QUALITY PROFESSIONAL SERVICES COMMITTEE MEETING

Wednesday, August 23, 2023
5:00pm-7:00pm

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

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

Members of the public may also participate at the following ZOOM Meeting Link:
https://alamedahealthsystem.zoom.us/j/9361457125?pwd=aUF4anZlK01IRklVMzZvQVY5NTdOZz09

Meeting ID:  936 145 7125
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/aeoijFgeyL

COMMITTEE MEMBERS
Kinkini Banerjee  Taft Bhuket, MD, Chair
Jennifer Esteen  David Sayen

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

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

SPECIAL NOTE: The governor-declared state of emergency that altered public meeting protocols during the Covid pandemic has been lifted. All Alameda Health System Board of Trustees meetings and Board of Trustees Committee meetings will be held in accordance with current Brown Act requirements. As a result, our meetings will be held via a hybrid of in-person and remote access.

The public is invited to attend the meetings in person or observe and participate in the meeting via the Zoom link above.

Public Comment Instructions
If you attend the meeting in person and wish to address the Board or Committee regarding an item on the agenda or in their purview, please complete a Speaker Card available near the entrance. If you need assistance, please see the Clerk of the Board.

If you attend the meeting remotely and wish to address the Board of Trustees or Committee regarding an item on the agenda or in their purview, send an email to cob@alamedahealthsystem.org PRIOR TO THE START OF THE MEETING. Your comment will be heard at the appropriate time. During the meeting, public comment requests may be submitted to the ZOOM meeting host or the Clerk of the Board, but requests must be submitted prior to the beginning of the public speaker time for that item.

Each speaker, whether in person or remote, will be allotted between one and three minutes to speak, depending on the number of speakers present.

OPEN SESSION / ROLL CALL

PUBLIC COMMENT: Non-Agenda Items

Public comment on each Action or Report/Discussion/Information item may take place after the staff presentation and prior to Committee action or discussion. To provide comment remotely, follow the "Public Comment Instructions" above. The Committee does not vote on Report/Discussion/Information items.

A. REPORT/DISCUSSION: QPSC Chair (estimated 10 min)
   Taft Bhuket, MD, Trustee

B. ACTION: Consent Agenda (estimated 10 min)

Public comment on all Consent Agenda items may be heard prior to the Committee’s vote. To provide comment remotely, follow the “Public Comment Instructions” above. The Committee does not deliberate on Consent Agenda items. Any member of the public or the Committee may request that a Consent Agenda item get pulled from the Consent Agenda for deliberation and to be voted on separately from the Consent Agenda.
B1. Approval of the Minutes of the July 26, 2023 Quality Professional Services Committee Meeting

B2. Policies and Procedures

Recommendation to the Board of Trustees for approval of the policies listed below.

System Wide Policies
- Visiting Hours/Visitors Policy
- Color Coded Wristband Procedure
- AHS Point of Care Testing – Personnel Responsibilities
- AHS Point of Care Testing (POCT)
- Patient Informed Consent

B3. Medical Staff Policies

Recommendation to the Board of Trustees for approval of the policies and form listed below.

AHS and AH Medical Staff Policies:
- Medical Staff Evaluation of Actions Related to Providers
- Medical Staff Delegated Credentialing Policy
- Medical Staff Moonlighting Practitioners

Approval of the following AHS and AH Medical Staff form:
- Delegated Credentialing Information Release / Acknowledgement

B4. Medical Staff Privilege Forms

Revised Privilege Form for AHS and AH:
- Gastroenterology Multifacility
- Neurology Multifacility

Revised Privilege Form for AHS:
- Pediatrics

Recommendation: Motion to Approve

END OF CONSENT AGENDA

Public comment on each Report/Discussion/Information item may take place after the staff presentation and prior to Committee discussion. To provide comment remotely, follow the “Public Comment Instructions” above. The Committee does not vote on Report/Discussion/Information items.
C. **REPORT/DISCUSSION: Medical Staff Reports** *(estimated 20 min)*
- AHS Medical Staff: Lan Na Lee, MD (Chief of Medical Staff)
  Edris Afzali, MD (SLH Leadership Committee Chair)
- AH Medical Staff: Nikita Joshi, MD (Chief of Medical Staff)

D. **REPORT/DISCUSSION: Quality Reports** *(estimated 10 min)*

D1. Regulatory Affairs, Quality TNM Dashboard  
*Ana Torres, Vice President, Quality*

D2. Post Acute  
*Richard Espinoza, Chief Operating Officer, Post Acute*

E. **INFORMATION: Planning Calendar/Issue Tracking** *(estimated 1-2 min)*  
*Taft Bhuket, MD, Chair*

F. **CLOSED SESSION** *(estimated 20 min)*

Public comment on Closed Session items may take place prior to the Board adjourning to the Closed Session. To provide comment remotely, follow the “Public Comment Instructions” above. An announcement of any action taken during the Closed Session will take place prior to the end of the Open Session.

F1. Consideration of Confidential Medical Staff Credentialing Reports  
*Chief of Staff, AHS Medical Staff*  
*Chief of Staff, AH Medical Staff*

F2. Regulatory Affairs, Risk Management, Patient Safety  
*[Health and Safety Code 101850(ai) (1)]*

*(Reconvene to Open Session)*

OPEN SESSION

G. **REPORT: Legal Counsel’s Report on Action Taken in Closed Session**  
*Ahmad Azizi, General Counsel*

ADJOURNMENT

**ADDENDUM ONE: ABCs of Communication**

**ADDENDUM TWO: Committee Charter**

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/](http://www.alamedahealthsystem.org/meeting-agendas-and-minutes/). By attending and participating in Board/Committee meetings, members of the public consent to audio recording of any statements they may make during the proceedings.

Disability Access
The Meeting Rooms are wheelchair accessible. Assistive listening devices are available upon request at the Clerk of the Board's Office. To request accommodation or assistance to participate in the meeting, please contact the Clerk of the Board. Requests made at least 48 hours in advance of the meeting will help to ensure availability.

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

The AHS Board of Trustees is committed to protecting the private health information (PHI) of our patients. We ask that speakers refrain from disclosing or discussing the PHI of others. Please also know that, should you decide to disclose your PHI, the Trustees will still likely refer your matter, to the extent it involves PHI, to the executive staff for a confidential review of the facts and for confidential handling. If you would like more information regarding the confidentiality of PHI as it relates to the Health Insurance Privacy and Accountability Act, please refer to 45CFR Section 164.101, et.seq.
No Written Materials
Agenda Item #A Chair Report

No written materials were submitted for this agenda item. Written materials may be distributed, or a verbal discussion of the item may take place at the meeting.
B. Consent Agenda (estimated 10 min)
No Written Materials
Agenda Item B1

The July QPSC Minutes will be included in the September packet.
B2 Policies COMBINED v2
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• Policy in PolicyTech | 08/2025 | 08/03/2023  
08/16/2023 | • CPC 08/03/2023  
• AHS MEC 08/16/2023 |
| Color Coded Wristband Procedure | Theresa Cooper | • Revised  
• Procedure in PolicyTech | 08/2025 | 08/03/2023  
08/16/2023 | • CPC 08/03/2023  
• AHS MEC 08/16/2023 |
| AHS Point of Care Testing – Personnel Responsibilities | Dr. Valerie Ng | • Revised  
• Policy in PolicyTech | 08/2025 | 08/03/2023  
08/16/2023 | • CPC 08/03/2023  
• AHS MEC 08/16/2023 |
| AHS Point of Care Testing (POCT) | Dr. Valerie Ng | • Revised  
• Policy in PolicyTech | 08/2025 | 08/03/2023  
08/16/2023 | • CPC 08/03/2023  
• AHS MEC 08/16/2023 |
| Patient Informed Consent | Nilda Perez | • Revised  
• PolicyTech Policy | 08/2025 | 08/03/2023  
08/16/2023 | • CPC 08/03/2023  
• AHS MEC 08/16/2023 |
VISITING HOURS/VISITORS

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

**PURPOSE**

To provide support for patients during their stay by accommodating visitors and encouraging visitation. To ensure that all visitors enjoy full and equal visitation privileges that are consistent with patient preference and our ability to provide patient and family centered care.

**POLICY**

It is the policy of Alameda Health System (AHS) to uphold patients’ rights to designate visitors of his/her/their choosing and to allow patient visitation, as authorized and in accordance with the provisions set forth below.

**DEFINITIONS:**

A. “Patient and family-centered care” is based on the assumption that “family” is the primary source of strength and support. Family-centered providers recognize that family members hold essential information that enhances the patient’s care.

B. Family – “Family” is defined by the patient as the group of significant people that normally provide physical, psychological, or emotional support.

C. “Visitors” are defined as any individual who presents to the health care facility for the purpose of visiting a patient.

**RESTRICTED VISITATION**

During flu season and other emerging public health situations/emergencies these visitation protocols may be amended to adhere to infection prevention and control safety guidelines.

Visitation approvals for patients on isolation precautions, will be allowed visitors once reviewed and approved by the charge nurse. Emergent situations will be handled by each site’s Infection Control manager in collaboration with the respective administrative leaders.

**PROCEDURE**

Visitor identification enforcement policy: All in-patient visitors that come into any of the AHS campuses are required to check-in and receive a visitor pass while at AHS. Badges are one day self-expiring badges that expire approximately 15 hours after activation. When red lines have
appeared the visitor badge is not valid and must be replaced immediately. Badges will be color coded for Highland Hospital ONLY.

- Emergency Department Red Visitor Badge
- ICU Yellow Visitor Badge
- 4th Floor Purple Visitor Badge
- 3rd Floor ISSU White Visitor Badge
- 5th Floor Yellow Visitor Badge
- 6th Floor Dark Blue Visitor Badge
- 7th Floor Green Visitor Badge
- 8th/9th Floor Blue Visitor Badge

Visiting hours are from 9 a.m. to 10 p.m. except for in FBC and ICU. From 10 p.m. to 9 a.m. is designated hospital quiet time. At the Wilma Chan Highland Campus a security officer is posted at the fourth-floor elevator area 24 hours a day to screen all persons entering the acute care hospital.

It is recommended that only two people should visit any patient at one time.

1. Children visiting must be supervised by responsible adults, other than the patient at all times. Children under 12 are not permitted in the ICU and NICU (see document)

Special arrangements may be made through the Nurse Manager or designee for visits for pre-op patients.

Limiting the number of family members and/or visitors in a room may be necessary due to space and patient access issues.

There may be special circumstances when staff may request families/visitors to leave the patient’s bedside for a limited time. Staff will explain to visitors the clinical rationale for the request, when visitors may return, and where they may wait. Examples of circumstances which may necessitate restrictions or limitations on visitors might include (but are not limited to), when:

- When there might be an infection control issue
- Visitation might interfere with the care of other patients.
- The hospital is aware of an existing court order restricting contact.
- The patient is undergoing care interventions; however, if possible, the patient requests that at least one visitor be allowed to remain in the room to provide support and comfort will be accommodated.
- During the resuscitation process we will do everything possible to accommodate family requests to be present if desired.

Only 1 visitor may stay overnight in private rooms with a bathroom. Arrangements must be made with the charge nurse. Minors (under 12) are not permitted to stay overnight except for exclusive breastfeeding. Exclusive breastfeeding is for babies under the age of 6 months and only if accompanied by a caregiver other than the patient.
Individuals who are disruptive to patient care or operations of the facility will be asked to leave. Acts or threats of violence, intimidation, vandalism, or verbal abuse will not be permitted or tolerated under any circumstances.

Visitors should refrain from sitting or lying on a patient’s bed.

1. POST ANESTHESIA CARE UNIT
   - Visiting patients in the PACU is not allowed unless permission is granted by the PACU nurse.

2. ICUs
   - No one under 12 years of age is allowed in the ICU’s unless special arrangements are made through the Charge Nurse.

3. EMERGENCY DEPARTMENT
   - The Emergency Department allows for the presence of a support individual (visitor) of the patient’s choice unless the individual’s presence infringes on safety or is medically or therapeutically contraindicated. If a visitor is already with a patient and the patient is agreeable the visitor may stay during rounds. Security will bring visitors back at the scheduled time after checking with the patient’s nurse. The Emergency Department Charge Nurse has the authority to suspend visiting anytime that there is a situation where visitors would be a safety issue, i.e., multiple GSW traumas. Visiting would resume as soon as the situation was resolved.

4. FAMILY BIRTH CENTER
   A. Family and friends should refrain from visiting if they are febrile, have diarrhea, or have symptoms of an upper respiratory infection. Cold sores should be covered with a mask until the lesion is dry and scabbed. Anyone exposed to a known communicable disease (such as chickenpox or influenza) is not allowed in the birth center. All visitors must clean their hands and forearms when entering the mother’s room, and before handling the infant.
   B. Each mother will be asked to designate her primary support person. This support person will have unlimited access to the mother and her infant(s). A mask will be provided to the support person if he/she/they have any signs of illness.
   C. Labor & Delivery patients will be allowed 4 visitors as well as a doula and an apprentice doula.
   D. All visitors will sign in and obtain a designated visitor badge to wear at all times while in the birth center. Visiting hours are as follows: L&D unrestricted; PP unrestricted for designated primary support person, 9 a.m. – 10 p.m. for all others; NICU 9 a.m. – 10 p.m. Visitors are allowed in the mother’s room or in the waiting room. They may not wait in the hallways or by the doors.
E. A member of the health-care team may request that the number and timing of visitors be limited at certain times to facilitate adequate patient access for care. Requests by staff members to limit the number of visitors and/or length of visit should include information that helps the family and friends understand the patient’s needs. If a visitor refuses to comply with the request to move to the waiting area, or is disruptive or violent, security will be notified.

F. Visitation during labor:
   i. No more than one visitor may accompany patients being evaluated in the OB Triage area for the initial 15 minutes. This is to protect the safety and privacy of other patients in the area.
   ii. After admission, the designated primary support person and a limited number of visitors may remain in the room throughout labor at the discretion of the birthing mother, the staff, and as dictated by patient safety.
   iii. Children of any age may be present during labor at the discretion of the birthing mother, the staff, and as dictated by patient safety. Another responsible adult must be present to care for the child.
   iv. During a non-emergent cesarean section, the designated primary support person may attend at the discretion of the patient. The support person is required to gown in appropriate attire, use head/hair cover, shoe cover, and mask. The support person is allowed to sit at the head of the OR table under the direction of Anesthesia Services. The surgeon, staff, or anesthesiologist may ask the support person to leave the room if complications arise, however, every effort will be made to permit the support person to remain at the bedside if desired.
   v. During an emergency cesarean birth, only surgical personnel are allowed in the operating room until the mother and infant are stable.
   vi. No more than two visitors may accompany patients in the post-anesthesia recovery area (PACU). No food or drink can be brought into the PACU. No children are permitted in the PACU.
   vii. The decision to allow visitors during the postpartum period is made by the patient and supported by the nursing staff based on maternal and infant needs.
   viii. The designated primary support person may remain with the patient overnight and will be provided with a couch or recliner and bed linens. The support person will provide her or his own food and personal items and will maintain a clean and orderly space, except for the first night on Postpartum when a special meal is prepared for the family.
   ix. Children of any age are encouraged to visit but may not stay overnight if they are under the age of 13. A responsible adult (not the patient) must be present to care for the child. Children who become disruptive or who will not remain in the patient’s room must be taken by a responsible adult outside the unit until the behavior is resolved.
   x. Postpartum will allow 4 visitors, with no ‘swapping’ of visitor.

G. NICU visitation:
   i. Only the mother and her designated, banded support person are allowed in the nursery. Either the mother or designated, banded support person may bring one other visitor to the bedside, not to exceed four at the bedside at any one time. There will be no ‘swapping’ of visitor’
ii. All visitors will be instructed on handwashing and must clean hands and forearms with antiseptic soap or waterless cleanser when entering the NICU.

i. The mother and her designated support person may visit at any time.

ii. Each infant may have only 2 visitors at a time. Visitation may be limited at the discretion of the infant’s nurse or other staff. Because infant care is the first priority, any visitor may be asked to leave in the event of any treatments, procedures, or emergencies.

iii. Children under the age of 12 are not allowed in the NICU unless they are siblings of the infant. Siblings are allowed brief visits in the NICU, with constant supervision by a responsible adult. During periods of communicable disease outbreaks, sibling visitation in the NICU may be suspended indefinitely at the discretion of the medical staff or infection-control nurse, or on community recommendations.

5. CRIMINAL JUSTICE

- Visitors are not allowed unless authorized by the law enforcement agency responsible for the patient.

6. VISITING PERSONNEL

- Alameda Health System personnel are required to observe regular visiting hours if they have friends who are patients.

SHERIFF/SECURITY CONTACT NUMBERS:
Alameda County Sheriff Office: 44100
Highland Security 44815

APPROVALS

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PURPOSE
1. To properly identify patients during any phase of their hospitalization.
2. To have a standardized process that identifies and communicates patient-specific risk factors or special needs by using color coded wristbands based upon the assessment of the patient, the patient’s wishes and medical status.
3. To achieve the following objectives:
   a. To reduce confusion associated with the use of color-coded wristbands by using colors standardized throughout California.
   b. To communicate patient safety risks to all health care providers.
   c. To include the patient, family members and significant others in the communication process and promote safe care.

Definitions
The following represents the meaning of each color-coded band:

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<tr>
<td>Red</td>
<td>Allergy</td>
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<tr>
<td>Yellow</td>
<td>Fall Risk</td>
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<tr>
<td>Light Purple</td>
<td>A.N.D Allow Natural Death</td>
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<tr>
<td>White</td>
<td>Patient Identification</td>
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RESPONSIBILITIES
1. Patients will be properly identified during any phase of his/her/their hospitalization. No hospital employee shall: administer any medications, remove any specimen (tissue, fluid or otherwise) or give therapy, injections, or any form of medication or surgical treatment without first checking I.D. wristband. Patients may have same or similar names, but the hospital number is unique and must be used in the identification process.

PROCEDURES
1. Application of color-coded wristbands: During the initial patient assessment, data is collected to evaluate the needs of the patient and a plan of care unique to the individual is initiated. Throughout the course of care, reassessment is ongoing, which may uncover additional pertinent medical information, trigger key decision points, or reveal additional risk factors about the patient. During the initial and reassessment procedures, allergies, DNR status and risk factors associated with falls may be identified. Assessment of potential risk is an interdisciplinary process: It is important to identify the staff members responsible for applying and removing color-coded wristbands, and the appropriate documentation needed and how it is communicated. The following procedures have been established to remove uncertainty in these processes:
COLOR-CODED WRISTBAND  
PROCEDURE  

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- Only the nurse performing the patient assessment is designated to apply or remove color-coded wristbands. Color-coded wristbands should be used for all patients with these conditions, including all inpatient and emergency department patients.
- The nurse performing the assessment is authorized to determine fall risk and patient allergies as determined by the assessment and place the appropriate color-coded wristband on the patient.
- The determination of a “Do Not Resuscitate” order must be consistent with hospital policy and must be documented in the patient’s medical record prior to the nurse placing the A.N.D. wristband on the patient.
- Handwriting is not permitted on color-coded wristbands.
- It should be documented in the patient’s medical record that the color-coded wristband was applied, per hospital policy. It is not necessary to document wristband color, only that the wristband corresponding to the condition assessed was applied.
- All color-coded wristbands shall be placed on the same wrist as the patient identification wristband.
- Upon application of the color-coded wristband, the nurse shall instruct the patient and family member(s), if present, that the wristband is not to be removed.
- In the event that any color-coded wristband(s) must be removed for a treatment or procedure, a nurse will remove the wristband(s). Upon completion of the treatment or procedure, risk shall be reconfirmed, and new wristband(s) immediately applied by the nurse.

2. **Patient/Family Involvement and Education:** Staff should assist and encourage the patient and family member(s) to be active partners in the care provided and safety measures being used. The nurse should educate all patients and family members to notify the nurse whenever a wristband has been removed and is not reapplied, or when a new band is applied, and they have not been given an explanation as to the reason.

3. **Hand-Off in Care:** The nurse shall reconfirm that the color-coded wristbands are consistent with the documentation in the medical record before invasive procedures, at transfer and during changes in level of care. The nurse shall also confirm this information is consistent with the knowledge of the patient, family members or other caregivers and what is in the patient’s chart. Errors are corrected immediately.

4. **Staff Education:** Staff education regarding color-coded wristbands will occur during the new orientation process and be reinforced as indicated.

5. **Patient Refusal:** If the patient is mentally competent and refuses to wear the color-coded wristband, an explanation of the benefits of wearing the color-coded wristband and the risks of not wearing the wristband will be provided to the patient. The nurse will reinforce that this is an opportunity to participate in the effort to prevent errors, and it is his/her responsibility as part of the team. The nurse will document in the medical record patient refusals, and the explanation provided by the patient. The patient will be requested to sign a Patient Refusal to Participate in the Wristband Process form.

6. **Surrogate Decision – Maker:** If the patient is not mentally competent, an appropriate surrogate decision maker will be selected to make decisions pursuant to hospital policy.
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**REFERENCES**

07_AHS Point of Care Testing (POCT) -- Personnel Responsibilities (July2023)
AHS POINT OF CARE TESTING – PERSONNEL RESPONSIBILITIES

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PURPOSE
To define the responsibilities of personnel performing point of care testing (POCT) throughout AHS.

POLICY
All POCT performed throughout AHS must comply with all elements specified in this policy and procedure.

DEFINITIONS:
1. Laboratory Director - The physician meeting the laboratory director requirements in 42 CFR 493, whose name appears on the laboratory service's CLIA certificate and is the Laboratory Director of record for the Centers for Medicare and Medicaid services. This is not to be confused with the job description title of "Director, Clinical Laboratory Operations" for the individual providing administrative oversight of the laboratory.

2. “Point of Care Testing” (POCT) is laboratory testing performed outside of the Clinical Laboratory for patient care. It is also referred to as “bedside”, “alternate site” or “near patient” testing.

PERSONNEL REQUIREMENTS
All POCT personnel must possess the necessary qualifications and licensure.

Licensure
1. For acute care inpatient units: only licensed personnel are able to render direct patient care and perform POCT.
2. For outpatient settings, unlicensed personnel are permitted to perform “waived” POCT if such testing is under supervision.
3. For any POCT requiring blood obtained via venipuncture (including fingerstick), any unlicensed person must possess a valid California Phlebotomy Certificate or equivalent.
Training

All test personnel (regardless of licensure status) must undergo initial training and assessment of competency at the time of initial training, six months after initial training when required, one year after initial training and annually thereafter, as defined below.

| Competency Assessment Frequency by Test Complexity and Regulatory/Accrediting Agency |
|-----------------------------------------------|------------------|------------------|------------------|------------------|
| Waived                                        | CLIA             | CALIFORNIA       | CAP              | TJC              |
| None                                          | None             | None             | Initial training | Initial training |
|                                               |                  |                  | Six months after | Annually          |
|                                               |                  |                  | initial training |                  |
|                                               |                  |                  | One year after   |                  |
|                                               |                  |                  | initial training |                  |
|                                               |                  |                  | Annually         |                  |
| Non-Waived                                    | Initial training | Initial training | Initial training | Initial training |
|                                               | Six months after | Six months after | Six months after | Annually          |
|                                               | initial training | initial training | initial training |                  |
|                                               | One year after   | One year after   | One year after   |                  |
|                                               | initial training | initial training | initial training |                  |
|                                               | Annually         | Annually         | Annually         |                  |
|                                               |                  |                  |                  |                  |

Abbreviations: CLIA, Clinical Laboratory Improvement Amendments: California, California Business and Professions Code, Division 2, Chapter 3; CAP, College of American Pathologists; TJC, The Joint Commission.

Initial Training
1. No one is allowed to perform instrument based POCT until after they have successfully completed initial training and demonstrated initial competency.

2. Each POCT has unique and specific initial training requirements defined by the lab.

3. Each POCT personnel shall complete the unique and specific initial training for each POCT they are expected to perform.

4. Initial training shall be documented.

5. Documentation of initial training shall be forwarded and maintained by the Point of Care Test Coordinator (POCC).

Competency Assessment
1. Competency must include all 6 elements at the time of initial training.
   a. Direct observations of routine patient test performance, including patient identification and preparation; specimen collection, handling, processing and testing.
   b. Monitoring the recording of test results, including as applicable, reporting critical results.
   c. Review of intermediate test results or worksheets, quality control records, proficiency testing results and preventive maintenance records.
   d. Direct observation of performance of instrument maintenance and function checks as applicable.
e. Assessment of test performance through testing previously analyzed specimens, internal blind testing samples or external proficiency samples
f. Evaluation of problem solving skills.

2. Competency assessment for non-waived testing shall be performed only by those meeting the CLIA and California regulations regarding qualifications for a Moderate Complexity Technical Consultant (i.e., licensure to perform high complexity testing in California or to practice medicine AND have two years of experience in moderate or high complexity testing in the specialty or specialties supervised).

3. All competencies shall be documented.

4. The 6 elements of competency assessment must be assessed for each individual on Each POCT.

5. Documentation of competency records shall be forwarded and maintained by the POCC.

**Proficiency Testing**
1. Each POCT personnel shall participate in external proficiency testing, when requested, for each POCT they perform.

2. Each POCT personnel shall perform testing on external proficiency specimen(s) as they would a patient specimen.

3. Documentation of who performed the testing and the test results shall be maintained.

4. If the tester obtains an unacceptable result, they shall undergo retraining.

**Patient Testing**
1. All patient testing shall be performed in accordance with the Policy and Procedures governing the specific POCT.

2. All relevant information for each specific POCT shall be documented (e.g., patient name, date and time of testing, test result, results of internal or external controls, etc.).

3. Each POCT person is responsible for notifying a supervisor on the patient care unit, the master trainer (see below) and/or the POCC if there is an issue with any POCT.

**Quality Control (QC)**
1. Quality control testing shall be conducted and documented for each POCT as specified in the specific POCT policy and procedure.
2. External liquid quality control materials shall be analyzed at the frequency specified in each specific POCT policy and procedure.

3. The temperature (and humidity when relevant) of the environment where POCT supplies are stored shall be regularly monitored and documented.

**POCT Program Organizational Structure**

1. **Overall Authority:**
   The Laboratory Director has the ultimate authority and responsibility for POCT.

   The POCT program links the Laboratory Director to each patient care POCT site via the Point of Care Coordinator and a network of Master Trainers (i.e., unit-based POCT liaisons; see below).

2. **Point of Care Coordinator (POCC):**
   The POCC is the Laboratory Director’s liaison to each POCT site. The POCC is based in the Clinical Laboratory.

   The POCC responsibilities include (but are not limited to):
   a. Knowledge of and competency in all POCTs
   b. Performing validation studies; Linearity checks, calibration, and imprecision studies on new instruments before deployment to the POCT site.
   c. Periodic quality checks, calibration, linearity and correlation studies on POCT instruments as applicable.
   d. Troubleshooting broken or non-functioning POCT analyzers.
   e. Training of all patient unit-based master trainers or designees
   f. Review of electronic POCT results and monthly receipt and review of all paper QC and environmental (e.g. temperature, humidity) logs.
   g. Completion of a monthly QA report to the Director, Clinical Laboratory Operations or designee for each POCT unit.
   h. Implementation of corrective action for unacceptable results.
   i. Oversight, review and maintenance of comprehensive and current AHS POCT employee competency records.
   j. Certification of employees in the POCT data management system who have completed their initial and/or annual competencies.
   k. Identification of and follow-up for site-specific POCT deficiencies.
   l. Maintenance of all relevant POCT documentation, including updating procedures when applicable.
   m. Provides collaboration and coordination activities to ensure appropriate inventory and use of POCT supplies.
   n. Communication from specific POCT sites to the Laboratory Director of any relevant POCT issue(s).
   o. Distribution of external proficiency testing specimens, collection of results from
individual POCT sites, and submission of results to the providing agency for evaluation.
p. Implementation of corrective action for unacceptable proficiency test results.

**Master Trainers:**
1. Each AHS campus or patient care unit shall have a designated “master trainer” to serve as the liaison with the Clinical Laboratory.

2. For ‘waived’ tests, each master trainer (or designee) shall be responsible for initial training, initial competency assessment, competency assessments at six months and one year after initial training, and annual competency assessment.

3. Each master trainer/designee shall assure documentation of all POCT related matters.

4. Each master trainer/designee shall assure POCT supply inventory is within expiration and has an adequate amount to sustain the unit.

5. Each master trainer/designee shall assure acceptable supply storage requirements (e.g. temperature, humidity) and act timely when storage conditions are out of range (e.g. relocate supplies when temperatures are out of range, notifies engineering of rising/lowering temperatures)

6. Each master trainer/designee shall maintain all POCT records for three years.

7. Each master trainer/designee shall assure that QC records are reviewed weekly and the review documented.

8. If QC issues are identified, each master trainer/designee shall collaborate with the lab POCC to assure that corrective action is taken and documented.

9. The POCC and the Clinical Laboratory are available as resources for troubleshooting POCT.

10. The master trainer/designee shall submit all POCT documentation (e.g., temperature monitoring, QC logs, patient test logs) monthly to the POCC for review by the 10th of the following month.

11. Each master trainer/designee shall assure that any documentation deficiency (ies) noted by the POCC is addressed with a corrective action plan.

12. Failure to correct the noted deficiency (ies) in a reasonable amount of time will result in POCT privileges being removed from the patient care unit.

**REFERENCES**
1. “Point of Care Testing (POCT) at AHS”, available on the AHS intranet.

3. Clinical Laboratory Improvement Act and Amendments, Federal Register. Available at: [http://www.ecfr.gov/cgi-bin/text-idx?SID=1248e3189da5e5f936e55315402bc38b&node=pt42.5.493&rgn=div5](http://www.ecfr.gov/cgi-bin/text-idx?SID=1248e3189da5e5f936e55315402bc38b&node=pt42.5.493&rgn=div5) (accessed 09/25/2020)


### APPROVALS

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AHS POINT OF CARE TESTING (POCT)

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

PURPOSE
To assure that all laboratory tests for patient care at AHS, regardless of where performed and by what methodology:
1. Are performed by trained and qualified personnel

2. Yield the same result as if the specimen had been tested in the central Clinical Laboratory (reference method, and to comply with the “single standard of care”; The Joint Commission, TJC), and

3. Comply with Federal (Clinical Laboratory Improvement Amendments of 1988, or CLIA ’88), State of California (Business and Professions Code, Division 2, Chapter 3) and Clinical Laboratory accrediting organizations (i.e., TJC; the College of American Pathologists, CAP).

DEFINITIONS
1. CLIA - Clinical Laboratory Improvement Amendments

2. Laboratory Director - The physician meeting the laboratory director requirements in 42 CFR 493, whose name appears on the laboratory service's CLIA certificate and is the Laboratory Director of record for the Centers for Medicare and Medicaid services. This is not to be confused with the job description title of "Director, Clinical Laboratory Operations" for the individual providing administrative oversight of the laboratory.

3. “Point of Care Testing” (POCT) is laboratory testing performed outside of the Clinical Laboratory for patient care. It is also referred to as “bedside”, “alternate site” or “near patient” testing.

POLICY
All POCT is performed under the licensure, oversight and supervision of the Clinical Laboratory.
1. The Laboratory Director is responsible for all POCT occurring at AHS.

2. Only qualified and trained personnel conduct POCT at AHS.
a. The Laboratory Director establishes the training, competency and proficiency requirements for the individual POCTs.
b. Training, competency and proficiency requirements are compliant with regulatory, accreditation and licensing requirements.

3. The Laboratory Director shall approve all POCT sites, personnel, reagents, test kits, devices and equipment.

4. Any Medical Director or Director/Manager at AHS whose unit performs POCT, including Medical Directors who hold State and CLIA licenses or certificates to operate a clinical laboratory independent of the AHS Clinical Laboratories, are responsible for adherence to the standards set forth in this policy.

PROCEDURE
Responsibilities of the Laboratory Director
1. The Laboratory Director, in consultation with various AHS subject matter experts as needed, is responsible for reviewing, recommending and approving all POCT.

2. The Laboratory Director or authorized designee:
   a. Provides expert advice and information for POCT, including but not limited to,
      i. identifying alternatives to various POCT,
      ii. determining criteria for medical necessity for POCT,
      iii. identifying procedures for adopting and implementing POCTs, and
      iv. establishing quality systems to assure accuracy of POCT results.
   b. Reviews all requests for POCT
   c. Recommends and approves all instruments, devices, procedures, reagents, materials and kits used in POCT, including
      i. new lots of previously approved reagents, and
      ii. supplies and new versions of any established POCT.
   d. Establishes and/or reviews procedures for all approved POCT, including relevant quality systems approaches and quality assurance issues.
   e. Collaborates with the Medical Staff, Nursing Services, Nursing Education and Training, Pharmacy and other areas as necessary in the training of individuals designated as trainers and supervisors of the personnel selected to perform POCT.
   f. Conducts periodic reviews of POCT performance, including regular monitoring for compliance with established guidelines.
   g. Distributes, as required, proficiency test specimens to each POCT site authorized to perform POCT.
   h. Conducts periodic inspection of the POCT sites for compliance with regulatory requirements.
   i. Monitors utilization of all POCT, including communication with each POCT site to recommend methods to improve efficiency and patient care/safety.
   j. Maintains a current master list of all testing sites performing POCT.
3. The Laboratory Director, in consultation with the requesting POCT site, approves which POCT can be performed as part of the nursing assessment process.

**Requesting POCT Privileges**

POCT privileges must be requested from and approved by the Laboratory Director, including:

1. Expansion of POCT already existent at AHS to a new POCT site

2. Introduction of any new POCT not currently available at AHS

**POCT Personnel and Site Requirements**

1. Only those personnel qualified to perform POCT, in accordance with Federal and State regulations and accrediting organization requirements, shall be allowed to perform POCT.

2. Prior to performing POCT, each test personnel must be trained and deemed competent. Refer to the separate Policy and Procedure “Point of Care Testing (POCT) Personnel Responsibilities” for personnel qualifications, training requirements and competency assessments.

**POCT Policies and Procedures**

1. The Clinical Laboratory is responsible for developing and maintaining the Policy and Procedure for each POCT.

2. The POCT site is responsible for adhering to the POCT Policy and Procedure for each POCT performed at that site, including but not limited to,
   a. Adhering to all elements and requirements in the separate Policy and Procedure “Point of Care Testing (POCT) Personnel Responsibilities.”
   b. Documenting POCT patient results as specified in site-specific procedures.
   c. Providing billing information.
   d. Performing Quality Control (QC) as required by the Clinical Laboratory and stated in the Policy and Procedures for each individual POCT.
      i. Submitting all QC reports to the Clinical Laboratory on a monthly basis for review, retention and corrective action (if needed).
      ii. Retaining all QC logs for 3 years as required by California law.
   e. Participating in external proficiency testing (PT)
      i. Each POCT site shall participate in periodic external PT.
         - The Clinical Laboratory shall be responsible for ordering and receiving the external PT materials.
         - The POCT site shall be responsible for identifying and assigning trained personnel to perform the external PT.
         - Different test personnel in rotation shall perform the external PT.
         - All external PT shall be tested in the same manner as a patient specimen.
         - All external PT results shall be submitted in a timely fashion to the Clinical Laboratory.
         - The Clinical Laboratory shall monitor the performance of the external PT.
      ii. Should any POCT personnel fail external PT:
         - The Clinical Laboratory shall recommend a corrective action plan.
         - The POCT site is responsible for implementing the corrective action plan.
         - No patient testing shall occur until the corrective plan is successfully
completed.

f. The Clinical Laboratory shall suspend the POCT privileges for any POCT site not adhering to POCT Policies and Procedures.
   i. The POCT site must submit a corrective action plan in which the site shall demonstrate their ability to perform POCT as expected.
   ii. The site must demonstrate evidence of successful and sustained corrective action before POCT privileges are restored.

Materials Management
1. Orders only those POCT supplies approved by the Clinical Laboratory
   a. The Clinical Laboratory shall provide Materials Management with a list of approved POCT supplies (POCT “formulary”).
   b. Materials Management and the Clinical Laboratory shall collaborate on the optimal POCT supply ordering schedule to minimize POCT reagent expiration prior to use and maximize cost-effectiveness of existing POCT supplies.

2. Delivers new lots and/or shipments of POCT reagents, devices, kits and supplies (e.g., glucose strips, glucose liquid controls, urine dipsticks, urine pregnancy test kits, Amniotest Nitrazine Swabs, etc.)
   a. Clinical Laboratory shall perform or arrange performance of necessary Quality Control (QC) testing to assure the newly received POCT supplies perform as expected and in compliance with manufacturer’s specifications.
   b. POCT supplies shall be released to POCT sites for use only if QC is within acceptable range.
      i. If QC is outside of acceptable range, the Clinical Laboratory shall resolve the issue(s) with the manufacturer.

3. POCT sites shall obtain necessary POCT supplies by written request (requisition).

4. POCT supply costs shall be charged to the individual POCT sites via supply requisition reconciliation.

Compliance
1. All clinical sites performing POCT must adhere to the policies established by the AHS Clinical Laboratory.

2. All POCT testing must be performed in compliance with Federal (CLIA ’88), State and Accrediting agency regulations.

3. If a POCT is out of compliance for a given test or procedure, (e.g. unacceptable quality of test performance or lack of documentation of results as outlined by policy), the Laboratory Director or designee shall notify the POCT site for timely corrective actions to be implemented by the testing site.

4. If the out of compliance situation(s) continue(s), the Laboratory Director shall notify the appropriate Administrators for corrective action, including discontinuation of POCT as necessary.
REFERENCES

2. Clinical Laboratory Improvement Act and Amendments. Federal Register. Available at: [http://www.ecfr.gov/cgi-bin/text-idx?SID=1248e3189da5e5f936e55315402bc38b&node=pt42.5.493&rgn=div5](http://www.ecfr.gov/cgi-bin/text-idx?SID=1248e3189da5e5f936e55315402bc38b&node=pt42.5.493&rgn=div5) (accessed 07/26/2023)


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09_33350_4 Patient Informed Consent_update 08 10 2023
PURPOSE
This policy outlines the process for obtaining informed consent before providing medical procedures and treatments. The goal of the informed consent process / discussion is to provide patients or their surrogate decision maker the ability to understand all relevant and material information needed to make a voluntary, fully informed decision regarding a procedure or treatment. The purpose of the Patient Informed Consent policy is to 1) promote informed consent as a process of effective communication between a provider and patient regarding possible risks of invasive procedures and/or treatments 2) establish guidelines for obtaining and documenting informed consent.

POLICY STATEMENT
Alameda Health System (AHS) recognizes and respects the patient’s right to be involved in the decision-making of all aspects of their care and to be informed of the risks, benefits and alternatives to proposed procedures and treatments to assure informed decision- making. AHS complies with all California and federal regulations, accreditation requirements and court decisions in identifying individuals with the appropriate legal authority to consent to medical treatment.

DEFINITIONS
"Advance health care directive" means either an individual health care instruction or a power of attorney for health care.

"Capacity" means a person's ability to understand the nature and consequences of a decision and to make and communicate a decision, and includes in the case of proposed health care, the ability to understand its significant benefits, risks and alternatives.

"Informed Consent" is a process through dialogue between the patient or a surrogate decision
maker and a physician/resident or Advanced-Practice Provider (APP) during which the patient or their surrogate decision maker is provided information about the planned procedure/treatment and an opportunity to ask questions. The goal of this process and conversation is the understanding by the patient or their surrogate decision maker of the risks, benefits, and alternatives to the procedure/treatment under discussion and agreement by the patient or agent to proceed.

“Surrogate Decision Maker” Individual authorized to make healthcare decisions on behalf of patient when incapacitated (or at the patient’s request) by Advanced Directive, Health Care Power Of Attorney, patient’s verbal authorization, (Surrogate, Agent), judicial action (Conservator, Court appointed surrogate decision maker), or case law (closest available relative, next of kin).

“Material Risk” is significant risk that a reasonable person in the patient’s position would find essential for deciding whether to accept or reject the proposed medical procedure or treatment. Includes risks with a high degree of likelihood, but a low degree of severity, as well as those with a very low degree of likelihood, but high degree of severity.

PROCEDURE

I. GENERAL OVERVIEW

A. Procedures that Require an Informed Consent

Informed consent is required for complex and significant diagnostic, therapeutic or surgical procedures). Examples include, but are not limited to:
1. Surgical procedures in the operating room (excludes simple laceration repair) or other clinical setting
2. Invasive procedures involving skin incision or puncture associated with serious risks and the potential to cause harm or adverse reactions (excludes venipuncture, IV therapy)
3. Blood transfusions or use of other blood products
4. Planned use of moderate sedation
5. Anesthesia
6. Electroconvulsive therapy
7. Non-invasive treatments of a diagnostic or therapeutic nature associated with substantial risk of harm (i.e., chemotherapy, biologic therapy)
8. Consents required by law (i.e., genetic testing, HIV, tubal ligation).

If there is any doubt as to whether a procedure requires an informed consent, it is appropriate for the physician to conduct an informed consent conversation with the patient and obtain consent with documentation from the patient.

1. Special Procedures. Special consent must be obtained as required by law. Examples include, but are not limited to:
   - Aid-in-dying medication administration
• Antipsychotic medication administration
• Blood transfusion
• Collagen injections
• Convulsive therapy
• Fertility/infertility treatment
• Fetal ultrasound for keepsake purposes
• Hemodialysis filters — reuse of hemodialysis filters
• HIV test
• Hysterectomy
• Implantation of cells, tissues and organs
• Investigational drugs or devices
• Medical information — release of medical information
• Opioid prescription
• Organs, tissue or fluids — use of organs, tissue or fluids
• Pelvic examination on an anesthetized or unconscious female
• Prenatal ultrasound for keepsake purposes
• Psychosurgery
• Research on human subjects (IDs)
• Sexual assault evidentiary exam
• Silicone implants
• Sperm/ova/embryos — donation of sperm/ova/embryos
• Sterilization
• Telemedicine
• Transplants
• Vaginal birth after C-Section (VBAC) by a midwife

2. Consent for Serial or Multiple Procedures. A patient undergoing serial, multiple treatments or procedures — for example, a series of debridements — is not required to provide informed consent each time. The Informed Consent to Procedure documentation in the electronic health record (EHR) should indicate that it pertains to multiple treatment encounters to achieve the therapeutic goal and that this was discussed with the patient, and/or the patient's surrogate decision maker.

3. Duration of the Informed Consent. Informed consent may be considered to have continuing force and effect through the duration of the procedure or treatment plan for which the patient has consented, until the patient or surrogate decision maker revokes the consent or until the patient's condition changes significantly so as to materially affect the nature of, or the risks of the procedure and/or the alternatives to the procedure to which the patient has previously consented. In such a case the physician has a duty to update and explain the nature of the treatment, possible complications, and/or effects of the treatments, alternatives, risks and benefits to the patient.
B. Emergency Exception

Emergency Exception. When a patient lacks capacity to make a health care decision and immediate treatment is required to prevent death or serious disability or to alleviate severe pain, and a surrogate decision-maker cannot be contacted, treatment may proceed without an informed consent because it is an emergency.

1. Limits on Treatment That May be Provided. Under the emergency exception, the treatment is limited to that which is necessary to treat the emergency. Efforts must continue to be made to contact the surrogate decision maker. When the emergency medical condition has been addressed and treated, informed consent must be obtained for subsequent nonemergent complex, invasive procedures.

2. Documentation of the Emergency. The physician should carefully document the medical rationale that an emergency existed. The physician must document the emergency medical condition and immediate need for treatment in the medical record. Documentation by a single physician is sufficient to meet this requirement. In addition, all efforts made to identify and talk with the surrogate decision maker should be documented in the patient’s record.

3. Refusal of Treatment. The right to self-determination necessarily includes the right to refuse recommended treatment. If a patient, or the patient's surrogate decision-maker, refuses treatment, the physician shall be contacted immediately so that he or she can explain the reason for the treatment and the possible implications of not accepting the care. If a competent patient persists in refusing care, such wishes shall be respected. Similarly, if a minor is legally authorized to consent to treatment, the minor also has the legal authority to refuse treatment.

   a. If a surrogate decision maker is refusing care recommended for the patient, such as when an surrogate decision maker refuses care for an adult or parents refuse care for the minor child, the attending physician shall consider whether the surrogate decision maker is acting in the patient's best interests and carrying out the patient's desires and if not, whether a court order for care should be considered. A court order should be considered if there appears to be medical neglect of a child or dependent adult.

   b. Any refusal of care must be documented in the medical record and by having the patient, surrogate decision maker sign the "Leaving Hospital Against Medical Advice" document if the patient will be leaving the facility.
II. GENERAL OVERVIEW

A. Obtaining and Documenting Informed Consent

Physician or Advanced-Practice Provider (APP) Responsibilities for Obtaining Informed Consent.

Responsibility for the informed consent discussion primarily rests with the attending physician who orders, performs or is in charge of the procedure or treatment. The attending physician may designate another attending physician, APP or resident physician to obtain informed consent under the following conditions when that designee has sufficient knowledge of the risk, benefits and alternatives of the recommended procedure or treatment, and the risks and benefits of the alternatives.

1. Informed consent involves a detailed discussion with the patient or their surrogate decision maker regarding the following material information:
   a. Nature of the proposed care, treatment, and services
   b. Potential benefits, risks, and side effects of the proposed care, treatment, and Services
   c. Likelihood of achieving goals
   d. Potential problems that might occur during recuperation
   e. Reasonable alternatives
   f. Risks, benefits and side effects related to the alternatives
   g. Risks related to not receiving the proposed care, treatment and services (informed refusal)
   h. Advanced-practice providers, another attending physician or residents may be performing important tasks related to the surgery, in accordance with hospital policy, based upon skill set, level of competence and under supervision of the responsible physician.
   i. Non-Physician, qualified medical practitioners may perform the procedure, important parts of the procedure or administration of anesthesia as licensed or credentialed to perform (i.e., CRNAs, PICC RN)
   j. Potential conflicting interest the physician may have, such as research or financial interests.

2. Overlapping Surgery. The attending surgeon or surgeon of record will inform the patient or surrogate decision maker of the potential for an overlapping surgery.
   a. The attending surgeon or surgeon of record will be present during key or critical portions of the procedure or surgery and in some circumstances, may participate in another operation following the key or critical portions of surgery.
   b. In this circumstance, the attending surgeon or surgeon of record will be immediately available or will ensure another qualified physician is immediately available.

3. The attending physician may delegate other health care practitioners (i.e., residents, nurse practitioners, physician assistants, CRNA, PICC RN) to provide patients with additional information that will serve to augment, but not substitute for the informed consent.
discussion.

4. **Questions or Concerns.** The physician/resident or APP is responsible for providing information if a patient or Agent/Surrogate expresses confusion, or requests clarification or additional information.

**Documenting Informed Consent.** The physician/resident or APP must document that informed consent has been obtained in the Informed Consent for Procedure document within the electronic health record or on a paper when necessary (i.e. downtime). In the case of an emergency exception, the physician must document in the medical record the circumstances necessitating emergency care and the probable result if treatment had been delayed or not provided. So as not to delay the delivery of emergency care, this documentation can be completed after the procedure.

**B. AHS Staff Responsibilities**

**Pre-Procedure Verification.** Hospital Staff/Nursing verifies that the provider obtained informed consent is documented in the medical record or on the Informed Consent for Procedure document. IF the patient has not previously signed their portion of the consent, staff will pull up the consent document for the patient (or their agent/surrogate) to sign as verification that they had an informed consent discussion with the provider and wish to proceed with their procedure/treatment. If the patient states they have any questions or concerns, staff must contact the provider so they can speak with patient. Until the informed consent process is completed and documented the procedure/treatment will not proceed.

**Witness.** There are specific instances when a witness is required. 1) When the patient is unable to sign their name or 2) When a Telephone Consent is used because an surrogate decision maker is not physically available to sign the Informed Consent document.

- The witness *(any member of the AHS staff that is not part of the procedural team)* is expected to confirm the identity of the patient using two patient identifiers if the patient is unable to sign their name and/or they sign the consent with an alternative signature, i.e. “X” or other mark.
- The witness should be present when the **Informed Consent obtained by telephone document** is signed by the patient’s provider and the patient’s legal representative.
- The witness should indicate that they observed the signing by entering their full name and placing their signature in the designated spaces on the Informed Consent document.

**C. Methods of Recording Signatures**

1. **Signatures.** *Informed Consent for Procedure document* must be signed, dated, and timed by the patient. When a person other than the patient signs the form, the relationship of the person to the patient (i.e., parent, guardian, or conservator) must be noted on the document. If the person is an Agent appointed pursuant to an **Advance Directive** or a **Durable Power of Attorney for Health care**, or a **Conservator or Guardian appointed by the Court**, the person should be asked to provide a copy of the papers establishing that relationship to be placed in the chart or provide a verbal delegation

- A person may verbally appoint a person (“surrogate”) to make their health care decisions by personally informing their attending provider
• The provider **must document this notification** in the patient’s medical record, including the name of the patient’s “verbally authorized surrogate”, stated relationship and date of notification.
• This appointment is only effective during the course of treatment, illness, or the inpatient encounter.
• *Note: An oral designation of surrogate supersedes a previous written directive.*

2. **Signature Alternative.** If the patient is not able to write his or her name, a mark may be used (e.g., "X"). The Patient's full name must be printed by a hospital representative and read out loud to the patient prior to the “X” signature. The patient must be instructed, to the extent possible, to place an "X" mark above or next to the printed name. Below the patient's mark, note the reason for the "X" mark. The hospital representative must witness the mark and sign the form as a witness.
• When the patient is signing to verify their consent, they can e-sign or physically sign with their full name or an alternative mark, if they prefer.
• AHS staff is required to witness the alternative marking and complete the appropriate pre-procedure identification of the patient using two patient identifiers for the procedure/ treatment, and then documenting the patient verified their identity and consent.

D. **Use of Interpreter Services**

1. **General Principle.** If Informed Consent is to be obtained from an individual who is not fluent in English, services of a qualified interpreter must be made available. If a document (e.g., *Informed Consent for Procedure document*) has not been translated into a language the patient understands, and time does not permit a written translation, the interpreter may orally translate the form for the patient and ask the patient to sign the English form if the patient agrees to the terms and conditions that the interpreter orally stated. If the interpreter is not present, the provider or staff present shall enter a note in the patient's record indicating who provided the interpretation and the date and time and mode of interpretation/translation (VMI, Phone). Please refer to "Interpreter Policy of Quality Assurance, Informed Consent and Use of Technology 7186-1".

2. **Documenting the Use of Interpreter Services.** If professional interpreter services are used, document service name and operator number (i.e., AT&T, #XXXXX) in the space allocated on the Informed Consent for Procedure document. **ALL** uses of interpreter services must be documented in the patient's medical record.

3. **Qualified Bilingual Staff (QBS).** QBS Level II (Provider) staff are permitted to perform interpretation and obtain Informed Consent per the AHS Language Services Policy. These providers have passed the Clinician Cultural and Linguistic Assessment (CCLA) and interpretation for the purpose of obtaining Informed Consent is within their scope of practice. The provider’s full name and QBS Level II should be entered in the designated spaces on the *Informed Consent for Procedure document.*

E. **Procedural Informed Consent by Telephone, Email and or Facsimile (Fax)**
1. It may be necessary to obtain consent from a patient’s family member, agent/surrogate
or other surrogate decision maker who is not physically present at the Hospital, but
only when ABSOLUTELY NECESSARY will this exception be allowed.

   a. In such cases, the information that would be conveyed to the decision-maker if they
were present in the Hospital (i.e., risks and benefits, alternatives and their risks and
benefits, the consequences of refusing the treatment, and any potentially conflicting
interest the physician or APP may have) must be conveyed using alternative means.

   b. If consent is given by telephone, email or facsimile, the conversation between the
physician/resident or APP and the patient or their agent/surrogate must be
witnessed by an AHS staff member (not part of the procedure team) and be
documented in the medical record.

F. Documentation of Consent By Alternative Methods

1. Telephone. The best method is a telephone conversation that allows a full discussion of
the information. If a telephone is not available, alternatives should be used such as
email or facsimile

   a. If consent is given by telephone, the physician/resident or APP should follow the
standard workflow for obtaining Informed Consent. When a physician or APP
conveys information via telephone, one AHS staff member shall participate in the
conversation as a witness for the purpose of listening to the conversation.

   b. The physician/resident or APP conducts the telephone discussion of Informed
Consent and documents the date and time of the conversation as well as what
information was conveyed in the appropriate section of the Informed Consent for
Procedure indicating consent was obtained by telephone.

   c. Staff verifies that the provider obtained informed consent and documented the
discussion in the Informed Consent for Procedure document “telephone consent”
section.

   d. Staff enter their full name and place their signature in the designated spaces on the
Informed Consent for Procedure document, also including that it was a telephone
consent.

   e. When consent is obtained by telephone, the consent should be documented, to the extent
possible, in a form sent to the surrogate decision maker by secure email. The appropriate
written information sheets concerning the recommended procedure and alternatives, plus all
of the consent forms that would routinely be completed for the procedure (usually including
at a minimum the "Conditions of Admission" and the "Informed Consent for Procedure")
shall be sent via secure email to the decision-maker for review and signature, with the
executed copy to be returned by facsimile or email.

   f. In addition, if the person has access to a facsimile or email, any written information
sheets concerning the recommended procedure and alternatives, plus all of the
consent forms that would routinely be completed for the procedure (usually
including at a minimum the "Conditions of Admission" and the "Informed Consent
for Procedure") shall be sent to the decision-maker for review and signature, with the executed copy to be returned by facsimile or email.

g. If the surrogate decision maker does not have access to a facsimile machine or e-mail, the physician or APP and nurses may document that consent was verbally provided in the patient's record.

2. **Email.** If consent is obtained by email, the responsible physician/resident or APP should make the request for informed consent by sending an email stating, to the extent practical, the reasons for and nature of procedure, the risks and benefits, the alternatives, and any potentially conflicting interest the physician/resident or APP may have. A copy of the email should be placed in the patient's medical record.

3. **Facsimile.** Only as a last resort and at the specific request of a surrogate decision maker is a facsimile used to obtain consent. A direct discussion by telephone with the patient's surrogate decision maker should generally be possible and the requirements above, under "Telephone" apply.

**MISCELLANEOUS**

**AHS Ethics Committee.** The Hospital will establish a multi-disciplinary committee as a subcommittee of the Ethics Committee and delegate to it the responsibility of acting as a surrogate decision maker for patients lacking capacity and without a legal surrogate decision maker. In acting as a surrogate decision-maker for the patient without capacity, the committee shall strive to ascertain what the patient's wishes are and to effectuate those wishes. The committee shall obtain the information that is required to be conveyed to the patient by the physician. In addition, the committee shall consult legal counsel and risk management to determine when to initiate a court proceeding for appointment of a conservator or Surrogate.

**Dispute among Surrogates.** If the people with equal decision-making priority disagree about health care decision, the case shall be referred to AHS's Ethics committee. The attending physician may act in accordance with the recommendation of the Ethics Committee or may contact the office of the General Counsel for possible guardianship proceedings.

**Minors.** In general, parents have a legal obligation to make health care decisions for a minor lacking legal authority to make their own health care decisions. Minors may consult for their own medical care if emancipated and under certain conditions, i.e., pregnancy, STDs, etc.

**REFERENCES**

1. California Hospital Association - Consent Manual 2022
2. The Joint Commission, 2023 Comprehensive Accreditation Manual for Hospitals, “Rights and Responsibilities of the Individual”; RI.01.03.01
3. 42 Code of Federal Regulations: §50.202-210; §482.24 (c)(2)(v); §482.51 (b)(2); §482.13(b)(2)
4. California Code of Regulations (CCR) Title 22, §70707.1 through §70701.
August 23, 2023

TO: Quality Professional Services Committee

FROM: Lan Na Lee, M.D., Alameda Health System Chief of Staff
      Nikita Joshi, M.D., Alameda Hospital Chief of Staff

SUBJECT: Agenda Item: B3

Meeting Date: August 23, 2023

Item Description: Medical Staff Policies, Procedures and Form- AHS and AH

COMMITTEE ACTION: Recommend Approval of Medical Staff Policies, Procedures & Forms

Background:
The Alameda Health System (AHS) and Alameda Hospital (AH) Medical Staff align policies, and procedures to provide continuity across the two Medical Staffs. The Medical Staff policies provide alignment of credentialing and privileging processes by offering a systematic approach to assessment across our facilities.

The medical staff form is one of the forms used in the application process for providers who are applying for membership and/or privileges on the AHS or AH Medical Staff.

Analysis:
The Alameda Health System (AHS) and Alameda Hospital (AH) Medical Staff policies align with the Bylaws and are key to the operational functions and compliance with regulatory requirements.

Prior Board Action: n/a

Board Action Requested:
Approval of the following AHS and AH Medical Staff policies:
   • Medical Staff Evaluation of Actions Related to Providers
   • Medical Staff Delegated Credentialing Policy
   • Medical Staff Moonlighting Practitioners

Approval of the following AHS and AH Medical Staff form:
   • Delegated Credentialing Information Release / Acknowledgement

Fiscal Impact: n/a

Budgeted/Authorized: n/a

Estimated Cost Savings: n/a

Strategic Plan Pillar: n/a
Alameda Health System

MEDICAL STAFF EVALUATION OF ACTIONS RELATED TO PROVIDERS

<table>
<thead>
<tr>
<th>Department</th>
<th>AHS Medical Staff</th>
<th>Effective Date</th>
<th>3/2022</th>
</tr>
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<tbody>
<tr>
<td>Campus</td>
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<td>Date Revised</td>
<td>8/2023</td>
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<td>Unit</td>
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<td>Next Scheduled Review</td>
<td>8/2026</td>
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<tr>
<td>Manual</td>
<td>Medical Staff</td>
<td>Author</td>
<td>Director of Medical Staff Services</td>
</tr>
</tbody>
</table>

Replaces the following Policies: Responsible Person Chief of Staff

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

Purpose
This policy describes the ongoing monitoring process the Alameda Health System (AHS) and Alameda Hospital (AH) Medical Staffs follow, when there are alerts related to a member of the Medical Staff/Advanced Practice Providers, by establishing a systematic process for reviewing and evaluating the reports.

Policy Statement
Alameda Health System conducts ongoing monitoring and review of any California Medical Board Notification of Actions Relating to the License or Practice of Physicians and Surgeons and the Continuous Query (QC) reports from the National Practitioner Databank (NPDB) and reports from providers of the events listed in the Medical Staff Bylaws Section captioned “Basic Responsibilities of Medical Staff.”

The ongoing review process is designed to ensure allegations and reports are reviewed timely, objectively and that actions taken are considered and instituted where appropriate to comply with the Medical Staff Bylaws and to maintain safety of care delivered to patients. Any data or information as part of the medical staff oversight and review process, are protected by California Evidence Code section 1157. Pertinent information identified in the review process shall be factored into decisions regarding what actions will be taken.

Procedure
1. Providers are required to notify the Medical Staff in writing of within seven (7) days of any of the events listed in the Medical Staff Bylaws Section captioned “Basic Responsibilities of Medical Staff.” The foregoing includes, but is not limited to, events related to their licensure, certification, registration, loss of membership, restriction or denial of privileges, employment, inability to provide care for more than 30 days, liability insurance, participation in federally funded health care organizations, professional liability suits, mental/physical health, felony or misdemeanor.

2. Medical Staff receives and reviews the California Medical Board proactive disclosure notifications of actions and NPDB CQ report which may be acquired through, but not limited to, information from the following sources:
a. Automated emails from the Medical Board of California subscription (MBC-ACTIONS@SUBSCRIBE.DCALISTS.CA.GOV)
b. NPDB CQ Reports

3. If the action triggers an automatic action, such as an automatic termination, suspension or restriction of membership and/or privileges under the Medical Staff Bylaws, the automatic action shall be immediately imposed in accordance with the Bylaws.

4. Reports related to a current Medical Staff Member, privileged provider or Advanced Practice Provider will be sent to the Department Chair/Division Chief (if applicable) along with any notice from the physician, documentation available on the licensure site and information reported to the NPDB.

5. The Division Chief (if applicable)/Department Chair (if no Division Chief) is required to review what is reported. Based upon the review, the Department Chair/Division Chief will assess if further information is required from the provider. If further information is required, the provider will be sent a letter that requires the additional information. The response will be reviewed by the Department Chair/Division Chief (if applicable). Upon completing review of what is reported and any response, the Department Chair/Division Chief (if applicable) will complete an Action Assessment Form (Attachment A to document their review of the report and recommend next steps.)

6. If the Chief/Chair is uncertain how to address a situation, the Chief/Chair may refer information to Credentials and/or Medical Executive Committee for further review and recommendation.

7. Documentation related to the report will be maintained in the provider’s credentialing file.

**Approvals**

<table>
<thead>
<tr>
<th>Bylaws Committee</th>
<th>AHS Core: 6/28/23</th>
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<tr>
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<td>Date: 8/10/23</td>
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<tr>
<td>Medical Executive Committee</td>
<td>Date: 8/11/23</td>
</tr>
<tr>
<td>QPSC</td>
<td>Date:</td>
</tr>
</tbody>
</table>
Attachment A

Alameda Health System Medical Staff Action/Allegation/Accusation Assessment Form

Date: _____________________

Provider Name: ________________

Report of action/allegation/accusation made by or received from: ________________________________

Reported on: ___________________________________________________

Brief summary of report: ____________________________________________

Division Chief (if applicable)/Department Chair Recommendation:

As Chair of the Provider’s Department or Division Chief, I have reviewed the reported action/allegation/accusation and recommend the following:

☐ No action at this time.
☐ Track/Trend and/or monitor for final outcome.
☐ Request additional information from the provider.
☐ Refer to QRC/Peer Review.
☐ Initiate FPPE.
☐ Refer to Well-Being Committee
☐ Limit/restrict privileges and/or membership (refer to MEC)
☐ Refer to Credentials Committee and/or Medical Executive Committee for further review/recommendation.
☐ Other

Explanation/details supporting the above recommendation(s):

_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

______________________  ___________________________      ____________
Name     Signature    Date

This is a quality improvement/peer review document of the hospital. It includes privileged and confidential information which is protected from disclosure pursuant to California Evidence Code, Section 1157 and other provisions of state and federal law.
Alameda Health System

MEDICAL STAFF DELEGATED CREDENTIALING POLICY

<table>
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<th>Department</th>
<th>Medical Staff</th>
<th>Effective Date</th>
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<td>Campus</td>
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<td>8/2026</td>
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<tr>
<td>Manual</td>
<td>Medical Staff</td>
<td>Author</td>
<td>Director, Medical Staff Office</td>
</tr>
<tr>
<td>Replaces the following Policies:</td>
<td>Responsible Person</td>
<td>Chief of Staff</td>
<td></td>
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Purpose

As an extension of the Alameda Health System (AHS) and Alameda Hospital (AH) Medical Staffs Bylaws to establish mechanisms for delegated credentialing regarding credentialing and privileging of licensed independent practitioners and advanced practice providers who provide patient care services at Alameda Health System and/or Alameda Hospital.

Policy

It is the policy of the AHS and AH Medical Staff to support delegated credentialing via contractual arrangements between Alameda Health System and payers and health plans who are deemed a peer review body under BPC Section 805(a)(1)(B)(ii). The Medical Staff data or information as part of the credentialing process, is protected by California Evidence Code section 1157. Dissemination of such information and records shall only be made where expressly required by law, to other peer review bodies for peer review purposes, pursuant to officially adopted policies of the Alameda Health System Medical Staff and Alameda Hospital Medical Staff.

Procedure

The Medical Staff Credentialing and Privileging of Practitioners policy and procedure describes the mechanisms regarding credentialing and privileging of licensed independent practitioners and advanced practice providers who provide patient care services at Alameda Health System and/or Alameda Hospital.

The AHS and AH Medical Staffs Credentialing Systems Controls policy and procedure describes the ongoing monitoring process for storing, modifying and securing credentialing information.

Access to medical staff records shall be limited to duly appointed officers and committees of the medical staff for the sole purpose of discharging medical staff responsibilities and subject to the requirements that confidentiality be maintained in accordance with Medical Staff bylaws, rules and policies.

The Medical Staff applications include consent in the form of an Information Release / Acknowledgement which authorizes release of information to third party payors, health
plans and other providers for the purposes of provider credentialing and enrollment, and billing and collections on behalf of Alameda Health System and its providers.

The Medical Staff will provide relevant credential file documentation via an electronic means as described in the delegation agreement. Data may be provided via:

- A secure electronic file transfer system.
- Secure E-mail
- Live interface, i.e., Zoom or TEAMS

Credentialing documentation will be restricted to data that is necessary to confirm compliance with National Committee for Quality Assurance (NCQA) standards for delegated credentialing.

In addition to complying with The Joint Commission accreditation standards, State and Federal regulations related to credentialing and privileging, the credentialing infrastructure is designed to align with the National Committee for Quality Assurance (NCQA) and to comply with regulatory requirements and align with national standards for delegated credentialing as outlined in any Alameda Health System delegation arrangement. The key elements, benefits and efficiencies for Health Plan / Provider Credentialing include and are not limited to the following:

- Reduce and improve payer enrollment timelines
- Physician Productivity including generation of RVUs earlier after hire
- Reduce loss of and delayed revenue
- Decrease paperwork for practitioners and staff

The AHS and AH Medical Staffs credentialing program includes the following standards:

- Governance including Medical Staff Bylaws, Policies and Procedures
- Internal Quality Improvement Process
- Credentials Committee
- Credentialing & Recredentialing Verifications
- Assessment of network providers and licensed independent health care professionals
- Quality Review / Peer Review and Ongoing Monitoring under BPC Section 805(a)(1)(A) Permitted disclosure “to other peer review bodies for peer review purposes
- Confidentiality of credentialing/recredentialing information without health care provider’s written permission or as required by law

**Approvals**

<table>
<thead>
<tr>
<th>AHS &amp; AH Credentials Committee</th>
<th>Date: 8/10/23</th>
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<tbody>
<tr>
<td>AHS Medical Executive Committee</td>
<td>Date:</td>
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<tr>
<td>AH Medical Executive Committee</td>
<td>Date: 8/11/23</td>
</tr>
<tr>
<td>Board/QPSC</td>
<td>Date:</td>
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# Alameda Health System

## MEDICAL STAFF MOONLIGHTING PRACTITIONERS

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<td>Manual</td>
<td>Medical Staff</td>
<td>Author</td>
<td>Director, Medical Staff Services</td>
</tr>
</tbody>
</table>

Replaces the following Policies:

| Responsible Person | Chief of Staff |

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

### Purpose

To define the process for satisfying the requirement of a resident (“moonlighting practitioner”) applying for Medical Staff membership and privileges at Alameda Health System (AHS) and/or Alameda Hospital (AH).

### Policy

Residents currently enrolled in an Accreditation Council for Graduate Medical Education (ACGME) or American Osteopathic Association (AOA) approved training program may provide services at AHS and/or AH outside of that training program, thereby waiving the qualifying criteria of a completed residency program, if certain requirements are satisfied. Further qualifications for training, experience and current competence of residents will be department-specific, defined further by each clinical service/department, and approved by their Program Director.

Residents approved by their program director to moonlight must ensure that moonlighting does not interfere with their ability to achieve the goals, objectives, assigned duties and responsibilities of their training program and must not interfere with their fitness for work nor compromise patient safety. Residents in ACGME-accredited training programs are responsible for complying with the ACGME program requirements, which requires that all moonlighting hours count towards total duty hours. Accordingly, it is the responsibility of their Program Director to approve moonlighting activities only if these activities comply with ACGME regulations.

### Procedure

1. All residents applying for Medical Staff membership and clinical privileges shall be subject to the following:
   a. maintain a current California Physician’s and Surgeon’s license from the California Medical Board;
   b. meet the requirements of the Medical Staff Bylaws, Article 4 Appointment to the Medical Staff, and Article 5 Exercise of Clinical Privileges;
   c. be approved by the Department Chair and their Program Director prior to release of an application;
d. provide a confirmation of good standing letter from their Program Director approving “moonlighting” at AH and/or AHS, and attesting to the resident’s training, experience and current competence to perform privileges requested with an attending provider back-up remotely; and

e. be minimally in their final year of training in their training program, unless special circumstances exist which justify allowing the participation of a PGY 3 resident.

2. Focused Professional Practice Evaluation (FPPE) / Proctoring
   a. Completion of routine FPPE/Proctoring for any resident applicants who will be a “moonlighting practitioner” should be completed within 30 days of their first clinical shift worked.

3. Supervision Requirements
   a. The Clinical Service where the resident is applying for privileges must ensure adequate supervision, oversight and maintain ultimate responsibility of the clinical care to ensure that patient quality and patient safety are not compromised. Supervision will be defined by each Clinical Service in consultation with the Program Director and/or Institutional DIO, and shall be subject to final approval by the Graduate Medical Education Committee.
   b. At a minimum, an attending provider must be available by telephone at all times and be available to come onsite if needed during each shift covered by a moonlighting practitioner.
   c. A department designee will review documentation and care provided by moonlighting resident to make sure appropriate clinical care was given during moonlighting resident’s shift.

4. Upon verification of completion of residency program, the practitioner will no longer be considered a moonlighting practitioner.

Approvals

<table>
<thead>
<tr>
<th>Credentials Committee</th>
<th>AHS</th>
<th>AH</th>
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<td>Graduate Medical Education Committee</td>
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<tr>
<td>QPSC</td>
<td>Date:</td>
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</table>
I hereby consent to the disclosure, inspection and copying of information and documents relating to my credentials, qualifications and performance (“credentialing and peer review information”) by and between “this Healthcare Organization” and other Healthcare Organization (e.g., hospital medical staffs, medical groups, independent practice association (IPAs), health plans, health maintenance organization (HMOs), preferred providers organization (PPOs), other health delivery systems or entities, medical societies, professional associations, medical school faculty positions, training programs, professional liability insurance companies (with respect to certification of coverage and claims history), licensing authorities, and businesses and individuals acting as their agents (individually and collectively, “other Healthcare Organization”), for the purpose of evaluating my professional training, experience, character, conduct and judgment, ethics and ability to work with others. I understand that this Healthcare Organization is part of a system of affiliated hospitals and facilities and I agree that they may exchange credentialing and peer review information and that care shall be taken to safeguard the privacy of patient and the confidentiality of patient records.

I am informed and acknowledge that federal and state laws provide immunity protections to individuals and entities for their acts and/or communications in connection with evaluating the qualification of healthcare providers. To the maximum extent permitted by law, I hereby release all persons and entities, including but not limited to this Healthcare Organization, which includes but is not limited to its medical staff, its agents and representatives, engaged in quality assessment, peer review and credentialing on behalf of this Healthcare Organization, from any liability they might incur for their acts and/or communications in connection with evaluation of my qualifications for membership and privileges and all persons and entities providing credentialing and peer review information to such representatives of this Healthcare Organization.

I understand that I shall be afforded such fair procedures with respect to my participation in this Healthcare Organization as may be required by state and federal law and regulation, including but not limited to, California Business and Professions Code Section 809 et seq, if applicable.

I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubt about such qualification. During such time as this application is being processed, I agree to update the application should there be any change in the information provided. In addition, any time after having been granted clinical privileges or membership, I agree to update this Healthcare Organization of any changes in information provided that may affect my continued qualifications for such clinical privileges or membership.

In addition to any notice required by any contract with this Healthcare Organization, while this application is pending and at any time after having been granted membership or privileges:

- I agree to notify this Healthcare Organization immediately in writing of the occurrence of any of the following: (i) the unstayed suspension, revocation or nonrenewal of my license to practice medicine in California; (ii) any suspension, revocation or nonrenewal of my DEA or other controlled substances registration; or (iii) any cancellation or nonrenewal of my professional liability insurance coverage.
- I further agree to notify this Healthcare Organization in writing, promptly and no later than seven (7) calendar days from the occurrence of any of the following: (i) receipt of written notice of any adverse action against me or my license by the Medical Board of California or a court taken or pending, including but not limited to, any accusation filed, temporary
restraining order, or imposition of any interim suspension, probation, or limitations affecting 
my license or my right to practice medicine; (ii) any adverse action against me by any other 
Healthcare Organization which has resulted in the filing of a Section 805 report with the 
Medical Board of California, or a report with National Practitioner Data Bank; (iii) the 
denial, revocation, suspension, reduction, limitation, nonrenewal or voluntary relinquishment 
by resignation of my medical staff membership or clinical privileges at any other Healthcare 
organization; (iv) any material reduction in my professional liability insurance coverage; (v) 
my receipt of written notice of any legal action against me, including, without limitation, any 
filed and served malpractice suit or arbitration action; (vi) my conviction of any felony; or 
(vii) my receipt of written notice of any adverse action against me under the Medicare, 
Medicaid, or Medi-Cal programs, including, but not limited to, fraud and abuse proceeding or 
convictions or exclusion from participation in any state or federal healthcare program.

- I hereby pledge to provide for the timely and continuous care of my patients.

I agree that my passwords and/or electronic signature used to access the Healthcare Organization 
computers shall only be used by me and that I will not disclose my password to any other individual. 
The use of a providers’ passwords is equivalent to the electronic signature of the provider. The 
provider shall not permit any physician, resident, advanced practice provider, or other person to use 
their passwords to access Healthcare Organization computers or computerized medical information.

I acknowledge that I have received and read and that I agree to be bound by the Bylaws, Rules and 
Regulations and policies the applicable Alameda Health System and/or Alameda Hospital Medical 
Staff, the hospital Bylaws, Rules and policies. I hereby affirm that the information submitted in this 
application and any addenda thereto (including my curriculum vitae if attached) is true, current, 
correct, and complete to the best of my knowledge and belief and is furnished in good faith. I 
understand that any material omission or misrepresentation may result in denial of my application or 
the suspension or termination of my privileges, membership, employment or physician participation 
agreement.

Consent to Release Information to Contractors for Health Services and Contracted Health Plans 
If I have assigned my professional fee billing and collection to Healthcare Organization, I hereby 
consent to Healthcare Organization providing access to payers for health services the information 
concerning me specified below for the purposes of my enrollment with payers; for payer 
credentialing, peer review and audits; and for Healthcare Organization’s billing and collection.

- My application for membership and/or clinical privileges;
- Information in my credential file relating to my relevant certification and licensure;
- Information in my credential file as part of my application 
  necessary to confirm compliance with regulatory standards for delegated credentialing.

This Information Release/Acknowledgment is binding and valid for as long as I am a member of the 
Alameda Health System or Alameda Hospital medical staff or have clinical privileges.

Print Name  Signature  Date
August 23, 2023

TO: Quality Professional Services Committee

FROM: Lan Na Lee, M.D., Alameda Health System Chief of Staff
       Nikita Joshi, M.D., Alameda Hospital Chief of Staff

SUBJECT: Agenda Item: B4

Meeting Date: August 23, 2023

Item Description: Medical Staff Specialty Privilege Forms

COMMITTEE ACTION: Approval of revised Medical Staff Privilege Form

Background:
The specialty privilege form(s) listed in the analysis section are either new privilege forms or revised privileges forms, both designed to offer a systematic approach for care across our facilities as applicable.

Analysis:
Whether new or revised, the Medical Staff privilege forms are updated through a succinct process using best practice and clinical evidence.

Prior Board Action: n/a

Board Action Requested:
Approval of revised privilege forms that offer a system-wide approach for privileges that support patient care at AHS.

Revised Privilege Form for AHS and AH:
• Gastroenterology Multifacility
• Neurology Multifacility

Revised Privilege Form for AHS:
• Pediatrics

Fiscal Impact: n/a

Budgeted/Authorized: n/a

Estimated Cost Savings: n/a

Strategic Plan Pillar: Access, Quality, Experience
Applicant's Name:

Instructions:

Gastroenterology - Multifacility
Delineation of Privileges

1. Click the Request checkbox to request a group of privileges such as Core Privileges or a Special Privileges.
2. Uncheck any privileges you do not want to request in that group.
3. Check off any special privileges you want to request.
4. Sign form electronically and submit with any required documentation.

<table>
<thead>
<tr>
<th>Required Qualifications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Membership</td>
</tr>
<tr>
<td>Meet all requirements for medical staff membership</td>
</tr>
<tr>
<td>Education/Training</td>
</tr>
<tr>
<td>Completion of an ACGME or AOA accredited Residency training program in Internal Medicine. <strong>AND</strong> Completion of an ACGME or AOA accredited Fellowship training program in Gastroenterology.</td>
</tr>
<tr>
<td>Continuing Education</td>
</tr>
<tr>
<td>Applicants must have 25 Category I CME credits per year directly related to the practice of gastroenterology (waived for applicants who have completed gastroenterology-related training during the previous 24 months). <strong>OR</strong> Applicant must be active in the applicable MOC (maintenance of certification) program</td>
</tr>
<tr>
<td>Certification</td>
</tr>
<tr>
<td>For all new applicants, current certification or active participation in the examination process leading to certification in Gastroenterology by the American Board of Internal Medicine or in Gastroenterology by the American Osteopathic Board of Internal Medicine or its equivalent. Board certification must be continuously maintained.</td>
</tr>
<tr>
<td>Clinical Experience (Initial)</td>
</tr>
<tr>
<td>Applicant must provide documentation of provision of gastroenterology services (100 cases) representative of the scope and complexity of the privileges requested during the previous year (waived for applicants who completed training during the previous year).</td>
</tr>
</tbody>
</table>
Clinical Experience (Reappointment)
Applicant must provide documentation of provision of clinical services (50 cases) representative of the scope and complexity of privileges requested during the previous 24 months.

Core Privileges in Gastroenterology

Description: Evaluate, diagnose, provide consultation, treat and manage patients with diseases and disorders of the gastrointestinal tract, including the esophagus, stomach, small intestine, large intestine, pancreas, liver, gallbladder and biliary system.

<table>
<thead>
<tr>
<th>Request</th>
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</table>

- Currently granted privileges

Attending and Ordering privileges

Provide inpatient and outpatient consultation. This includes evaluation, diagnosis and medical management of gastroenterology or hepatology patients. Privileges include medical management of general medical conditions which are encountered in the course of caring for the gastroenterology or hepatology patient.

Focused Professional Practice Evaluation Requirements

- Currently granted privileges

Privilege Cluster: Gastroenterology Procedures

<table>
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- Currently granted privileges
### Moderate (Procedural) Sedation

**Description:** Moderate Sedation/Analgesia ("Conscious Sedation") is a drug-induced depression of consciousness. No interventions are required to maintain a patent airway, spontaneous ventilation is adequate and cardiovascular function is maintained.

**Qualifications**

**Education/Training**  
The applicant must provide evidence of training and supervised experience during residency and/or fellowship OR if training occurred greater than 1 year ago the applicant must provide evidence of ongoing clinical practice.

**Clinical Experience (Initial)**  
Applicant must provide documentation of provision of clinical services representative of the scope and complexity of the privileges requested during the previous year (waived for applicants who completed training during the previous year).

**Clinical Experience (Reappointment)**  
Applicant must provide documentation of provision of clinical services representative of the scope and complexity of the privileges requested during the previous 24 months.

**Additional Qualifications**  
- Current ACLS certification.  
- Completion of AHS Procedural Sedation Competency, initially and at time of reapplication.

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**Request**  
Request all privileges listed below.
<table>
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</thead>
</table>

Click shaded blue check box to Request all privileges. Uncheck any privileges you do not want to request.

- Currently granted privileges

- Moderate Sedation
**Privilege Cluster: ERCP Procedures**

**Description:** An endoscopic retrograde cholangio pancreatogram (ERCP) is a procedure that combines the use of a flexible, lighted scope (endoscope) with X-ray pictures to examine the tubes that drain the liver, gallbladder and pancreas.

**Qualifications**

**Education/Training**  
Completion of an ACGME or AOA accredited Fellowship training program in Gastroenterology.

**Clinical Experience (Initial)**  
Applicant must provide documentation of provision of clinical services (25 cases) representative of the scope and complexity of the privileges requested during the previous year (waived for applicants who completed training during the previous year).

**Clinical Experience (Reappointment)**  
Applicant must provide documentation of provision of clinical services (20 cases) representative of the scope and complexity of privileges requested during the previous 24 months. Applicants must qualify for and be granted primary privileges in gastroenterology.

**Additional Qualifications**  
Current California Fluoroscopy Certificate/Permit required. Fluoroscopy Privileges: Current California Fluoroscopy Certificate/Permit, in accordance with Title 17, Article 1, section 30463, required for fluoroscopy use any time in or outside of operating area; radiology technician cannot be used in lieu of individual licensed provider.

**Request**

*Click shaded blue check box to Request all privileges.*

*Uncheck any privileges you do not want to request.*

- Currently granted privileges

**Procedures**

- ERCP (Current California Fluoroscopy certificate/permit required)
## TELEMEDICINE PRIVILEGES INPATIENT OR OUTPATIENT CARE

**Description:** These privileges are intended to support existing specialty privileges for physicians and Advanced Practice Providers who are not otherwise classified as Telemedicine ONLY providers.

### Qualifications

Clinical services are limited to only those aspects of existing privileges granted that can be provided remotely.

### Request

*Request all applicable privileges listed below.*

If you want to request **all** privileges, click the **shaded blue check box**.

Uncheck any privileges you do **not** want to request.

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<tr>
<th>AHS Core</th>
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- Currently granted privileges

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<td>□</td>
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</table>

**TELEMEDICINE**

- □ Telehealth initial and follow up consultations
- □ Virtual Check-ins
- □ E-Visits

### Acknowledgment of Applicant
I have requested only those privileges for which by education, training, current experience, and demonstrated competency I believe that I am competent to perform and that I wish to exercise at Alameda Health System hospital(s) and I understand that:

A. In exercising any clinical privileges granted, I am constrained by applicable Hospital and Medical Staff policies and rules applicable generally and any applicable to the particular situation.

B. Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of the Medical Staff Bylaws or related documents.

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**Department Chair Recommendation - Privileges**

I have reviewed the requested clinical privileges and supporting documentation and make the following recommendation(s):

<table>
<thead>
<tr>
<th>Privilege</th>
<th>Condition/Modification/Deletion/Explanation</th>
</tr>
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<tbody>
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**Department Chair Recommendation - FPPE Requirements**

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<th>FPPE Requirements</th>
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</table>

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Signature of Chief/Desigee

Date

Signature of Department Chair/Desigee

Date
Applicant's Name:

Instructions:

1. Click the Request checkbox to request a group of privileges such as Core Privileges or a Special Privileges.
2. Uncheck any privileges you do not want to request in that group.
3. Check off any special privileges you want to request.
4. Sign form electronically and submit with any required documentation.

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<td>Meet all requirements for medical staff membership.</td>
</tr>
<tr>
<td>Education/Training</td>
</tr>
<tr>
<td>Completion of an ACGME accredited Residency training program in Neurology.</td>
</tr>
<tr>
<td>Certification</td>
</tr>
<tr>
<td>Current certification or board eligibility in the examination process leading to certification in Neurology by the American Board of Psychiatry and Neurology.</td>
</tr>
<tr>
<td>Clinical Experience (Initial)</td>
</tr>
<tr>
<td>Applicant must provide documentation of provision of neurology services (50 cases) representative of the scope and complexity of the privileges requested during the previous year (waived for applicants who completed training during the previous year).</td>
</tr>
<tr>
<td>Clinical Experience (Reappointment)</td>
</tr>
<tr>
<td>Applicant must have provided clinical services (25 cases) representative of the scope and complexity of privileges requested during the past 24 months.</td>
</tr>
</tbody>
</table>
**Core Privileges in Neurology**

**Description:** Diagnosis, treatment and consultation related to disease or impaired function of the brain, spinal cord, peripheral nerves, muscles, and autonomic nervous system, as well as the blood vessels that relate to these structures.

### Request all privileges listed below.

<table>
<thead>
<tr>
<th>AHS Core</th>
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</table>

Click **shaded blue check box** to Request all privileges. Uncheck any privileges you do not want to request.

- **Currently granted privileges**
  - Admit to inpatient or appropriate level of care
  - Perform history and physical examination
  - Evaluate, diagnose, provide consultation, medically manage, and treat patients with acquired or congenital disease, disorders or impaired function of the neurological system.

**Procedures**

- EEG/Video monitoring
- Performance and interpretation of basic neurophysiology tests including EEG and evoked potential studies (auditory, visual, and somatosensory).
- Performance and interpretation of EMG, nerve conduction, and autonomic testing
- Perform muscle or nerve biopsy
- Lumbar puncture including administration of intrathecal medications (without fluoroscopy)

### Focused Professional Practice Evaluation (FPPE)/Routine Proctoring Requirements

<table>
<thead>
<tr>
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- Three (3) retrospective Neurology case reviews that are representative of the scope and complexity of privileges requested.

### Stroke Care

**Qualifications**

**Certification**

NIH Stroke Scale Certification at initial appointment

**OR**

Documentation of completion of NIH Stroke Scale Certification

**Clinical Experience (Initial)**

Applicant must attest to providing (5 cases) representative of the scope and complexity of the privileges requested during the previous year (waived for applicants who completed training during the previous year).

**Clinical Experience (Reappointment)**

Applicant must have provided clinical services (5 cases) representative of the scope and complexity of privileges requested during the past 24 months.
Acknowledgment of Applicant

I have requested only those privileges for which by education, training, current experience, and demonstrated competency I believe that I am competent to perform and that I wish to exercise at Alameda Health System hospital(s) and I understand that:

A. In exercising any clinical privileges granted, I am constrained by applicable Hospital and Medical Staff policies and rules applicable generally and any applicable to the particular situation.

B. Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of the Medical Staff Bylaws or related documents.
Practitioner's Signature

Date

Department Chair Recommendation - Privileges

I have reviewed the requested clinical privileges and supporting documentation and make the following recommendation(s):
Applicant’s Name:

Instructions:

1. Click the Request checkbox to request a group of privileges such as Core Privileges or a Special Privileges.
2. Uncheck any privileges you do not want to request in that group.
3. Check off any special privileges you want to request.
4. Sign form and submit with any required documentation.

Membership
Meet all requirements for medical staff membership

Education/Training
For initial applicants, effective January 1, 2020, completion of an ACGME or AOA accredited Pediatric or Family Medicine Residency training program.

AND
For initial Neonatal-Perinatal applicants, completion of an ACGME or AOA accredited Neonatal-Perinatal Medicine Fellowship

Continuing Education
Applicant must have 25 Category I CME credits per year directly related to the practice of pediatrics (waived for applicants who have completed training during the previous 24 months)

Certification
Current certification or board eligibility in the examination process leading to certification within 3 years of residency training by the relevant American Board of Pediatrics or Family Medicine or by the American Osteopathic Board of Pediatrics or Family Medicine. Applicant must be active in the Maintenance of Certification (MOC) program in pediatric care by the relevant American Board of Medical Specialties or American Osteopathic Board

OR
For Neonatal-Perinatal providers, current certification or board eligibility in the examination process leading to certification in Neonatal-Perinatal Medicine by the American Board of Pediatrics

Clinical Experience (Initial)
Applicant must provide documentation of provision of pediatric services (50 cases) representative of the scope and complexity of the privileges requested during the previous year (waived for applicants who completed training during the previous year).

Clinical Experience (Reappointment)
Applicant must provide documentation of provision of clinical services (50 cases) representative of the scope and complexity of privileges requested during the previous 24 months.

Additional Qualifications
Current BLS or PALS certification required
ORNRP certification required if requesting privileges to attend deliveries or work in NICU of anticipated normal newborn
Core Privileges in Pediatrics

**Description:** Provision of primary care services, evaluate, diagnose, treat and provide primary care to patients from birth to young adulthood, including those with acute and chronic disease including health promotion, performing history and physicals, outpatient consultation and management and emergency care of the general pediatric patient. Practitioners with these privileges may render emergency care and treat illnesses that are complicated but fall within the usual and customary scope of practice of a board certified or fully trained general pediatrician or family practitioner.

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<td>Uncheck any privileges that you do not want to request.</td>
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</tbody>
</table>

- Outpatient care of patients 0-21 years of age
- Admit to inpatient and care and management of normal newborns in newborn nursery
- Attend deliveries of newborns
- Critical Care Admission and management of patient in NICU

**Focused Professional Practice Evaluation (FPPE)/Routine Initial Proctoring**

Three (3) retrospective case reviews that are representative of the scope and complexity of privileges requested.

Primary Procedural Privileges

<table>
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<tr>
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</tbody>
</table>

- Removal of foreign body: cornea, conjunctive, ear, nose
- Cautery of anterior nares
- Circumcision of infant less than 1 month of age (corrected for prematurity) with or without local anesthetic
- Skin tag removal
- Lingual frenulectomy
- Wound care, I&D abscess, simple debridement, aspiration, wound closure and local anesthetic techniques
- Wart destruction
- Treatment of partial thickness burns
<table>
<thead>
<tr>
<th>Request</th>
<th>ECG Interpretation-Preliminary</th>
<th>Urinary catheterization</th>
<th>Management of simple fractures and dislocations</th>
<th>Minor surgical procedures involving nails, skin, and subcutaneous tissue</th>
<th>Endotracheal intubation</th>
<th>Hyperalimentation</th>
<th>Lumbar puncture</th>
</tr>
</thead>
</table>

Three (3) retrospective case reviews that are representative of the scope and complexity of privileges requested.

**Specialty Procedural Privileges**

**Qualifications**

**Education/Training**

Request: Request all privileges listed below. Uncheck any privileges that you do not want to request.

<table>
<thead>
<tr>
<th>Request</th>
<th>Umbilical venous catheter</th>
<th>Umbilical artery catheter</th>
<th>Continuous positive airway pressure management</th>
<th>Ventilator management</th>
<th>Arterial puncture</th>
<th>Thoracentesis</th>
<th>Chest tube placement</th>
</tr>
</thead>
</table>

Three (3) retrospective case reviews that are representative of the scope and complexity of privileges requested.

**Moderate (Procedural) Sedation**

**Description:** Moderate Sedation/Analgesia ("Conscious Sedation") is a drug-induced depression of consciousness. No interventions are required to maintain a patent airway, spontaneous ventilation is adequate and cardiovascular function is maintained.
Qualifications

**Education/Training**  The applicant must provide evidence of training and supervised experience during Residency and/or Fellowship OR if training occurred greater than 1 year ago, the applicant must provide evidence of ongoing clinical practice.

**Clinical Experience (Initial)**  Applicant must provide documentation of provision of clinical services representative of the scope and complexity of the privileges requested during the previous year (waived for applicants who completed training during the previous year).
Clinical Experience (Reappointment)

Applicant must provide documentation of provision of clinical services representative of the scope and complexity of the privileges requested during the previous 24 months, as of and at time of reapplication.

Additional Qualifications

Current NRP or PALS

Decision Table

Request

Request all privileges listed below.

Uncheck any privileges that you do not want to request.

A
N
D

Moderate Sedation

Focused Professional Practice Evaluation (FPPE)/Routine Initial Proctoring

AHS Core

Request

Three (3) retrospective case reviews of administration of moderate sedation.

Primary Privileges in Developmental-Behavioral Pediatrics

Education/Training

Completion of an ACGME or AOA accredited fellowship training program in Developmental-Behavioral Pediatrics or Neurodevelopmental Disabilities

Certification

Current certification or eligibility in the examination process leading to certification in Developmental-Behavioral Pediatrics by the American Board of Pediatrics OR Current certification or eligibility in the examination process leading to certification in Neurodevelopmental Disabilities by the American Board of Psychiatry and Neurology (ABPN)

Request

CORE PRIVILEGES

Admit, evaluate, diagnose, consult, manage, and provide treatment to patients presenting with cognitive, language, motor, behavioral, or emotional concerns, delays, or disorders. These conditions may be associated with additional psychiatric conditions, medical illnesses, genetic disorders, or neurological conditions. In addition to a thorough physical, neurological, and neurobehavioral examination, the evaluation may include the use of laboratory and genetic testing, as well as the administration of standardized psychological, psycho-educational, or neuropsychological assessments. The evaluation may also include gathering additional information from immediate and/or extended family members; teachers and/or other school- or preschool-based staff; or community-based workers, such as social workers or public health nurses, to obtain information necessary for diagnosis of the child.

Treatment may include individual, family, parenting, and group therapy.
Prescribe psychopharmacological therapy for neurobehavioral and neurodevelopmental disorders and monitor progress of children on therapy.

**Primary Privileges in Pediatric Cardiology**

**Description:** Evaluate, diagnose, provide consultation, treat, and provide comprehensive care to patients with cardiovascular problems, including congenital and rheumatic disease.

**Qualifications**

**Education/Training:** Completion of an ACGME accredited fellowship training program in Pediatric Cardiology.

**Certification:** Current certification or board eligibility in the examination process leading to certification in Pediatric Cardiology by the American Board of Pediatrics.

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**TELEMEDICINE PRIVILEGES INPATIENT OR OUTPATIENT CARE**

**Description:** These privileges are intended to support existing specialty privileges for physicians and Advanced Practice Providers who are not otherwise classified as Telemedicine ONLY providers.

**Qualifications**

Clinical services are limited to only those aspects of existing privileges granted that can be provided remotely.

**Request all privileges listed below.**

Click shaded blue check box to Request all privileges. Uncheck any privileges you do not want to request.
Acknowledgment of Applicant

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**Department Chair Recommendation - Privileges**

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<th>Signature of Division Chief/Designee</th>
<th>Date</th>
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<tr>
<th>Signature of Department Chair/Designee</th>
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</table>
C. Medical Staff Reports (estimated 20 min)
Alameda Health System Medical Executive Committee (MEC)
Report to the Quality Professional Services Committee of the Board
August 23, 2023

A. Community
  - Alameda Hospital Status Report and Planning for the Future
    o Joint Powers Affiliation Agreement (JPA) Affiliation Benefits
    o Financial challenges and seismic requirements
  - Trauma Program - Interventional Radiologists

B. Quality
  - Medical Staff Governance
    o Approval of the Alameda Health System (AHS) and Alameda Hospital (AH) Medical Staff documents which are key to the operational functions and compliance with regulatory requirements.
  - Quality Safety Committee
    o True North Metrics: 11 of the year-to-date metrics below goal; 1 met goal for May 2023
  - Physician Lead Throughput Pilot- Doc of the Day
    o Emergency Department Throughput
      ▪ AH and SLH bed inpatient utilization
    o Metrics tracking
    o Responsible for evaluating all Highland ED admissions to Adult Medicine
    o Facilitate discharges at Highland
    o Evaluating all transfers from Highland to San Leandro and Alameda Hospitals

C. Staff/Patient Experience
  - Search Committees / Department Chair Recruitment
    o Emergency Medicine
    o Imaging and Radiology
    o Orthopaedic Surgery
    o Psychiatry
  - Patient Centeredness (Pt. Experience Data- May 2023 data)
    o Performance with the strategic goals include a focus is on metrics including Hospital Nursing/Doctor Communication, Likelihood of recommending. FY23 Patient Centered goals are the same for Highland and San Leandro Hospital.
    o Review of metrics for both Highland and San Leandro Hospitals
      ▪ Hospital Doctor Communication (HCAHPS)
        Current performance for Highland 83.2% and San Leandro 78.1%
      ▪ Likely to recommend HCAHPS Rate the hospital 9-10
        Current performance for Highland 76.3% and San Leandro Hospital 65.6%

D. Sustainability
  - Department Reports
    o The Department report from Psychiatry was presented.
## Psychiatry Board Report

<table>
<thead>
<tr>
<th>QUALITY CARE</th>
<th>OPERATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Reducing assaults through security, improved medication treatment, debriefs, staff education on diagnoses, hardwired identification of Highest Risk for Violence.</td>
<td>• Reducing PES ambulance wait times via workflow improvements.</td>
</tr>
<tr>
<td>• Addressing deficiencies in suicide and nutritional assessments via monitoring with 100% compliance expected this quarter.</td>
<td>• Analyzed inpatient length of stay: 1/3 ready for lower level of care.</td>
</tr>
<tr>
<td>• Improving substance use treatment via screening, education, care coordination.</td>
<td>• Stabilized IOP/PHP program and staffing; programs now financially sustainable, stable and back in growth phase.</td>
</tr>
<tr>
<td>• Pharmacy projects to reduce overrides, polypharmacy, and ensure appropriate monitoring.</td>
<td>• Wellness Program started at both campuses with caseloads of 200 visits/week with great growth potential.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>STRENGTHS</th>
<th>OPPORTUNITIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Celebrated Joint Commission survey with zero findings at John George Psychiatric Hospital.</td>
<td>• Need for more sub-acute treatment options: specialty centers for chronically aggressive patients as well as more options for transitional housing / crisis residential beds.</td>
</tr>
<tr>
<td>• Successful Kaiser psychiatry resident rotations continue at JGPH.</td>
<td>• Expand outpatient services to meet unmet needs in community.</td>
</tr>
<tr>
<td>• Supported community via events, partnerships, marketing, newsletter.</td>
<td>• Consider embedded behavioral health model for consultation / liaison service.</td>
</tr>
<tr>
<td>• Robust psychiatry CME program with topical behavioral health topics</td>
<td>• Continue to Improve partnership with Alameda County Behavioral Health to work on shared goals and improved care for our patients.</td>
</tr>
</tbody>
</table>
Executive Summary: SLH Leadership Committee

**QUALITY**

1. Continued Focus discussion: Surgical Services
   a. Ortho elective blocks moving to SLH, pain medicine
   b. Expansion from 2 to 3 anesthesiologist supported blocks
   c. GYN elective block expected to move to SLH in September
2. POET clinic (Pre Op Evaluation and Testing): anesthesia’s preop clinic
3. Protocol for comprehensive team approach to urgent airway management (not crashing/coding) in the works. Unified approach of managing physicians to know their next steps when emergencies arise especially afterhours, weekends. Protocol will apply to Alameda and San Leandro.
4. New Case Request and Consent Process – Providers will consent patients, no witness signature required.
5. HD Access Pre-Op evaluation – <2 vs 3+ missed dialysis sessions require workup and anesthesia input for preop clearance.
6. In House CT go live date 9/13/2023

**STAFF/PATIENT EXPERIENCE**

1. TNM by Ana Torres: lots of ‘Green’ compared to system TNM
2. Care Experience By Dr Angela Ng – top score improvement of ~10%, overall, still room for improvement

**COMMUNITY**

1. SLH welcomes new Peri-Operative Manager: Grief, Trudy
2. Irene Fernandez Charge RN = Daisy Award
The Medical Executive Committee met on August 11, 2023, to review and approve the routine items from the Departmental reports, Committees reports and Administrative reports. MEC report includes the organizational pillars listed below:
- Community
- Quality
- Sustainability

A. Community
- Alameda Hospital District Board Presentation to Alameda Health System Medical Executive Committee

B. Quality
- The MEC reviewed and approved the Clinical Practice Council items below:
  - Policies and Procedures
  - Order Sets
  - Epic Order Sets
- The MEC reviewed and recommends approval of documents which are key to the operational functions and compliance with regulatory requirements.

C. Sustainability
- Contingency planning of the infrastructure and operational needs
  - HVAC update and future direction
- Joint Planning Committee meeting is scheduled in September 2023
D. Quality Reports (estimated 10 min)
Quality Patient Safety Committee – Board of Trustees  
Executive Summary - Regulatory Affairs Report, August 2023

A. Key Point #1 – Site Visits
   1. CMS EMTALA Survey 07/10/23 – 07/13/23, Highland Hospital & San Leandro Hospital

B. Key Point #2 – CDPH Reportable Events
   1. Three (3) events self-reported to California Department of Public Health in July.

C. Key Point #3 – Joint Commission Complaints
   1. None

D. Key Point #4 – Joint Commission Sentinel Events
   1. None

E. Key Point #5 – Joint Commission 2023 Triennial Survey
   1. AHS Core corrective action plans (ESCs) and monitoring in progress.
D3 TNM EXECUTIVE SUMMARY
QPSC Executive Summary: Care Quality True North Metrics Results for May 2023
Annette Johnson, MBA – Director of Quality Analytics
August 23rd, 2023

There is a total of 11 True North Metrics under the Care Quality Pillar, which are balanced across IOM STEEP dimensions of quality: Safe, Timely, Effective, Efficient, Equitable, and Patient Centered. The menu of metrics is inclusive of all service lines and are intended to improve efficiencies, workflows and to support patient flow across the system.

**Key Point 1: Hospital Acquired Harms**
It is predicted that AHS will not meet our harm reduction goal. AHS is averaging approximately 71.6 events a month, exceeding our target of 65 or less. AHS experienced an increase in events during the fall and winter with performance improving in the spring. The majority of in hospital harms are patient falls (89%). Fall reduction efforts include increased availability of fall reduction equipment, and leveraging hourly rounding to reduce the likelihood patients will need to leave their bed unsupervised as their toileting needs are met and possessions are within reach.

**Key Point 2: Hospital and Post-Acute Handwashing Compliance**
Work is underway to increase hand hygiene auditing by “secret shoppers’ to balance the auditing performed by unit staff. Hand Hygiene met compliance in May.

**Key Point 3: Ambulatory Access Metrics**
Third Next Available Appointment for Primary and Specialty Care met target for the month. All four access metric are worse than goal for FYTD. To address access a Primary Taskforce has been established to understand the root causes and expand access. Specialty Care continues to leverage technology to expand access. Beginning in March the Ambulatory Call Center began to review and clean up referrals to reduce duplicates and ensure an accurate count of the Specialty Care Backlog and improved performance has been maintained for the third month in a row. Ambulatory continues to recruit providers to fill vacancies and expand services.

**Key Point 4: Acute All-Cause 30-day Readmission Rate**
Performance improved in May (11.42%) failing to meet target by less than 1%. As a result of the previous months increased rates performance for the fiscal year is less 0.2% high than goal. Alameda Hospital has the highest readmission rate for both current month and year to date. SL and Medical Arts pharmacy assistance programs are being leveraged to assist uninsured and underinsured patients with discharge medication. The Complex Care teams continues to serve medically vulnerable patients experiencing homelessness. AHS is participating in Quality Improvement initiative with the community FQHC’s, health plans and Sutter to create overarching Care Transitions workflows.

**Key Point 5: Adult Health Maintenance Up to Date**
After a promising start to the fiscal year performance began to decline in December through April. In May AHS broke this 5-month streak with improved performance nearly equivalent to the prior fiscal year. As a result of all these performance fluctuations performance FY2023 is consistent with FY2022. Demonstrating neither an increase nor a decrease. Improvement work focused on patient outreach, maximization of every patient touchpoint to encourage health care screenings and preventive care, and special events to promote cancer screenings.

**Key Point 6: Median Time form Decision to Admit to Inpatient Bed**
All three acute care campuses saw improved performance between Jan and April. Unfortunately wait times for inpatients boarded in the Emergency Department increased in May by 2 hours. Efforts to decrease wait times and reduce Emergency Department Boarders includes a new pilot launched in August where 24/7 an Emergency Physicians will be assigned to monitor ED volumes and bed availability across the system and assist in overcoming obstacles to intra system transfers and discharges. This work is in addition increased staffing levels at the Community Hospitals to sustain higher census volumes and increase bed availability, and expanded Bed Control Coordination.

**Key Point 7: Patient Experience Metrics**

Nursing communication Top box score for AHS System in May had a slight increase for the consecutive month to 73.97% (21st percentile). The FYTD score increased to 71.09% (11th percentile) but is not meeting the goal yet.

The composite score increased in May, 74.92%, from 73.93% in April. While AHS has yet to achieve the target, performance improvement has shown consistent improvement throughout the year and has improved by nearly 5% absolute percentage points.

Performance improvement work for these metrics includes continued an in-person New Nurse Orientation (NNO) patient experience module which includes a communication training component led by the patient experience team. Purposeful hourly rounding (PHR) is encouraged on units and training with 4Ps is included in NNO to reduce call light response times, falls, pressure wounds, and increase patient satisfaction and nursing efficiency. Medication sheets are included in the Patient Admission Handbook as well as the nurse let patient introduction at admission and provides opportunity for patients to ask questions and understand what to expect during their care. Nurse leader rounds have expanded to Emergency Department, Pre-OP and Post-Op to allow for real time service recovery. Alameda Hospital’s Emergency waiting room is undergoing renovation to improve patient flow and comfort. Work is underway to improve signage in all three hospitals’ Emergency Departments to further orient our patients. Monthly patient survey data and weekly comment reports are sent to patient facing department leaders. Leaders are expected to share results with staff and action plans with their team to address opportunities and promote service recovery.
D5 Regulatory Affairs REPORT
Regulatory Affairs
QPSC Report
- OPEN Session

Nilda Perez – System Director of
Regulatory Affairs
ALAMEDA HEALTH SYSTEM
I. Regulatory Events Summary – Open Session

A. Site Visits and Complaints
   1. CMS EMTALA compliance survey 07/10/23 – 07/13/23 at Highland Hospital and San Leandro Hospital. Outcome pending.

B. CDPH Self-Reported Events
   1. 07/13/23, San Leandro Hospital – Assault allegation
   2. 07/14/23, San Leandro Hospital – Assault allegation
   3. 07/21/23, John George Psychiatric Hospital – Assault with injury

C. Joint Commission Complaints

D. Joint Commission Sentinel Events
   1. No Joint Commission Sentinel Events reported in July 2023

E. The Joint Commission 2023 Triennial Survey, 04/18/23 -04/21/23
   1. AHS Core corrective action plans (ESCs) were all accepted by the Joint Commission!
   2. Action plans and monitoring are underway within the organization.
D6 TNM DASHBOARD
<table>
<thead>
<tr>
<th>Pillar</th>
<th>True North Metric</th>
<th>FY 22 Baseline</th>
<th>FY23 Goal</th>
<th>Current Month</th>
<th>FY23 YTD</th>
<th>Trend Legend: Blue AHS Performance, Orange Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety</td>
<td>Healthcare Acquired Patient Harm ↓</td>
<td>784</td>
<td>Less Than* M=65</td>
<td>68</td>
<td>788</td>
<td><img src="https://example.com" alt="Safety Graph" /></td>
</tr>
<tr>
<td></td>
<td>Hospital &amp; Post-Acute Handwashing Compliance ↑</td>
<td></td>
<td>81.80%</td>
<td>90.3%</td>
<td>88.4%</td>
<td><img src="https://example.com" alt="Graph" /></td>
</tr>
<tr>
<td>Timeliness</td>
<td>Days to Third Next Available (Primary Return) ↓</td>
<td>25</td>
<td>22.5</td>
<td>27</td>
<td>27</td>
<td><img src="https://example.com" alt="Graph" /></td>
</tr>
<tr>
<td></td>
<td>Days to Third Next Available Appointment (Specialty Return) ↓</td>
<td>14</td>
<td>12.6</td>
<td>35</td>
<td>18.5</td>
<td><img src="https://example.com" alt="Graph" /></td>
</tr>
<tr>
<td></td>
<td>% Continuously Assigned Patients Seen in Primary Care in the Last 2 Years ↑</td>
<td>42.50%</td>
<td>46.75%</td>
<td>40.1%</td>
<td>41.5%</td>
<td><img src="https://example.com" alt="Graph" /></td>
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<tr>
<td></td>
<td>Total Number of Patients on a Specialty Backlog ↓</td>
<td>3567</td>
<td>3210</td>
<td>3647</td>
<td>4626</td>
<td><img src="https://example.com" alt="Graph" /></td>
</tr>
<tr>
<td>Effectiveness</td>
<td>All-cause 30 day Readmissions ↓</td>
<td>11.68%</td>
<td>10.79%</td>
<td>11.42%</td>
<td>11.0%</td>
<td><img src="https://example.com" alt="Graph" /></td>
</tr>
<tr>
<td></td>
<td>Adult Health Maintenance Up to Date ↑</td>
<td>70.25%</td>
<td>77.28%</td>
<td>69.3%</td>
<td>70.3%</td>
<td><img src="https://example.com" alt="Graph" /></td>
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<tr>
<td>Efficiency</td>
<td>ED Waiting Time</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td><img src="https://example.com" alt="Graph" /></td>
</tr>
<tr>
<td></td>
<td>Time in ED from Decision to Admit to Inpatient Bed ↓</td>
<td>5:50</td>
<td>5:18</td>
<td>7:13</td>
<td>6:35</td>
<td><img src="https://example.com" alt="Graph" /></td>
</tr>
<tr>
<td>Patient Centeredness</td>
<td>Hospital Nursing Communication (HCAHPS)↑</td>
<td>73.04%</td>
<td>79.42%</td>
<td>74.0%</td>
<td>71.4%</td>
<td><img src="https://example.com" alt="Graph" /></td>
</tr>
<tr>
<td></td>
<td>Likelihood of Recommending (Composite) ↑</td>
<td>70%</td>
<td>77%</td>
<td>74.9%</td>
<td>73.0%</td>
<td><img src="https://example.com" alt="Graph" /></td>
</tr>
</tbody>
</table>

* AHS is on quest for zero harms

Trend Graphs include data for last 12 months
<table>
<thead>
<tr>
<th>Metric</th>
<th>Definition</th>
<th>Setting</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthcare-Acquired Patient Harms</td>
<td>The number of potential health-care acquired patient harms Includes: CLABSI, CAUTI, MRSA BSI, C-Diff, SSI for Acute Med-Surg/Critical Care, and Patient Falls and Hospital Acquired Pressure Injuries for all areas (practically, not inclusive of ambulatory)</td>
<td>HAI: Acute-Medical Fall/HAPI - All sites * Ambu not included</td>
<td>NHSN/ Midas</td>
</tr>
<tr>
<td>Handwashing Compliance (Hospital &amp; Post-Acute)</td>
<td>Percentage of observed encounters where handwashing was completed (denominator = 200/unit/month)  * Note: Any unit with incomplete / missing data submission, will be counted as 0% for that period</td>
<td>Acute-Medical Post-Acute</td>
<td>Sentact</td>
</tr>
<tr>
<td>Days to Primary Care (Third Next Available Appointment Primary Return)</td>
<td>The average length of time in days between the day a patient makes a request a Primary Care appointment and the third next available appointment.</td>
<td>Post-Acute</td>
<td>Epic - Manual</td>
</tr>
<tr>
<td>Days to Specialty Care (Third Next Available Appointment Specialty Return)</td>
<td>The average length of time in days between the day a patient makes a request a Specialty Care appointment and the third next available appointment.</td>
<td>Ambulatory</td>
<td>Epic - Manual</td>
</tr>
<tr>
<td>Number of Patients on Specialty Backlog</td>
<td>The total number of patients on the backlog awaiting a new patient appointment to be scheduled (*does not include optometry)</td>
<td>Ambulatory</td>
<td>Epic - Manual</td>
</tr>
<tr>
<td>All-cause 30-day Readmissions</td>
<td>Percentage of encounters, regardless of payer type, with an unplanned readmission to any AHS facility within 30 days for any cause among encounters for acute care inpatients with a principal discharge diagnosis/procedure for a clinical classification category in the Cardiorespiratory, Cardiovascular, Medicine, Neurology, or Surgery/Gynecology cohort. Note: This measure approximates, but likely does not match, the value of the corresponding CMS readmission measure.</td>
<td>Acute-Medical only Post-Acute (cascade) JGP (cascade)</td>
<td>Midas K2</td>
</tr>
<tr>
<td>Healthcare Maintenance Up to Date</td>
<td>Percentage of preventative screenings which are up to date for AHS patients (includes screening/counseling for: breast/cervical/colon cancer, depression, tobacco, chlamydia, HIV, influenza immunization)  Note: Patients can get “partial” credit if some, but not all, screenings complete</td>
<td>Ambulatory</td>
<td>K2</td>
</tr>
<tr>
<td>Time in ED from Decision to Admit to Inpatient Bed</td>
<td>Median time from Decision to Admit to departure from the emergency department for admitted patients.  Decision to Admit = First Admit Disposition  Admit = Time patient admitted to Inpatient Unit</td>
<td>Acute-Medical JGP (cascade)</td>
<td>Epic</td>
</tr>
<tr>
<td>HCAHPS – Nurse Communication</td>
<td>Percentage of patients who rated nursing communication top box. Nurse Communication is a composite composed of three questions related to nursing care, attitude, attention paid to personal needs, and how well the nurses explained the care they were providing</td>
<td>Acute-Medical</td>
<td>Press Ganey</td>
</tr>
<tr>
<td>Likelihood of Recommending (Composite)</td>
<td>Percentage of patients who would recommend AHS (includes rehab, JGP, acute, ambulatory, ED, outpatient surgery, dental, radiology)</td>
<td>Acute-Medical &amp; JGP Ambulatory Post-Acute</td>
<td>Press Ganey</td>
</tr>
<tr>
<td>% Continuously Assigned Patients Seen in Primary Care in Last 2 Years</td>
<td>Percentage of patients continuously assigned to AHS (i.e., 11 out of previous 12 months) with a primary care visit in the previous 24 months.</td>
<td>Ambulatory</td>
<td>K2</td>
</tr>
</tbody>
</table>
D7 TNM REPORT
True North Metric Dashboard Review
Care Quality

Annette Johnson, MBA
DIRECTOR OF QUALITY ANALYTICS
TNM Care Quality

Care Quality Pillar
There is a total of 11 True North Metrics under the Care Quality Pillar, which are balanced across IOM STEEP dimensions of quality: Safe, Timely, Effective, Efficient, Equitable, and Patient Centered. The menu of metrics is inclusive of all service lines and is intended to improve efficiency, workflows, and to support patient flow across the system.

Hospital Acquired Harms:
Alameda Health System is continuously driving towards the goal of zero preventable harm. At minimum this fiscal year AHS would like to achieve a 10% decrease in the volume of harms as compared to Fiscal Year 2022. The harm index includes following 7 harm types: Central Line Associated Blood Stream Infections (CLABSI), Catheter Associated Urinary Tract Infections (CAUTI), MRSA Blood Stream Infections (MRSA BSI), C. Difficile infections, surgical site infections (SSI), patient falls, and hospital acquired pressure injuries (HAPI).

AHS is averaging approximately 71.6 harm events per month this fiscal year, exceeding our target of 65 or less per month. AHS experienced an increase in events during the fall and winter with performance improving in the spring. The most common harm type remains falls and accounts for nearly 80% of the AHS Harm Index. There were 52 fall events in May with 0 physical injuries. Fall reduction efforts include increased availability of fall reduction equipment including chair alarms, environmental assessments to decrease trip risks, collocating patient assignments to ensure nurse proximity to reduce the likelihood patients will need to leave their bed unsupervised. There were 10 hospital acquired infections 9 occurred at Highland (CLABSI 1, CAUTI 3, C-Diff 2, SSI 3) and 1 C-Diff occurred at Alamedas Hospital. To reduce the likelihood of CLABSI and CAUTI, efforts are focused on reducing device days via daily assessment of device necessity, maintenance of devices (Central Lines and Catheter) to reduce the opportunity for infection and preparing a new protocol to allow nurse to removal of foleys without physician order. SSI improvement work has focused on pre-operative infection prevention care particularly chlorhexidine gluconate (CHG) cleansing, which reduces germs on skin prior to surgical incision. The SSI workgroup has been redesigned in order to systematically review the process from beginning (Preoperative) to end and will focus on Colon surgeries as this is the most common procedure for an infection to occur.

Hospital and Post-Acute Handwashing Compliance
Practicing hand hygiene is a simple yet effective way to prevent infections and can prevent the spread of germs, including those that are resistant to antibiotics and are becoming difficult, if not impossible, to treat. Per the Centers for Disease Control and Prevention (CDC) on average, healthcare providers clean their hands less than half of the times they should. For fiscal year 2023 AHS is targeting a minimum 10% increase in hand hygiene compliance with long term goal of driving compliance to 95% or greater. Work is underway to increase hand hygiene auditing by “secret shoppers’ to balance the auditing performed by unit staff. The goal is to achieve 200 audits per unit per month. Both the volume of observations and compliance have shown consistent improvement meeting target in May.

Third Next Available Appointment Primary and Specialty Care (Return Patients):
Third Next Available Appointment (TNAA) is the industry standard measure of the patient’s ability to seek and receive care with the provider of their choice, at the time they choose, and indicates how long a patient waits to be seen. This measure is used to assess the average number of days to the third next available appointment for an office visit. In contrast to first and second available appointments (often the result of last-minute cancellations, working patients into the schedule, or other events), the TNAA best represents the performance of the appointment access system. AHS is targeting a 10% decrease from
baseline for both Primary and Specialty Care established patients. In May, Primary Care and Specialty Care did not meet goal. Primary Care performance has worsened compared to the previous fiscal year, adding two more days for patients waiting for a return appointment. Specialty Care performance improved in the first half of the year. Unfortunately, this trend reversed direction in the second half of the year with wait times increasing in 3 of the last six months reach a peak in May of 35 days. As results Specialty Care performance is now worse than the previous fiscal year. Efforts are underway to hire and fill any provider vacancies.

**Percent of Continuously Assigned Patients Seen in Primary Care in the last 2 Years**

In addition to AHS commitment to access to care for established patients, AHS is committed to establishing routine care with all patients assigned to us via our Managed Medi-Cal partners. AHS is targeting a 10% relative increase in number of patients assigned and seen as compared to fiscal year 2022. By actively engaging these patients in care we improve their likelihood of receiving preventive healthcare and health care screening. Performance began to decline in October and is now worse than FY2022 baseline. A Primary Care Taskforce comprised of ambulatory system and local clinic leaders continues to meet regularly to address capacity challenges and explore strategies to maximize access. Progress is underway to re-evaluate panel sizes and explore automated processes within Epic to manage panels; pilot session limits and same day access at several sites; and develop operational dashboards to support data-driven decision making and evaluation of interventions.

**Total Number of Patients on a Specialty Backlog**

Specialty Backlog measures the number of patients new to a Specialty care waiting to be scheduled for their first appointment and helps AHS assess whether there is enough specialty access to meet patient demand. AHS is targeting a 10% decrease in volume as compared to Fiscal Year 2022. The volume of patients waiting for Specialty care increased in fiscal year 2022 when patients began seeking care previously deferred due to the pandemic. Until March the demand for specialty care has remained steady at just under 5000 referrals awaiting scheduling each month. Indicating that for each new patient scheduled a new referral is received, keeping the volume of patients waiting consistent. Beginning in March the Ambulatory Call Center launched an effort to clean up referrals, eliminating duplicates and sending referrals back to referring providers when patients have not responded or contact information is bad. As result the specialty care backlog improved by approximately 800 referrals and this improvement has been maintained for 3 months. AHS is exploring new innovations and technology to improve the quality and efficiency of care and is now working to expand appointment availability to assist with the backlog of patients. Additionally, AHS is focused on recruiting and filling any special care provider vacancies.

**Acute All-Cause 30-Day Re-admit:**

AHS is targeting a 10% reduction in readmissions as compared to the previous fiscal year. Performance remains elevated above goal for the fourth month in a row though May rates improved missing target by less than 1%. FYTD rates are less than 0.2% above target and demonstrates an improvement over the previous fiscal year. Alameda Hospital has the highest readmission rate for both current month and year to date.

The Care Management Team has implemented several improvements to better prepare patients for discharge and ensure their post discharge needs are met. These include early identification and referral for patients who need Health Advocates, Substance Use support, and/ or Community Health Workers to address post-acute care needs. SL and Medical Arts pharmacy assistance programs are being leveraged to assist uninsured and underinsured patients with discharge medication. The Complex Care teams continue
to serve medically vulnerable patients experiencing homelessness, which is now a covered benefit through Enhanced Care Management. AHS is participating in Quality Improvement initiative with the community FQHC’s, health plans and Sutter to create overarching Care Transitions workflows.

Adult Health Maintenance Up to Date
This year AHS is targeting a 10% improvement in the percentage of preventative screenings which are up to date for AHS assigned patients (includes screening/counseling for: breast/cervical/colon cancer, depression, tobacco, chlamydia, HIV, influenza immunization). Patients can get “partial” credit if some, but not all, screenings are complete. After a promising start to the fiscal year performance began to decline in December through April. In May AHS broke this 5 month streak with improved performance nearly equivalent to the prior fiscal year. As a result of all these performance fluctuations performance FY2023 is consistent with FY2022. Demonstrating neither an increase nor a decrease. Improvement work focused on patient outreach, maximization of every patient touchpoint to encourage health care screenings and preventive care, and special events to promote cancer screenings.

Median Time from Decision to Admit to Inpatient Bed:
Median Time from Decision to Admit to Inpatient Bed continues as a True North Metric for another fiscal year. AHS is targeting a 10% reduction in wait time as compared to the previous fiscal year. All three acute care campuses saw improved performance between Jan and April. Unfortunately wait times for inpatients boarded in the Emergency Department increased in May by 2 hours. Highland hospital median wait times are longest and range from a low of 10 hours and 11 minutes in February to high of 22 hours and 30 minutes in December. San Leandro and Alameda both maintain wait times between 4 hours and 45 minutes and 2 hours and 30 minutes.

<table>
<thead>
<tr>
<th></th>
<th>System</th>
<th>Highland</th>
<th>San Leandro</th>
<th>Alameda</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>May YTD</td>
<td>May YTD</td>
<td>May YTD</td>
<td>May YTD</td>
</tr>
<tr>
<td>25% of Admits w/in</td>
<td>3:03</td>
<td>3:02</td>
<td>7:54</td>
<td>6:45</td>
</tr>
<tr>
<td>50% of Admits w/in (Median)</td>
<td>7:13</td>
<td>6:35</td>
<td>19:46</td>
<td>16:19</td>
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<tr>
<td>75% of Admits w/in</td>
<td>21:57</td>
<td>19:35</td>
<td>31:18</td>
<td>28:07</td>
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</table>

Efforts to decrease wait times and reduce Emergency Department Boarders includes a new pilot launched in August where 24/7 an Emergency Physicians will be assigned to monitor ED volumes and bed availability across the system and assist in overcoming obstacles to intra system transfers and discharges. This work is addition increased staffing levels at the Community Hospitals to sustain higher census volumes and increase bed availability, and expanded Bed Control Coordination.

Hospital Nursing Communication (HCAHPS) Experience
Industry wide Nursing Communication is the number one driver of patient satisfaction in the acute inpatient care setting. AHS is targeting the national 50th percentile (79.42%) as per Centers for Medicare and Medicaid Services (CMS). Nursing communication Top box score for AHS System in May had a slight increase for the consecutive month to 73.97% (21st percentile). The FYTD score increased to 71.09% (11th percentile) but is not meeting the goal yet. HGH and SLH campuses increased for this metric in the month of May.

Nurse leader rounding with the expectation of 100% of patients rounded on, continues to be reinforced with daily reports sent to track compliance. The number of leaders trained to round continues to increase. The in-person New Nurse Orientation (NNO) patient experience module has been updated
including a communication training component led by the patient experience team. Purposeful hourly rounding (PHR) is encouraged on units and training with 4Ps is included in NNO to reduce call light response times, falls, pressure wounds, and increase patient satisfaction and nursing efficiency. Hourly rounding sheet translated into multiple languages was developed by staff for staff use to better comply with hourly (or every two hours) rounding expectation. Medication sheets are included in the Patient Admission Handbook as well as the nurse let patient introduction at admission and provides opportunity for patients to ask questions and understand what to expect during their care.

**Likelihood of Recommending (Composite)**
AHS has expanded monitoring of patient experience beyond inpatient HCAHPS and Ambulatory CG-CAHPS to include all service lines with the creation of the Likelihood of Recommending Composite metric. This metric measures the percentage of patients willing to recommend AHS to others and includes survey results from Inpatient Acute Rehabilitation, John George, Acute inpatient, Ambulatory, Emergency Department, Outpatient Services, Dental and Radiology. AHS is targeting a 10% improvement at the composite level and National 50th percentile for each service line. The composite score increased in May, 74.92%, from 73.93% in April. While AHS has yet to achieve the target, performance improvement has shown consistent improvement throughout the year and has improved by nearly 5% absolute percentage points.

Improvement efforts beyond what is mentioned above include expansion of
D8 Post Acute REPORT
Alameda SNF’s/SA Quality Measures

Alameda Hospital D/P Snf

Quality measures

Learn more about quality measures

Find out why these short-stay measures are important

Find out why these long-stay measures are important

Get current data collection period

Quality measures rating

★ ★ ★ ★ ★

Much above average
Fairmont Quality Measures

Alameda County Medical Center D/P Snf

Quality measures

Learn more about quality measures

Find out why these short-stay measures are important

Find out why these long-stay measures are important

Get current data collection period

Quality measures rating

⭐⭐⭐⭐⭐⭐

Much above average
CDPH Visits

- 5 CDPH self reports – 1 Fairmont, 1 South shore, 3 Park Bridge
  - 5 resulted in no findings
  - 2 complaint visits for Park Bridge – both resulted in no findings
  - 100% no findings

- 1 finding from pending review from July – POC submitted, audits performed of identification of others and training/education completed

- POC accepted by CDPH/CMS
Fairmont Annual Survey

• CDPH/CMS: 7/24 though 7/28
  – 4 surveyors for 5 days

• **Annual Survey results: 3 deficiencies**
  • California state average is 16 deficiencies per facility
  • **82% better than the state average**

• Phenomenal teamwork, collaboration, daily processes/attention to detail

• Residents/families at the center of care
• Culture of trust, empathy, and proactiveness
• SMART as part of culture

• Bar-B-Que celebration to honor and recognize our Fairmont team: 8/11
Fairmont Annual Life Safety Survey

• Life Safety CDPH/CMS:
  – 1 Surveyor 7/31/23

• Life Safety: 6 deficiencies
• California state average is 7.4 deficiencies per facility
• 19% better than the state average

• Strong processes, detailed and improved preventative management program
• Continued training on regulatory items shared with our Engineers
• SMART implemented and continues

• Surveys will place Fairmont back at 5 stars in every CMS category
Thank you

Questions?
E. Planning Calendar_Issue Tracking (estimated 1-2 min)
No Written Materials
Agenda E Planning Calendar/Issue Tracking

No written materials were submitted for this agenda item. Written materials may be distributed, or a verbal discussion of the item may take place at the meeting.
ADDENDUM ONE: ABCs of Communication
Agreements for Better Communications and Processes

**Prevailing Premise:** Effective organizational communication creates trust and supports business objectives.

1. Trustee responsibility includes overseeing effective operations in order to ensure accountability and effective delivery of care. The Board is the entity that is responsible for compliance with laws and policies. The Board must always act in a manner that supports the organizational mission and meets the needs of patients while ensuring the organization’s sustainability.

2. Individual Trustees have limited power. The source of trustee power comes from the Board as a whole (the majority); the same principle applies to trustee authority within committees. To ensure accountability and eliminate duplication, requests to staff for specific future action, reports etc., must come through formal consensus of the majority or formal motion. Staff responding to “individual” requests for data or documents can be accommodated only if the work required is limited and the information is readily available.

3. Trustees are expected to come to meetings prepared to participate and act if necessary. A Trustee who has a question about an agenda item should seek clarification with the appropriate staff prior to the Board meeting. When concerns remain after staff input, the trustee should advise the chair and staff that he/she may raise the issue in the public meeting.

4. If one Board member requests information about an issue that may be of concern to other board members, the CEO or staff will provide a timely response, sharing the query and the analysis with all members of the board. The Clerk of the Board is the “gatekeeper” for all communications; thus, she should be informed of communications going to and from the Board from staff or other agencies.

5. It is the responsibility of individual trustees to notify Clerk of the Board in the event of an anticipated absence at a meeting or scheduled event.

6. Within the first year of appointment, every Board member should have visited/toured at least 90%, if not all, the sites which formally fall with the AHS system.

7. Meetings dates for standing committees and Board Meetings, once set, should not be moved unless extreme emergency. Should such emergency occur, changes go to the Clerk of the Board who distributes to all Trustees.

8. It will be the responsibility of the Board Chair to conduct a time efficient and effective public meeting where respectful discourse can occur without personal attack and disrespect.
9. All items from staff to be included on/in Board agenda or packet must be in the hands of the clerk and submitted by the specified time or they cannot be included. Addendums should not be posted after formal agenda is posted.

10. Service and program changes that may be expected to have a patient and/or staff impact should always be brought to the board for review and approval. Service expansions, additions and reductions, and new or revised provider contracts should also be vetted with the board of trustees.

11. Staff should always provide the most timely information in the initial agenda packet and avoid supplemental materials distributed at the meeting whenever possible. When updated materials are necessary due to changing environmental conditions staff should include narrative explaining any changes from original documents.

12. A Board tracking system and action calendar will be developed and will become a formal part of each Board agenda.

13. A common template for all information supporting agenda items will be consistently used. A template for “committee reports” should also follow a common format so all reports have same or similar elements. Reports for action by trustees should always include certain details as determined by the board depending on environmental conditions. Such considerations should include financial impact, safety, staffing and alternative options.

14. Committee reports should be drafted by the committee chair or other trustee committee member with input from staff. Written committee reports will appear in the agenda packet under committee reports.

15. The AHS CEO should identify which staff have permission to contact trustees directly regarding AHS business. Staff should go through CEO before contacting individual BOT members; and notify CEO after communication.

16. Timeline / tracking system for significant Board reports should be developed so public and Board knows when to expect such report. Committee work plans and timelines should be driven by Board Meeting timelines and dates, not the reverse.

17. The CEO must commit to and produce weekly updates highlighting issues and progress throughout the system.

18. Staff working with AC Supervisors should immediately report contacts to CEO and Trustees (Friday updates good place for inclusion). Communications between AHS and Alameda County staff is welcomed, and staff should ensure that significant requests for information from the Board of Supervisors is always approved by the Board or, in some cases the Board Chair, before submission to supervisors. The information sharing is critical whenever staff is responding to requests from the BOS Health Committee.
Appendix J

QUALITY AND PROFESSIONAL SERVICES COMMITTEE CHARTER

1. Membership.

1.1. Trustees. The Quality and Professional Services Committee ("QPSC") will be comprised of not fewer than three (3) Trustees and the Chiefs of Staff from each of the Medical Staffs (nonvoting members).

1.2. Staff Liaison. Chief Executive Officer (or his/her designee)

2. Meetings.

The Committee shall meet once each month. Meetings of QPSC are subject to the agenda/notice requirements of the Brown Act.

3. Purpose/Goals/Responsibilities

3.1. Purpose. QPSC is established to provide oversight and leadership for medical staff credentialing, review of organizational policies, and monitoring of organizational, quality assurance, performance improvement, and safety programs. QPSC is charged with continuing the practice of direct communication with medical staff leaders on issues of clinical operations and patient care.

3.2. Delegated Authority – Credentialing. The Board of Trustees has delegated authority to QPSC to act on behalf of the full Board of Trustees on matters related to approving credentials recommended by each of the medical staffs.

3.2.1. The Board of Trustees delegation of authority to QPSC related to credentialing is unrestricted except as it relates to certain credentialing decisions discussed below (section 3.2.3 below).

3.2.2. Following a positive recommendation from the applicable Medical Staff Executive Committee (MEC) on an application, QPSC may grant the privileges identified by the MEC. QPSC shall review and evaluate the qualifications and competencies of the practitioner applying for appointment, reappointment or renewal, or modification of clinical privileges and render its decision. A positive decision by QPSC shall result in the status or privileges requested.

3.2.3. An applicant is ineligible for the credentialing process above and requires consideration of the full Board of Trustees if at the time of appointment or since the time of reappointment, any of the following has occurred:

3.2.3.1. There is a current challenge or previously successful challenge to licensure or registration.

3.2.3.2. The applicant has received an involuntary termination of Medical Staff membership at another organization.

3.2.3.3. The applicant has received involuntary limitation, reduction, denial, or loss
of clinical privileges.

3.2.3.4. There has been a final judgment adverse to the applicant in a professional liability action which in the opinion of the MEC represents a significant clinical departure from accepted standards of practice.

3.2.3.5. QPSC is not recommending that privileges be granted to the applicant.

3.3. Delegated Authority – Policies and Procedures. The Board of Trustees has delegated authority to QPSC to act on behalf of the full Board of Trustees on matters related to approving policies and procedures that have been approved and recommended by the appropriate medical staff.

3.3.1. All actions of QPSC taken pursuant to this delegation by the Board of Trustees shall be forwarded to the Board of Trustees for ratification on a regular basis.

3.4. Other Responsibilities. QPSC shall receive reports and make recommendations to the Board on matters related to any of the following in conjunction with the Board’s safety and quality of patient care responsibilities:

3.4.1. organizational quality assurance report and quality related reports related to Medical Staff and AHS organizational performance including departmental quality assurance reports, mortality and morbidity rates, significant adverse drug reactions, medication errors, transfusion reactions, and infection rates;

3.4.2. patient satisfaction;

3.4.3. Medical Staff monitoring and special committee reports, and results of performance improvement team activities;

3.4.4. other reports related to patient care and safety including safety committee reports, assessments of the buildings and grounds (at least annually);

3.4.5. reports related to the adequacy of access to all services;

3.4.6. risk management reports of all unusual occurrences and significant potential and actual liabilities;

3.4.7. staff competency reports of all unusual occurrences and significant potential and actual liabilities;

3.4.8. AHS performance improvement plan (at least annually);

3.4.9. survey and regulatory reports, including Department of Health Services;

3.4.10. licensure and certification reports;

3.4.11. sentinel events or near-miss sentinel events and analysis thereof;

3.4.12. corrective action plans in response to survey or regulatory reports, complaints and sentinel events, including review of all plans of correction to regulatory reports;

3.4.13. Medical Staff peer review and performance improvement activities;

3.4.14. reports related to adequacy of house staff supervision;

3.4.15. additions or modifications to Medical Staff Bylaws and Rules and Regulations; and

3.4.16. additions or modification to the medical staff and organizational clinical policies and procedures.

4. Reporting to Full Board

QPSC will report (written report) to the full Board at the next Board meeting following the meeting of the Committee.