	27.65%	1.56%		28.31%	0.90%	
Other Govt %	2.01%	3.10%	-1.08%		1.64%	1.94%	-0.30%		1.79%	-0.15%	
Self-Pay %	3.02%	1.92%	1.10%		2.76%	2.95%	-0.18%		2.54%	0.22%	
Total Payor Mix %	100.00%	100.00%	0.00%		100.00%	100.00%	0.00%		100.00%	0.00%	

April 2026 Financial Report
Medicare GMLOS Benchmark – Trend of Excess Days

Acute Care Hospitals: HGH, SLH, AH (excludes any rehab)

- LOS Variance Days | April: There were 2,778 excess days which is an 8.0% monthly increase. This reflects the total number of actual days in a bed in excess of the allowed number of days compared to the Medicare acuity model benchmark.

- Medicare GMLOS Benchmark: Compares the total AHS patient population against the Federal Medicare regulatory guidelines, regardless if the patient is a non-Medicare State (APR) payer or a Medicare Federal (MSDRG) payer.

April 2026 Financial Report
YTD Highlights

- Favorable YTD revenue variance of $10.7M.
  - Net patient revenue below budget ($1.4), higher charges/volumes partially offset by collection percentage - 0.5% below budget.
  - Other government programs above budget ($2.6) with offsetting supplemental revenue impacts.
  - Other operating income above budget by ($9.9M) driven from retail pharmacy ($4.4M), one-time items of SAC law settlement on older claims ($3.1M).

- Unfavorable YTD expense variance of $27.4M.
  - Labor costs unfavorable by $22.6M due to higher FTE and wage rates, employee benefits ($6.9M), retirement ($2.5M).
  - Non-labor cost unfavorable by $4.8M from unfavorable variances in pharmaceuticals ($4.0M), and facilities ($6.0M) offset by favorable utilities ($2.0M) , computer IT refresh ($1.1M)

	April 2026				Year-To-Date				FY 2025	
	Actual	Budget	Variance	% Var	Actual	Budget	Variance	% Var	YTD	% Var
Operating revenue	$ 131,821	$ 135,951	$ (4,130)	(3.0)%	$ 1,363,800	$ 1,353,094	$ 10,706	0.8%	$ 1,327,080	2.8%
Operating expense	133,111	135,719	2,608	1.9%	1,371,446	1,344,041	(27,405)	(2.0)%	1,311,845	(4.5)%
Operating income (loss)	**(1,290)**	**232**	**(1,522)**	**(656.0)%**	**(7,646)**	**9,053**	**(16,699)**	**(184.5)%**	**15,235**	**(150.2)%**
Other non-operating activity	(359)	(1,382)	1,023	74.0%	(3,167)	(3,958)	791	20.0%	(3,929)	19.4%
Net Income (loss)	**$ (1,649)**	**$ (1,150)**	**$ (499)**	**(43.4)%**	**$ (10,813)**	**$ 5,095**	**$ (15,908)**	**(312.2)%**	**$ 11,306**	**(195.6)%**
EBIDA adjustments	2,905	3,795	(890)		27,011	28,851	(1,840)		35,966	
EBIDA	**$ 1,256**	**$ 2,645**	**$ (1,389)**		**$ 16,198**	**$ 33,946**	**$ (17,748)**		**$ 47,272**	
Operating Margin	(1.0)%	0.2%	(1.2)%		(0.6)%	0.7%	(1.3)%		1.1%	
EBIDA Margin	1.0%	1.9%	(0.9)%		1.2%	2.5%	(1.3)%		3.6%	
Total FTEs	4,923	5,111	188	3.7%	5,157	5,130	(27)	(0.5)%	5,093	

April 2026 Financial Report
Net Patient Services Revenue Highlights

- Gross patient service revenue favorable driven by inpatient services.
  - General Acute inpatient days above budget; Length of Stay on target and CMI increased above trend.
  - Trauma cases higher than budget by 9.7% for month and 3.7% YTD.
  - Inpatient surgery below budget 12.7% for month and 6.6% YTD.
  - ED visits above budget by 0.2%,for the month and 3.2% YTD.
  - Outpatient surgery below budget 5.1% and higher than budget 5.5% YTD.
  - Clinic visits above budget 2.8% and lower than budget by 0.1% YTD.
  - SNF and Subacute census at 95% consistent with budget.
  - JGP census was 83% consistent with trend; PES visits below budget 14.3% and above budget 2.5% YTD.
- NSPR Collection ratio below budget for month and YTD.
  - Medicare cost report adjustment in the month ($7.9M). SLH FY16 ($4.0M) and HGH FY20 ($3.9M)
  - Commercial mix improved consistent with higher trauma cases

	April 2026				Year-To-Date				FY 2025	
	Actual	Budget	Variance	% Var	Actual	Budget	Variance	% Var	YTD	% Var
Inpatient service revenue	$ 228,504	$ 217,941	$ 10,563	4.8%	$ 2,225,052	$ 2,221,098	$ 3,953	0.2%	$ 2,142,191	3.9%
Outpatient service revenue	156,278	152,953	3,326	2.2%	1,579,292	1,471,752	107,540	7.3%	1,433,966	10.1%
Professional service revenue	43,880	44,003	(123)	(0.3)%	423,637	421,455	2,182	0.5%	428,153	(1.1)%
Gross patient service revenue	428,663	414,897	13,766	3.3%	4,227,981	4,114,305	113,676	2.8%	4,004,311	5.6%
Deductions from revenue	(354,311)	(333,793)	(20,518)	(6.1)%	(3,425,134)	(3,310,042)	(115,092)	(3.5)%	(3,229,977)	6.0%
Net patient service revenue	**74,352**	**81,104**	**(6,752)**	**(8.3)%**	**802,847**	**804,264**	**(1,416)**	**(0.2)%**	**774,334**	**(3.7)%**
Collection % - NPSR	17.3%	19.5%	(2.2)%		19.0%	19.5%	(0.5)%		19.3%	
Capitation and HPAC	4,363	4,545	(181)	(4.0)%	44,516	44,937	(421)	(0.9)%	46,164	(3.6)%
Other government programs	47,486	45,415	2,071	4.6%	456,770	454,150	2,620	0.6%	455,507	0.3%
Other operating revenue	5,620	4,887	733	15.0%	59,667	49,744	9,924	20.0%	51,075	16.8%
Total operating revenue	**$ 131,821**	**$ 135,951**	**$ (4,130)**	**(3.0)%**	**$ 1,363,801**	**$ 1,353,094**	**$ 10,706**	**0.8%**	**$ 1,327,080**	**2.8%**

Medicare Cost Report-based and other settlement-related adjustments in FY 2024-25 and FY 2025-26

Takeaway: Volatile, tied to cost reports submitted many years ago, many factors can lead to significant pickups or hits, AHS is working to stabilize

Adjustment category	Income adjustments in FY25	Income adjustments in FY26 YTD	Notes
CMS reopening pieces of closed years for court verdicts, etc. (older years as far back as 1997)	$0.2M	$0.7M	Hershey verdict, SSI ratio recalculation –judicially required of CMS or for other reasons
Settlement of cost reports on normal (delayed) schedule and release of reserves/balances	$4.2M	($1.0M)	Negative factors include Medicaid days submitted for Medicare DSH, bad debt
CMS reopening outlier payments only (FY13, FY16, FY20)	($2.4M)	($6.2M)	Medicare outlier payments are linked to estimations of costs which can change significantly on later audit; cataloguing to better anticipate these paybacks
SNF Supplemental reconciliation following audit	$1.0M	($2.4M)	Exclusion of subacute days generated $2.4M payback settling FY21, no longer included in submissions
Total Cost Report / Settlement adjustments in FY	**$3.1M**	**($8.9M)**	

Note: Medicare Cost Report adjustments of ($2.2M) in March 2026 and ($7.9M) in April, and SNF settlement of $2.4M in March, were offset by +$3.6M in positive adjustments in earlier months of FY26, for cumulative ($8.9M) adjustments in FY26 YTD

April 2026 Financial Report
Governmental and Other Revenue Highlights

- Other government programs favorable from GPP ($4.3M) offset by Prop 56 ($2.1M). YTD, favorable from CY25 GPP ($4.3M), Rate Range CY2024 ($4.2M), Alameda Alliance P4P ($1.2M), parcel tax ($0.8M), FEMA ($0.2M) offset by unfavorable variance for SNF Supplemental FY21 final reconciliation payment ($2.4M), Prop56 ($3.6M), Measure A ($0.5M). DP-NF Pass-through payment for CY2024 was $23.8 million which was $1.5M lower than the anticipated funding of $25.8M and will be an on-going variance.

- Other operating revenue favorable from SRH management fee ($0.5M) and Grant Revenue ($0.2M). YTD, favorable driven by the settlement on low pay patient accounts ($3.1M), SRH management fee excluded from the budget ($3.3M), Alameda Alliance incentive ($0.3M), higher retail pharmacy ($4.4M) offset by unfavorable grant activity ($1.8M).

	April 2026				Year-To-Date				FY 2025	
	Actual	Budget	Variance	% Var	Actual	Budget	Variance	% Var	YTD	% Var
Net patient service revenue	74,352	81,104	(6,752)	(8.3)%	802,847	804,264	(1,416)	(0.2)%	774,334	(3.7)%
Capitation and HPAC	4,363	4,545	(181)	(4.0)%	44,516	44,937	(421)	(0.9)%	46,164	(3.6)%
Medi-Cal Waiver	12,751	8,474	4,278	50.5%	89,155	84,736	4,419	5.2%	93,067	(4.2)%
Measure A and parcel tax	12,760	12,760	0	0.0%	127,842	127,595	247	0.2%	128,111	(0.2)%
Supplemental Programs	21,975	24,182	(2,207)	(9.1)%	239,772	241,819	(2,047)	(0.8)%	234,330	2.3%
Other government programs	**47,486**	**45,415**	**2,071**	**4.6%**	**456,769**	**454,150**	**2,619**	**0.6%**	**455,507**	**0.3%**
Grant Revenue	1,544	1,376	168	12.2%	11,880	13,507	(1,628)	(12.0)%	13,451	(11.7)%
Other Operating Revenue	4,076	3,512	565	16.1%	47,789	36,236	11,552	31.9%	37,624	27.0%
Other operating revenue	**5,620**	**4,887**	**733**	**15.0%**	**59,668**	**49,744**	**9,925**	**20.0%**	**51,075**	**16.8%**
Total operating revenue	**$ 131,821**	**$ 135,951**	**$ (4,130)**	**(3.0)%**	**$ 1,363,801**	**$ 1,353,094**	**$ 10,706**	**0.8%**	**$ 1,327,080**	**2.8%**

April 2026 Financial Report
Expense Highlights excluding Labor

- Purchased services unfavorable due to clinical services ($0.2M) and Vizient ($0.2M). YTD, favorable variance in budget timing offset by management consultants ($0.4M).
  - Budget misclassifications: Software licensing fees are recorded as amortization and on budget. Outside medical services budget was too high caused by duplicate ambulance invoices in prior year that were subsequently refunded. Expenses consistent with trend. Coders were included under registry and favorable to budget.
- Material and supplies consistent with budget. YTD, unfavorable due to pharmaceuticals ($4.0M), surgical supplies ($1.4M), medical supplies ($0.6M) and inventory adjustment ($1.0M) offset by favorable computer equipment ($1.1M).
- Facilities unfavorable from facility repairs ($0.7M) offset by favorable facility leases ($0.1M). YTD, unfavorable from facility repairs ($6.0M), computer equipment repair ($0,3M) offset by favorable utilities ($2.0M). Facility repairs occurred at Highland Hospital ($2.9M), Alameda Hospital ($1.9M), and San Leandro Hospital ($0.7M).
- Depreciation and amortization unfavorable from lower equipment depreciation ($0.3M) offset by higher lease and software amortization ($0.5M). YTD, favorable from lower equipment depreciation ($4.1M) offset by higher lease and software amortization ($3.2M).
- General and administrative favorable across many departments. YTD, favorable from recruitment expense ($0.8M), insurance ($0.7M) and other expense ($0.4M) offset by the remaining unfavorable variance ($0.4M) across many cost centers.

	April 2026				Year-To-Date				FY 2025	
	Actual	Budget	Variance	% Var	Actual	Budget	Variance	% Var	YTD	% Var
Labor costs	$ 102,873	$ 106,218	$ 3,345	3.1%	$ 1,060,612	$ 1,037,968	$ (22,644)	(2.2)%	$ 992,921	(6.8)%
Purchased services	8,530	8,113	(417)	(5.1)%	86,260	89,242	2,982	3.3%	86,311	0.1%
Materials and supplies	13,480	13,549	69	0.5%	138,200	132,338	(5,862)	(4.4)%	128,204	(7.8)%
Facilities	3,481	2,878	(603)	(21.0)%	36,934	32,620	(4,314)	(13.2)%	31,996	(15.4)%
Depreciation and amortization	2,588	2,400	(188)	(7.8)%	23,869	24,763	894	3.6%	32,310	26.1%
General and administrative	2,159	2,561	402	15.7%	25,571	27,110	1,539	5.7%	40,103	36.2%
Total operating expense	**$ 133,111**	**$ 135,719**	**$ 2,608**	**1.9%**	**$ 1,371,446**	**$ 1,344,041**	**$ (27,405)**	**(2.0)%**	**$ 1,311,845**	**(4.5)%**

April 2026 Financial Report
Expense Highlights – Labor

- Staff and registry favorable for month ($3.1M) and YTD ($14.0M).
  - Staff salaries and registry favorable driven higher rate ($0.4M).and lower FTEs (162 FTEs/$2.7M). YTD, unfavorable due to higher rate ($13.7M) and higher FTEs (20 FTEs/$0.3M)
- Provider salaries and contracts favorable for month ($0.8M) and favorable YTD ($0.7M).
  - Provider salaries favorable from lower FTEs (26 FTEs/$0.8M) and lower rate ($0.2M). YTD, favorable from higher FTEs (20 FTEs/$4.5M) offset by lower rate ($6.5M) includes paternity payout last month ($1.6M). FY26 recruitment unrealized.
  - Physician contract services unfavorable for month ($0.3M) and YTD ($1.3M) due to locum expense.

	April 2026				Year-To-Date				FY 2025
	Actual	Budget	Variance	% Var	Actual	Budget	Variance	% Var	YTD
Salaries and wages (staff)	$ 57,549	$ 59,121	$ 1,572	2.7%	$ 606,836	$ 582,777	$ (24,059)	(4.1)%	$ 553,845
Salaries and wages (providers)	12,007	13,077	1,070	8.2%	128,493	130,448	1,955	1.5%	123,279
Registry	2,569	4,118	1,549	37.6%	31,924	42,026	10,102	24.0%	43,147
Physician contract services	3,906	3,624	(282)	(7.8)%	37,752	36,459	(1,293)	(3.5)%	35,420
Employee benefits (taxes, insur	17,776	17,790	14	0.1%	171,647	164,797	(6,850)	(4.2)%	158,009
Retirement	9,066	8,488	(578)	(6.8)%	83,960	81,461	(2,499)	(3.1)%	79,220
Total labor costs	**$ 102,873**	**$ 106,218**	**$ 3,345**	**3.1%**	**$ 1,060,612**	**$ 1,037,968**	**$ (22,644)**	**(2.2)%**	**$ 992,921**
Compensation ratio	78.0%	78.1%	0.1%		77.8%	76.7%	-1.1%		74.8%
Paid FTEs - staff	4,434	4,494	60	1.3%	4,567	4,511	(56)	(1.2)%	4,616
Paid FTEs - providers	377	403	26	6.5%	410	403	(7)	(1.7)%	289
Paid FTEs - registry	133	214	81	37.9%	182	216	34	15.7%	235
Total FTEs	4,944	5,111	167	3.3%	5,159	5,130	(29)	(0.6)%	5,140

April 2026 Financial Report
Expense Highlights – Benefits

- Employee benefits approximates budget with unfavorable variance self-funded health ($0.3M), FICA ($0.4 M) offset by lower Kaiser health plan ($0.6M) and other benefits ($0.1M). YTD, unfavorable from higher self-funded health ($11.4M), FICA ($1.6 million) offset by lower Kaiser health plan ($4.2M), other benefits ($2.2M), and timing of resident housing allowance ($0.8M).
- Retirement unfavorable from AHS retirement plan ($0.5M) and other plans ($0.1M). YTD, unfavorable from ACERA ($0.9M), AHS retirement plan ($0.4M), union plans ($0.8M) and other plans ($0.4M).

	April 2026				Year-To-Date				FY 2025
	Actual	Budget	Variance	% Var	Actual	Budget	Variance	% Var	YTD
Salaries and wages (staff)	$ 57,549	$ 59,121	$ 1,572	2.7%	$ 606,836	$ 582,777	$ (24,059)	(4.1)%	$ 553,845
Salaries and wages (providers)	12,007	13,077	1,070	8.2%	128,493	130,448	1,955	1.5%	123,279
Registry	2,569	4,118	1,549	37.6%	31,924	42,026	10,102	24.0%	43,147
Physician contract services	3,906	3,624	(282)	(7.8)%	37,752	36,459	(1,293)	(3.5)%	35,420
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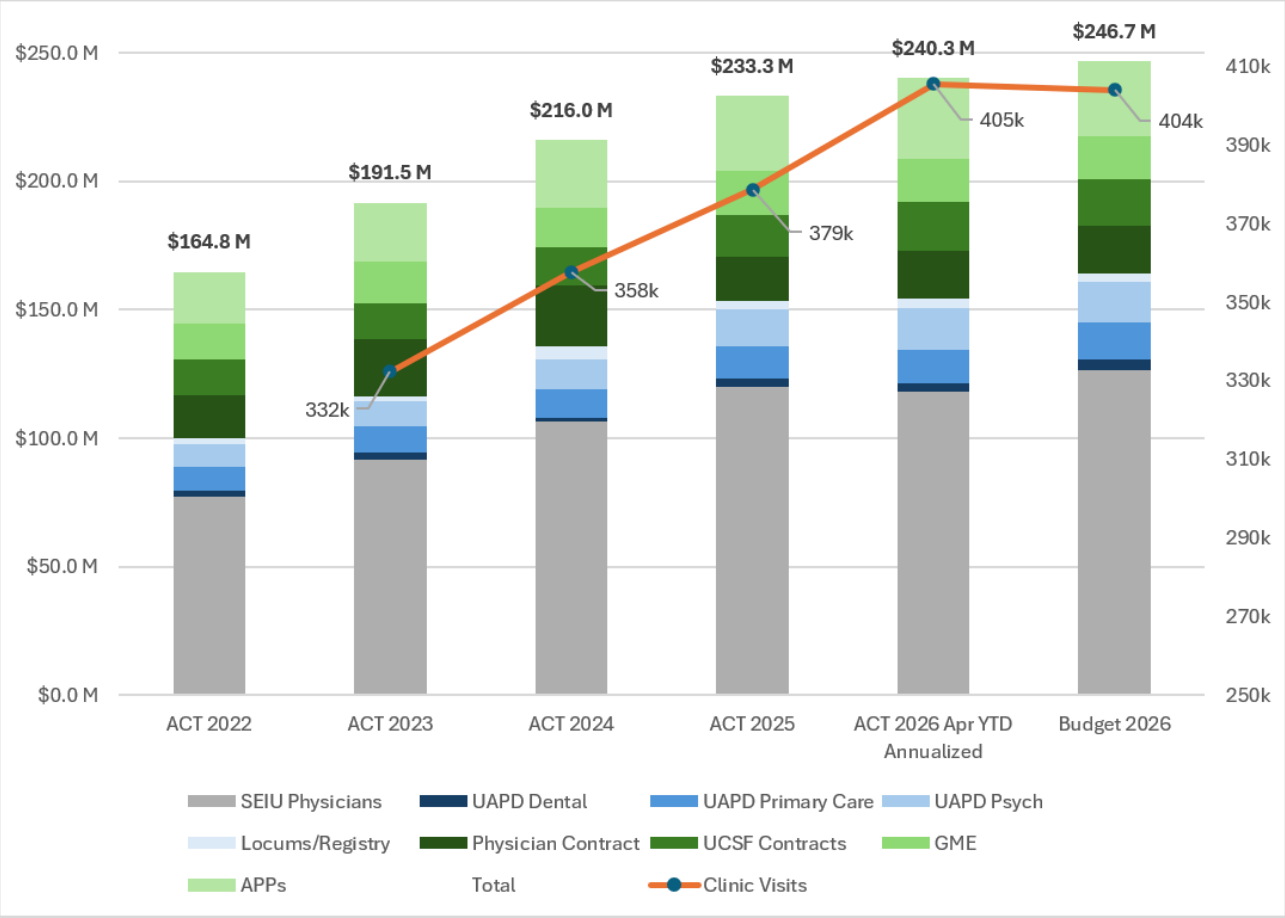
Retirement	9,066	8,488	(578)	(6.8)%	83,960	81,461	(2,499)	(3.1)%	79,220
Total labor costs	**$ 102,873**	**$ 106,218**	**$ 3,345**	**3.1%**	**$ 1,060,612**	**$ 1,037,968**	**$ (22,644)**	**(2.2)%**	**$ 992,921**
Compensation ratio	78.0%	78.1%	0.1%		77.8%	76.7%	-1.1%		74.8%
Paid FTEs - staff	4,434	4,494	60	1.3%	4,567	4,511	(56)	(1.2)%	4,616
Paid FTEs - providers	377	403	26	6.5%	410	403	(7)	(1.7)%	289
Paid FTEs - registry	133	214	81	37.9%	182	216	34	15.7%	235
Total FTEs	4,944	5,111	167	3.3%	5,159	5,130	(29)	(0.6)%	5,140

April 2026 Financial Report
Total Provider Expense



	ACT 2022	ACT 2023	ACT 2024	ACT2025	Act 2026 Apr YTD Annualized	Budget 2026
Clinic Visits		332,403	357,741	378,682	405,462	403,957
% Change			7.6%	5.9%	7.1%	-0.4%

Paid FTEs	ACT 2022	ACT 2023	ACT 2024	ACT 2025	ACT 2026 Apr YTD Annualized	Budget 2026
SEIU Physicians	180.0	197.1	213.2	223.1	222.8	243.1
UAPD Dental	8.7	9.8	8.3	9.0	9.4	11.4
UAPD Primary Care	27.8	28.4	30.7	32.7	30.7	34.8
UAPD Psych	17.1	17.4	19.2	23.9	26.4	23.5
GME	134.6	136.8	137.4	139.1	139.1	138.2
APPs	76.8	81.6	84.6	90.8	93.4	91.3
Subtotal Physicians	**445.0**	**471.1**	**493.3**	**518.6**	**521.7**	**542.3**
% Change		*6%*	*5%*	*5%*	*1%*	
Change Paid FTE		*26.1*	*22.2*	*25.2*	*3.2*	

Service Type	ACT 2022	ACT 2023	ACT 2024	ACT 2025	ACT 2026 Apr YTD Annualized	Budget 2026
SEIU Physicians	$77.3 M	$91.8 M	$106.3 M	$120.2 M	$118.2 M	$126.4 M
UAPD Dental	$2.3 M	$2.7 M	$1.7 M	$2.8 M	$3.2 M	$4.1 M
UAPD Primary Care	$9.4 M	$10.3 M	$10.9 M	$12.6 M	$12.9 M	$14.7 M
UAPD Psych	$8.7 M	$9.6 M	$11.7 M	$14.7 M	$16.4 M	$15.7 M
Locums/Registry	$2.2 M	$1.7 M	$5.3 M	$3.0 M	$3.6 M	$3.2 M
Physician Contract	$17.0 M	$22.4 M	$23.3 M	$17.1 M	$18.6 M	$18.6 M
UCSF Contracts	$14.0 M	$14.0 M	$15.1 M	$16.2 M	$19.1 M	$18.1 M
GME	$13.9 M	$16.1 M	$15.6 M	$17.3 M	$16.5 M	$16.6 M
APPs	$20.0 M	$22.9 M	$26.1 M	$29.3 M	$31.7 M	$29.3 M
Subtotal Physicians	**$164.8 M**	**$191.5 M**	**$216.0 M**	**$233.3 M**	**$240.3 M**	**$246.7 M**

Notes:

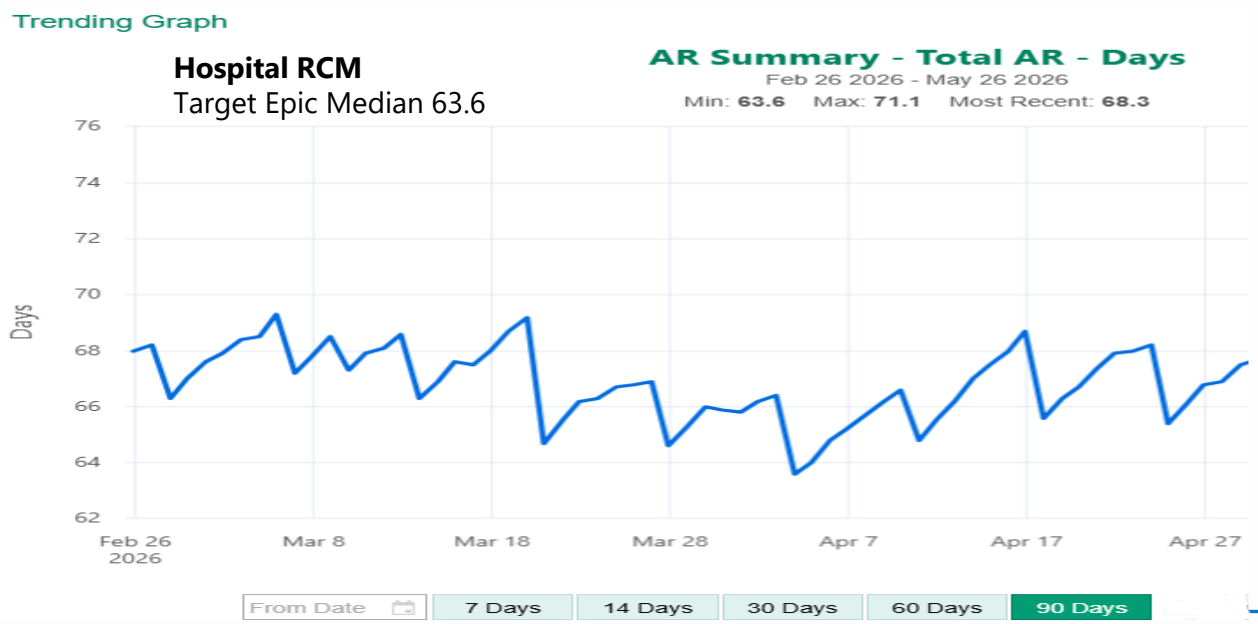
1. FY26 SEIU excludes President and admin staff dollars.
2. Dignity Health GME moved to UCSF in FY26.
3. Locums: FY2024-2026 for John George-Psych, General Surgery & Eastmont Wellness center.
4. GME FTEs include residents.

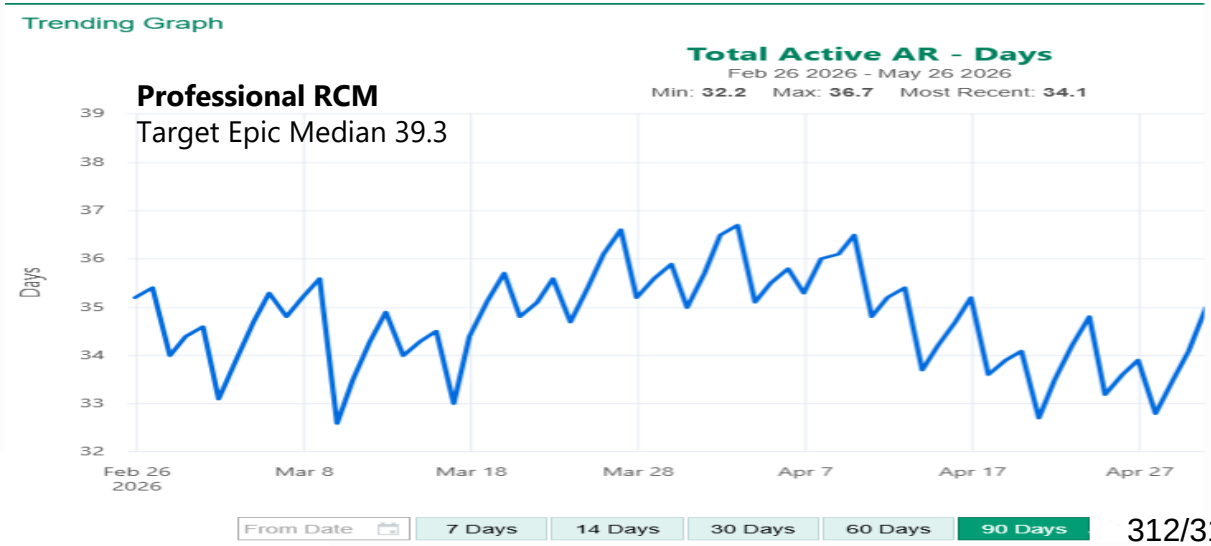
April 2026 Financial Report
Balance Sheet Key Metrics

- Days in Cash are 0.7 days and lower than year-end; typically, below 5.0 days.
- Gross AR Days increased 2.5 days and Net AR Days increased by 2.4 days. See next slide for additional detail. 5
- Days in Accounts Payable increased due to timing of the check run and implementation of Hyland/Onbase (automation of AP processes). The target is 30 days.
- Net Position is negative $72.4M and increased $10.6M from June 30,2025 reflecting YTD Net Loss.
- Net Negative Balance is a receivable of $42.4M. NNB consists of the liquidity facility (loan) of $13.8M and the restricted cash of $28.3M; and is expected to be below the June 30,2026 credit ceiling of $95.0M at the end of the fiscal year.

	Apr-26	Mar-26	FY 2025
Days in cash	0.7	0.6	2.9
Gross days in patient receivable	65.2	62.7	62.4
Net days in patient receivable	43.1	40.7	43.8
Due from/(to) third-party payors	$ 166,151	$ 387,608	$ 158,555
Due from/(to) County	$ (9,648)	$ (117,719)	$ 49,680
Days in accounts payable	39.5	34.8	38.3
% of AP over 60 days	1.6%	3.7%	4.0%
Net position - fund balance/(deficit)	$ (72,443)	$ (70,793)	$ (61,798)
Net negative balance - receivable/(payable)	$ 42,401	$ (65,963)	$ 26,949

April 2026 Financial Report
Patient Accounts Receivable Trending





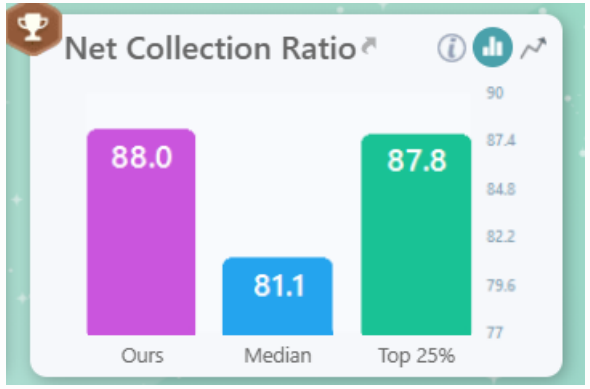
Hospital Revenue Cycle Key Indicators

- HB AR Days increased by 2.1 days compared to prior month. March AR Days were 65.8 and April AR Days were 67.9.
- Charges were high in April at $409.6M driving AR higher in May. Collections turn-around time is approximately 30-45 days from the date of billing
- April collections were higher at $61.7M compared to monthly trend of approximately $61.4M.

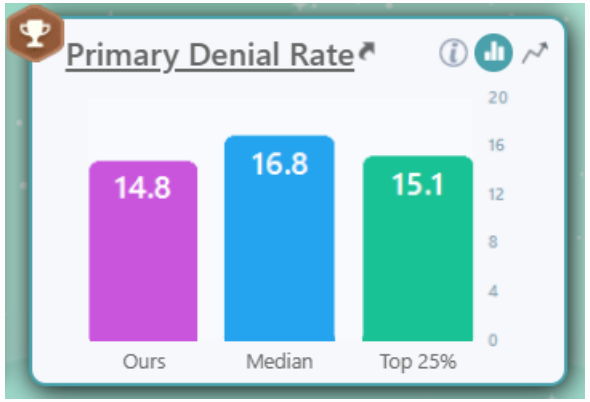
Professional Revenue Cycle Key Indicators

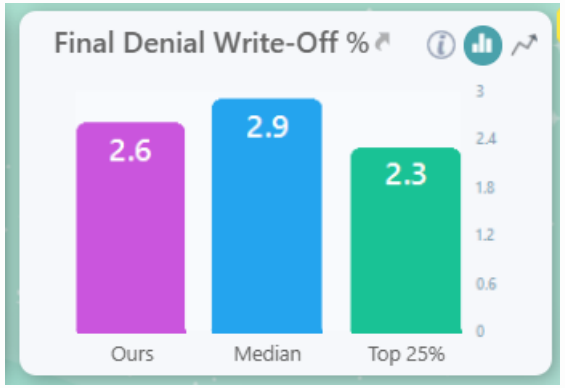
- PB AR Days decreased by 0.7 days compared to prior month. March AR Days were 35.7 and April AR Days were 35.0.
- April collections reported was $13.0M. This is above the monthly trend of approximately $11.9M
- Enterprise CDI launched to address provider clinical documentation along with charge automation, and usage of Epic tools. Pilot project in progress with inpatient services - Critical Care, Obstetrics & Gynecology. Outpatient continues with Neurology, Optometry, Pediatrics, Nephrology. Orthopedics, OMG, and ENT closed.

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



- AHS is currently collecting 88.0% of expected payments. AHS is typically around the Top 25th percentile of all safety net hospitals.
- We have identified an issue with Medicare non-covered service that are not separately payable and is considered contractual adjustment.
- Net collection ratio metric shows the ratio of payments collected (less any refunds) to expected reimbursement for hospital accounts that were fully resolved within the past 91 days.





- Primary denial rate is 14.8% of net collections. AHS is typically around the Top 25% percentile of safety net hospitals and represents all claim that payers have adjudicated. Less work rework and steady cash flows.
- Final denial write-off rate is 2.6% of net collections and approximates the top 25th percentile of safety net hospitals and represents all claims with a final denial and closed accounts.

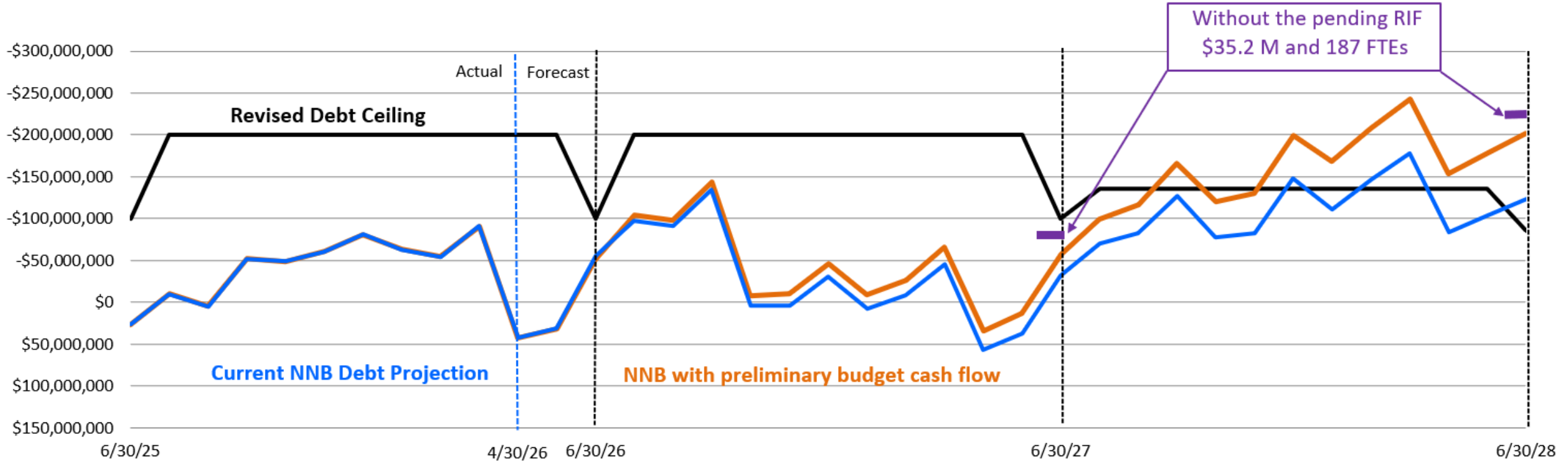
April 2026 Financial Report
Patient collections are growing year over year

PATIENT COLLECTIONS
(in thousands)

	Behavioral Health	Epic	Total FY 2026	FY 2025	FY 2024	FY 2023	FY 2022
Jul	11,928	67,883	79,811	72,694	79,592	74,260	59,732
Aug	28,651	82,136	110,787	79,768	69,313	58,590	57,374
Sep	-	66,819	66,819	69,741	63,322	76,063	61,968
Oct	868	82,323	83,191	76,783	63,122	59,796	49,923
Nov	11,569	71,370	82,939	78,747	57,781	56,939	52,057
Dec	7,275	65,241	72,516	94,631	63,867	67,018	68,121
Jan	6,034	63,286	69,320	89,014	68,757	71,452	62,292
Feb	4,293	90,269	94,562	68,511	75,852	57,886	52,269
Mar	9,323	78,320	87,643	91,851	54,720	65,320	62,888
Apr	13,109	74,689	87,798	74,892	61,895	55,307	56,235
May	-	-	-	74,339	102,015	63,795	69,591
Jun	-	-	-	72,211	71,208	70,027	53,187
Total	**93,050**	**742,336**	**835,386**	**943,182**	**831,444**	**776,453**	**705,637**
% change between fiscal years			4.9%	13.4%	7.1%	10.0%	

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

April 2026 Financial Report
NNB Debt Forecast



One-time cash items	(in millions)
FQHC (settlement)	$ 30.2
Old Waiver (fy11)	19.8
FY26 impact	50.0
DP-NF (final payment)	26.0
HPAC - AB85 Realignment	19.6
EPP (payment acceleration)	42.4
FY27 impact	88.0
TOTAL	**$ 138.0**

	2026	2027	2028
NNB limit at June 30th	100,000	100,000	85,000
NNB intra period limit	200,000	200,000	135,000

- Impact of the FY2027 preliminary budget reflected in the orange line. AHS has not achieved a balanced budget.
- One-time funding assisted AHS in remaining below the NNB limit for FY2026 and FY2027. The NNB is projected to exceed the NNB limit starting in FY2028 if interventions are not taken.
- As a reminder, the NNB Permanent Agreement was modified for FY2026 and FY2027 and reverts back to the original agreement in FY2028.

April 2026 Financial Report
NNB Debt Forecast – Material Items

Material Items Included in NNB Forecast

(in thousands)

	May-26	Jun-26	FY27 Q1	FY27 Q2	FY27 Q3	FY27 Q4
GPP (quarterly)	$ -	$ -	$ 22,352	$ 22,352	$ 27,394	$ 19,325
EPP (semi-annual)	-	-	-	72,317	-	42,417
QIP	-	-	-	56,842	-	56,842
Medi-Cal Rate Range	-	-	-	-	45,831	-
BHCS (JGP/Alameda County) - fy26	5,343	6,084	12,167	-	-	-
BHCS (JGP/Alameda County) - fy27	-	-	-	18,900	18,900	25,200
HPAC	-	-	-	21,600	10,800	10,800
AB85 Realignment	-	-	-	4,789	19,636	-
SNF DP-NF (final pmt Jan-27)	-	-	-	-	26,000	-
Waiver recoupment (fy11, fy12)	29,169	-	-	-	-	-
St. Rose Hospital LOC	-	(4,400)	15,000	-	(7,500)	7,500
Donation to St. Rose Hospital	-	(10,507)	-	-	(10,507)	-
	$ 34,512	$ (8,823)	$ 49,519	$ 196,800	$ 130,554	$ 162,084

Prior Year Reimbursement Settlements

AB915 (fy14-fy20)	(17,000)	TBD
Physician SPA (fy08 - fy13)	(25,100)	TBD
	$ (42,100)	

- Table is consistent with prior month.
- St. Rose IGT remains delayed and Epic implementation will stress the current cash flow, which may require additional support from AHS.