BOARD OF TRUSTEES REGULAR MEETING  
WEDNESDAY, SEPTEMBER 13, 2023  
5:00pm to 9:00pm  

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

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

ZOOM Meeting Link:¹  
https://alamedahealthsystem.zoom.us/j/9361457125?pwd=aUF4anZtK01IRklVMzZvQVY5NTdOZz09  
Meeting ID: 936 145 7125  
Meeting Password: 20200513  

One tap mobile  
+14086380968,,9361457125# or  
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Dial by your location  
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Find your local number: https://alamedahealthsystem.zoom.us/u/agoA8zDn2  

MEMBERS  
Kinkini Banerjee, President  
Jennifer Esteen, Vice President  
Taft Bhuket MD Jet Chapman  
Alan E. Fox Mark Friedman  
Nely Obligacion David Sayen  
Sblend A. Sblendorio  

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

A. DISCUSSION: Executive Officers Report (Estimated 10 min)
   Kinkini Banerjee, President
   Jennifer Esteen, Vice President
   David Sayen, Secretary/Treasurer
   Mark Friedman

   Jacqueline Brown, Brown Associates

B. CEO Report (Estimated 15 min)
   James E.T. Jackson, Chief Executive Officer

C. MEDICAL STAFF REPORTS (Estimated 20 min)
   - AHS Medical/Administrative Dyad: LanNa Lee, MD, Chief of Medical Staff
     Ro Lofton, Chief Administrative Officer
     Edris Afzali, MD, SLH Leadership Cmte Chair
   - AH Medical/Administrative Dyad: Nikita Joshi, MD, Chief of Medical Staff
     Mario Harding, Chief Administrative Officer
D. **COMMITTEE AND TRUSTEE REPORTS (Estimated 15 min)**

**D1. Human Resources Committee: July 19, 2023**  
*Jet Chapman, Committee Chair*

**D2. Quality Professional Services Committee: July 26 and August 23, 2023**  
*Taft Bhuket, MD, Committee Chair*  
*David Sayen, Acting Committee Chair*

**D3. Finance Committee: September 6, 2023**  
*Alan E. Fox, Committee Chair*

**D4. AD Hoc Committees Updates**

a. CEO Performance Evaluation  
b. Fall Retreat Planning

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E. **CONSENT AGENDA: ACTION (Estimated 10 min)**

Public comment on all Consent Agenda items may be heard prior to the Board’s vote. The Board does not deliberate on Consent Agenda items. Any member of the public or the Board 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.

**E1. Approval of the Minutes from the July 12, 2023, Board of Trustees Meetings**

**E2. Receiving the Minutes from the July AHMG Board of Directors Meetings**

**E3. Approval of System Wide Policies and Procedures**

The Quality Professional Services Committee recommended approval of the Policies listed below at the July 26, 2023 Committee meeting.

**System Wide Policies, Plans, and Procedures**

- Neutropenic Patient Care Policy  
- Security Management Plan  
- MEDICAL CARE OF PATIENTS AT JOHN GEORGE PSYCHIATRIC HOSPITAL (JGPH)  
- SLH IP 2022 Assessment 2023 Plan  
- Highland Hospital Outpatient Pharmacy Quality Assurance and Medication Error Reporting  
- Highland Hospital 340B Drug Pricing Policy Program  
- MEDICATION BORROWING AND LOANING BETWEEN AHS INPATIENT

The Quality Professional Services Committee recommended approval of the Policies listed below at the August 23, 2023 Committee meeting.

- Visiting Hours/Visitors Policy  
- Color Coded Wristband Procedure
E4. Medical Staff Policies

The Quality Professional Services Committee recommended approval of the Policies listed below at the August 23, 2023 Committee meeting.

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

E5. Approval of Contracts

The Finance Committee recommends approval of the Contract listed below.

E5a. Amendment to the B360 biomedical equipment maintenance services agreement with Agiliti Healthcare, Inc. to extend term for delivery of services. The term of this amendment is effective October 1, 2023 through April 30, 2024. The estimated impact of this amendment is $1,542,560.

Mark Amey, Chief Information Officer

E5b. Amendment to the M360 biomedical equipment management services agreement with Agiliti Healthcare, Inc. to extend term for delivery of services. The term of this amendment is effective October 1, 2023 through April 30, 2024. The estimated impact of this amendment is $1,033,440.

Mark Amey, Chief Information Officer

END OF CONSENT AGENDA

F. ACTION/DISCUSSION (Est 75 Min)

Public comment on all Action items may be heard prior to the Board’s vote.

F1. DISCUSSION: Patient Family Advisory Committee Report
Jeanette Dong, Chief Strategy Officer

F2. DISCUSSION: Equity Analytics Workgroup Report
Annette Johnson, Director Quality Analytics
U. Mini B. Swift, MD Vice President, Population Health

F3. ACTION/DISCUSSION: Approval of the Third Amended and Restated Subordination Agreement and Consent
Ahmad Azizi, General Counsel

G. DISCUSSION: Board Calendar and Tracking (Estimated 5 min)
H. STAFF REPORTS (Written)

Public comment on each Staff Report item may take place as needed. There is typically no Board discussion on these written reports. The Board does not vote on Staff Reports.

   Kimberly Miranda, Chief Financial Officer

H2. Public Affairs and Community Engagement Report
   Alice Kinner, Administrative Director

(General Counsel Announcement as to Purpose of Closed Session)

CLOSED SESSION (Estimated 90 min)

Public comment on Closed Session items may take place prior to the Board adjourning to the Closed Session. An announcement of any action taken during the Closed Session will take place prior to the end of the Open Session.

1. Public Employee Performance Evaluation
   [Pursuant to Government Code Sections 54957(b)(1)]
   Title: Chief Executive Officer

2. Labor Negotiation
   [Government Code Section 54957.6]
   AHS Designated Representatives: Lorna Jones, CHRO
   Unrepresented Employee: Chief Executive Officer

3. Conference with Labor Negotiators
   [Government Code Section 54957.6]
   AHS/AHMG Designated Representatives: IEDA
   Employee Organization: SEIU 1021

4. Conference with Labor Negotiators
   [Government Code Section 54957.6]
   AHS Designated Representatives: Lorna Jones
   Employee Organization: SEIU 1021

5. Conference with Legal Counsel – Anticipated Litigation
   [Government Code Section 54956.9(d)(4)] Initiation of litigation: 1 case
   Ahmad Azizi, General Counsel

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

(Reconvene to Open Session)
General Counsel Report on Action Taken in Closed Session

TRUSTEE COMMENTS

ADJOURNMENT

ADDENDUM 1: ABCs of Communication

ADDENDUM 2: Board Attendance Tracker

Our Mission
Caring, Healing, Teaching, Serving All

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

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

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

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

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

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

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

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

Difference - Invited – Valued – Embraced

Equitable, Inclusive, and Just Culture
At
Alameda Health System
Project Update – James Jackson, CEO
Monday, August 28, 2023
Agenda:

• Getting to Know Each Other

• Overview of Inclusive Culture Proposal

• Recap of Leadership Workshops

• Project Status

• Championing the Work – How We Partner

• Next Steps
Getting to Know Each Other:

• Share with us your connection to Inclusive Culture both personally and professionally.
• **Opportunity Statement:** This opportunity will engage the Board of Trustees and Executive Leadership Team in a Community of Practice (CoP) to build an accountable culture of inclusion, equity, and justice.

  • By making inequitable arrangements of power and marginalization visible, the CoP will
    • Cultivate a leadership culture that values courageous conversations
    • Respects and actively seeks diverse perspectives
    • Builds trust to facilitate effective collaborations

• **Deliverables:**
  • Create a shared vision for Inclusive Culture with alignment on goals and measurable outcomes.
  • Build relational trust within the ELT, BOT, and between the two groups through behavioral change and accountability.
  • Implement DEI learning and practice processes for continuous improvement relatable to AHS’s unique and complex situations.
  • Leverage data to assess culture health and leader/employee experience for continuous monitoring and iteration.
Leadership DNA – AHS Board of Trustees – June 30, 2023 – Session Summary

• **Definition of Inclusive Culture**
  - Dignity
  - Respect/Welcoming
  - Empathy
  - Brave/Comfortable
  - Integrity
  - Co-conspirator (mentorship/ally)
  - Community
  - Intentional
  - Development and Growth
  - Failing forward
  - Humility/Openness

• **Leadership behaviors that foster Inclusive Culture**
  - Excited
  - Intrigued
  - Expected
  - Connected
  - Contemplative
  - Optimistic
  - Necessary start

• **Three Measures of Accountability**
  - Challenge dominant culture/norms
  - Consider the historically excluded
  - Present information that is clear, concise, and absorbable

• **Future Opportunities**
  - BoT Succession/Onboarding
  - Representation
  - Board compensation/composition
  - Create value add for BOD service
  - Lived experience requires new norms to be established (inclusion equity concern)
  - Build out operating principles to increase communication with the group
  - Create tangible outcomes
  - Committee discipline – remember we are here for public

• **Recommendations**
  - Align on whom the Board serves and the purpose
  - Establish operating principles for inclusive board meetings and interactions
  - Design Board of Trustee training (unconscious bias, microaggressions, power, and dominance)
  - Prioritize Future Opportunities
• Definition of Inclusive Culture
  • Respect
  • Empathy
  • Mindfulness of other experiences and backgrounds
  • Listening

• Lessons Learned
  • Connecting leadership development to inclusive culture
  • All leaders attend in person
  • Separate session for Leaders and direct reports - open dialogue and a safe space
  • More time to go deeper

• Future Opportunities
  • Deeper dive into tough topics such as bias and dominance, inclusive culture, and justice
  • Session held off-site

• Recommendations – Move forward with Inclusive Leadership Training
  • Healthcare Executive Leadership Journey
  • Instructor Led
  • 6 modules – offered by Charlotte and Inclusive Leaders Group
  • 1 module - Microaggression/Macroaggressions/Anti-Blackness – designed by Illy & Jacqueline
  • Virtual and/In-person
Inclusive Culture Assessment Project Timeline

- **TBD**: Inclusion Assessment Budget Approval
- **September 5**: Confirm participants & demographics
- **September 8**: Finalize Communications & Campaign Plan
- **September 21**: Design Assessment
- **October 24**: Deploy
- **November 7**: Close Survey
What You Can Expect from Us

• Discover
  • Understand your vision for the organization, including your commitment to building an inclusive culture
  • Showcase how an inclusive culture can improve employee engagement, equity, and justice
  • Ideas to build employee and leader engagement

• Provide Support to
  • Equip you and your leadership team with the information and tools to advocate effectively for the Inclusion initiatives across the organization
  • Help you create and communicate the importance of inclusion to employees, stakeholders, and the public

• Deliver
  • Tailored recommendations that align with AHS objectives and unique needs.
  • Consultation to help address concerns and questions
  • Alignment with HEDI and Huron to connect various initiatives

• Stay Connected
  • Provide regular updates on the progress of Inclusive Culture initiatives, including successes and challenges - Meeting cadence to be determined
What We Need from You

• Leverage various media and forums of communication to
  • Reinforce that Inclusion is about the “People” (leaders, staff, patients), creating an environment where Difference is Invited, Valued, and Embraced
  • Articulate your vision and personal commitment to creating an inclusive organizational culture and how it aligns with AHS’ mission and vision
  • Encourage participation in the cultural assessment

• Support this effort by
  • Holding ELT accountable to reinforce to engage actively and champion this work
  • Encouraging leaders to attend the executive training
  • Understanding and exemplifying the behaviors and skills required for an inclusive culture
    • and to their teams

• Ensure the AHS resources are in place to help move the initiatives forward
• Acknowledge resistance or concerns about Inclusive Culture and address them openly and constructively
Next Steps

• Submit the proposal for budget approval – August 25
• Kick off Culture Assessment – September 5
• Update to the Board of Trustees – September 13
• Kick off ELT training – September 29
B. CEO Report (Estimated 15 min)
No Written Materials
Agenda Item B CEO REPORT

No written materials were submitted for this agenda item. If materials become available, the item will be updated in Boardvantage and on the internet. A verbal discussion of the item may take place at the meeting.
C. MEDICAL STAFF REPORTS (Estimated 20 min)
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
- Staff/Patient Experience
- 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
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: Grieff, Trudy  
2. Irene Fernandez Charge RN = Daisy Award
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
  - The Department report from Psychiatry was presented.
## QUALITY CARE

- Reducing assaults through security, improved medication treatment, debriefs, staff education on diagnoses, hardwired identification of Highest Risk for Violence.
- Addressing deficiencies in suicide and nutritional assessments via monitoring with 100% compliance expected this quarter.
- Improving substance use treatment via screening, education, care coordination.
- Pharmacy projects to reduce overrides, polypharmacy, and ensure appropriate monitoring.

## OPERATIONS

- Reducing PES ambulance wait times via workflow improvements.
- Analyzed inpatient length of stay: 1/3 ready for lower level of care.
- Stabilized IOP/PHP program and staffing; programs now financially sustainable, stable and back in growth phase.
- Wellness Program started at both campuses with caseloads of 200 visits/week with great growth potential.
- Formed workgroups on criminal justice, quality metrics, Alameda County Behavioral Health Partnership

## STRENGTHS

- Celebrated Joint Commission survey with zero findings at John George Psychiatric Hospital.
- Successful Kaiser psychiatry resident rotations continue at JGPH.
- Supported community via events, partnerships, marketing, newsletter.
- Robust psychiatry CME program with topical behavioral health topics

## OPPORTUNITIES

- Need for more sub-acute treatment options: specialty centers for chronically aggressive patients as well as more options for transitional housing / crisis residential beds.
- Expand outpatient services to meet unmet needs in community.
- Consider embedded behavioral health model for consultation / liaison service.
- Continue to improve partnership with Alameda County Behavioral Health to work on shared goals and improved care for our patients.
D. COMMITTEE AND TRUSTEE REPORTS (Estimated 15 min)
No Written Materials
Agenda Item D1 HR

No written materials were submitted for this agenda item. If materials become available, the item will be updated in Boardvantage and on the internet. A verbal discussion of the item may take place at the meeting.
No Written Materials
Agenda Item D2 QPSC

No written materials were submitted for this agenda item. If materials become available, the item will be updated in Boardvantage and on the internet. A verbal discussion of the item may take place at the meeting.
No Written Materials
Agenda Item D3 Finance Committee

No written materials were submitted for this agenda item. If materials become available, the item will be updated in Boardvantage and on the internet. A verbal discussion of the item may take place at the meeting.
No Written Materials
Agenda Item D4 Ad Hoc

No written materials were submitted for this agenda item. If materials become available, the item will be updated in Boardvantage and on the internet. A verbal discussion of the item may take place at the meeting.
BOARD OF TRUSTEES REGULAR MEETING  
WEDNESDAY, JULY 12, 2023  
5:00pm to 9:00pm

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

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

MEMBERS

Kinkini Banerjee, President  
Jennifer Esteen, Vice President  
Taft Bhuket MD Jet Chapman  
Alan E. Fox Mark Friedman  
Nely Obligacion David Sayen  
Sblend A. Sblendorio

BOARD OF TRUSTEES REGULAR MEETING MINUTES

THE MEETING WAS CALLED TO ORDER AT 5:03 pm

ROLL CALL WAS TAKEN AND THE FOLLOWING TRUSTEES WERE PRESENT:  Kinkini Banerjee, Taft Bhuket, MD, Jetreneee C. Chapman, Jennifer Esteen, Alan E. Fox (left at ), Mark Friedman, Nely Obligacion, David Sayen, and Sblend A. Sblendorio

ABSENT: None

Mr. Azizi announced that Trustee Chapman was attending the meeting remotely under the Just Cause clause of the Brown Act.

PUBLIC COMMENT: Non-Agenda Items

A. DISCUSSION: Executive Officers Report  
Kinkini Banerjee, President  
Jennifer Esteen, Vice President  
David Sayen, Secretary/Treasurer  
Mark Friedman

A1.Aiming for Health Equity: The Bullseye of the Quadruple Aim, JHM, 2021

A2.The Quintuple Aim for Health Care Improvement, JAMA, 2022
A3. Board Meeting Discussion Tracker

Trustee Banerjee reviewed the Board Discussion Planner and Tracker. She clarified that the list was only for Board meetings and did not include the various other meetings and conferences Trustees attend.

Trustee Fox asked if the follow-up should include who was responsible for the follow up and the date it was coming back to the Board or committee. Trustee Banerjee said that was a good suggestion.

Trustee Esteen said this was a comprehensive list of discussion items that gave the institution and Board the heart and body. Having the pillars identified was helpful. Equity and diversity had to be in the cross hairs of everything they did. This demonstrated that they had been talking about these metrics.

Trustee Banerjee said a lot of this work was informed by HEDI and other committees. There was a relentless focus on patient centeredness and this chart helped demonstrate that.

Trustee Sayen said he liked the way this carried the story through. He said the second article made him consider that if they did not focus on equity and inclusion they would do worse in the other categories. They could not focus on part of the goal without focusing on all of it.

Trustee Obligacion asked to add timelines and a status of the progress.

Trustee Banerjee asked Mr. Jackson about follow-up regarding the Bridge Clinic work presented in April. Mr. Jackson said there were a number of actions taken from the suggestions. He wanted to come back with a more formal follow-up to talk about the progress they’ve made.

B. CEO Report

James E.T. Jackson, Chief Executive Officer

Mr. Jackson reviewed the report available here: https://www.alamedahealthsystem.org/board-of-trustees-meetings/

Trustee Obligation said there were public comments at the last Board meeting about CEO rounding at John George. Mr. Jackson said both he and Mr. Fratzke rounded at John George immediately following that meeting. He said no violence was acceptable, but the number of injuries and severity of injuries were improving. Mr. Fratzke also met with SEIU representatives to discuss the situation. They had some work to do.

C. Medical Staff Reports

- AHS Medical/Administrative Dyad: LanNa Lee, MD, Chief of Medical Staff
  Ro Lofton, Chief Administrative Officer
  Edris Afzali, MD, SLH Leadership Cmte Chair

- AH Medical/Administrative Dyad: Nikita Joshi, MD, Chief of Medical Staff
  Mario Harding, Chief Administrative Officer
Dr. Lee and Dr. Puranam reviewed the report beginning on agenda packet page 21.

Trustee Esteen asked if the Food is Medicine program had health education classes. Dr. Puranam said the program used a mixed approach. They had some health classes with a nutritionist and a nurse practitioner. The open-source wellness portion had an exercise component and a little mental health as well.

Trustee Banerjee said just a few months ago there were a lot of vacancies. She asked how resourced Dr. Puranam felt. Dr. Puranam said it was still challenging given the shrinking pool of applicants. There were plans to work with recruiters to reach out to various programs to increase the candidate pool.

Dr. Joshi reviewed the report beginning on agenda packet page 25.

Dr. Afzali reviewed the report beginning on agenda packet page 24.

Trustee Esteen asked about the length of stay for the pediatric mental health patients. Dr. Afzali said it came in waves. They had not had much movement with the County and no updates about Willow Rock

Trustee Banerjee said the pediatric length of stay would be on the tracker.

D. COMMITTEE AND TRUSTEE REPORTS

D1. Audit and Compliance Committee: June 21, 2023
Mark Friedman, Committee Chair

Trustee Friedman reviewed the Audit and Compliance Committee meeting of June 21, 2023. The meeting materials are available here: https://www.alamedahealthsystem.org/board-of-trustees-meetings/

D2. Quality Professional Services Committee: June 28, 2023
Taft Bhuket, MD, Committee Chair

Trustee Bhuket reviewed the QPSC meeting of June 28, 2023. The meeting materials are available here: https://www.alamedahealthsystem.org/board-of-trustees-meetings/

D3. Finance Committee: July 5, 2023
Alan E. Fox, Committee Chair

Trustee Fox reviewed the Finance meeting of July 5, 2023. The meeting materials are available here: https://www.alamedahealthsystem.org/board-of-trustees-meetings/

E. CONSENT AGENDA: ACTION

E1. Approval of the Minutes from the May 10, 2023, Board of Trustees Meetings

E2. Receiving the Minutes from the MAY/JUNE AHMG Board of Directors Meetings
E3. Approval of System Wide Policies and Procedures

The Quality Professional Services Committee recommends approval of the Policies listed below.

**System Wide Policies, Plans, and Procedures**

- Catheter Directed Thrombolysis panel (for PERIPHERAL thrombolysis ONLY)
- MERT and Pharmacy Summary Q1.2023
- Pump Library Summary Updates
- AHS Alaris Comfort Care Library
- HGH CADD Library
- Medications: Hazardous Drugs Preparation and Handling
- Medications: Formulary Development, Management and Maintenance
- Patients Own Medications: Storage, Security, Handling, and Administration
- Vancomycin Pharmacy Dosing Policy
- Medication Prescribing and Ordering
- AH 340B Policy and Procedures
- System Injectable Medication List
- SBAR – KCL Infusion rate of 40mEq/hr order panel change
- SBAR - Addition of IV Buprenorphine infusions
- SBAR - ICU vs. non-ICU sections + adjunct agents for alcohol withdrawal order set
- 2022 AH Antibiogram
- 2022 SLH Antibiogram
- System TNK Policy
- SBAR – D10W Infusion Rate Change in the Hypoglycemia Order Panel
- DKA HHS Transition Panel D10W changes
- COMPLIMENTARY LOCAL TRANSPORTATION: CAB, UBER, LYFT, BUS, BART, PARATRANSIT
- AHS guide to NIPPV
- ED Code OB Protocol
- PA NP in ED SP and Practice Guidelines
- Fast MRI Protocol
- HGH Infection Prevention Plan
- Medical Record Content & Documentation Requirements Policy

E4. Medical Staff Polices

The Quality Professional Services Committee recommends approval of the Policies listed below.

AHS and AH Medical Staff Policies:

- Medical Staff Applications Levels
- Medical Staff Temporary Privileges

E5. Approval of Contracts

The Finance Committee recommends approval of the Contracts listed below.
E5a. Agreement with The Regents of the University of California on behalf of the University of California, San Francisco, Department of Neurological Surgery for provision of neurosurgery coverage services. The term of this agreement is August 1, 2023 through July 31, 2025. The estimated impact of this agreement is $5,735,907.
Mark Fratzke, Chief Operating Officer

E5b. Agreement with Bay Area Community Services for provision of medical respite services, including residential services, wraparound services, and housing solutions. The term of this agreement is August 1, 2023 through July 31, 2026. The estimated impact of this agreement is $2,678,400.
Dana Littlepage, Vice-President Patient Care Services

E5c. Agreement with Infor (US), LLC for provision of enterprise resource planning software services. The term of this agreement is August 1, 2023 through July 31, 2026. The estimated impact of this agreement is $1,602,401.
Kevin Shorten, Vice President of Applications

E6. Approval of FY 23 Compliance and Internal Audit Annual Workplan
Marilyn Boston, Chief Compliance and Privacy Officer/VP Compliance & Internal Audit

Trustee Banerjee said they did not have agenda item E2 so they could not vote on that.

Trustee Bhuket requested removal of agenda item E5a from the consent agenda to allow for additional discussion.

Trustee Fox said the top line of page 4 of the Board minutes needed an “and.”

Trustee Banerjee requested removal of agenda item E3 from the consent agenda to allow for additional discussion.

Trustee Bhuket moved, Trustee Esteen seconded to approve agenda items E1 as amended, E4, E5b, E5c.

ACTION: A motion was made and seconded to approve agenda items E1 as amended, E4, E5b, E5c. A roll call was taken and the motion passed.
AYES: Trustees Banerjee, Bhuket, Chapman, Esteen, Fox, Friedman, Obligacion, Sayen, and Sblendorio
NAYS: None
ABSTENTION: None

Trustee Bhuket asked if there were any performance metrics included in agenda item E5a, the agreement with The Regents of the University of California. Dr. Tornabene said there were not at this time.

Trustee Friedman moved, Trustee Sblendorio seconded to approve agenda item E5a.
ACTION: A motion was made and seconded to approve agenda item E5a. A roll call was taken and the motion passed.
AYES: Trustees Banerjee, Bhuket, Chapman, Esteen, Fox, Friedman, Obligacion, Sayen, and Sblendorio
NAYS: None
ABSTENTION: None

Trustee Banerjee said that agenda item E3 included some items that seemed less like policies and more like reports, such as the Medication Event Summary on agenda packet page 49, the Medication Reconciliation report on agenda packet page 58, and the Medication Error Reduction Plan on agenda packet page 67. Trustee Banerjee asked if they were supposed to approve these items and requested clarification if they were.

Trustee Friedman moved, Trustee Fox seconded to approve agenda items E3 and E6.

ACTION: A motion was made and seconded to approve agenda item E5a. A roll call was taken and the motion passed.
AYES: Trustees Banerjee, Bhuket, Chapman, Esteen, Fox, Friedman, Obligacion, Sayen, and Sblendorio
NAYS: None
ABSTENTION: None

F. ACTION/DISCUSSION

F1.DISCUSSION: The Joint Commission Updates
Nilda Perez, System Director of Regulatory Affairs

Ms. Perez reviewed the report beginning on agenda packet page 334.

Trustee Fox asked if environment of care was part of the survey. Ms. Perez said each facility was responsible for the environment of care. It was a significant part of the survey. Quality care needed to happen in a safe environment. It had the most standards under the Joint Commission. She said one of the opportunities they’ve identified was the need to operationalize what compliance looks like. They were working a lot on that process in 2023 and hoped to see good results going forward.

Trustee Banerjee asked about action plans and if they would need a resurvey. Ms. Perez said all of the action plans had been submitted on time. The Commission had not yet responded with questions and they would not resurvey as there were no condition level findings.

F2.DISCUSSION: BETA Healthcare Group, Building a High Reliability Organization
Darshan Grewal, System Director of patient Safety

Ms. Grewal reviewed the report beginning on agenda packet page 353.

Trustee Bhuket asked if the acuity scale was built by AHS or BETA. Ms. Grewal said it was built by AHS, but BETA had a dashboard that was used the same way. Trustee Bhuket
asked how it was benchmarked with their other program. He also asked how much AHS paid BETA each year. Mr. Azizi said he would provide that information.

Trustee Esteen said that as the insurance carrier BETA had tremendous incentive to provide these programs and then AHS got so much benefit from the programs.

Trustee Obligacion asked for clarification on the Culture of Safety survey response rate. Ms. Perez said the overall response rate for the entire organization was 74%. It was significant that 73 out of 160 departments had a 100% response rate. The report demonstrated that staff wanted to participate.

Trustee Banerjee said the optics of the survey has been a challenge. Physician survey participation can be lower than other groups. Dr. Tornabene said over the last few years they have restructured the survey so that physicians were not assigned to a physical area but rather the medical staff department structure, which has helped. There has also been key engagement from physician leaders who have been using the survey to develop local action. Lastly they have been looking at the people who should be responding and making sure they are the people who were working for AHS every day.

Trustee Esteen would like to see some of the information from the debriefs in their next update. Ms. Grewal said that she had found that people really didn’t want a whole lot. They wanted to be heard, respected, valued, and they wanted to be part of changes that had impact on their work.

Trustee Banerjee said she attended a BETA conference that discussed harm events. They talked about how people were inclined to create distance from mistakes when all families want was closure, they wanted to know what happened. We feared validating their pain.

G. DISCUSSION: Board Calendar and Tracking (Estimated 5 min)

H. STAFF REPORTS (Written)

H1. Chief Financial Officer Report,  
    Kimberly Miranda, Chief Financial Officer  
    H1a. May 2023 Financial Report

H2. John George Hospital Operations Update  
    Mark Fatzke, Chief Operating Officer  
    Mario Harding, Chief Administrative Officer, Community Hospitals

H3. Public Affairs and Community Engagement Report  
    Alice Kinner, Administrative Director

Mr. Azizi said the Board would meet in closed session to discuss the items set forth on the agenda.

Trustee Obligacion announced that as the Deputy Director of SEIU 1021 she would recuse herself from agenda item 1.
Trustee Bhuket announced that as an employee of Alameda Health Medical Group he would recuse himself from agenda item 1.

**CLOSED SESSION**

1. **Conference with Labor Negotiators**
   [Government Code Section 54957.6]
   AHS/AHMG Designated Representatives: IEDA
   Employee Organization: SEIU 1021

2. **Public Employee Performance Evaluation**
   [Pursuant to Government Code Sections 54957(b)(1)]
   Title: Chief Executive Officer

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

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

**ADJOURNMENT: 9:15 pm**

This is to certify that the foregoing is a true and correct copy of the minutes of the meeting of July 12, 2023, as approved by the Board of Trustees on September 13, 2023.

Ronna Jojola Gonsalves
Clerk of the Board

APPROVED AS TO FORM:

Reviewed by: _________________________________
Ahmad Azizi
General Counsel
No Written Materials
Agenda Item E2 AHMG Minutes

No written materials were submitted for this agenda item. If materials become available, the item will be updated in Boardvantage and on the internet. A verbal discussion of the item may take place at the meeting.
PURPOSE
To provide guidelines on the management of patients that are immune-compromised due to low white blood cell.

BACKGROUND
Patients that are immune-compromised due to a low white blood cell count may be more vulnerable to infection. Compromised patients are often infected by their own (endogenous) microorganisms or are colonized and infected by microorganisms transmitted by the inadequately washed hands of Healthcare workers.

DEFINITIONS
A. Neutropenia: a decrease in the number of circulating neutrophils in the blood evidenced by an absolute neutrophil count (ANC) less than 1000/mm³.

B. Fever: defined as a temperature greater than or equal to 38°C Celsius (100.4°F). Fever is the most reliable and often then only sign of infection in patients with neutropenia. Neutropenic patients may not express classic signs of infection (e.g. redness, edema and pus) and in some cases may not be able to manifest fever because they have a suppressed immune system.

C. Protective Precautions are indicated for patients with:
   a. WBC of <1000 plus fever
   b. ANC of <500 or an ANC <1000 with strong probability of falling to <500 within 48 hours.

POLICY
A. In addition to Standard Precautions, the following infection prevention guidelines will be followed:
B. Post Protective Precautions signs visible to all entering room.
C. The use of private rooms should be considered whenever possible. (does not have to be negative pressure room, nor does room door have to be closed).
D. If semi-private, patient will be kept separate from patients who are infected or who have conditions that make infection transmission likely.
E. All health care workers and visitors will adhere to performing strict hand hygiene upon entering and exiting the patient room and during patient care as indicated by the hand hygiene policy. If patient is receiving Chemotherapy, soap and water must be used.
F. Instruct patient to perform hand hygiene frequently.
G. Consider visitor limitations to those with upper respiratory infections. Masks are to be worn if individuals (employees, family, visitors, etc.) entering the room have the possibility of an actual upper respiratory infection (URI).
H. No fresh flowers or standing water in containers.
I. Neutropenic patients and other immunosuppressed patients will wear a mask when outside of their assigned room or when being transported to a procedure.
J. Aseptic technique will be followed when performing all invasive procedures, or when providing daily care to any invasive tubing.
K. Healthcare personnel or visitors who have a communicable disease (including colds and other respiratory symptoms) should not care for this patient or enter the room.
L. Avoid live vaccination and persons who have recently had them.

REFERENCES


ATTACHMENTS
Protective Precaution Door Sign

APPROVALS

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<tr>
<th>Infection Control Committee</th>
<th>System</th>
<th>Alameda Hospital</th>
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PURPOSE
The purpose of the Security Management Plan is to define Alameda Health System’s (AHS) safety and security program to mitigate risk of personal injury or property loss and support AHS’ goal of providing a safe and secure environment for employees, medical staff, patients, vendors, visitors, and volunteers.

The mission of the Security Management Plan is to provide and promote the safest possible physical environment using a systematic approach based on the mission, vision, and values of Alameda Health System, healthcare security best practices, general safety policies, and all regulatory requirements. The Board of Trustees oversees and reviews the development and implementation of the Environment of Care Security Management Program, in conjunction with the Vice President of Support Services, AHS Director of Security, and Contract Security.

SCOPE
The Security Management Plan applies to all AHS facilities and is designed to work in concert with the Environment of Care Management Plans (i.e., Workplace Violence, Hazardous Materials, Life and Fire Safety, Emergency Management, etc.). The fundamental mission of the Security Management Plan is to provide security services to all persons, all properties, and to protect the interests of AHS through the efficient use of personnel, technology, prevention activities, and response to service requests. The program is intended to identify and manage – through effective response procedures - general and high security risks for the protection of all employees, medical staff, patients, vendors, visitors, and volunteers.

FUNDAMENTALS

A. Visibility of security personnel throughout Alameda Health System facilities helps prevent crime and provides a safer environment for employees, medical staff, patients, vendors, visitors, and volunteers.

B. An assessment of risks to identify potential problems is essential to reducing crime, injury, and other security incidents.
C. Analysis of security incidents provides information to predict and prevent crime, injury, and other safety and security incidents.

D. Educating workforce members enhances their awareness related to criminal activity. Workforce members are trained to recognize and report potential or actual incidents to ensure a timely response by security or law enforcement. Workforce members in sensitive areas are trained for competence in the security measures designed for those areas and their responsibilities to assist in protection of patients, visitors, staff, and property.

OBJECTIVES
The Security Management Plan objectives are intended to identify, mitigate, and reduce risk; assess and implement corrective actions, and prevent or reduce personal injuries and property losses. Objectives for the Security Management Plan are developed from information gathered during routine and incident-specific risk assessments, annual evaluation of the previous year’s plan, performance measures, Security department reports and environmental patrols. Objectives to fulfill the Security Management Plan are:

A. Respond to and investigate all potential and actual security incidents involving patients, visitors, AHS personnel or property in a timely fashion. Analysis of security incidents and other data to reduce and prevent crime, injury, and other incidents from occurring and reoccurrence.

B. At New Employee Orientation (NEO), provide all employees instruction on how to contact security for emergency and non-emergency response along with information pertaining to maintaining personal and work environment safety. Staff are instructed to recognize and report potential or actual security incidents in a timely manner. In addition to the basics of security reporting, the security team to provide in-service de-escalation training for AHS staff on an as requested basis. During de-escalation training, the Contract Security trainer educates hospital employees to ensure any incidents of workplace violence are immediately addressed.


D. Perform documented twenty-four-hour security patrols of all hospital buildings and properties to identify potential safety risks and provide a visible presence to serve as a crime deterrent.

E. Provide a visible uniformed security presence to deter crime, and increase safety to patients, visitors, and staff with twenty-four-hour security presence in all emergency departments (Creedon Wound Care & Support Services Center excluded).

F. Utilize the AHS Threat Assessment Policy to assess all threats internal and external.
G. Advise staff of serious crimes occurring on campus by distributing timely security alert memos warning staff of security events.

H. Weapon and Contraband screening of all patients and visitors entering patient facing AHS facilities (Creedon Wound Care and the SSC excluded).

I. Access to the grounds, buildings, and sensitive areas is limited by enforcement of staff and visitor identification policies and by controlling authorized access to sensitive areas. Sensitive areas are restricted by adjusting the schedule for locking and unlocking areas in accordance with security concerns, access restrictions, and areas deemed security sensitive (see Sensitive Areas Policy).

J. Timely response to emergencies and requests for assistance. Crime, fire, injury, or other incidents are reported and documented. Communication is maintained externally with local law enforcement agencies and other civil authorities. Internal communications to hospital administration are provided as needed.

K. Vehicle code laws on the AHS grounds are enforced including control of parking and access to the emergency ramp. Parking enforcement is based upon authorized parking permits (where applicable see AHS Parking Policy).

L. Timely response to requests for escorts and door openings or other routine requests for assistance is provided.

M. The potential for workplace violence is evaluated as part of risk assessments. Programs and training classes are developed to educate facility personnel (see Workplace Violence Policy).

N. Enforcement of the AHS no-smoking policy (see Smoking Policy)

O. Using Information, Collection, and Evaluation System (ICES). The following is reported to the EOC Committee:
   a. Security Incidents
   b. Security Conditions
   c. Investigations
   d. Basic security activities and services

ORGANIZATION AND RESPONSIBILITY

A. The Alameda Health System Executive Leadership Team supports and authorizes additional security measures for special circumstances such as domestic violence, gang-related activities, forensic patients, response to threats, civil unrest, and fire life safety incidents.
B. The Alameda Health System Executive Leadership Team in collaboration with the AHS Security Director, and the Alameda County Sheriff’s Sergeant at the WCHHC evaluates the needs of local law enforcement and deploys appropriate numbers of Sheriff Deputies and security staff to support the mission and purpose of the Security Management Plan.

C. The AHS Security Director and Contract Security Portfolio Manager work in collaboration with other department heads in managing all aspects of the security program. The AHS Security Director and Contract Security Portfolio Manager advises the AHS Executive Leadership Team on security issues that may necessitate changes to policies, orientation, required education, or purchasing of equipment for the AHS facilities. The AHS Security Director and Contract Security Portfolio Manager evaluate current programs and identify new programs and activities to better educate and protect the patients, staff, and the organization of any security risk.

D. The AHS EOC committee receives reports on the activities of the Security Program from Contract Security. The AHS Director of Environmental Health & Safety and EOC Committee reviews the reports and communicates concerns on identified issues and regulatory compliance to the facility’s Senior Executive Leadership.

E. Department heads or their designees that manage security sensitive areas are responsible for training their personnel in any special security procedures or precautions. Where necessary, Contract Security assists department heads in developing department security programs or policies. Employees and contractors are responsible for learning and following departmental and Alameda Health System’s procedures for security.

F. Department leadership accountability for new AHS employees receiving orientation, contractors working in the department oriented to AHS security procedures, and annual employee education and documentation pertaining to the follow topics:
   1. Identification Badges
   2. Security services contact information
   3. Reportable incidents (disturbances with patients or visitors, lost/stolen property of patients, visitors, or employees, suspicious people/items, smoking on the Alameda Health System campuses)
   4. Weapons and Contraband
   5. Forensic Patients
   6. Access control
      i. Keys, cards, codes
      ii. Regular office hours and after-hours
      iii. Parking
      iv. Visitor policies
      v. Panic alarms/buttons
   7. Securing personal items
   8. Infant abduction prevention and response
PROCESSES OF THE SECURITY MANAGEMENT PLAN

EC.01.01.01 The Medical Center plans activities to minimize risks in the environment of care.

EP4 Security Management Plan
AHS has developed and maintains a written management plan describing the processes it implements to effectively manage or prevent security incidents and emergencies affecting the facility, patients, and staff that the environment may present. This plan is evaluated annually and changed as necessary based on changes in conditions, regulations, standards and identified needs.

EP 5 Management of the Security Processes
The AHS Security Director and Contract Security Portfolio Manager are assigned to coordinate the development, implementation, and monitoring of AHS security program activities at AHS facilities.

EC.02.01.01 The Medical Center identifies and manages its security risks.

EP1 Risk Assessment
AHS conducts triannual system-wide Security Risk Assessments of the following items:

1. Physical plant size, including current and planned changes, patient population, the volume of visits, community setting.
2. Community crime patterns, neighborhood patterns of change.
3. Exterior lighting, landscaping, communication systems, and parking issues.
4. Security program leadership, policies, procedures, functions, activities, staffing, and deployment.
5. Physical and electronic security systems.

In addition, the AHS Security Director and Contract Security Portfolio Manager gather data from information gathered during routine and incident-specific risk assessment activities to implement countermeasures to mitigate risk. At the patient care level, AHS staff conduct proactive risk assessments to identify the potential for adverse impact on the safety and security of patients, staff, and visitors entering AHS facilities. This is done by identifying events deemed safety risks and reporting it through the Alameda Health System MIDAS Safety Management reporting system.

EP3 Risk Assessment to Implement Procedures
Information from risk assessments and other sources contributes to the development and implementation of new procedures, activities and/or access controls to reduce the probability of security risks from occurring.

EP5 Maintains Grounds and Equipment
Members from the AHS Parking Team, Sheriff’s Department, and contract security staff conduct rounds to report on interior and exterior lighting, functionality of safety equipment, access doors, and other problems in need of service or repair.

**EP7 Identification Program**

All employees, staff, vendors, contractors, and volunteers are required to wear an AHS photo identification badge on their upper body while on duty. Identification badges are to be displayed picture side out. Contract Security personnel manage enforcement of the identification program. Personnel who fail to display identification badges are questioned by security and reported to their department head. Department leaders are required to ensure all employee identification badges are confiscated from personnel upon termination by their supervisor.

Departments with vendors/contractors on campus on a regular basis (> 3 times per week) are required to submit a vendor badge request. Medical supply vendors, pharmaceutical representatives, medical device representatives or any other vendor arriving to campus on an infrequent basis (<1 time per week) are required to register with the SYMPLR Vendor Management system administered by the Materials Management department.

Patient identification is provided at the nursing unit where patients are first admitted. If a patient’s wristband is damaged it is replaced by the nursing staff. Patient identification is not removed upon discharge. Patients are instructed to remove the identification band at home.

Visitors of patients are issued a color-coded badge or wristband as identification while in the facility. Color coded badges are issued by security personnel via the Security Visitor Management System. Each badge or wristband indicates which floor or area the visitor is allowed access to. The badge or ribbon must be worn on the outermost garment, and clearly visible always. Visitors to some specific units may be requested to contact the ward for visitation approval, e.g., Labor & Delivery, Newborn Nursery, and Behavioral Health. The security officers and Nursing staff, assist in enforcement of visitor identification policies.

**EP8 Sensitive Areas**

The AHS Security Director and Contract Security Portfolio Manager work with hospital leadership to identify security sensitive areas. The appropriateness of declaring an area security-sensitive is based on the potential for violence or use of weapons; especially vulnerable populations such as the elderly, infants, and children; the availability of drugs, money, and unsecured personal property; identification and access for visitors/employees in all areas of Alameda Health System.

In collaboration with departmental leadership, the following areas are currently designated as sensitive areas:

1. Emergency Departments (Alameda Hospital, Highland Hospital, San Leandro Hospital)
2. Pharmacy (Alameda Hospital, Fairmont Hospital, Highland Hospital, John George, San Leandro Hospital)
3. Family Birthing Center (Highland Hospital)
4. Intensive Care Unit (Alameda Hospital, Highland Hospital, San Leandro Hospital)
5. John George Psychiatric Hospital (Triage, PES, Unit B, Unit C, Unit D)
6. Loading Docks
7. Medical Records (HIM)
8. Cashier office
9. Information Systems

For a comprehensive list by campus please see Sensitive Areas Policy.

Access to and from the identified security sensitive areas are controlled by either card key readers, security personnel, CCTV, or door locks. Personnel assigned to work in security sensitive areas receive department level continuing education on an annual basis that focuses on special precautions or responses that pertain to their area.

**EP9 Security Procedures / Child or Infant Abduction Prevention**

AHS designed and implemented security procedures that address actions taken in the event of a security incident. These include Alameda County Sheriff’s Deputies (ACSD) and Contract Security personnel responses for normal activities (such as door opening and escorts), urgent activities (such as requests for assistance and stand-by, reports of theft, and other crime), and emergency responses (such as immediate patient or staff danger, fire alarms, disasters, and similar activities.)

General policies for these types of events provide guidance for Sheriff’s Department personnel, security staff, and other AHS staff to follow. The policies also provide a process to inform hospital leadership. It also allows for implementation for network-wide emergency activity. In addition, Sheriff’s Deputies, Contract Security personnel, and other staff are trained to respond to specific emergency management plan codes as defined in those plans.

AHS has designed and implemented security procedures that address the precautions for preventing and handling of an infant or pediatric abduction. Staff receive ongoing training and drills are conducted to maintain their awareness.

A Code Pink/Code Purple is announced over the internal page system as well as to selected radio pagers. Security dispatch also broadcasts all emergency codes to security officers via radio and to respond to events. Designated hospital staff and security officers respond to doors and specified areas to observe for persons with children or packages. AHS personnel respond to assume control of the scene and further coordinate additional resources as needed. Other staff are assigned to check designated areas and respond to the unit involved to document information and provide support to the parents.

*Please see Code Pink & Code Purple policies.*

**EP10 Hospital Follows Identified Security Procedures**

Various security policies including emergency preparedness drills and infant abduction response are tested annually; staff responses are documented, evaluated, and critiqued. As appropriate, corrective action is provided; additional training offered, or program improvements made.
EC.03.01.01 Staff Education

**EP 2** All new staff must attend a New Employee Safety Orientation as part of the new employee orientation. The New Employee Safety Orientation addresses key issues (i.e., Active Shooter and Workplace Violence) and objectives of various areas in the Environment of Care.

External law enforcement and security personnel are provided a forensic orientation sheet upon entry into the facility that provides instructions for emergency procedures for the facility, internal notifications and communication, patient interaction, and distinction between administrative and clinical seclusion and restraint.

**PREVENTATIVE MEASURES – WEAPON SCREENING**
As a preventative measure to address the potential risk of an Active Shooter event, security officers are posted at patient facing hospital and outpatient clinic entrances (excluding Creedon Wound Care, Park Bridge, and South Shore) to conduct weapon screening of patients and visitors via magnetometers ( walkthrough metal detectors).

Magnetometers are placed at facility entrances and all visitors and patients are screened via the magnetometer. Those entering with acute emergencies are screened *after* the patient is stabilized. In the event of an emergency patient who cannot be screened, security officers will stand by at the treatment room to ensure staff safety and to collect any dangerous or contraband items found with the patient.

The emergency ambulance entrance does not have a magnetometer due to patients arriving via gurney or wheelchairs which would automatically activate the magnetometer. Patients entering via the emergency ambulance entrance are screened by security officers via a hand search and a hand-held wand (metal detector), and their property is searched for contraband. Security officers work with AHS staff to inform them if an area of a patient cannot be searched due to medical condition. Security officers follow the patients and stand by until AHS staff can access the patient, then security will remove dangerous items and contraband.

Contraband bins have been installed at public entrances where weapon screening is conducted. The purpose for these bins is to discourage individuals from hiding their contraband (knives, tools etc.) in the surrounding landscaped areas and to control contraband items from entering the facility. Visitors are offered options for contraband items including returning the item to a vehicle or having a friend or family member hold the item outside. Under no circumstances should an AHS employee or security officer hold on to contraband and return it to a patient or visitor. Please see weapon screening policy.

Contraband is any instrument, device, or item likely to cause injury, death, or a safety concern to patients, visitors, or staff. Contraband includes but is not limited to:

a. Firearms and ammunition
b. Explosives material
c. Knives/box cutters/razor blades
d. Chemical agents (mace, pepper spray)
e. Impact weapons (nunchaku, batons)

f. Tasers

g. Ice picks/knitting needles/cork screws

h. Leatherman or multi-tools

i. Flammable liquids

j. Alcohol based/aerosol canisters

k. Syringe

l. Scissor

m. Metal forks/cutlery

n. Metal nail files/metal comb picks

o. Alcoholic beverages

p. Illegal/illicit controlled substances/drugs

q. Marijuana - while legal in the state of CA is not permitted in AHS Facilities

r. Drug paraphernalia

s. Lighters/matches

t. Hammer(s)
u. Tools such as screw drivers, wrenches, ratchets, etc.

v. Any items which are deemed unsafe to enter the facility.

**CONTRACT SECURITY SERVICES**

Inter-Con Security (ICS) provides contract unarmed security services to AHS. The Security Services department provides proactive patrol and response to mitigate or reduce potential occurrences of incidents which can impact safety and security. ICS security officers apply verbal de-escalation techniques and will physically restrain individuals on a case-by-case basis; however, they do not provide law enforcement services. In the event law enforcement services are needed a request is made to the designated agency within the jurisdiction.

The AHS Security Director, ICS Portfolio Manager, and ICS Security Account Managers oversee day-to-day security operations and communicate with as many departments and levels of the organization as needed to provide a reasonably safe and secure environment. The Security Services department protects individuals and AHS property against harm or loss, including workplace violence, theft, infant abduction, and managing access control. The Security Services department solves problems through partnerships, providing a visible presence, and providing safety and security education to AHS personnel. AHS and Security leadership emphasizes quality service from well-trained, compassionate, and professional security staff. AHS and ICS personnel promote security protocols and general awareness. Alameda Health System employees are responsible for learning security-related policies and procedures and for reporting hazards and incidents.

Assignment of security officers encompasses the categories of patrol, call response, and fixed post locations. Security patrol, response, and operational activities include, but are not limited to, crime prevention, fire prevention, identification of maintenance problems which can lead to security risks and safety hazards, alarm monitoring, and use of video surveillance of various areas. The allocation of security personnel is based on community crime trends in the vicinity of the AHS facility, local law enforcement crime trend reports for a one-block radius of the facility,
the facility/department’s security incident data, the facility/department’s patient volume, and the facility/department’s emergency code activation data (i.e., Code Gray activations).

SECURITY OFFICER ASSIGNMENT & SECURITY HOURS OF OPERATION
- Alameda Hospital & South Shore Rehabilitation (24 hours per day, 7 days per week)
- Eastmont Wellness Center (Monday - Friday 7:30 am to 6 pm, Saturdays as needed)
- Fairmont Rehabilitation Center (24 hours per day, 7 days per week)
- Hayward Wellness Center (Monday - Friday 7:30 am to 5:30 pm, Saturdays as needed)
- John George Psychiatric Hospital (24 hours per day, 7 days per week)
- Newark Wellness Center (Monday - Friday 8 am to 5 pm, Saturdays as needed)
- Park Bridge Rehabilitation (24 hours per day, 7 days per week)
- San Leandro Hospital (24 hours per day, 7 days per week)
- Wilma Chan Highland Hospital Campus (24 hours per day, 7 days per week)

SECURITY OFFICER EDUCATION & TRAINING
ICS Security Leadership provides:
1. Orientation and education of its staff and documents all training; The following training and competencies are required for the Security Team:
   - California Security License requirements.
   - Health Insurance Portability and Accountability Act. (HIPAA)
   - Bloodborne Pathogen/Infection Control.
   - Emergency Medical Treatment and Active Labor Act (EMTALA)
   - Fire Response Protocols.
   - PPE to include the location of and proper don/doff procedures (OSHA)
   - Safety procedures.
   - MRI Safety (OSHA).
   - Suicide Prevention: environmental risk factors, finding help in emergencies, overcoming stigmas relating to mental illness and suicidality, achieving a better understanding of behavioral health in general.
   - De-escalation and managing aggressive behavior.
   - Use of Force.
   - Customer Service.
   - Security Incident Response Procedures for the facility.
   - Lockdown procedures.
   - Emergency notification procedures.
   - Emergency communications procedures.
   - Securing a crime scene.
2. Competency-based ICS staff evaluations of initial, on-going, and special performance issues.

POLICE SERVICES
The Alameda County Sheriff’s Department (ACSO) provides police services at the Wilma Chan Highland Hospital Campus and liaises with law enforcement agencies for all Alameda Health System campuses.

The AHS Security Director and ICS Portfolio Manager work in collaboration with the following Law Enforcement agencies on security-related issues.

- Alameda County Sheriff’s Department (Highland Hospital, John George Psychiatric Hospital, and Fairmont Rehabilitation)
- Alameda Police Department (Alameda Hospital, Park Bridge Rehabilitation, South Shore Rehabilitation, Marina Wellness and Creedon Wound Care)
- Hayward Police Department (Hayward Wellness Center)
- Newark Police Department (Newark Wellness Center)
- Oakland Police Department (Eastmont Wellness Center and Support Services Center)
- San Leandro Police Department (San Leandro Hospital)

SECURITY EVENT DOCUMENTATION

Security incidents and conditions are reported quarterly and summarized statistically by ICS leadership for the AHS Security Director and the Vice President of Support Services. The Director of Security reports and makes recommendations to Alameda Health System Administration, key Department Leaders, and the Environment of Care Committee for further follow-up and/or improvement.

ANNUAL EVALUATION OF PERFORMANCE MEASURES

The following measures help Alameda Health System and security leaders identify changes in Alameda Health System’s security performance and develop countermeasures for negative changes:

1. Program measures address preventive and compliance activities.
   a. EOC/Safety Performance Measures
2. Event measures address security incident reports, which identify trends in overall security happenings.
   a. Scalable Event Reports
3. Activity measures address routine security services and periodic testing of the responsiveness of security staff members.
4. Data on workplace crimes, trends, and avoidable occurrences.
5. Aversion and the reduction in vehicle burglary, vehicle theft and vandalism.
6. Trends in the incidents of employee assaults from patients.

When an adverse change occurs, the leaders assess the relative severity of the change and determine an appropriate response.

APPROVALS
<table>
<thead>
<tr>
<th>Department</th>
<th>Date:</th>
<th>Date:</th>
<th>Date:</th>
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</thead>
<tbody>
<tr>
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<td>05/2020</td>
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<tr>
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<td>07/2020</td>
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PROTOCOL FOR MEDICAL PATIENTS AT JOHN GEORGE PSYCHIATRIC HOSPITAL (JGPH)

<table>
<thead>
<tr>
<th>Department</th>
<th>Behavioral Health</th>
<th>Effective Date</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Campus</td>
<td>John George Psychiatric Hospital</td>
<td>Date Revised</td>
<td>10/2019, 6/2023</td>
</tr>
<tr>
<td>Category</td>
<td>Clinical</td>
<td>Next Scheduled Review</td>
<td>6/2025</td>
</tr>
<tr>
<td>Document Owner</td>
<td>Chair of Psychiatry</td>
<td>Executive Responsible</td>
<td>Chief Medical Officer</td>
</tr>
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PURPOSE
To establish standards and guidelines for medical care of patients at John George Psychiatric Hospital (JGPH). John George Psychiatric Hospital will establish processes that contribute to continuing care of patient’s ongoing medical conditions; as well as optimal response to and interventions for any medical decline including medical emergencies.

A. Prior to acceptance of patient at JGPH.
1. JGPH is free standing psychiatric facility with limited ability to take care of patients with acute medical problems and certain medical conditions. All referrals are screened by psychiatrist using the Medical Transfer Acceptance Guidelines (Appendix A)
2. All patients who are sent out to emergency rooms for treatment are screened for medical stability for return by internist on call.

B. JGPH Psychiatric Emergency Services (PES)
1. All patients arriving at JGPH receive a brief screening evaluation by psychiatrist and nursing. Any patient needing medical attention that cannot be provided at JGPH are transferred to nearest emergency room for treatment and accepted back when medically stable.
2. All patients admitted to the PES receive a comprehensive nursing assessment and a psychiatric assessment by psychiatrist.
3. There is a psychiatrist present in PES 24/7 to respond to all urgent medical concerns in person.
4. Internists round daily in the PES to assess any patients that are referred to them by psychiatrists for assessment of any acute medical conditions.
5. Internists are available 24/7 by phone for any consults for medical care of the patients.
6. Nurses are assigned to patients on a 1:6 ratio. Nursing assessments are done and documented q shift.
7. Q15 min checks is the minimal level of observation for all patients in PES.
C. JGPH Inpatient Unit

1. Nurses are assigned to patients on a 1:6 ratio. Nursing assessments (behavioral and physical) are done and documented q shift.
2. All patients admitted to the inpatient unit receive a H&PE by internist within 24 hrs of arrival.
3. Internists round on the unit daily to do initial evaluations, follow up on patients needing medical attention and assess patients referred for evaluations by psychiatrists and nursing.
4. For any medical decline observed by nursing staff, internal medicine physicians are on phone call 24/7. Nursing staff refer to Escalation Guidelines for Medical Decline in the JGPH Medical Emergency Response Policy.
5. In case of a medical emergency 911 is called. Staff follow the JGPH Medical Emergency Response Policy.

APPROVALS

<table>
<thead>
<tr>
<th>Department</th>
<th>System</th>
<th>Alameda</th>
<th>AHS/Highland/John George/San Leandro</th>
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<tr>
<td>Department</td>
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<tr>
<td>Pharmacy and Therapeutics (P&amp;T)</td>
<td>6/2023</td>
<td>N/A</td>
<td>9/2019</td>
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<tr>
<td>Clinical Practice Council (CPC)</td>
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<td>N/A</td>
<td>N/A</td>
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<td>11/2019</td>
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<td>Board of Trustees</td>
<td>01/2020</td>
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<td>N/A</td>
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Infection Prevention and Control Annual Plan
San Leandro Hospital
John George Psychiatric Hospital

2022 Assessment | 2023 Plan
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San Leandro Hospital performed as expected in preventing central line and indwelling urinary catheter infections keeping its infection ratio under the expected value. The goals were achieved due to the efforts of the bedside staff and managers in implementing the policies placed oriented to complying with current scientific guidelines. The utilization of devices rate did not meet goals. Although it is recognized that San Leandro Hospital already keep its number of devices at minimum and no over utilization has been observed. Others Infection control goals were met in surgeries and procedures, and hospital onset of multidrug resistance microorganism. Those strategies will continue during 2023. The ongoing Covid 19 pandemic impacted the way of health services are being delivered, San Leandro Hospital has focused in reducing the risk of spreading Covid 19 to keep patients and employee safe. The efforts have avoided not only further disruptions of patient care but also avoided patient’s harm. During the 2023 year, the policies and recommendations will continue to be adjusted to reflect and align with up-to-date public health recommendations.

San Leandro Hospital has made consistent progress in meeting its infection control and prevention goals in 2022, reaffirming a trend from 2015 forward. The hospital is committed to continuing this progress in 2023 and beyond.

John George Psychiatric Hospital faced significant challenges in 2022 due to the COVID-19 pandemic. A total of 3 outbreaks disrupted services of inpatient care in the units. The protocol for aerosolized transmissible disease in the workplace as referral facility together with administrative measures were updated. The hospital was able to successfully mitigate the spread of the virus and continue to provide essential mental health services to its patients while complying with regulations. The hospital is committed to continuing its efforts in infection control and providing a safe environment for mental health services in 2023.
Covid 19 Pandemic Assessment Update

The emergency declared by global pandemic of covid 19 has ended as of May 2023. Current Infection control policies and procedures are being evaluated for updates that reflect new realities of living with a highly contagious Covid 19 virus. The goal is to put in place strategies to mitigate Covid 19 spread while continuing to provide healthcare services in a safe environment.

During the 2023, Infection control office will monitor trends and participate to assure that recommendations by public health services are implemented accordingly in San Leandro Hospital and John George Psychiatric Hospital.

2022 Infection Control Plan Evaluation

2022 was another extremely challenging year for Alameda Health System and in San Leandro specifically. The main efforts during 2022 were focused on the interventions to mitigate Covid spread to keep healthcare workers, patients, and visitors safe.

Our targeted surveillance priorities outcomes are described below.

<table>
<thead>
<tr>
<th>Outcome Measures</th>
<th>San Leandro</th>
<th>TNM</th>
<th>NHSN Target Performance</th>
<th>Actual Performance San Leandro Yr2022</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hand Hygiene compliance</td>
<td>---</td>
<td>95%</td>
<td>78%</td>
<td></td>
</tr>
<tr>
<td>Central Line Associated Blood Stream Infections (CLABSI)</td>
<td>0.589</td>
<td>SIR &lt;1</td>
<td>0.769</td>
<td></td>
</tr>
<tr>
<td>Catheter Associated Urinary Tract Infections (CAUTI)</td>
<td>0.65</td>
<td>SIR &lt;1</td>
<td>0.765</td>
<td></td>
</tr>
<tr>
<td>All Surgical Site Infections (SSI)</td>
<td>0.738</td>
<td>SIR &lt;1</td>
<td>1.028</td>
<td></td>
</tr>
<tr>
<td>MRSA Blood Stream Infections (BSI)</td>
<td>0.726</td>
<td>SIR &lt;1</td>
<td>0.000</td>
<td></td>
</tr>
<tr>
<td>Clostridioides difficile (C. diff) infections</td>
<td>0.524</td>
<td>SIR &lt;1</td>
<td>0.000</td>
<td></td>
</tr>
<tr>
<td>Influenza Vaccine of amongst staff</td>
<td>---</td>
<td>95%</td>
<td>98%</td>
<td></td>
</tr>
</tbody>
</table>

Hand Hygiene

Hand Hygiene: Goal Not Met:

In 2022, per audits from secret shoppers, hand hygiene (HH) compliance overall for San Leandro Hospital was 78%; slightly higher than the performance in 2021 (77%). Target performance is to be above 95%.

Action:
Continue unit-based champions and engage additional “secret shoppers” to perform increased auditing. For 2022, advocate for and present business case for electronic hand hygiene monitoring system.

Evaluation
- Secret Shopper strategy did not success. Keeping a secret shopper was challenged and not consistent.
- AHS continues to make hand hygiene an organizational priority as it is part of the Culture of Safety.
Patient Safety Component

Device Related:

Central Lines Associated Blood stream infections (CLABSI):

**Goal Met:** 2022 SIR>1 (0.769)

During the 2022-year, one case of blood stream infection met the criteria for CLABSI. The expected number of CLABSI was at 1.3. Thus, San Leandro Hospital SIR was equal to 0.7. meeting the goal set at SIR>1.

The analysis of the case concluded the infection to a contamination of the line via patients’ hands. As other components of the prevention bundle were in place and closely monitored.

- Actions carried out.
- Daily assessment of the indications for central line requirements and alternative access evaluation or prompt removal (e.g., midline).
- Audit and monitor elements of performance for CLABSI prevention bundle.
- The number of lines patient day is closer to target. SUR> 1.3. The utilization rate can be explained for the number of patients with hemodialysis catheter. The ratio of dialysis catheters vs PICC/CVC at SLH is 3:1. San Leandro Hospital provide inpatient dialysis services and procedures related with dialysis access.
Root Cause Analysis (RCA):

The CLABSI event was observed in a PICC line after 40 days of insertion being used for TPN. The microorganism identified was a common commensal (Staph Epidermis grew in 6 consecutive samples). Risk factors identified were TPN, Patient with traumatic brain injury constantly reaching out and pulling line. It was concluded that the line may have been contaminated while manipulating it.

As surveillance, prospectively all TPN lines will be assessed during weekdays. The purpose is to monitor bundle compliance.

Patient with TBI that required Central Venous Access such as the PICC line, will be subject to additional daily assessment by the IP in order deescalate or identify and address potential risks.

Maintenance has been found to be appropriate with a bundle compliance above 95%. Line utilization is at minimum with a ratio of 1:3 PICC to Dialysis catheter. The percentage of lines present in a given day is less than 5% on average.

Central Venous Catheters are rarely used and de-escalate between 48 hours.

Other actions to improve are related to hand hygiene, blood culture collections and multidisciplinary analysis when cases are identified.

Catheter-Associated Urinary Tract Infections:

**Goal Met: 2022 SIR>1 (0.765)**

During the 2022, San Leandro Hospital registered one CAUTI event. Based on the 2021 SIR, the expected number of events was 1.3 cases for 2022. The 2022 SIR is 0.7 meeting the goal. The RCA concludes that urine culture in patients with chronic foley must be consulted with ID Physician to discuss proper indication and potential for colonization and defer treatment.

Interventions executed:

- Audit and monitor elements of performance for CAUTI prevention.
- Assess and suggest alternatives to indwelling catheters such as external female catheter and condom catheter.
- Prompt removal for cases and alternatives for patients with diagnosis of acute urine retention, hematuria, and close monitoring of I&Os.

Evaluation:

- The number of indwelling catheter patient days is closer to target. SUR> 1.028. San Leandro Hospital is the acute care reference for long term care facilities in the area. The use of Foley catheter are chronic indwelling catheter users transferred from those facilities for management of acute episodes. The attending team is effective and cooperates in prompt removal of lines in indicated cases leading the facility to successfully prevent UTI in patients with indwelling catheters.
SLH Catheter-Associated Urinary Tract Infection
2021Q1 – 2022Q2

Standard Infection Ratio not calculated due to low frequency of the events.

CONFIDENTIAL PEER REVIEW COMMUNICATION – PROTECTED BY EVIDENCE CODE SECTION 1157
Procedure Module

*Surgical Site Infections (SSI):*

**Goal Met: 2022 SIR> 1 (0.00).** The number of SSI identified during 2022 was equal to zero.

Total of procedures performed at San Leandro Hospital OR during 2022 is described below.

(Yellow indicates procedures in plan for surveillance following /NHSN SSI criteria)

<table>
<thead>
<tr>
<th>Procedure</th>
<th>IN</th>
<th>OUT</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>AAA - Abdominal aortic aneurysm repair</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>AMP</td>
<td>116</td>
<td>6</td>
<td>122</td>
</tr>
<tr>
<td>APPY - Appendix surgery</td>
<td>38</td>
<td>3</td>
<td>41</td>
</tr>
<tr>
<td>AVSD</td>
<td>20</td>
<td>129</td>
<td>149</td>
</tr>
<tr>
<td>BILI - Bile duct, liver, or pancreatic surgery</td>
<td>5</td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>BRST</td>
<td>25</td>
<td>71</td>
<td>96</td>
</tr>
<tr>
<td>CEA</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>CHOL - Gallbladder surgery</td>
<td>61</td>
<td>20</td>
<td>81</td>
</tr>
<tr>
<td>COLO - Colon surgery</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>FX - Open reduction of fracture</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>GAST - Gastric surgery</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>HER</td>
<td>13</td>
<td>0</td>
<td>13</td>
</tr>
<tr>
<td>HPRO - Hip prosthesis</td>
<td>16</td>
<td>0</td>
<td>16</td>
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<tr>
<td>HYST - Abdominal hysterectomy</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td>KPRO - Knee prosthesis</td>
<td>10</td>
<td>3</td>
<td>13</td>
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<tr>
<td>NEPH - Kidney surgery</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td>OVRY - Ovarian surgery</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td>PACE - Pacemaker surgery</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td>PVBY - Peripheral vascular bypass surgery</td>
<td>17</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>REC - Rectal surgery</td>
<td>5</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>SB - Small bowel surgery</td>
<td>16</td>
<td>0</td>
<td>16</td>
</tr>
<tr>
<td>SPLX - Spleen surgery</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td>THYR - Thyroids</td>
<td>0</td>
<td>1</td>
<td>1</td>
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<tr>
<td>THOR - Thoracic surgery</td>
<td>3</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>VHYS - Vaginal hysterectomy</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>XLAP - Exploratory abdominal surgery</td>
<td>22</td>
<td>4</td>
<td>26</td>
</tr>
<tr>
<td>NO - &quot;Repair&quot; &quot;Biopsy&quot; &quot;I&amp;D&quot; &quot;Debr&quot;</td>
<td>397</td>
<td>335</td>
<td>732</td>
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<tr>
<td>Total</td>
<td>767</td>
<td>573</td>
<td>1323</td>
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<tr>
<td>Surveillance</td>
<td>168</td>
<td>12.70</td>
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</table>

Actions involved:

- Continue monitoring and surveillance, with reports back to the surgeons and OR/IC committees.
- Continue EOC interdisciplinary rounds to identify and address risk to keep preventing SSI.
Evaluation:

The number of SSI remains at target for the year. Surveillance has been continued and SLH has joined other initiatives to continue improving and prioritizing patient safety.

**SLH All Surgical Site Infection**

**Standardized Infection Ratio, 2021Q1 – 2022Q4**

![Graph showing SIR ratio for SLH All Surgical Site Infection]

**MDRO and CDI Module**

**MRSA Bacteremia:**

**Goal Met: 2022 SIR>1 (0.89).** The goal was to have zero cases of hospital acquired MRSA in blood. To keep the SIR less than 1, SLH needs to have less than 1.2 cases a year. During the 2022, there were no cases that met criteria for hospital acquired MRSA in blood. Goal met.

<table>
<thead>
<tr>
<th></th>
<th>2020</th>
<th>2021</th>
<th>2022</th>
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<tbody>
<tr>
<td>HO MRSA</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>SIR</td>
<td>0.000</td>
<td>0.000</td>
<td>0.000</td>
</tr>
<tr>
<td>Goal 2023</td>
<td>Zero cases SIR &gt;1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Actions 2022:**

- Identified colonized MRSA patients upon admission.
- EOC rounds to assess for cleaning.
- Continue:
  - CHG Bathing for high-risk patients.
  - Transmission based precautions.
  - RCA and multidisciplinary group comprehensive analysis of cases.
**Clostridioides difficile (CDI):**

Goal Met SIR>0.00. The established goal for 2022 CDI infection SIR. The 2022 SIR is equal to 0.00 based on NHSN data. SLH reported one case of hospital onset of CDI in the ARU and 5 CDI cases of community onset or present on admission. The hospital onset case was classified as secondary to antibiotic use as no other specific risk factors were identified during the RCA.

**Actions:**

- Hand Hygiene.
- Environmental cleaning.
- Continue to monitor and prompt appropriate testing following AHS guidelines.
- Follow PCR and prompt testing when diarrhea is the main diagnosis.
- Prompt initiation of precautions and environmental cleaning.
- Auditing and feedback of findings to unit managers during EOC rounds.
- RCA and multidisciplinary group comprehensive analysis.

![SLH Hospital-Onset Clostridium difficile](image)

Standard Infection Ratio not calculated due to low frequency of the events.

**TB Program:**

Alameda Health System identified 33 new cases of active pulmonary and extra pulmonary TB amongst our acute care facilities. The TB program is tightly coordinated with the Alameda County TB Control Program from the Department of Public Health.

During 2021, 22 new cases were identified. The increase in new cases observed correlates with data from the TB Control Program regarding an estimated 26% increase in cases observed during 2022 from 2021.
AHS TB and Respiratory protection program:

Zero conversion in testing was reported for the AHS employees. The TB Exposure plan continues in place. screening and isolation of patients based on clinical assessment by providers is ongoing. The mandatory annual TB screening for employees and the respiratory protection program continue in place.

John George Psychiatric Hospital was classified as “Referral facility” and a protocol for transferring patients with suspected or confirmed cases was developed following CALOSHA “Aerosol Transmissible Diseases.” Guide.

Surveillance Activity: M. tuberculosis Statistics updated as 2022.

(Source: Alameda County Public Health Department, Tuberculosis Control Section)

Alameda County TB Facts 2022 – Overview

During 2022, 127 tuberculosis (TB) cases were reported to Alameda County (excluding the City of Berkeley, which has its own local health department). The 2022 TB case rate in Alameda County was 8.4 cases per 100,000 residents, a 27% increase from the 2021 rate. The 2022 rate ranks second among all jurisdictions in California and is 1.8 times higher than the California state rate of 4.7 cases per 100,000 residents. The 2022 rate for Alameda County is higher than the other Bay Area counties, including Santa Clara (7.5 per 100,000), San Francisco (7.1 per 100,000), San Mateo (6.2 per 100,000), and Contra Costa (5.3 per 100,000) county.

Patient Demographics.

Similar to previous years, the majority of TB cases were male (64%). During 2022, the largest proportion of TB cases occurred among adults aged 65 years old and older (43%), and the lowest proportion occurred among children 0 to 4 years old (Table 1).

The majority of 2022 TB cases (92%) occurred among non-White residents (Table 1). From 2020 to 2022 Asian/Pacific Islander (API) residents in Alameda County had an average annual case rate of 15.6 cases per 100,000 residents, followed by Hispanic/Latino residents at 3.9 cases per 100,000 residents.

<table>
<thead>
<tr>
<th>Table 1. Number of TB Cases and Rates per 100,000, Alameda County, 2020-2022</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
</tr>
<tr>
<td>Males</td>
</tr>
<tr>
<td>Females</td>
</tr>
<tr>
<td>Age Group</td>
</tr>
<tr>
<td>0-4 yrs</td>
</tr>
<tr>
<td>5-24 yrs</td>
</tr>
<tr>
<td>25-44 yrs</td>
</tr>
<tr>
<td>45-64 yrs</td>
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<tr>
<td>65+ yrs</td>
</tr>
<tr>
<td>Race/Ethnicity</td>
</tr>
<tr>
<td>Black/African American</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
</tr>
<tr>
<td>Filipino</td>
</tr>
<tr>
<td>Chinese</td>
</tr>
<tr>
<td>Asian Indian</td>
</tr>
<tr>
<td>Vietnamese</td>
</tr>
<tr>
<td>Other Asian**</td>
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<tr>
<td>Amer Ind/Native AK</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
</tr>
<tr>
<td>White</td>
</tr>
<tr>
<td>Birthplace</td>
</tr>
<tr>
<td>United States</td>
</tr>
<tr>
<td>Outside of United States</td>
</tr>
</tbody>
</table>

* Categories with <10 average annual cases are unstable and not presented
** Includes Bangladeshi, Burmese, Cambodian, Korean, Laotian, Nepalese, and Thai
During 2022, 94% of TB cases identified were born outside of the U.S. (Table 1). The most frequent birthplaces outside of the U.S. were the Philippines, India, China, Vietnam, and Guatemala. The 2020-2022 average annual case rate for those born outside of the U.S. was 19.9 per 100,000 residents, 27 times the rate for cases born in the U.S. (<1.0 per 100,000). Of 2022 cases born outside of the U.S., 62% resided in the U.S. for 10 or more years before being diagnosed with TB. The largest proportion of 2022 TB cases occurred among residents of Fremont (22%), Oakland (20%), and Hayward (16%). Five-year average rates were highest in the 94606-zip code of Oakland.

### Table 2. Clinical and Laboratory Characteristics of TB Cases, Alameda County, 2022

<table>
<thead>
<tr>
<th>Site of disease</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pulmonary only</td>
<td>88</td>
<td>69.3%</td>
</tr>
<tr>
<td>Extrapulmonary only</td>
<td>30</td>
<td>23.6%</td>
</tr>
<tr>
<td>Both</td>
<td>9</td>
<td>7.1%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Among cases with any pulmonary disease (N=97)</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Sputum smear</td>
<td>Positive</td>
<td>57</td>
</tr>
<tr>
<td></td>
<td>Negative</td>
<td>33</td>
</tr>
<tr>
<td></td>
<td>Not done</td>
<td>7</td>
</tr>
<tr>
<td>Cavitary disease*</td>
<td>Present</td>
<td>38</td>
</tr>
<tr>
<td></td>
<td>Absent</td>
<td>59</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Comorbidities</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV/AIDS</td>
<td>3</td>
</tr>
<tr>
<td>Diabetes</td>
<td>38</td>
</tr>
<tr>
<td>End-stage renal disease</td>
<td>3</td>
</tr>
<tr>
<td>Other immunosuppression**</td>
<td>11</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>8</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Drug resistance among culture-positive cases (N=103)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Resistance to any TB medications</td>
<td>12</td>
</tr>
<tr>
<td>Resistance to INH only</td>
<td>6</td>
</tr>
<tr>
<td>Resistance to PZA only</td>
<td>3</td>
</tr>
<tr>
<td>Resistance to RIF only</td>
<td>3</td>
</tr>
<tr>
<td>Multidrug resistance (i.e., resistant to at least isoniazid and rifampin)</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Nucleic Acid Amplification Test (NAAT) on Pulmonary Specimen at TB diagnosis</th>
<th>Among cases with any pulmonary disease and sputum smear performed (N=90)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Sputum smear positive (N=57)</td>
<td>NAAT performed</td>
<td>54</td>
</tr>
<tr>
<td>Sputum smear negative (N=33)</td>
<td>NAAT positive</td>
<td>52</td>
</tr>
</tbody>
</table>

* Per X-ray, CT, or other chest imaging; ** Due to a medical condition, such as hematologic or reticulendothelial malignancies or immunosuppressive therapy, such as prolonged use of high-dose adrenocorticosteroids.

Clinical Characteristics.

Of all 2022 TB cases, 76% had pulmonary involvement and 24% were extrapulmonary only (Table 2). Of all pulmonary cases, a majority (59%) were acid-fast bacilli (AFB) smear-positive and 61% did not have evidence of cavitary disease on chest radiography. Only 2% of 2022 TB cases were co-infected with HIV and the most common comorbidity was diabetes (30%). Eighty-five patients (67%) reported having a usual source of care in the past 2 years.

Drug Resistance

A similar proportion of drug-resistant isolates were identified among culture-positive cases in 2022 and 2021 (12% and 13%, respectively). During 2022, all 12 drug resistant TB cases were resistant to at least one of the first-line TB medications (i.e., isoniazid, rifampin, ethambutol or pyrazinamide). Of the 10 cases resistant to only one first-line drug, 6 cases were resistant to isoniazid, 3 cases were resistant to pyrazinamide, and 1 case was resistant to rifampin. Two cases were multidrug-resistant TB (Table 2).

Diagnostic Testing.

Among 2022 TB cases with any pulmonary disease that had a sputum smear performed, 78% received a nucleic acid amplification (NAA) test at diagnosis, similar to 2021 cases (75%). Like 2021, more 2022 cases with positive sputum AFB smears received NAA tests compared to patients with negative sputum AFB smear (95% and 49%, respectively).
The number of cases with negative sputum AFB smear receiving a NAA test decreased from 2021 to 2022 (60% and 49%, respectively).

Summary
TB remains an important public health problem in Alameda County. Cases in the county increased 27% from 2021, a much higher increase than that seen at the state level. This increase may be due to a variety of factors as the COVID-19 pandemic continued into year three, such as more healthcare utilization, increased immigration, and providers now performing more diagnostic procedures than the prior years. A large proportion of Alameda County TB cases continue to occur among older adults, those born outside of the U.S., and non-U.S. born cases who have been in the U.S. for 10 or more years before TB diagnosis; all are known risk factors for latent TB infection (LTBI). Reports have also indicated that 80%-86% of all TB cases are due to LTBI reactivation. Therefore, identifying and treating LTBI is a key TB control strategy. TB Control also continues to encourage early diagnosis through the use of NAA tests regardless of sputum smear results, as this practice may facilitate earlier TB treatment initiation and reduce disease transmission.

Evaluation of 2022 TB Program Effectiveness

<table>
<thead>
<tr>
<th>Goal 2022</th>
<th>Target 2022</th>
<th>Outcome 2022</th>
<th>Effectiveness 2022</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify and place early isolation of suspected cases of M. tuberculosis</td>
<td>100% of suspected TB Cases</td>
<td>100% based on follow-up screening and no TB exposures resulting in conversions.</td>
<td>Goal Met</td>
</tr>
</tbody>
</table>

2022 Activities/Analysis
TB continues to be an important public health problem in Alameda County. 80-85% of all TB cases are due to Latent Tuberculosis Infection (LTBI) reactivation. Therefore, identifying and treating LTBI is a key TB Control strategy. AHS operates TB Clinics weekly.
Early diagnosis using NAA testing may facilitate earlier TB treatment initiation and reduce disease transmission. NAA testing is available for all AHS specimens.
In 2022, there were no employee TB screening conversions identified by our Employee Health Department.
Continue employee TB screening annually.

2019-2022 Count of TB Cases, Alameda County** & California (**excludes the City of Berkeley)

<table>
<thead>
<tr>
<th>YEAR</th>
<th>ALAMEDA COUNTY**</th>
<th>CALIFORNIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019</td>
<td>114</td>
<td>2114</td>
</tr>
<tr>
<td>2020</td>
<td>98</td>
<td>1706</td>
</tr>
<tr>
<td>2021</td>
<td>101</td>
<td>1750</td>
</tr>
<tr>
<td>2022</td>
<td>127</td>
<td>1843</td>
</tr>
</tbody>
</table>

2022 TB Cases Rates by Location

<table>
<thead>
<tr>
<th>Location</th>
<th>Rate per 100,000 Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alameda County**</td>
<td>8.4</td>
</tr>
<tr>
<td>California</td>
<td>4.7</td>
</tr>
<tr>
<td>United States</td>
<td>2.5</td>
</tr>
</tbody>
</table>

Biologic Site of Infection by Year, Alameda County

<table>
<thead>
<tr>
<th></th>
<th>2020</th>
<th>2021</th>
<th>2022</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total # of Cases</td>
<td>98</td>
<td>101</td>
<td>127</td>
</tr>
<tr>
<td>% pulmonary only</td>
<td>71%</td>
<td>73%</td>
<td>76%</td>
</tr>
<tr>
<td>% extrapulmonary only</td>
<td>29%</td>
<td>27%</td>
<td>24%</td>
</tr>
</tbody>
</table>
2022 Biologic Site of TB Disease, Highland Hospital – Alameda Health System

<table>
<thead>
<tr>
<th>Site</th>
<th>Culture Positive N (%)</th>
<th>CultureNegative N (%)</th>
<th>Total</th>
<th># of employee TB screening conversion (work-related)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pulmonary</td>
<td>16 (70%)</td>
<td>1 (10%)</td>
<td>17</td>
<td>0</td>
</tr>
<tr>
<td>Extra-Pulmonary</td>
<td>4 (17%)</td>
<td>9 (90%)</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>Pulmonary &amp; Extra-Pulmonary</td>
<td>3 (13%)</td>
<td>0</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>23</td>
<td>10</td>
<td>33</td>
<td></td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>Goal 2022</th>
<th>Target 2022</th>
<th>Outcome 2022</th>
<th>Effectiveness 2022</th>
</tr>
</thead>
<tbody>
<tr>
<td>100% Compliance with transmission-based precautions as recommended by CMS</td>
<td></td>
<td></td>
<td>Implemented prevention measures have mitigated risk to patients and staff.</td>
</tr>
<tr>
<td>related to:</td>
<td></td>
<td></td>
<td>Staffing concerns, compliance issues, supply chain issues, staff education, etc. are addressed in real time and/or during routine meeting forums (daily huddles, Restoration and Oversight Committee, command center, etc.)</td>
</tr>
<tr>
<td>• Limiting entrance to the facilities and visitor handling</td>
<td>100% compliance</td>
<td>Continued prevention efforts and surveillance activity</td>
<td></td>
</tr>
<tr>
<td>• Optimizing staff/visitor/patient protections during triage and/or registration</td>
<td></td>
<td></td>
<td>Executed interventions to be aligned and in accordance with public health guidelines.</td>
</tr>
<tr>
<td>• Implementation of standards, policies and procedures for undiagnosed respiratory illness and COVID-19</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Implementation of infection surveillance of suspected/confirmed COVID-19 and communication to appropriate stakeholders.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Education and monitoring of staff</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Emergency staffing strategies</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Patient care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Environmental cleaning and disinfection</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Hand hygiene</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Personal protective equipment (PPE)

2022 Activities

- Ongoing prevalence surveys, report findings to nursing leadership, implement immediate corrective for observed breaks in technique/practice.
- Ongoing survey of documentation for Isolation Precautions
- Ongoing screening of all employees at points of entrance to hospitals and clinics
- Ongoing social distancing practice of staff in common areas and office spaces
- Limit visitors to the facilities and patients
- Continue to follow state and local health officials that will help guide restoration, continued risk assessments, and mitigation/prevention strategies

Accreditation Survey Activity 2023:

Highland Hospital, San Leandro Hospital and John George Psychiatric completed the triennial Joint Commission survey in April 2023.

Final reporting is pending. For SLH findings as follow:

<table>
<thead>
<tr>
<th>EOC</th>
<th>SPD High Level Disinfection</th>
<th>Sterile Supply</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uncapped Eye wash station in OR</td>
<td>Surgical instruments with residual tape.</td>
<td>The laryngeal blade was found unwrapped in the anesthesiology cart.</td>
</tr>
<tr>
<td></td>
<td>No following manufacturer’s instructions for HLD of TEE</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No following manufacturer’s instructions for HLD of vaginal probe.</td>
<td></td>
</tr>
<tr>
<td>Limited/Moderate</td>
<td>Pattern/High</td>
<td>Limited/High</td>
</tr>
<tr>
<td>Plans for correction have been developed and implemented.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
2022 San Leandro Hospital Acute Care Risk Assessment

Based on trends, statistics and results of surveys, the risk assessment for San Leandro Hospital has been updated to reflect areas to focus for the 2023 year. Based on historical patterns and trends, current IP staffing and skill mix, recent deemed status mock survey and impacts of an ongoing global pandemic, the following is a best-estimation risk assessment for San Leandro Hospital:

<table>
<thead>
<tr>
<th>INFECTION EVENT</th>
<th>PROBABILITY OF OCCURRENCE</th>
<th>LEVEL OF HARM FROM EVENT</th>
<th>IMPACT ON CARE</th>
<th>READINESS TO PREVENT</th>
<th>RISK LEVEL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(How likely is this to occur?)</td>
<td>(What would be the most likely?)</td>
<td>(Will new treatment/care be needed for Patients/staff?)</td>
<td>(Are processes/resources in place to identify/address this event?)</td>
<td></td>
</tr>
<tr>
<td>Score</td>
<td>High</td>
<td>Med.</td>
<td>Low</td>
<td>None</td>
<td>Serious Harm</td>
</tr>
<tr>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>X</td>
</tr>
<tr>
<td>Facility-onset Infections(s)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Device- care- or Procedure related</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Catheter Associated Blood Stream Infections</td>
<td>X</td>
<td>x</td>
<td>X</td>
<td>X</td>
<td>7</td>
</tr>
<tr>
<td>Catheter Associated Urinary Tract Infections</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>7</td>
</tr>
<tr>
<td>SSI</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>6</td>
</tr>
<tr>
<td>C. Diff</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>6</td>
</tr>
<tr>
<td>Ventilator Associated Infection</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>6</td>
</tr>
<tr>
<td>Other (specify):</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resistant Microorganism</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CROs</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>C. Auris</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>MRSA</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>VRE</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>VRSA/VISA</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>ESBL</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Other MDROs</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Patient-related</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>COVID</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Influenza*</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>4</td>
</tr>
<tr>
<td>Tuberculosis*</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>6</td>
</tr>
<tr>
<td>Other (specify):</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outbreak-related</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scabies</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>4</td>
</tr>
<tr>
<td>MRSA/CROs/CANDIDA AURIS</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>5</td>
</tr>
<tr>
<td>MRSA/CROs/CANDIDA AURIS</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>5</td>
</tr>
<tr>
<td>Occupational Health</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scabies/Lice Exposure</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>4</td>
</tr>
<tr>
<td>Tuberculosis Exposure</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>4</td>
</tr>
<tr>
<td>Bloodborne Exposure</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>5</td>
</tr>
<tr>
<td>Vaccine Preventable</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>4</td>
</tr>
<tr>
<td>Bloodborne Exposure</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>4</td>
</tr>
<tr>
<td>Other (specify):</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Building and Facility</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Construction and Renovation</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Water Intake</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>6</td>
</tr>
<tr>
<td>Surge Capacity</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>6</td>
</tr>
<tr>
<td>Community</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Internal Cluster/Outbreak</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>6</td>
</tr>
<tr>
<td>External Outbreak</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>6</td>
</tr>
</tbody>
</table>

* Risk assessment should take into account the frequency of this disease in the community as part of determining probability of occurrence. Data from State/local health department may be informative.

Date Prepared: 3/10/2023
2022 John George Psychiatric Hospital Behavioral health and Psychiatric Emergency Services Risk Assessment

<table>
<thead>
<tr>
<th>INFECTION EVENT</th>
<th>PROBABILITY OF OCCURRENCE</th>
<th>LEVEL OF HARM FROM EVENT</th>
<th>IMPACT ON CARE</th>
<th>READINESS TO PREVENT</th>
<th>RISK LEVEL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Score</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility-onset Infections(s)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Catheter Associated Blood Stream Infections</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Catheter Associated Urinary tract Infections</td>
<td>0</td>
<td>2</td>
<td>3</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>SSI</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>C. Diff</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Ventilator Associated Infection</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Other (specify):</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resistant Microorganism</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CROs</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Candida Auris</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>MRSA</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>VRE</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>VRSA/VISA</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>3</td>
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<tr>
<td>ESBL</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Other MDROs</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Patient-related</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>COVID</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Influenza*</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Tuberculosis*</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Other (specify):</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outbreak-related</td>
<td></td>
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<tr>
<td>Scabies</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>MDRO/CROs/CANDIDA AURIS</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>1</td>
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<tr>
<td>COVID</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Occupational Health</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scabies/Lice Exposure</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Tuberculosis Exposure</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Bloodborne Exposure</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Vaccine Preventable</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>No vaccine Preventable</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Other (specify):</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical and Facility</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Construction and Renovation</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Water Intrusion</td>
<td>3</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Surge Capacity</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Community</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Internal Outbreak/Outbreak</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>External Outbreak</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Bioterrorism</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

* Risk assessment should take into account the frequency of this disease in the community as part of determining probability of occurrence. Data from State/local health department may be informative.

Date Updated:
5/17/2023

80/284
INFECTION CONTROL PLAN 2023

Introduction:

This document is a comprehensive evaluation, risk assessment, prevention and control plan completed annually. This document may be revised at any time based on significant changes in the healthcare setting and infection control field.

Infection Prevention and Control:

The purpose of the Infection Prevention and Control Department is to minimize the morbidity, mortality, and economic burden related to healthcare-associated infections (HAI) through prevention and control endeavors in both patient and staff populations. Using epidemiological principles, pertinent data are collected and analyzed, to determine risk factors associated with infection and to define mechanisms of transmission and prevention. Process measures, guidelines and standards and other surveillance methodologies are based on current guidelines and recommendations from Centers for Disease Control and Prevention (CDC), Association of Perioperative Registered Nurses (AORN), Association for the Advancement of Medical Instrumentation (AAMI), Association for Professionals in Infection Control and Epidemiology (APIC), Society for Healthcare Epidemiology of America (SHEA); American National Standards Institute (SHEA) and other nationally recognized organizations (including local and state public health officials), who set standards/guidelines for infection prevention. The most current CDC/NHSN surveillance definitions and comparative databases are utilized to evaluate patient outcomes. The Infection Preventionist uses this information to seek opportunities for improvement; and then plans, implements, and evaluates control strategies. As a resource within San Leandro Hospital and the community, the Infection Preventionist educates other professionals and the public about the risk of infection and measures to minimize and eliminate risk, and to enhance patient safety and quality.

The objectives of the program are to:

Monitor and evaluate the infection risks and the appropriateness of risk intervention and reduction activities for all patients and personnel. Promote prevention, identification, and control of healthcare-associated infections in patients, staff, practitioners, visitors, and families.

- To provide directions, information, and guidelines in relation to:
  - Facilities, equipment, and procedures necessary to implement standard and additional (transmission-based) precautions for control of infections.
  - Cleaning, disinfecting, and reprocessing of reusable equipment
  - Waste management
  - Protection of health care workers from transmissible infections
  - Infection control practices in special situations

Vision Statement

Alameda Health Systems is committed to providing superior patient care. Alameda Health System’s Infection Prevention and Control’s program reduces health care associated infections.

Mission Statement

The mission of the infection prevention and control program is to promote a healthy and safe environment by preventing transmission of infectious agents among patients, staff, and visitors. The goal of the infection prevention program is to provide surveillance, prevention, and control strategies to reduce/eliminate HAIs to the irreducible minimum. This will be accomplished in an efficient and cost-effective manner by a continual assessment and modification of our services based on regulations, standards, scientific studies, internal evaluations, and guidelines.
These strategies are intended to support the Alameda Health Systems in the areas of People, Service, Quality, Growth/Community, and Finance.

1. **People**
   - To facilitate participation of each healthcare worker in infection prevention strategies at their level
   - To promote disease prevention, and control, in HAI reduction
   - To promote a safe environment for patients, families, visitors, staff, physicians, and others
   - To limit unprotected exposure to pathogens

2. **Service**
   - To provide service excellence

3. **Quality**
   - To ensure the safety, health, and welfare of all patients
   - To evaluate processes and outcomes to continuously improve quality, safety, and efficiency.

4. **Growth/Community**
   - To promote education for patients, and as needed, their families about infection prevention.
   - To enhance patient the experience by improving quality of care through reducing HAIs

5. **Finance**
   - To provide evidence-based infection prevention strategies in a cost-effective manner
   - To enhance cost savings through continuous reduction of HAIs

**Scope of Service**

This Infection Control Program Plan applies to Alameda Health System (AHS) San Leandro Hospital. The infection prevention program reports through the Alameda Health Systems Patient Safety and Quality, and Medical Executive Committees. The System Director of Infection Prevention, along with the Infection Prevention and Control Committee Chair, determine the specific focus of surveillance, education, and consultation efforts on an ongoing basis, dependent on hospital epidemiology, community disease surveillance and real or perceived local, national or world threats. The Director of IPC reports through the Quality Department to the Vice President of Quality.

Alameda Hospital’s data, Infection Prevention assessments and plan is presented separately, as that facility continues to operate under a separate Medical Executive Committee and licenses.

**Geography, Community, Population, Care, Treatment and Services**

Alameda Health System (AHS) is a major public health care provider as a Safety-Net Healthcare System, and medical training institution recognized for its world-class patient and family centered system of care. Alameda Health System (AHS) is headquartered in the east bay area in Oakland, California. This plan includes the care of inpatients, outpatients, all diagnostic or treatment areas, and support services at San Leandro Hospital and John George Psychiatric. AHS is comprised of three acute care hospitals (Highland Hospital, Alameda Hospital, and San Leandro Hospital), one psychiatric hospital (John George Psychiatric Hospital), one acute rehab facility (San Leandro Hospital) and a multitude of outpatient primary care and specialty clinics, all located in Alameda County, California.
True North Metric Goals for 2022 – Quality Pillar

These metrics represent a high level of accountability to our community and are a balanced scorecard for AHS’ performance across these pillars. These metrics demonstrate a need for a high degree of continuous performance improvement, while advancing specific operational goals to achieve our strategic plan.

Hospital Acquired Infection Index (HAI):
Alameda Health System is driving towards zero HAIs and is targeting yet another 10% reduction in HAIs for fiscal year 2022, as compared to previous fiscal year. The composite HAI standardized infection ratio (SIR) includes Central Line Associated Blood Stream Infections (CLABSI), Catheter Associated Urinary Tract Infections (CAUTI), MRSA Blood Stream Infections (MRSA BSI), C. difficile infections, and surgical site infections associated with colon and abdominal hysterectomy surgical procedures (SSI). The SIR is a model developed by NHSN and compares the actual number of HAIs reported to the number that would be predicted, given the standard population, adjusting for several risk factors that have been found to be significantly associated with differences in infection incidence. An SIR less than 1.0 is desirable indicating that fewer HAIs were observed than predicted.

Throughout the COVID pandemic AHS has seen a rise in HAIs. This trend is not unique to AHS, per the Association for Professionals in Infection Control and Epidemiology (APIC) there has been an observed increase in HAIs across the industry. San Leandro Hospital has been able to maintain SIR at goal and look forward to achieving zero HAIs.

Infection Prevention and Control is partnering with various departments such as Quality, Nursing, Medicine, Pharmacy, and Microbiology, among others, to establish collaboration for each of our CMS and TNM-reportable HAI measures.

<table>
<thead>
<tr>
<th>Metric</th>
<th>CMS National SIR – 50th Percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAUTI</td>
<td>0.676</td>
</tr>
<tr>
<td>CDI</td>
<td>0.544</td>
</tr>
<tr>
<td>CLABSI</td>
<td>0.596</td>
</tr>
<tr>
<td>MRSA</td>
<td>0.727</td>
</tr>
<tr>
<td>SSI</td>
<td>0.732</td>
</tr>
</tbody>
</table>

Statistics YTD (January 2022-December 2022):

San Leandro Hospital

<table>
<thead>
<tr>
<th>SLH 2022 Facility Statistic</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>- Licensed Beds</td>
<td>91</td>
</tr>
<tr>
<td>- Average daily census</td>
<td>56</td>
</tr>
<tr>
<td>- Average Length of Stay (ALOS; days)</td>
<td>6</td>
</tr>
<tr>
<td>- ED OP Visits</td>
<td>25.669</td>
</tr>
<tr>
<td>- Emergency room admits</td>
<td>2.734</td>
</tr>
<tr>
<td>- Admissions</td>
<td>3.512</td>
</tr>
<tr>
<td>- Total Patient Days including nursery</td>
<td>20.429</td>
</tr>
<tr>
<td>- Surgeries performed (inpatient and outpatient)</td>
<td>1.887</td>
</tr>
<tr>
<td>- Patient Observation Days</td>
<td>741</td>
</tr>
<tr>
<td>- Overall discharges</td>
<td>3.407</td>
</tr>
</tbody>
</table>
John George Psychiatric Hospital

<table>
<thead>
<tr>
<th>JGP 2022 Facility Statistic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Licensed Beds</td>
</tr>
<tr>
<td>Average daily census</td>
</tr>
<tr>
<td>Average Length of Stay (ALOS; days)</td>
</tr>
<tr>
<td>Admissions</td>
</tr>
<tr>
<td>Emergency room admits</td>
</tr>
<tr>
<td>Total Patient Days including nursery</td>
</tr>
<tr>
<td>Overall discharges</td>
</tr>
</tbody>
</table>

Alameda County description:

Alameda County is the 7th most populous county in California, with a population of approximately 1,658,131 people in 2019 with a growth rate of 0.47% in the past year according to the most recent United States census data (not including those who are uncounted due to homelessness or undocumented immigration).

<table>
<thead>
<tr>
<th>Alameda County Demographics*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age and Sex</td>
</tr>
<tr>
<td>Persons under 18 years</td>
</tr>
<tr>
<td>Persons 65 years and over</td>
</tr>
<tr>
<td>Female persons</td>
</tr>
<tr>
<td>Race and Hispanic Origin</td>
</tr>
<tr>
<td>White alone</td>
</tr>
<tr>
<td>Black or African American</td>
</tr>
<tr>
<td>American Indian and Alaska Native</td>
</tr>
<tr>
<td>Asian alone</td>
</tr>
<tr>
<td>Native Hawaiian and Other Pacific Islander</td>
</tr>
<tr>
<td>Two or More Races</td>
</tr>
<tr>
<td>Hispanic or Latino</td>
</tr>
<tr>
<td>Language</td>
</tr>
<tr>
<td>Language other than English spoken at home, percent of persons aged 5 years+, 2011-2015</td>
</tr>
</tbody>
</table>

Population Characteristics
Foreign born persons, percent, 2015-2019 (1 in 3 residents is an immigrant) **
- Asia (62%)
- Latin America (26%)
- Europe (7%)
- Africa (2%)
- Oceania (2%)
- Northern America (1%)

| Documented Immigrants** | 75% |
| Undocumented Immigrants** | 25% |

**Health**

- With a disability, under age 65 years, percent, 2015-2019 5.6%
- Persons without health insurance, under age 65 years, percent 5.1%

**Income & Poverty**

- Median household income (in 2019 dollars), 2015 – 2019 $112,017
- Per capita income in past 12 months (in 2019 dollars), 2015-2019 $53815
- Persons in poverty, percent 9.4%

*United States Census Bureau, Alameda County, California Quick Facts, Retrieved, April 24, 2023, from https://www.census.gov/quickfacts/fact/table/oaklandcitycalifornia,sanleandrocitycalifornia,alamedacitycalifornia,alamedacountycalifornia/PST045219


### Incidence of Reportable Communicable Diseases, Alameda County 2022

<table>
<thead>
<tr>
<th>Communicable Disease (2015)</th>
<th>Incidence rate/100,000 population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carbapenem-resistant <em>Enterobacteriaceae</em> (CRE)</td>
<td>6.9</td>
</tr>
<tr>
<td><em>Tuberculosis</em> (2020)</td>
<td>Case rate/100,000 population</td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>8.4</td>
</tr>
<tr>
<td>Asian/ Pacific Islander</td>
<td>15.6</td>
</tr>
<tr>
<td>Birthplace United States</td>
<td>&lt;1</td>
</tr>
<tr>
<td>Birthplace Outside of United States</td>
<td>19.9</td>
</tr>
</tbody>
</table>


*Communicable Diseases, Published January 2019

*** Tuberculosis in Alameda County, Published March 20, 2023

Authority and Responsibilities of the Infection Prevention and Control Committee
The Core (Highland Hospital, San Leandro Hospital, and John George Psychiatric Hospital) Infection Prevention and Control Committee is a multidisciplinary committee with the overall authority and responsibility for the Infection Prevention and Control Program. The IPCC reports to the Medical Executive Committee through the Quality and Patient Safety Committee.

The infection control committee shall be composed of staff including physicians, to include members of the Medical House Staff (ad hoc), nurses, clinical laboratory, pharmacy, sterile processing, infection prevention, administration, infectious disease, facilities, environmental services, quality, and other Ad Hoc members as necessary and appropriate.

The IPCC shall be chaired by a physician (or designee) who has credentials, knowledge, and special experience in infection prevention and control. The MD chairperson must complete the infection control educational requirements mandated by the State of California (SB 1058).

Infection Preventionist, Chair of the Infection Control Committee, along with the System Director of Infection Prevention and Control, has authority to institute any surveillance, prevention and control measures or studies when there is reason to believe that any patient or personnel may be in danger from a potential or actual outbreak of, or exposure to, infectious disease.

Infection Prevention and Control Committee Responsibilities:

- Meet at least 11 times annually.
- Maintain a record of its proceedings.
- Submit reports of its activities and recommendations to Quality & Patient Safety, the Medical Executive Committee, and other hospital specific and system-wide committees as needed.
- Review and maintain policies and procedures pertaining to the infection control program in accordance with accrediting or governing organization requirements.
- Update annually the IC Program Plan and Risk Assessments.
- Develop and implement a preventive program designed to identify and minimize infection risks.
- Review the antimicrobial susceptibility/resistance trends in conjunction with the Antimicrobial Stewardship Committee.
- Reviews proposals, protocols, epidemiology outcomes, or special infection control studies to be conducted throughout the hospital.

Quorum:

Three physicians of the medical staff, two of which are members of the committee, and 50% of infection prevention and control department staff.

Voting Members:

Voting is the majority of those in attendance. The majority carries.
Surveillance Plan 2023

The surveillance plan at AHS is determined by the annual IC Risk Assessment, data summary of previous year, regulatory requirements, mandated public health reporting, and IC staffing resources. CDC National Healthcare Safety Network (NHSN) definitions are used to determine healthcare-associated infections (HAI) for indicators reportable to NHSN. All other HAI definitions will follow CDC’s definitions (unless otherwise noted by outside payor organizations).

AHS Infection Prevention team identifies HAI, communicable diseases, and significant microorganisms by reviewing a combination of the following:

- Checking data mining reports from the EMR daily
- Microbiology reports
- Referrals from hospital staff and physicians
- Daily admissions case finding
- Public Health Department communications
- Patient medical records
- IC surveillance and tracer rounding
- Readmission’s data

Infection prevention validation process for case/event identification will include initial event/case identification by individual infection preventionists. If unable to use inter-rater reliability for consensus, the case will be sent to the system director of infection prevention for final decision. If unable to determine, case/event will be forwarded to NHSN for final decision. The ID physician who serves as Chair of the IC Committee will be consulted if needed.

Planning for 2023

The effectiveness of the Infection Prevention and Control Program Plan can be determined by evaluation of the program scope, achievement of stated objectives, and outcomes of performance metrics at established performance levels.

Active hand hygiene monitoring remains a struggle as it is difficult to recruit and retain secret shoppers; thus, Infection Prevention is advocating for an electronic hand hygiene monitoring system. All other findings have been corrected in real time via just-in-time education and/or policy updates.

The program planning for 2023 is based largely on the effectiveness and outcomes of the program surveillance activities from 2022, risk assessment of known populations, processes, and environmental risks.

The most significant event affecting the community is the global COVID-19 pandemic. The program’s resources were stressed in the calendar year 2022 as the ongoing pandemic fundamentally affected and perhaps changed the scope, objectives, performance, and effectiveness of the planned program activities.

Risk Assessment priorities for 2023

- CLABSI (7 points)
- CAUTI (7 points)
- MRSA (7 points)
- MDRO - CROs- (7 points)
- COVID/Outbreak (7 points)
- Candida auris (6 points)
- Tuberculosis (6 points)
Hand Hygiene

<table>
<thead>
<tr>
<th>Goal 2023</th>
<th>Target 2023</th>
<th>Outcome 2023</th>
<th>Effectiveness Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase compliance:</td>
<td>AHS: 95%</td>
<td>95%</td>
<td>Goal Met / No Met</td>
</tr>
<tr>
<td>Increase observations</td>
<td>200 per unit</td>
<td>100%</td>
<td></td>
</tr>
</tbody>
</table>

2023 Interventions:
- Establish unit goals following Leapfrog guide and monitor monthly.
- Communicate to the different department managers the progress in hand hygiene observation by department.
- Transition of reporting and monitoring of HH throughout Sentact.
- Continue recruitment of Secret Shopper through the volunteer program or health path interns.
- Develop at least one education campaign a year reinforcing proper hand hygiene.

Device Associated Surveillance

Central Line-Associated Blood Stream Infections

<table>
<thead>
<tr>
<th>Goal 2023</th>
<th>Target 2023</th>
<th>Outcome 2023</th>
<th>Effectiveness Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than expected CLABSI events</td>
<td>SIR/SUR &lt;1</td>
<td>SIR 0</td>
<td>Goal Met / No Met</td>
</tr>
<tr>
<td></td>
<td>SUR 0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2023 Planned Interventions:
- Increase observations and compliance with Hand Hygiene.
- Keep the number of Central lines to a minimum (Less than 10%).
- Prompt removal when appropriate it. (Daily assessment of necessity review with the attending team).
- Bundle compliance auditing above 95% compliance: (Indication, Dressing, Swap caps, Insertion site, IV Tubing) and provide feedback to the managers.
- Daily audit of TPN lines when in house.
- Daily assessment of TBI patient with central lines.
- Blood Culture contaminant monitoring for trends.
- Participate and collaborate with the Educational Department in in-services opportunities (Scrub the hub, Dressings, etc.).
- Participate actively in multidisciplinary/initiative workup groups to reduce CLABSI/CAUTI or HAI.
- RCA and multidisciplinary group comprehensive analysis in events reported.
- Supply and appropriate medical devices are in place and or identify any issues and escalate accordingly.
Catheter-Associated Urinary Tract Infections

<table>
<thead>
<tr>
<th>Goal 2023</th>
<th>Target 2023</th>
<th>Outcome 2023</th>
<th>Effectiveness Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than expected CAUTI events</td>
<td>SIR/SUR &lt;1</td>
<td>SIR 0 SUR 0</td>
<td>Goal Met / No Met</td>
</tr>
</tbody>
</table>

2023 Planned Interventions:

- Increase observations and compliance with Hand Hygiene.
- Continue monthly surveillance following NHSN criteria for CAUTI determination.
- Keep the number of indwelling catheters at target (Less than 10%)
- Prompt removal when appropriate. (Daily assessment of necessity review with the attending team).
- Bundle compliance auditing above 95% compliance: (Indication, Pericare, Statlock, Tubing straight, Closed system, etc.) and provide feedback to the managers.
- Urine Culture monitoring for trends.
- Participate and collaborate with the Educational Department in in-services opportunities (FC Maintenance, Routine care, sample collection)
- Participate actively in multidisciplinary/initiative workup groups to reduce CLABSI/CAUTI or HAI. RCA and multidisciplinary group comprehensive analysis in events reported.
- Supply and appropriate medical devices are in place and or identify any issues and escalate accordingly.

Procedure-Associated Surveillance:

Surgical Site Infections

<table>
<thead>
<tr>
<th>Goal 2023</th>
<th>Target 2023</th>
<th>Outcome 2023</th>
<th>Effectiveness Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than expected SSI (COLO)</td>
<td>SIR &lt;1</td>
<td>SIR 0</td>
<td>Goal Met / No Met</td>
</tr>
</tbody>
</table>

2023 Planned Interventions:

- Continue monthly surveillance following NHSN criteria for SSI determination.
- Quarter EOC -Infection Control rounds,
- Monitoring of Bundle.
- Participate and collaborate with the Educational Department in in-services opportunities.
- Participate actively in multidisciplinary/initiative workup groups to reduce SSI or others HAI. RCA and multidisciplinary group comprehensive analysis in events reported.
- Supply and appropriate medical devices are in place and or identify any issues and escalate accordingly.
**Hospital-Acquired C-Diff and Multi-Drug Resistant Organisms**

**MRSA in Blood**

<table>
<thead>
<tr>
<th>Goal 2023</th>
<th>Target 2023</th>
<th>Outcome 2023</th>
<th>Effectiveness Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than expected HO of MRSA in blood.</td>
<td>SIR &lt;1</td>
<td>SIR 0</td>
<td>Goal Met / No Met</td>
</tr>
</tbody>
</table>

2023 Planned Interventions:

Continue monthly surveillance following NHSN criteria for Hospital onset of MRSA in blood determination.

Daily CHG bathing to positive MRSA patients with high risk for MRSA in blood such as presence of wound/lines/tubes.

Bimonthly EOC Rounds in MedSurg – Units and provide feedback report to the unit managers.

Participate and collaborate with the Educational Department in in-services opportunities.

Participate actively in multidisciplinary/initiative workup groups to reduce MRSA in blood or HAI.

RCA and multidisciplinary group comprehensive analysis in events reported.

Supply and appropriate medical devices are in place and or identify any issues and escalate accordingly.

**Hospital-Acquired Clostridioides difficile:**

<table>
<thead>
<tr>
<th>Goal 2023</th>
<th>Target 2023</th>
<th>Outcome 2023</th>
<th>Effectiveness Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than expected HO of CDI in blood.</td>
<td>SIR &lt;1</td>
<td>SIR 0</td>
<td>Goal Met / No Met</td>
</tr>
</tbody>
</table>

2023 Planned Interventions:

Continue monthly surveillance following NHSN criteria for Hospital onset of Clostridioides difficile in blood determination.

Daily CHG bathing to positive CDI patients.

Bimonthly EOC Rounds in MedSurg – Units and provide feedback report to the unit managers.

Participate and collaborate with the Educational Department in in-services opportunities.

Participate actively in multidisciplinary/initiative workup groups to reduce CDI or HAI.

RCA and multidisciplinary group comprehensive analysis in events reported.

Supply and appropriate medical devices are in place and or identify any issues and escalate accordingly.
### Hospital-Acquired Multi-Drug Resistant Organisms

<table>
<thead>
<tr>
<th>Goal 2023</th>
<th>Target 2023</th>
<th>Outcome 2023</th>
<th>Effectiveness Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than expected HO of VRE in blood.</td>
<td>SIR &lt;1</td>
<td>SIR 0</td>
<td>Goal Met / No Met</td>
</tr>
</tbody>
</table>

#### 2023 Planned Interventions:

- Continue monthly surveillance following NHSN criteria for Hospital onset of VRE in blood determination.
- Daily CHG bathing to positive VRE patients with high risk for VRE in blood such as presence of wound/lines/tubes.
- Bimonthly EOC Rounds in MedSurg – Units and provide feedback report to the unit managers.
- Participate and collaborate with the Educational Department in in-services opportunities.
- Participate actively in multidisciplinary/initiative workup groups to reduce VRE in blood or HAI.
- RCA and multidisciplinary group comprehensive analysis in events reported.
- Supply and appropriate medical devices are in place and or identify any issues and escalate accordingly.

### Hospital-Acquired Carbapenem Resistant Microorganisms:

<table>
<thead>
<tr>
<th>Goal 2023</th>
<th>Target 2023</th>
<th>Outcome 2023</th>
<th>Effectiveness Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than expected HO of CRO in blood.</td>
<td>SIR &lt;1</td>
<td>SIR 0</td>
<td>Goal Met / No Met</td>
</tr>
</tbody>
</table>

#### 2023 Planned Interventions:

- Continue monthly surveillance following CDC and Public Health Department criteria for Hospital onset of CROs.
- Continue use of MDRO evidence-based strategies using CDC, SHEA, APIC guidelines for reducing incidence of MDROs.
- Daily CHG bathing to positive CROs patients and patient with high risk for CROs colonization such as presence of wound/lines/tubes.
- Bimonthly EOC Rounds in patient care units and provide feedback report to the unit managers.
- Participate and collaborate with the Educational Department in in-services opportunities.
- Participate actively in multidisciplinary/initiative workup groups to reduce CRO colonization.
- RCA and multidisciplinary group comprehensive analysis in events reported.
- Supply and appropriate medical devices are in place and or identify any issues and escalate accordingly.
Mycobacterium Tuberculosis Surveillance:

<table>
<thead>
<tr>
<th>2023 Goals</th>
<th>Program Priority</th>
<th>Planned Actions for 2023</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prompt identification and early isolation of suspected cases of TB disease</td>
<td>High</td>
<td>TB Risk Classification: Medium Risk</td>
</tr>
<tr>
<td>Continue clinical rounds with pulmonary physician on all highly suspected TB cases.</td>
<td></td>
<td>Administrative:</td>
</tr>
<tr>
<td>Make sure cases diagnosed at AHS have a physician and are receiving appropriate care.</td>
<td></td>
<td>• Continue employee TB screening annually.</td>
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<tr>
<td></td>
<td></td>
<td>• Continue TB education by e-learning annually.</td>
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<tr>
<td></td>
<td></td>
<td>• Perform contact investigation when exposures occur and review case for educational opportunities.</td>
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<tr>
<td></td>
<td></td>
<td>• Review and/or update ATD Control Plan annually.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Environmental Controls:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Primary environmental controls</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Secondary environmental controls (AIIR and HEPA)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Respiratory Protective Equipment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Continue implementing a respiratory protection program.</td>
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<tr>
<td></td>
<td></td>
<td>o Continue FIT testing annually.</td>
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</tbody>
</table>

**Surveillance Activity: Immediate Use Steam Sterilization (IUSS):**

<table>
<thead>
<tr>
<th>Goal 2023</th>
<th>Target 2023</th>
<th>Outcome 2023</th>
<th>Effectiveness 2023</th>
</tr>
</thead>
<tbody>
<tr>
<td>Achieve 100% of Pass Loads</td>
<td>&lt;100%</td>
<td>&lt;100%</td>
<td>Goal Met/Goal Not met</td>
</tr>
<tr>
<td>Achieve IUSS below the AHS benchmark of &lt;2%</td>
<td>&lt;2%</td>
<td>&lt;1%</td>
<td>Goal Met/Goal Not met</td>
</tr>
</tbody>
</table>

2023 Activities
Quarterly infection control rounds in SPD/HLD process identified the following opportunities for improvement.
Scorecard report monthly to the IC Committee with analysis and follow up on findings.

**Surveillance Activity: COVID-19 Focused Infection Control & Prevention 2023**

<table>
<thead>
<tr>
<th>Goal 2023</th>
<th>Target 2023</th>
<th>Outcome 2023</th>
<th>Effectiveness Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>100% Compliance with current guidelines for testing and isolation.</td>
<td>100%</td>
<td>Practices at San Leandro Hospital reflect current guidelines and update recommendations.</td>
<td>Goal Met / No Met</td>
</tr>
</tbody>
</table>
Zero cases of hospital acquired Covid-19 infection among patients/staff. 0 cases

Interventions:
Implementation of standards, policies and procedures for undiagnosed respiratory illness and COVID-19.
Continuing of infection surveillance of suspected/confirmed COVID-19 and communication to appropriate stakeholders.
Monitor compliance with current testing and isolation practices.
Participation in webinars, workshops, COCA calls, and other meetings scheduled by public health authorities in order to update guidelines and recommendations for Acute Care Hospitals.

Dialysis:

<table>
<thead>
<tr>
<th>Goal 2023</th>
<th>Target 2023</th>
<th>Outcome 2023</th>
<th>Effectiveness Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>At least 95% Compliance with Infection Control practices evaluated quarterly.</td>
<td>100%</td>
<td>100% Compliance</td>
<td>Goal Met / No Met</td>
</tr>
</tbody>
</table>

2023 Interventions:
Infection Control rounds quarterly evaluating the following practices:
Compliance with HH and TBP.
Compliance with respiratory hygiene, sharp safety, safe injections practices, cleaning, and disinfection.
Hemodialysis catheter connection and disconnection compliance.
Appropriate central line dressing and maintenance is evaluated during bundle rounds.
Medication preparation and storage.
Supply rooms and storage.
Linen Management, waste management.
Vaccination status logs and reports.
Dialysis cultures report.
Follow up on notifications of exposures and assist in management.

Environment of Care:

<table>
<thead>
<tr>
<th>Goal 2023</th>
<th>Target 2023</th>
<th>Outcome 2023</th>
<th>Effectiveness Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>All units/areas will be compliant with a minimum of 95% or above for the areas of EOC evaluated.</td>
<td>100%</td>
<td>Evaluated areas for EOC will be on compliance 95% or above.</td>
<td>Goal Met / No Met</td>
</tr>
</tbody>
</table>
All the construction and renovation Class II, III, IV will be approved by Infection Control. | 100% | ICRA for construction and renovation project Class II and above. | Goal Met / No Met

Interventions:
Scheduled EOC rounds at least quarterly in all patient care areas of the hospital.
Performed EOC rounds jointly with regulatory affairs and other departments.
Provide feedback report to the managers and follow up on findings.

**John George Psychiatric Hospital**

<table>
<thead>
<tr>
<th>Goals 2023</th>
<th>Target 2023</th>
<th>Outcome 2023</th>
<th>Effectiveness Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>All units/areas will be compliant with a minimum of 95% or above for the subjects of EOC evaluated during Infection control rounds at the end of the year.</td>
<td>100%</td>
<td>Evaluated areas for EOC will be on compliance 95% or above.</td>
<td>Goal Met / No Met</td>
</tr>
<tr>
<td>Hand Hygiene: Reinforce and promote proper hand hygiene in the patients care areas. Assess and monitor for appropriate location and function of the sinks and gel dispenser.</td>
<td>100%</td>
<td>All opportunities to improve to promote and reinforce hand hygiene have been addressed.</td>
<td>Goal Met / No Met</td>
</tr>
<tr>
<td>PPE: Reinforce and promote proper PPE utilization and assess availability in the units.</td>
<td>100%</td>
<td>All opportunities to improve to promote and reinforce PPE have been addressed.</td>
<td>Goal Met / No Met</td>
</tr>
<tr>
<td>Outbreaks: Provide guidance and monitor for interventions.</td>
<td>100%</td>
<td>Outbreak were successfully mitigated within the source unit.</td>
<td>Goal Met / No Met</td>
</tr>
</tbody>
</table>

Interventions:
Scheduled EOC rounds at least quarterly in all patient care areas of the hospital.
Performed EOC rounds jointly with regulatory affairs and other departments.
Provide feedback report to the managers and follow up on findings.
Report and lead interventions recommended by public health department on outbreak mitigation measures for infectious diseases.
Evaluation of infection control practices and update as needed.
Program Elements and Resources

Resource Allocation: Needs for 2023 to effectively manage IP program.

Infectious Disease Physician adviser. Infection Control Director as liaison and overseen the program. 1 Infection Prevention Manager, 1/3 Epidemiology Data Manager, 1 TB Coordinator. Request for two additional Infection Preventionist have been made to support the San Leandro Hospital and John George Psychiatric.

Needs as assessed through observational and direct Computer, Hardware, Microsoft Office software, EPIC (Bugsy Module), NHSN SAMS access.

Resources: CDC/SHEA guidelines, APIC Text (online access), CMS Conditions of Participation (COP).

AORN Standards (online access), The Joint Commission Standards (online access), AAMI Standards (online access).

Personnel: Infection control professional CIC certified.
Highland Hospital Outpatient Pharmacy Quality Assurance and Medication Error Reporting

<table>
<thead>
<tr>
<th>Site</th>
<th>Highland Hospital Outpatient Pharmacy</th>
<th>Previous Revision Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Effective Date</strong></td>
<td>No Date Set</td>
<td><strong>Date Revised</strong></td>
</tr>
<tr>
<td><strong>Document Owner</strong></td>
<td>MGR SYS MED SAFETY-CLIN PHARM</td>
<td><strong>Next Scheduled Review</strong></td>
</tr>
<tr>
<td><strong>Executive Responsible</strong></td>
<td>Please Fill In</td>
<td><strong>No Review Date</strong></td>
</tr>
<tr>
<td><strong>Approvals</strong></td>
<td>BOT, QPSC</td>
<td></td>
</tr>
</tbody>
</table>

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

**Purpose**

To provide guidelines for standardized reporting of adverse medication errors and actions taken in response to these events.

**Policy**

Adverse medication events (ADE’s) will be reported regularly. Highland Hospital Outpatient Pharmacy, as part of the Alameda Health System, subscribes to a Just Culture algorithm.

**Definitions**

1. Medication Error – any preventable event that may cause or lead to inappropriate medication use or patient harm, while the medication is in the control of the health care professional, patient, or consumer and is determined based on the one or more of the following types or criteria:

2. Types of Medication Error – include prescribing errors, transcribing errors, dispensing errors, and medication administration errors. The specifics are categorized on the following:

   a. Prescribing
      i. Contraindicated
      ii. Duplicate Drug Order
      iii. Illegible/Unclear Order
      iv. Inappropriate Order / Altered Order
      v. Incomplete Order
      vi. Miscalculated Order
      vii. Abbreviation (Non-Standard)

   b. Transcribing:
      i. Transcribing (copying) error
      ii. Order Not Sent to Pharmacy
      iii. Verbal Order (V.O.) Written Incorrectly
iv. Wrong Patient
v. Labeling error

c. Dispensing
i. Contraindicated
ii. Incorrect Dose
iii. Failed to Verify Order
iv. Improper preparation/compounding
v. Miscalculated Dose
vi. Mislabeled, packaging and nomenclature.
vii. Incorrect Drug
viii. Wrong Patient
ix. Charting Error

Procedure

1. An electronic occurrence report must be completed via the Midas- Safety Alert system.
i. An occurrence report of the medication error must be entered into Midas as soon as it is discovered.
ii. An investigation of each medication error shall start as soon as is reasonable possible, but no later than 2 business days from the date the medication error is discovered.
iii. Reports are stored electronically within the Midas reporting system.

2. Report should contain:
i. The date, location, and participants in the quality assurance review
ii. The pertinent data and other information relating to the medication error(s)
iii. The review and documentation of any patient contacted, as required.
iv. The findings and determinations generated by the quality assurance review.
v. Recommend changes to pharmacy policy, procedure, systems, or processes, if any

3. The Pharmacy Director, Manager, PIC, or designee shall review these documents for completeness and accuracy (i.e. ensuring that the parameters of the event completed by the employee are correct).

4. The Pharmacy Director, Manager, PIC, or designee will take appropriate action as applicable and document such actions in the Midas.

5. The Pharmacy Director, Medication Safety Officer, Pharmacy Manager, and PIC have access to medication errors and adverse drug reactions that have been entered into the Midas system, via a manager’s worklist.

6. The record of quality assurance review must be easily retrievable in the pharmacy for at least 1 year from the date the record was created. Records will be retrievable via the Midas reporting system.
   ➢ To access Midas Reports:
• Click on Function ➔ Reporting ➔ User Report Processing
• Under Report, go to **RM_EventSummary_MedErrors Excel** and Output Device, go to **Excel**
• Click on Compile on the upper right hand corner
• Enter date range
• Enter the facility of the med events you’d like to review
• Press Ok

7. Data collected via the Midas shall be reviewed by the P&T Workgroup (MERP), focused on Medication Error Reporting and Review. Reviews occur at least quarterly, with an emphasis on Monthly reviews.

8. The P&T Workgroup shall determine appropriate follow-up actions that are needed to reduce the likelihood of similar errors in the future.

9. Recommendations may include:

   i. Use of continuous quality improvement principles to improve medication use processes and outcomes.
   ii. Referral to appropriate Peer Review Committees
   iii. Staff Education efforts
   iv. IT/Epic system improvements and safeguards

10. Patient Reporting by Pharmacy

   i. When a wrong drug is dispensed by Pharmacy and administered to a patient or Pharmacy causes a clinically significant delay in therapy, the pharmacist must communicate directly to the patient or patient’s agent that a medication error has occurred, and the steps required to avoid injury or mitigate the error.

   ii. When a wrong drug is dispensed by Pharmacy and administered to a patient or Pharmacy causes a clinically significant delay in therapy, the pharmacist must communicate directly to the prescriber that a medication error has occurred.

11. Reporting errors from automated dispensing systems

   i. Highland Outpatient Pharmacy operates an unlicensed automated drug delivery system (ScriptPro) within the premises of the pharmacy.
   ii. Any complaint, error, or omission involving the automated dispensing system (ScriptPro) shall be reviewed as part of the pharmacy’s quality assurance program pursuant to Section 4125
   iii. Quality Assurance events related to the ScriptPro must be reported to the Board at the time of annual renewal of the pharmacy license.

**References**

1. California Code of Regulations, Article 12, Section 1711
2. California Code, Business and Professional Code - BPC 4125
## APPROVALS

<table>
<thead>
<tr>
<th></th>
<th>System</th>
<th>HH/SLH/JG/FM</th>
<th>Alameda Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacy Departmental</td>
<td>Date: 6/2023</td>
<td></td>
<td></td>
</tr>
<tr>
<td>System Pharmacy and Therapeutics</td>
<td>Date: 6/2023</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CPC</td>
<td>Date: 7/2023</td>
<td></td>
<td></td>
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<tr>
<td>Medical Executive Committee</td>
<td>Date: 7/2023</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Board of Trustees</td>
<td>Date:</td>
<td></td>
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</tbody>
</table>
Purpose

The purpose of this policy is to establish guidance regarding Highland Hospital (HGH) and all child sites’ compliance with the rules and regulations set forth by the Health Resources and Services Administration’s Office of Pharmacy Affairs (“OPA”) pertaining to the Section 340B Drug Discount Program.

Background

Section 340B of the Public Health Service Act (1992) requires drug manufacturers participating in the Medicaid Drug Rebate Program to sign a pharmaceutical pricing agreement (PPA) with the Secretary of Health and Human Services.

a. This agreement limits the price that manufacturers may charge certain covered entities for covered outpatient drugs.

The 340B Program is administered by the federal Health Resources and Services Administration (HRSA) in the Department of Health and Human Services (DHHS).

Upon registration on 340B OPAIS (Office of Pharmacy Affairs Information System), Alameda Health System:

a. Agrees to abide by specific statutory requirements and prohibitions.

b. May access 340B drugs.

340B Policy Statements

HGH develops and maintains policies and procedures to ensure compliance with the guidelines and regulations of the 340B Drug Pricing Program for outpatients as outlined by Health Resources and Services Administration (HRSA)/Office of Pharmacy Affairs (OPA).

It is the policy of HGH to participate in the 340B Program, to comply with all rules and regulations of the 340B Program, and to implement procedures and safeguards to protect the integrity of the 340B Program including but not limited to the prevention of Duplicate Discounts/rebates under Medicaid, and the prohibition against transferring drugs purchased.
under 340B to anyone other than a patient of the entity, as well as adherence to the 340B Eligible Patient criteria.

The 340B Program savings will support HGH’s mission to serve all and stretch federal resources and by providing more comprehensive services to patients.

HGH maintains auditable records demonstrating compliance with the 340B Program. These reports are reviewed by HGH biannually as part of its 340B Oversight Committee and compliance program.

Scope:

This policy applies to the 340B Programs Covered Entities/Child Sites identified below. All employees, contract employees, or agents providing services under 340B Program at HGH or a child site must adhere to this policy.

a. DSH050320: Alameda Health System – Highland General Hospital
b. DSH050320A: Alameda Health System – JGP Emergency PES (Psych Emergency Services)

Procedure:

I. Eligibility:

HGH ensures that 340B drugs are dispensed/administered/prescribed only to eligible patients. HGH will also ensure that the following 340B eligibility determination filters are implemented:

1. Validates site eligibility. Care site must be within the four walls of the covered entity or listed as a child site on the HRSA OPAIS database as the point of service.
2. Determines patient status at the point of service.
   a. Patient must be in outpatient status at the time the medication is dispensed or administered based on medication type received.
3. HGH must maintain records of individual’s health care. If the patient only receives prescriptions from the pharmacy, the patient is not considered as 340B eligible.
4. HGH deems patient care delivered via telehealth to constitute the provision of health care services by a health care professional that has a documented arrangement with HGH such that responsibility for care provided remains with HGH.
5. HGH must determine provider eligibility.
a. Provider is either employed by the covered entity or provider health care on a contractual or other arrangement (e.g., referral for consultation), such that responsibility for the care provided remains with the covered entity.
b. Pharmacists who are employed by Alameda Health System, practicing under a collaborative practice agreement within a clinic, may at times prescribe medications.

   a. Pharmacists are considered eligible providers under these terms.

6. HGH determines patient’s Medicaid status at the point of service to prevent duplicate discounts.  

   a. GPO prohibition – Highland Hospital and child site John George Hospital are registered on the OPAIS 340B database as participating in the 340B Program are subject to the GPO prohibition and cannot obtain covered outpatient drugs through a GPO or other group purchasing arrangement.

   b. HGH may not purchase covered outpatient drugs through a GPO for any of its clinics/departments within the four walls of the hospital at any point in time. If HGH is unable to purchase a covered outpatient drug at the 340B price, written notification should be sent to OPA immediately.

   c. HGH will purchase using a non-GPO account and only replenish with 340B drugs once 340B patient eligibility is confirmed and can be documented through auditable records. Monthly audits are completed to ensure program integrity and report any violations.

II. Definitions:

1. 340B Eligible Patient – An individual is considered a “340B Eligible Patient” only if:

   a. HGH has an established relationship with the individual such that HGH maintains records of the individual’s health care; and,

   b. The individual receives health care services from a health care professional who is either employed by HGH or who provides health care under contractual or other arrangements (e.g., referral or consultation) such that the responsibility for the individual’s care remains with HGH. If health care is provided under referral for consultation, HRSA-recommended documentation is accessible:

      i. Request for referral

   c. The entity maintains responsibility for the patient’s health care services

   d. An individual shall not be considered an “340B Eligible Patient” if the only health care service received by the individual from HGH is the dispensing of a drug or drugs for subsequent self-administration in a home setting or other institutional settings.

      • **Referral Exception**: Though not a common practice, prescriptions written outside the Hospital may be filled with 340B drugs if they are written pursuant to a referral

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and (1) the referral and outcome of the referral are documented in the patient’s medical record or (2) the patient obtained subsequent services from the Hospital for the same condition after the referral.

2. Covered Drug—HGH does not purchase covered outpatient drugs for its outpatient registered facilities using a Group Purchasing Organization (GPO)
   a. HGH interprets the definition of covered outpatient drugs to include – ‘An FDA-approved prescription drug, an over the counter (OTC) drug that is written on a prescription and a biological product that can be dispensed only by a prescription (other than a vaccine) or FDA-approved insulin.
   b. The following drugs and drug categories are excluded from 340B and are GPO exclusion exempt: vaccines, normal saline & water for injection, gases, contrast media/diagnostic agents, large volume fluids without additives, topicals, romiplostim, hyaluronan and hyaluronate derivatives, 503B purchased drugs, cellulose oxidized, state supplied emergency medication (e.g., Covid medications under emergency use approval) manufacturers/labelers that do not participate in 340B program, and bundled items. A detailed list of items and categories can be available through EHR.
   c. Controlled Substance Ordering System (CSOS): HGH is enrolled in the CSOS program which allows for secure electronic transmission of controlled substance orders without the paper DEA 222 Form. All pharmacists are enrolled with DEA to acquire a CSOS digital signing certificate in order to place control substance orders.

3. Covered Entity – covered entities include six categories of hospitals: disproportionate share hospitals (DSHs), children’s hospitals, and cancer hospitals exempt from the Medicare perspective payment system, sole community hospitals, rural referral centers, and critical access hospitals (CAHs). Hospitals in each of these categories must be (1) non-profit, (2) be owned and operated by or under contract with state or local governments, and (3) except for CAHs, meet the payer-mix criteria related to the Medicare DSH program. ²

4. Diversion – Pursuant to the 340B Program rules and regulations, 340B participating entities are prohibited from reselling or otherwise transferring outpatient drugs purchased at the statutory discount to an individual who is not a 340B Eligible Patient of HGH. Any such practice qualifies as “Diversion.”

5. Duplicate Discount – A “Duplicate Discount,” which is prohibited by the 340B statute, occurs when manufacturers provide both a 340B discount on a drug and pay a Medicaid rebate to the State on the same drug.

**Contract Pharmacy Operations:** ³

HGH uses contract pharmacy services in accordance with HRSA requirements and guidelines.

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Page 4 of 19
HGH has obtained sufficient information from the contract pharmacy contractor to ensure compliance with applicable policy and legal requirements.

1. HGH registers each contract pharmacy location on the HRSA 340B Database prior to the use of 340B drugs at that site.

2. HGH uses a replenishment model using an 11-digit to 11-digit NDC match.
   a. Non-replenishment 340B inventory is never stored at the contract pharmacies, as all 340B stock is supplied through the replenishment model.

3. 340B-eligible prescriptions are presented to contract pharmacies via e-prescribing, hard copy, fax, or phone
   a. HGH Pharmacy staff verify patient, prescriber, and outpatient clinic eligibility via the electronic health record system.
   b. Updates are made to this mechanism by the HGH staff annually or on demand based on patient, provider, or contract pharmacy requests.


5. HGH implements bill-to, ship-to arrangement with the contract pharmacies.
   a. Contract Pharmacies order 340B drugs on behalf of HGH, based on eligible accumulation, as determined by HGH staff, through the drug wholesaler.
      i. Orders are triggered by the usage of package size of covered drugs determined by 11-digit NDC.
      ii. Replenishment orders through the wholesaler.
      iii. The wholesaler notifies HGH staff of medication shipped to contract pharmacies.

6. Contract Pharmacies receive 340B drug shipments. Orders are received by authorized pharmacy staff at the contract pharmacies.

7. Contract Pharmacy staff verify quantity received with the quantity ordered.
   a. Identifies inaccuracies.
   b. Resolves inaccuracies with the wholesaler.
   c. Document resolution of inaccuracies.

8. Contract Pharmacies notify HGH if they do not receive 11-digit NDC replenishment order within 90 days (about 3 months) or original order fulfillment request.

9. HGH reimburses contract pharmacies at a pre-negotiated rate per fill for such drugs.

10. HGH can review the invoice for drugs shipped to its contract pharmacies on demand.

11. HGH pays the invoice to wholesaler for all 340B drugs.

12. Contract Pharmacies provider HGH access to all pertinent reimbursement accounts and dispensing records. HGH staff retrieve and review 340B purchases every month.

13. Contract Pharmacies adjust claims when variance or discrepancy has occurred.
   a. Contract Pharmacies uses approved method regarding reconciliation between inventory and invoices with adjustment as necessary to match NDC or cost changes.
   b. Claim adjustments may occur only within 30 days of original billing and not without prior notice and approval of HGH.

14. Contract Pharmacies will not use 340B drugs for Medicaid patients (carve-out):
   a. Contract pharmacies will only dispense 340B drugs to patients who are eligible per HGH Electronic Health Record.
b. Highland Hospital does not count 340B drug accumulation for Medicaid patients and therefore prevent(s) duplicate discounts for outpatient prescriptions.

15. HGH will audit all adjudicated claims at the contract pharmacies monthly and communicate any errors or inaccuracies to contract pharmacy staff within 5 business days of findings.

16. Independent external audits will be conducted annually to ensure program integrity. All audit results will be communicated to HGH within 90 days from the date of the audit.
   a. HGH will document and make corrections based on audit findings.
   b. All progress made will be documented and communicated to key stakeholders at the 340B Oversight Committee.

III. Responsibilities

This section includes stakeholders and determines their roles and responsibilities in maintaining 340B program integrity and compliance. The following staff members are key stakeholders in the 340B program, including governance and compliance, and should be standing members of the 340B Oversight Committee. HGH will identify who serves as the entity’s authorizing official and primary contact for the 340B Program. These individuals are the sponsors of the 340B Oversight Committees.

1. Chief Financial Officer and/or VP of Finance
   a. Must account for savings and use of funds to provide care for the indigent under the indigent care agreement.
   b. Responsible for communication of all changes to the Medicare Cost report regarding clinics or revenue centers of the cost report.
   c. Responsible for communication of all changes to Medi-Cal/Medi-Cal Managed Care reimbursement for pharmacy services/products that impact 340B status (i.e., 340B AAC, modifiers).
   d. Accountable for savings and use of funds to provide care for the indigent under the indigent care agreement.

2. Chief Operations Officer (COO)
   a. Responsible for attesting to the compliance of the program in the form of recertification.
   b. Responsible as the principal officer in charge of the compliance and administration of the program.
   c. Accountable agent for 340B compliance.
   d. Responsible as the Authorizing Official for the 340B program.

3. System Director of Pharmacy
   a. Agent of the COO responsible to administer the 340B program to fully implement and optimize appropriate savings and ensure current policy statements and procedures are in place to maintain program compliance.
   b. Must maintain knowledge of the policy changes that impact the 340B program which includes, but is not limited to, HRSA/OPA rules and Medicaid changes.
   c. Must coordinate constant knowledge of any change in clinic eligibility/information
d. Responsible as the primary contact for the 340B program.

4. System 340B Manager
   b. Day to day management of the 340B program.
   d. Responsible for documentation of policies and procedures.
   g. Ensures appropriate safeguards and system integrity.
   h. Ensure compliance with 340B program requirements for qualified patients, drugs, providers, vendors, payers, and locations.
   i. Review and refine 340B cost saving report, detailing purchasing, and replacement practices, as well as dispensing patterns.
   j. Monitors ordering processes, integrating most current pricing from wholesalers, and analyzes invoices, shipping, and inventory processes.
   k. Design and maintain an internal audit plan of the compliance of the 340B program.
   l. Responsible for annual or semiannual physical inventory of pharmacy items.
   m. Designs the annual plan to cover all changes in the 340B program from the preceding year.

5. VP of Compliance and Internal Audit
   a. Design and maintain an internal audit plan of the compliance of the 340B program.
   b. Designs the annual plan to cover all changes in the 340B program from the preceding year.

6. Director of Finance/Reimbursement
   a. Responsible for communication of all changes to the Medicare Cost Report regarding clinics or revenue centers.
   b. Responsible for communication of all changes to Medicaid reimbursement for pharmacy services/products that affect 340B status.
   c. Engage pharmacy in conversations that affect reimbursement.
   d. Responsible for modeling all managed care contracts (with/without 340B).

7. Revenue Cycle (Billing and Revenue Integrity) and Revenue IS:
   a. Correct any findings identified through internal self-audits, independent external audits, or other methods.
   b. IS team will conduct systematic correction in the electronic operating system.
   c. IS team defines process and access to data for compliant identification of outpatient utilization for eligible patients.
   d. Achieves the data to make them available to auditors when audited.

8. Office of the General Counsel ("OGC")
   The OGC will provide legal counsel on an as-needed basis.

9. Pharmacy Buyer
   Responsible for maintaining three distribution accounts, i.e., non-GPO account, 340B account, and GPO account. Responsible for maintaining direct accounts for GPO ("own use") class of trade as well as direct 340B accounts.
a. Responsible for ordering all medications from the specific accounts as appropriate.
b. Manage purchasing, receiving and inventory control processes.
c. Responsible for segregation, removal, and/or return of 340B drugs, including reverse distributor transactions.
d. Continuously monitor product min/max levels to effectively balance product availability and cost-efficient inventory control.
e. Manage purchasing, receiving and inventory control processes.
f. Coordinate annual inventory cycle counts.
g. Monitor ordering processes, integrating most current pricing from wholesaler, analyze invoices, shipping, and inventory processes.

10. System 340B Analyst
   a. Defines process and access to data for compliant identification of outpatient utilization for eligible patients.
   b. Archives the data to make them available to auditors when audited.
   c. Responsible for maintenance and testing of 340B management software.
   d. In conjunction with any split-billing software vendor, develop and implement standard data interface controls which, at a minimum, shall perform necessary and reasonable checksum and duplicate record verifications.

IV. Program Integrity Procedures

1. As a participant in the 340B Drug Pricing Program, HGH shall meet all 340B Program eligibility requirements.

2. HGH OPA Database covered entity listing is complete, accurate, and correct.
   a. HGH, a member of AHS (Alameda Health System), a public Hospital Authority organized and existing under the laws of the State of California, provides health care services to low-income individuals.
      i. For the most recent cost reporting period that ended before the calendar quarter involved, HGH had a disproportionate share adjustment percentage greater than or equal to 11.75 percent.

   1. Reference Medicare Cost Report -Worksheet E Part A, line 33

3. HGH complies with all requirements and restrictions of Section 340B of the Public Health Service Act and any accompanying regulations or guidelines including, but not limited to, the prohibition against duplicate discounts/rebates under Medicaid, and the prohibition against transferring drugs purchased under 340B to anyone other than a patient of the entity.
   a. HGH maintains auditable records demonstrating compliance with the 340B requirement
   b. Prescriber has participated in credentialing process therefore obtaining prescribing privileges and agrees to the rules and regulations established by HGH Medical Staff
and is under contractual or other arrangements with the entity, and the patient receives a health care service from this professional such that the responsibility for care remains with the entity.

i. The eligible prescriber listing is managed using credentialing software maintained by the Medical Staff Office & Credentialing and information from this database is imported into the HGH electronic health record system.

c. 340B drugs are used in outpatient facilities that appear as reimbursable on the most recently filed CMS cost report.

d. Hospitals maintain records of the individual’s health care.

e. Patient is an outpatient at the time medication is administered or dispensed.

f. HGH has systems/mechanisms and internal controls in place to ensure ongoing compliance with all 340B requirements.

g. HGH has mechanisms in place to prevent diversion (see V. 340B Procurement, Inventory Management and Dispensing).

h. HGH has mechanisms in place to prevent duplicate discounts (see VI. Safeguards to Prevent Duplicate Discounts). “UD” modifier and “08” modifier components will be audited quarterly internally. Any discrepancies will be communicated to the appropriate team for correction and resubmission. Discrepancies above self-disclosure thresholds will be reported based on self-disclosure guidelines.

i. HGH has an internal audit plan and conducted quarterly (see Section VII).

j. HGH may use contract pharmacy services (if applicable), and the contract pharmacy arrangement is performed in accordance with OPA requirements and guidelines.

4. HGH obtains sufficient information from the contract pharmacy to ensure compliance with applicable policy and legal requirements, and HGH has utilized an appropriate methodology to ensure compliance.

5. HGH has identified locations where it dispenses or prescribes 340B drugs:

   a. Within the four walls of the parent entity.
   b. With off-site outpatient locations that are fully integrated into the hospital, reimbursable on the most recently filed Medicare Cost Report, and registered on 340B OPAIS; and
   c. HGH owned and operated in house outpatient pharmacy.


7. Material Breach:

A breach of 340B compliance requirements includes any adverse event that results in diversion and/or duplicate discounts.

The material breach threshold is defined as:

   a. A violation(s) that exceed 5% of hospital 340B purchases, program savings, or impact to any manufacturer, and
   b. Remains non-correctable within 30 days.
HGH acknowledges its responsibility to contact OPA as soon as reasonably possible if there is any change in 340B eligibility or material breach by the hospital of any of the foregoing policies.

Violations identified through internal self-audits, independent external audits, or other methods that exceed the 5% threshold and remain non-correctable within the entity-defined period timeframe of review, will be immediately reported to HRSA and applicable manufacturers.

HGH elects to receive information about the 340B Program from trusted sources, including, but not limited to:
   i. The Office of Pharmacy Affairs;
   ii. The 340B Prime Vendor Program, managed by Apexus;
   iii. Any OPA contractors.

8. 340B Program Education and Competency:

Program integrity and compliance are the responsibility of all 340B key stakeholders. Ongoing education and training are needed to ensure that these 340B key stakeholders have the knowledge to guarantee compliant 340B operations.
   1. Alameda Health System Compliance department determines the knowledge and educational requirements for each 340B Program role (refer to “Responsibilities” section of this policy)
   2. 340B key stakeholders complete initial basic training upon hire.
      a. Watch “introduction to the 340B Drug Pricing Program” on PVP website.
      b. Complete OnDemand modules on the PVP website.
   3. 340B key stakeholders complete additional training as identified and pertaining to their responsibilities.
   4. HGH provides educational updates and training, as needed to all staff.
   5. HGH conducts annual verification of 340B program competency.
   6. Training and education records are maintained per organizational policy and available for review.

9. 340B Enrollment, Recertification, Change Requests:

1. OPA requires entities to recertify their information as listed in the OPA database annually. HGH’s Authorizing Official annually recertifies HGH’s information by following the directions in the recertification email sent from the OPA to HGH’s Authorizing Official by the requested deadline. Specific recertification questions will be sent to: 340b.recertification@hrsa.gov
2. HGH has available the requirement documents:
   a. Medicare Cost Report:
      i. Worksheet S, S-2, S-3
      ii. Worksheet E, Part. A
   iii. For outpatient facilities:
      a) Worksheet C
      b) Worksheet A
      c) Working trial balance.
b. Certification of ownership status.

3. On an annual basis, review Medicare Cost Report and confirm program status as outpatient.

4. On a quarterly basis, review Medicaid Exclusion File for accuracy as a curve in the program.

5. On a quarterly basis, review OPA 340b-database to confirm or revise listed NPI (National Provider Identifier) numbers.

6. Enrollment Procedure: New Clinic Sites:
   a. The HGH Director of Pharmacy evaluates a new service area or facility to determine if the location is eligible for participation in the 340B Program. The criteria used include service area must be fully integrated into DSH, appear as a reimbursable clinic on the most recently filed cost report, have outpatient drug use, and care for patients that meet the 340B patient definition.
   b. If a new clinic meets these criteria, the Director of Pharmacy under the guidance of the Authorizing Official completes the online registration process during the registration window:
      - January 1–January 15 for an effective start date of April 1
      - April 1– April 15 for an effective start date of July 1
      - July 1–July 15 for an effective start date of October 1
      - October 1– October 15 for an effective start date of January 1

   This includes submitting cost report information, as required by OPA. [http://www.hrsa.gov/opa/eligibilityandregistration/index.html](http://www.hrsa.gov/opa/eligibilityandregistration/index.html)

7. Changes to the Hospital’s Information in the OPA Database:

It is HGH’s ongoing responsibility to inform OPA of any changes to its information or eligibility. As soon as HGH is aware of its eligibility change, it will notify OPA immediately and stop purchasing of the 340B drugs as soon as HGH files its cost report with a disproportional share percentage < 11.75%. Change form will be submitted to OPA as soon as HGH is aware of the need to make a change to its database entry. HGH will expect changes to be reflected within 2 weeks of submission of the changes/requests.

V. 340B Procurement, Inventory Management and Dispensing

340B inventory is procured and managed in the following settings:

1. **Highland Hospital Outpatient Retail Pharmacy**
   a. Prescription eligibility – HGH uses a physical inventory model for its outpatient retail pharmacy operations. The in-house pharmacy is closed door (processing only...
prescriptions that meet eligibility) and identifies as a Medicaid “carve-in” operation. Patient eligibility status is confirmed using one of the following mechanisms:

i. Receipt of an electronic prescription from the hospital electronic health record
ii. Receipt of a faxed prescription
iii. Receipt of telephone orders which are reduced to writing
iv. Receipt of a paper prescription that is either electronically generated from the hospital electronic health record or written by an eligible provider. If applicable, the paper prescription form will contain the appropriate watermarks and barcodes associated with either EHR (Electronic Health Record) generated prescriptions or those security requirements by CA Board of Pharmacy and Department of Justice Office of the Attorney General

b. Medication replenishment - HGH Staff places orders from Wholesaler through daily inventory reviews and shelf inspections of PAR levels.

c. Medication Storage – Upon receipt of inventory, HGH Staff examine the wholesaler invoice against the order, and reports inaccuracies to the wholesaler.

d. Records - HGH Staff maintains records of 340B related transactions in accordance with California State Board of Pharmacy Rules and Regulations.

e. Security - All inventories are stored in the pharmacy. Only pharmacy employees have access to the pharmacy using proximity badges.

f. HGH Staff (and/or external vendor) conduct an annual physical inventory.

2. **Facility Administered Medications (Mixed Use Areas):**

a. HGH uses a 340B-replenishment inventory within the mixed encounter settings of the facility.

b. Inventory of medications in the mixed encounter setting is maintained using virtual inventory rather than maintenance of physical segregation. Virtual inventory requires initial purchase of unique 11-digit NDCs at a non-340B/non-GPO acquisition cost. As inventory is consumed, discrete units of the depleted inventory are tracked to ascertain whether the inventory was dispensed to outpatients (340B eligible) or inpatients (not eligible for 340B).

c. HGH Staff places inventory replenishment orders from Wholesaler through daily inventory reviews and shelf inspections

d. HGH Staff checks in inventory by examining the wholesaler invoice against the order, and reports inaccuracies to the wholesaler.

e. HGH Staff maintains auditable records of 340B related transactions in accordance with the California State board of Pharmacy Rules and Regulations.

f. All inventory is stored either in the pharmacy maintained with a security system or in the ADS machines throughout the inpatient hospital and outpatient areas. Only pharmacy employees have access to the pharmacy using proximity badges. Only approved personnel have access to the ADS using fingerprint identification.
Mixed-use inventory replenishment is monitored by using split-billing software. Key points to address appropriate access to wholesaler accounts and split billing software include:

a. HGH identifies all pharmacy purchasing accounts.
b. HGH identifies which accounts are used for each 340B eligible location to purchase 340B drugs
c. HGH places 340B, GPO, and WAC drug orders, based on orders created from the split-billing system.
   a. 340B drugs are ordered at an 11-digit NDC level.
   b. Appropriate processes are in place to ensure proper ordering, tracking, and adjusting of accumulators for controlled substances
d. HGH receives shipments.
e. HGH verifies quantity received with the quantity ordered.
   a. Identifies inaccuracies.
   b. Resolves inaccuracies
   c. Documents resolution of inaccuracies
f. HGH documents manual manipulations to the 340B split-billing accumulator, including reason for manual manipulations.
g. HGH reviews purchasing records with dispensing records biannually to ensure that covered outpatient drugs purchased through the 340B program are used only for 340B eligible patients.
h. HGH staff reports significant discrepancies to HGH management within one business day.
i. HGH maintains records of 340B – related transactions for a period of 3 years in a readily retrievable format.
   a. These reports are reviewed by Highland Hospital as part of its 340B oversight and compliance program.
j. The infusion center data tracked by split-billing software is not used for inventory tracking purposes. Data is used only as a secondary reference tool.

h. Wasted/Expired 340B medication:
   a. HGH pharmacy staff documents destroyed or wasted drugs.
   b. System 340B analyst adjust the 340B accumulators based on reported waste.

i. HGH Staff (and/or external vendor) conduct an annual physical inventory.
0. Purchase mixed-use inventory (according to eligible accumulations).
1. Administered and dispensed drugs to patients.
2. Accumulator accumulates drug on an 11-digit NDC match until the unit of use is met, prepares order, uses patient/clinic/prescriber information to determine the appropriate contract for ordering.

<table>
<thead>
<tr>
<th><strong>GPO</strong></th>
<th><strong>Non-GPO (Non-340B WAC)</strong></th>
<th><strong>340B</strong></th>
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<tr>
<td>GPO/Inpatient class of</td>
<td>Products that do not have an 11-digit NDC match on the 340B contract but are otherwise</td>
<td>Patients met 340B patient definition and</td>
</tr>
<tr>
<td>trade: Inpatient status</td>
<td>eligible for 340B purchase</td>
<td>received services on an outpatient basis in a</td>
</tr>
<tr>
<td>determined by the hospital at the date/time of administration</td>
<td>Non-340B eligible outpatients, i.e.: Administration or dispensing occurred at a clinic within 4 walls of covered entity, but not 340B eligible Medicaid carve-out outpatients Lost charges or wasted product</td>
<td>340B registered/participating hospital clinic</td>
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<tr>
<td>GPO/Outpatient class of</td>
<td></td>
<td></td>
</tr>
<tr>
<td>trade: Offsite/unregistered outpatient clinics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Replenishment drug order(s) are placed according to eligible accumulations.</td>
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</tr>
</tbody>
</table>

3. Outpatient Clinic Administered Medications (Highland Wellness Center Clinics)

a. HGH uses 340B medications in all the outpatient ambulatory care clinics.

b. All medications ordered for immediate administration must be documented in the EHR (Electronic Health Record) or medical record
c. Most medications are stored in ADS Machines located in the clinic. Any unavailable medications prescribed for immediate administration must be requested via a patient-specific requisition form and brought to the main K-3 Pharmacy for filling and charging through the EHR.

d. If there are no ADS available, approved medications can be requested through a requisition form, and securely stored in the medication area of the clinic. When administered, these medications must be documented using the EHR to include administration date, patient identifiers and the medication administered.

e. Medication replenishment - HGH Staff places orders from Wholesaler through daily inventory reviews and shelf inspections of PAR levels daily.

f. Medication Storage – Upon receipt of inventory, HGH Staff examines the wholesaler invoice against the order, and reports inaccuracies to the wholesaler.

g. Records - HGH Staff maintains records of 340B related transactions in accordance with California State Board of Pharmacy Rules and Regulations.

h. All inventory is stored either in the pharmacy maintained with a security system or in the ADS machines throughout outpatient clinics. Only pharmacy employees have access to the pharmacy using proximity badges needed to access the department. Only approved personnel have access to the ADS using fingerprint identification.

i. All patients treated in the outpatient infusion center meet the criteria for 340B eligibility. Inventory of medications for the Outpatient Infusion Center is physically segregated from all other medications in the pharmacy and is purchased on a separate and dedicated 340B account. Drug utilization data for these patients will not accumulate on our “virtual inventory” management system.

j. HGH Staff (and/or external vendor) conducts an annual physical inventory.

3. Drug Shortage/340B Price not available

a. Highland Hospital will purchase covered outpatient drugs at 340B price. During times of Drug Shortages or when 340B price is not available, HGH will contact the drug manufacturer.

b. Covered outpatient drug will be purchased on a non-GPO account if the 340B price is not available. If the drug cannot be purchased on a non-GPO account, HGH may use GPO alternative only if Highland Hospital documents and maintains records that all other options have been exhausted.

c. Highland Hospital must attempt to purchase drug at 340B price every time an order is made.

4. Contract Pharmacy:

a. Separate 340B and non-340B purchased inventory is used for Contract Pharmacies.
b. Pharmacy staff dispense 340B drugs only to patients meeting all the criteria in the “Patient Eligibility/Definition” policy.

Inventory Replenishment system (340B/non-340B) is maintained at Contract Pharmacies.

1. Highland Hospital Pharmacy staff identifies all accounts used for purchasing drugs at contract pharmacies for 340B and non-340B
2. Highland Hospital purchases inventory according to eligible accumulations recorded for 340B replenishment at contract pharmacies.
2. Contract Pharmacies dispense drugs to patients.
3. HGH staff track drug utilizations based on patient eligibility including service location and provider information. This accumulation occurs at the 11-digit NDC level and a full package size will be accumulated before replenishing inventory.

VI. Safeguards to Prevent Duplicate Discounts

a. HGH is a CA Medi-Cal “Carve in” facility and bills Medicaid per reimbursement requirements, and as reflected its information on the OPA website as Carve in. HGH bills Medicaid per Medi-Cal reimbursement requirements, and as such HGH has reflected its information on the OPA website/Medicaid Exclusion (http://opanet.hrsa.gov/340B/Views/CoveredEntity/SearchDirectory)
   a. HGH informs OPA immediately of any changes to its information on the OPA website/Medicaid Exclusion File
      i. HGH is responsible for the accuracy of the information in Medicaid Exclusion File (MEF) The MEF (Medicaid Exclusion File) lists covered entities that have decided to use 340B drugs for their Medicaid patients and to bill Medicaid for those drugs (carve-in). Having this information in the MEF (Medicaid Exclusion File) indicates to the states and manufacturers which drugs are not subject to Medicaid rebates, and helps ensure the prevention of duplicate discounts, as prohibited by statute.
      ii. Covered entities are required to ensure that information in the MEF is accurate each quarter and at the time of annual recertification.

b. To identify 340B-eligible claims submitted to Medicaid by the Highland Hospital Outpatient Pharmacy, the MISC 1/MSC 1 field has the qualifier titled “08 – 340B/Share Pricing/Public Health”.

c. Highland Hospital does not in the course of regular business bill Out of State Medicaid and Managed Medicaid for 340B drugs in the hospital mixed-use and retail pharmacy.

d. A UD Modifier is used for physician-administered claims to identify a 340B purchased drug by using the reporting modifier “UD” in conjunction with the procedures code on the state or federal billing form. When a claim is filed with Medicaid for administering drugs purchased under the 340B drug discount program, a modifier “UD” along with the 11-digit National Drug Code (NDC).

e. John George Psychiatric Hospital, child site, does not bill Medi-Cal and is paid at an hourly/per diem rate for all patient care services by the County of Alameda.
VII. Emergency and Disaster Medication

Bioterrorism/ FEMA process:

HGH has an agreement with FEMA, Oakland Urban Search and Rescue Task Force (US&R TF), and Alameda County to supply (sell) certain medications during a declared emergency. The purpose of emergency medication is to respond to a disaster in the United States, which overwhelms the resources of local or state authorities. The Emergency medications will not be used for HGH’s patients. All emergency meds are physically separated from the mixed-use inventory and purchased on GPO exclusively upon disaster activation.

Flexibility During Emergency:
In the event of a State of Emergency providers may work past term date if necessary due to hospital occupancy.

VIII. Loan/Borrow Processes:

The borrowing and lending process is evaluated based on different criteria, such as 340B status, emergent need, or inventory availability at each pharmacy. See policy: “Borrowing and Loaning Medications Between AHS Inpatient Pharmacies.”

IX. Monitoring and Reporting:

1. Monitoring
   a. The entity uses the process outlined in: 340B Compliance Self-Assessment: Self-Audit Process to Ensure 340B Compliance. Additional monitoring or reporting includes:
      i. Daily monitoring of accrual file upload to wholesaler
      ii. Ongoing monitoring of unreconciled dispenses and wastes
      iii. Ongoing collaboration with Pharmacy IT (Information Technology) to ensure products, units, quantities, prices are up-to-date and correctly represented.
   b. Review of outpatient retail pharmacy prescriptions to ensure eligibility

2. 340B Compliance Overview
   a. The 340B Compliance Review summarizes all activities necessary to ensure comprehensive review of 340B compliance at HGH. HGH staff is responsible and accountable for overseeing this review process, as well as taking corrective actions based upon findings.
<table>
<thead>
<tr>
<th>Activity</th>
<th>Frequency</th>
<th>HGH Eligibility</th>
<th>No Diversion</th>
<th>No Duplicate Discount</th>
<th>GPO Prohibition</th>
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<tbody>
<tr>
<td>Review of all OPA database information for HGH, indigent care agreement with state/local government, and Medicare Cost Report (Worksheet E, Part A and Worksheet A), prior to recertification Internal Compliance&lt;br&gt;&lt;i&gt;Staff responsible: Director of Pharmacy, System 340B Manager &amp; CFO&lt;/i&gt;</td>
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<tr>
<td>Review of 340B Self-Audit Reports (mixed-use &amp; outpatient pharmacy)&lt;br&gt;&lt;i&gt;Staff responsible: System 340B Manager, Director of Pharmacy, CFO, COO&lt;/i&gt;</td>
<td>Quarterly</td>
<td>✓</td>
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<tr>
<td>Review of quarterly contract price load&lt;br&gt;&lt;i&gt;Staff responsible: Director of Pharmacy, System 340B Manager, System 340B Analyst&lt;/i&gt;</td>
<td>Quarterly</td>
<td></td>
<td></td>
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<td>✓</td>
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<td>Update of prescriber eligibility files with outpatient patient management processing system&lt;br&gt;&lt;i&gt;Staff responsible: Provider Service Director and EHR IT manager, system 340B manager&lt;/i&gt;</td>
<td>Monthly</td>
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<td>Split-Billing software maintenance (CDM-NDC mapping, updates, etc.)&lt;br&gt;&lt;i&gt;Staff responsible: System 340B Analyst, System 340B Manager&lt;/i&gt;</td>
<td>Daily or Weekly</td>
<td>✓</td>
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b. Quarterly internal audits will be performed by designated pharmacy staff and reviewed by the Director of Pharmacy. HGH staff are responsible and accountable for overseeing this review process, as well as taking corrective actions based upon findings.
   i. Infusion Center audit:
   Audits will include, but not limited to, ensuring the patient meets 340B eligibility, the medications were purchased from the 340B account specific for infusion center and that the medications are dispensed from our physically segregated inventory for the infusion center.
   ii. Mixed-use area/hospital audits:
   Audits will include, but not limited to, ensuring the patients meeting 340B eligibility, the charge on dispense data is accurate, patient status is outpatient, patient had an order for the medication and was written by an eligible provider and the medication accumulated in the correct account in our virtual inventory records.

2. Reporting Non-Compliance
   a. HGH acknowledges that if there is a breach of the 340B requirements, HGH may be liable to the manufacturer of the covered outpatient drug that is the subject of the
violation, and depending upon the circumstances, may be subject to the repayment of interest and/or removal from the list of eligible 340B entities.

b. As HGH identifies areas/types of non-compliance related to entity eligibility, diversion, or duplicate discount, HGH will notify OPA, and any associated drug manufacturers complete with appropriate documentation/records along with a plan for corrective action.

c. Threshold to self-report:
Violations identified through internal self-audits, independent external audits, or other methods that exceed the 5% threshold and remain non-correctable within the entity-defined period timeframe of review, as defined as Material Breach under this Policy, will be immediately reported to HRSA and applicable manufacturers. The Self-Disclosure Tool included in this Policy may be utilized to assist Covered Entity in self-reporting a Material Breach.

References

1. Section 340B of the Public Health Service Act.
2. Apexus 340B University

APPROVALS

<table>
<thead>
<tr>
<th>Compliance Dept.</th>
<th>System</th>
<th>AHS Core</th>
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<td>Clinical Practice Committee</td>
<td>Date: 7/2023</td>
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<td>Medical Executive Committee</td>
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MEDICATION BORROWING AND LOANING BETWEEN AHS INPATIENT PHARMACIES

PURPOSE
To describe procedures for medication borrowing and loaning between the following AHS Inpatient Hospital Pharmacies:

340B Covered Entities
• Highland Hospital Inpatient Pharmacy
• Alameda Hospital Pharmacy
• John George Pharmacy

Non-340B Entities:
• San Leandro Hospital Pharmacy
• Fairmont Pharmacy

*no medication can ever be borrowed or loaned from the Highland Hospital Outpatient Pharmacy

POLICY
I. 340B covered entities:
   For AHS inpatient hospital pharmacies that participate in the 340B program, the covered entity must be aware of all departments that receive medication and understand the purchasing source of these drugs.

Borrowing and Loaning can only be done under the following scenarios:
1) For GPO only inventories: Medication listed on the system wide GPO exclusion list or medication purchased from a GPO only distributor.
2) Under public health emergency, if a medication is on shortage, covered entity (CE) can borrow from another CE to maintain appropriate patient care. CE is forced to “borrow/purchase” on GPO product from another entity as the last resort when no other options are available. Refer to 340B Public Health Emergency Policy for detail.

II. Between 340 B covered entity (Loaner) and non-340B covered entity (Borrower):
   1. Non-340B entity will initiate a cost transfer for the drug at the WAC price to the
340B covered entity.

III. Between 340 B covered entity (Borrower) and non-340B covered entity (Loaner)
   1. 340B covered entity will return the borrowed drug purchased on WAC account. If not available, 340B covered entity will initiate a cost transfer for the WAC cost to the non-340B covered entity.

IV. The Loaner will log record the transaction on a borrow/loan transaction log (Attachment #1) which includes:
   2. the date
   3. facility
   4. medication
   5. NDC and
   6. name of the staff requesting the medication

V. Between Non 340B Inpatient Pharmacies:
   1. Any borrowing of medication must be initiated by a pharmacist or pharmacy technician. In facilities without a pharmacist on-site when a medication is needed, the on-call pharmacist must be contacted.
   2. The Borrower must obtain the exact 11-digit NDC of the needed medication from the Loaner.
   3. The Borrower must then confirm with their wholesaler that they can order this same 11-digit NDC medication for shipment within the next 3 days.
      a. If the exact NDC is not available, then the Borrower will need to call another none 340B AHS facility, other hospital in the area, or order directly thru their wholesaler.
      b. If the Borrow confirms the exact NDC is available, then call the Loaner and confirm that the replacement has been ordered and will be delivered within the next 3 days.
         i. It is the responsibility of the Borrower to deliver the replacement stock within 3 days to the Loaning pharmacy
         ii. If the NDC received from the wholesaler is different than ordered:
            1. It is the responsibility of the borrowing facility to contact the wholesaler and request the original NDC.
            2. If the wholesaler is not able to provide the original NDC, then the borrowing facility will need to compensate the loaning facility the cost of the original NDC. The NDC returned cannot be different than the NDC borrowed.
   4. The Loaner will log record the transaction on a borrow/loan transaction log (Attachment #1) which includes:
      a. the date
      b. facility
      c. medication
      d. NDC and
5. Name of the staff requesting the medication

The Loaner will be responsible for confirming that the borrow/loan transaction log has no outstanding entries > 3 days.

## APPROVALS

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| AHS System Wide Policies & Procedures | Theresa Cooper | • Revised  
  • Policy in PolicyTech | 08/2025 | | | • CPC 08/03/2023  
  • AHS MEC 08/16/2023 |
| Visiting Hours/Visitors Policy | Theresa Cooper | • Revised  
  • Procedure in PolicyTech | 08/2025 | | | • CPC 08/03/2023  
  • AHS MEC 08/16/2023 |
| Color Coded Wristband Procedure | Theresa Cooper | • Revised  
  • Procedure in PolicyTech | 08/2025 | | | • 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 | | | • CPC 08/03/2023  
  • AHS MEC 08/16/2023 |
| AHS Point of Care Testing (POCT) | Dr. Valerie Ng | • Revised  
  • Policy in PolicyTech | 08/2025 | | | • CPC 08/03/2023  
  • AHS MEC 08/16/2023 |
| Patient Informed Consent | Nilda Perez | • Revised  
  • PolicyTech Policy | 08/2025 | | | • CPC 08/03/2023  
  • AHS MEC 08/16/2023 |
VISITING HOURS/VISITORS

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 visitors’
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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COLOR-CODED WRISTBAND PROCEDURE  

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Reference # Version

EFFECTIVE DATE: 9/1/2023
LAST REVIEW DATE: 

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:
a. 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.

b. 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.

c. 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.

d. Handwriting is not permitted on color-coded wristbands.

e. 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.

f. All color-coded wristbands shall be placed on the same wrist as the patient identification wristband.

g. 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.

h. 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**

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             |
| Initial training                                 | None                            | None            | Initial training| Initial training|
| Six months after initial training                 |                                 |                 | Six months after|                 |
| One year after initial training                   |                                 |                 | One year after  |                 |
| Annually                                         |                                 |                 | initial training|                 |
|                                                  |                                 |                 | Annually         |                 |
| Note 1: When a licensed independent practitioner performs waived testing that does not involve an instrument, the organization may use the medical staff credentialing and privileging process to document evidence of training and competency in lieu of annual competency assessment |

| Non-Waived                                       | Initial training | Initial training | Initial training | Initial training |
|                                                  | Six months after| Six months after | Six months after | Six months after |
|                                                  | initial training| initial training | initial training | initial training |
|                                                  | One year after  | One year after   | One year after   | One year after   |
|                                                  | initial training| initial training | initial training | initial training |
|                                                  | Annually         | 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.
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 (accessed 09/25/2020)


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08_AHS Point of Care Testing_POCT_revised Jul 2023
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 (accessed 07/26/2023)


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PATIENT INFORMED CONSENT

Effective Date 9/1/2023  Date Revised 01/04/2022; 08/06/2023
Document Owner NILDA PEREZ (SYSTEM DIRECTOR, REGULATORY AFFAIRS)
Next Scheduled Review 08/06/2026
Executive Responsible Director, Regulatory Affairs

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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

1. **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
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, #XXXXXX) 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
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>Committee</th>
<th>AHS Core</th>
<th>AH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bylaws Committee</td>
<td>6/28/23</td>
<td></td>
</tr>
<tr>
<td>Credentials Committee</td>
<td>Date:</td>
<td>8/10/23</td>
</tr>
<tr>
<td>Medical Executive Committee</td>
<td>Date:</td>
<td>8/11/23</td>
</tr>
<tr>
<td>QPSC</td>
<td>Date:</td>
<td></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>
<thead>
<tr>
<th>Department</th>
<th>Medical Staff</th>
<th>Effective Date</th>
<th>8/2023</th>
</tr>
</thead>
<tbody>
<tr>
<td>Campus</td>
<td>AHS</td>
<td>Date Revised</td>
<td></td>
</tr>
<tr>
<td>Unit</td>
<td>All</td>
<td>Next Scheduled Review</td>
<td>8/2026</td>
</tr>
<tr>
<td>Manual</td>
<td>Medical Staff</td>
<td>Author</td>
<td>Director, Medical Staff Office</td>
</tr>
</tbody>
</table>

Replaces the following Policies: Responsible Person Chief of Staff

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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</thead>
<tbody>
<tr>
<td>AHS Medical Executive Committee</td>
<td>Date:</td>
</tr>
<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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</tbody>
</table>
Alameda Health System

MEDICAL STAFF MOONLIGHTING PRACTITIONERS

<table>
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<th>Department</th>
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<td>6/2019, 8/2020, 8/2023</td>
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<tr>
<td>Unit</td>
<td>Medical Staff</td>
<td>Next Scheduled Review</td>
<td>8/2026</td>
</tr>
<tr>
<td>Manual</td>
<td>Medical Staff</td>
<td>Author</td>
<td>Director, Medical Staff Services</td>
</tr>
<tr>
<td>Replaces the following Policies:</td>
<td>Responsible Person</td>
<td>Chief of Staff</td>
<td></td>
</tr>
</tbody>
</table>

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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<th>Graduate Medical Education Committee</th>
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<th>Medical Executive Committee</th>
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<th>AH</th>
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<th>QPSC</th>
<th>AHS</th>
<th>AH</th>
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<tbody>
<tr>
<td>Date:</td>
<td></td>
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</tbody>
</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  

167/284  
Revised 8-7-2023
1. Amendment to the B360 biomedical equipment maintenance services agreement with Agiliti Healthcare, Inc. to extend term for delivery of services. The term of this amendment is effective October 1, 2023 through April 30, 2024. The estimated impact of this amendment is $1,542,560.

   Mark Amey, Chief Information Officer

2. Amendment to the M360 biomedical equipment management services agreement with Agiliti Healthcare, Inc. to extend term for delivery of services. The term of this amendment is effective October 1, 2023 through April 30, 2024. The estimated impact of this amendment is $1,033,440.

   Mark Amey, Chief Information Officer

Recommendation: Motion to Recommend Approval for the above contracts to the Board of Trustees
"Type of Contract" Definitions
For BOT Summaries

<table>
<thead>
<tr>
<th>Definitions</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Contract / New Agreement</td>
<td>First time agreement contract with a new vendor, contracting with a previous vendor after a GAP between contracts, or a contract with a vendor for separate independent project, for example construction projects with the same general contractor.</td>
</tr>
<tr>
<td>Replacement Contract</td>
<td>Contracting with an existing vendor to replace the contract document (previous Terms and Conditions are replace by new contract). Contract has expired and AHS will continue services (with NO GAPS in service), but will replace agreement with new Terms and Conditions.</td>
</tr>
<tr>
<td>Amendment</td>
<td>Amendment to modify contract’s Terms and Conditions and/or increase contract NTE amount, without extending the duration of the contract.</td>
</tr>
<tr>
<td>Extension</td>
<td>Amendment that extends the duration and may modify other contract terms, including the contract NTE amount.</td>
</tr>
<tr>
<td>Renewal</td>
<td>Existing Terms and Conditions and NTE are being renewed for additional annual periods. Contracts with auto-renewal clauses fall in this category.</td>
</tr>
</tbody>
</table>
Contractor/Vendor Name: Agiliti Healthcare, Inc.

Description: Agiliti Healthcare, Inc. (Agiliti”) is one of two contracted providers of biomedical engineering services for the maintenance and repair of medical equipment at Alameda Health System (“AHS”). Agiliti is responsible for the provision of services (“Services”) with the exception of imaging equipment which is serviced under separate arrangement with a different provider. Agiliti Services are provided under 2 separate agreements (“Agreement 1” and “Agreement 2”, collectively “Agreements”) with key elements outlined below:

- Agreement #1 - The B360 equipment maintenance agreement (“B360”) covers + 5,000 individual pieces of equipment across all AHS facilities, including provision of the following services:
  - Preventive Maintenance
  - Electrical Safety Checks
  - Equipment Repair
  - Equipment Tracking
  - Life-cycle Management

- Agreement #2 – The M360 equipment management agreement (“M360”) provides for the management of specific movable equipment from pickup, delivery, cleaning, maintenance, recalls, and inventory-level management. This allows for real-time provisioning and management of specialized equipment when needed while reducing unnecessary rental requests and associated costs. Contracted services are currently provided at Wilma Chan Highland Hospital (“WCHC”) and include the following:
  - Beds
  - Infusion Pumps
  - Ventilators
  - Specialty equipment

To ensure uninterrupted provision of all necessary maintenance and sourcing for our biomedical equipment needs, AHS leadership has conducted an extensive review of services under the current B360 and M360 agreements and is negotiating renewal terms to ensure uninterrupted provision of these critical services when the current agreements expire. For simplicity and ease of management, services currently provided under separate arrangements (Agreements 1 and 2) will be combined into a single renewal agreement at the conclusion of the ongoing negotiations. This will allow for seamless coordination between our equipment maintenance and inventory/rental management services provided by Agiliti (i.e. identify opportunities to utilize existing assets instead of sourcing short-term rentals to backfill equipment out
for service). To allow sufficient time to complete the renewal negotiations and advance the resulting renewal agreement for subsequent Board review and approval, AHS leadership is now requesting Board approval to extend the current B360 and M360 agreements each by 7 months.

**Contract Type and Term:**

- Agreement #1 Extension Amendment for a fixed term of 7 additional months (October 1, 2023 through April 30, 2024).
- Agreement #2 Extension Amendment for a fixed term of 7 additional months (October 1, 2023 through April 30, 2024).

**Termination Clause:**

Each party shall have the right to terminate these Agreements by providing 30 days prior written notice to the other party.

**Total Spend with Vendor:**

<table>
<thead>
<tr>
<th>Description</th>
<th>Board Approval</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agreement #1 Extension Amendment (10/1/2023 – 4/30/2024)</td>
<td>Requested</td>
<td>$1,542,560</td>
</tr>
<tr>
<td>Agreement #2 Extension Amendment (10/1/2023 – 4/30/2024)</td>
<td>Requested</td>
<td>$1,033,440</td>
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<tr>
<td>Total Estimated Spend:</td>
<td></td>
<td>$2,576,000</td>
</tr>
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</table>

**Estimated Cost Savings:**

N/A

**Fiscal Implications:**

Proposed spend in FY 24 budget.

**Reasons for Recommendation:**

The maintenance and repair of medical equipment is vital to the daily operation of AHS and our ability to provide safe and effective treatment to our patients. Agiliti is a trusted partner with a positive record in the timely and effective provision of these essential services.

**Impacted Facilities:**

<table>
<thead>
<tr>
<th>JGPH</th>
<th>Highland</th>
<th>Fairmont</th>
<th>San Leandro</th>
<th>Alameda</th>
<th>Clinic(s)</th>
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<tbody>
<tr>
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<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
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</table>

**Coordination with Medical Staff:**

N/A

**Administrative Review:**

Chief Technology Officer

**Prior BOT Review/Action:**

Board of Trustees approval January 2020 of the B360 Agiliti Healthcare Agreement for Biomedical Services.

**Executive Sponsor**

Chief Information Officer
# Monthly Report
## Lifetime Vendor Spend - Sept 2023

<table>
<thead>
<tr>
<th>Vendor Name</th>
<th>Revised Contract Term</th>
<th>Proposed Contract Spend</th>
<th>Total Lifetime Vendor Spend (including proposed contract)</th>
<th>Proposed Contract Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Siemens Industry Inc.</td>
<td></td>
<td>$152,086.00</td>
<td>$52,866,300.13</td>
<td>Calibrate Critical Pressure Monitors at HGH</td>
<td>Executed</td>
</tr>
<tr>
<td>ePlus Technology, Inc.</td>
<td></td>
<td>$695,699.04</td>
<td>$1,979,074.29</td>
<td>This agreement is between ePlus Technology, Inc. and AHS outlining terms for reselling Cisco's Software As A Service offerings. The subscription term starts on the Go Live Date and can be renewed unless either party provides written notice not to renew. The agreement also covers pricing, payment terms, additional services, and warranty information.</td>
<td>Executed</td>
</tr>
<tr>
<td>PJI Construction</td>
<td>6/26/2023 – 1/19/2024</td>
<td>$159,720.00</td>
<td>$1,852,717.10</td>
<td>Bin Storage Project Construction</td>
<td>Executed</td>
</tr>
<tr>
<td>PJI Construction Inc.</td>
<td>7/10/2023 - 8/25/2023</td>
<td>$28,540.00</td>
<td>$2,615,379.60</td>
<td>Shower renovation.</td>
<td>Executed</td>
</tr>
<tr>
<td>PJI Construction, Inc.</td>
<td>7/10/2023 - 8/18/2023</td>
<td>$14,050.00</td>
<td>$2,600,889.60</td>
<td>Hopper Sink Installation</td>
<td>Executed</td>
</tr>
<tr>
<td>The Ratcliff Architects</td>
<td>7/14/2023 – 12/31/2023</td>
<td>$34,400.00</td>
<td>$2,547,910.79</td>
<td>SPD Addition validation study</td>
<td>Executed</td>
</tr>
<tr>
<td>PJI Construction, Inc.</td>
<td>8/18/2023 - 11/30/2023</td>
<td>$23,940.00</td>
<td>$2,610,779.60</td>
<td>Perform gutter clearing and installation of aluminum gutter screens around exterior perimeter of East Building.</td>
<td>Executed</td>
</tr>
<tr>
<td>Anderson Flooring Company</td>
<td>9/11/2023 – 12/29/2023</td>
<td>$73,822.00</td>
<td>$2,804,751.24</td>
<td>Floor replacement as part of Pharmacy flooring project</td>
<td>Executed</td>
</tr>
<tr>
<td>Traditions Behavioral Health</td>
<td>2/28/21-12/31/24 (Same)</td>
<td>$318,088.16</td>
<td>$92,830,671.77</td>
<td>Amended contract to include Interim Chair of Psychiatry role</td>
<td>Executed</td>
</tr>
<tr>
<td>UCSF MFM</td>
<td>8/1/2017-7/31/21</td>
<td>$924,583.33</td>
<td>$1,302,686.64</td>
<td>Extended contract for another year</td>
<td>Executed</td>
</tr>
<tr>
<td>UCSF OMFS</td>
<td>7/1/2021-10/31/23</td>
<td>$678,021.86</td>
<td>$5,584,936.37</td>
<td>Extended contract for another 4 months and included incentive metrics for FY24</td>
<td>Executed</td>
</tr>
<tr>
<td>Alameda Inpatient Medical (AIM)- Core</td>
<td>8/2/21-10/31/23</td>
<td>$656,449.28</td>
<td>$23,191,226.33</td>
<td>Extended contract for 3 months to allow AHS and vendor to negotiate renewal</td>
<td>Executed</td>
</tr>
<tr>
<td>Alameda Inpatient Medical (AIM) - Alameda</td>
<td>3/7/22-3/6/24 (Same)</td>
<td>$2,657.28</td>
<td>$23,191,226.33</td>
<td>Amended contract to include a jeopardy shift for Hospitalist Throughput Pilot for 1 week</td>
<td>Executed</td>
</tr>
</tbody>
</table>
# BOT Previously Approved Contracts - FY24 (July 1, 2023 - June 30, 2024)

<table>
<thead>
<tr>
<th>#</th>
<th>Vendor</th>
<th>Amount Requiring BOT Approval</th>
<th>Start Date</th>
<th>Ending Date</th>
<th>BOT approved Date</th>
<th>Agenda Summary</th>
<th>Executive Sponsor</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>The Regents of the University of California on behalf of the University of California, San Francisco, Department of Neurological Surgery</td>
<td>$5,735,907</td>
<td>8/1/2023</td>
<td>7/31/2025</td>
<td>FC - 7-5-23 BOT Approved 7/12/23</td>
<td>Renewal for neurosurgery services agreement.</td>
<td>Chief Operating Officer</td>
</tr>
<tr>
<td>2</td>
<td>Bay Area Community Services</td>
<td>$2,678,400</td>
<td>8/1/2023</td>
<td>7/31/2026</td>
<td>FC - 7-5-23 BOT Approved 7/12/23</td>
<td>Renewal for provision of medical respite care services, including residential services, wraparound services, and housing solutions.</td>
<td>Vice-President of Patient Care Services</td>
</tr>
<tr>
<td>3</td>
<td>Infor (US), LLC</td>
<td>$1,602,401</td>
<td>8/1/2023</td>
<td>7/31/2026</td>
<td>FC - 7-5-23 BOT Approved 7/12/23</td>
<td>Renewal for provision of enterprise resource planning software services.</td>
<td>Vice-President of Applications</td>
</tr>
</tbody>
</table>

**Total Amount for FY 24 year to date**  $10,016,708
F1. Patient Family Advisory Committee Report
Patient and Family Advisory Committee (PFAC)
PFAC Summary

• Purpose – Develop a systemwide PFAC to:
  – Incorporate the patient perspective in decision making
  – Improve patient experience, engagement, safety and quality
  – Shift organizational culture to ultimately become patient-centric, aligning with the strategic plan
Background

- The AHS Strategic Plan prioritizes the patient in the center of the overall plan. Patient voice is critical and essential to achieve the goals and strategic actions identified in the plan.

- The Community Pillar identifies a strategic action to establish a patient/family advisory committee (PFAC). The initial PFAC will be systemwide including, inpatient, ambulatory and mental health.

- A PFAC will be re-established at Alameda Hospital and an additional new committee at San Leandro Hospital.

- Other PFACs may also be considered over time.
PFAC Working Group

• Angela Ng, MD, Director, Care Experience
• Jan Robertson, Senior Patient Relations Manager
• Sarah Rahman, MD, Associate Chief Informatics Officer
• Holly Garcia, Director, Ambulatory Operations
• Jeanette Dong, Chief Strategy Officer
• Ethan Torrence, Administrative Fellow
PFAC Working Group Tasks

• Patient-facing staff met to discuss history, best practice research and PFAC concept
• Reviewed and compiled best practice documents, such as by-laws, mission statements and goals
• Identified ways to embed patient voice in the AHS culture
• Acknowledged the PFAC is the first step of many to include patient voice
History and Existing Patient Voice

- IOP Client Council
- Resident Councils at SNFs
- Co-Applicant Board (CAB)
- Institutional Review Board (IRB)
PFAC Structure

**Committee Structure**

- Patient and family members (majority) and staff
- Terms of membership
  - Two years – Option to apply to renew if desired
  - Staggered terms
- Sample Guidelines/Bylaws/Charters from other PFACs
- Mission Statement and Responsibilities

**Meeting Logistics**

- Meet regularly (10-12 times per year)
- Develop meeting agendas and maintain minutes
- Seek a balance of PFAC-initiated and staff-initiated projects
PFAC

• Recruitment of Patient and Family Advisors
  – Selection process will include application and interview

• Orientation
  – Familiarize members with AHS policies, procedures, and the committee's purpose
  – Facility rounding

• Staffing
  – 1 FTE for project management, committee facilitator, administrative support, coordinate meetings and communication

• Volunteer Stipend with Gift Cards
  – Encourage participation

• Cost Per Year
  – Develop budget for estimated cost for development and maintenance

• Socializing the Concept
  – Utilize PACE
  – Complete readiness assessment
Incorporating a PFAC at AHS

• Link to Quality
  – Participate in risk/safety assessments
  – Secret shopper

• New Services, Expansion, and Projects
  – PFAC included in Strategy Department intake process
  – Patient Focus Group is required prior to SMART Committee

• Patient Voices Trust
  – Collection of patients to share their experiences and provide feedback

• Listening Sessions/Town Halls
Questions
F2. Equity Analytics Workgroup Report
AHS Equity Analytics Workgroup

Annette Johnson, Director Quality Analytics

U. Mini B. Swift MD MPH FACP, Vice President, Population Health
“Lack of adequately disaggregated data can contribute to the unmet needs of underrepresented populations by rendering them invisible when:

- policies are made,
- resources are allocated,
- and programs are designed and implemented;

it reflects systemic inequities and, when oppressed or excluded racial or ethnic groups are involved, **systemic racism**.”
Equality Analytics is:
• Numerous regulatory organizations require collection, stratification
• AHS Strategic plan includes a commitment stratification and improved outcomes for all patients
Equity Analytics Workgroup: Alignment Across AHS

- Established 11/2022
- Includes Data Miners and Farmers from across the organization

**Purpose**
- Design goals, strategies, objectives for data related to equity
- Monitor regulatory and best practice landscape related equity data collection and measurement

**Objectives**
- Standardization
- Collaboration
- Prioritize
- Sharing best practices and training

---

IT/BI
Value Based Care
Patient Engagement
Finance (GPP)
Human Resources
Quality
Ambulatory
Population Health
FY 2024 Priorities

Validation
- Demographic Data Collection Training
- Data validation

Structure
- External stratification requirements
- Internal equity standards
- Standard template for analysis/dashboard

Utilization
- Equity data literacy training
Dual Reporting Structure Equity Analytics Team

- HEDI-B Committee
  - Periodic Report Outs

- Data Governance Committee
  - Resources projects, dashboards and reports

- Equity Analytics Workgroup
  - Subject Matter Expertise
  - Operationalize Measurement
  - Monitors Results
  - Monitor Regulatory Requirement
Questions?

Thank-You
F3. Approval of the Third Amended and Restated Subordination Agreement and Consent
TO: Board of Trustees
FROM: Ahmad Azizi, General Counsel
DATE: September 13, 2023
SUBJECT: Agenda Item: Approval of Resolution 2023-013, Granting Authorization to the CEO to execute the Third Amended And Restated Subordination Agreement And Consent

BOARD ACTION: Approve Resolution.

The Alameda County Joint Powers Authority (the “Authority”) previously issued lease revenue bonds (the “Existing Bonds”) to finance the construction of the new Acute Care Tower, the Highland Care Pavilion, and other facilities on the Highland Hospital campus. The Existing Bonds are supported by a site lease and lease agreement, both between Alameda County (the “County”) and the Authority, covering the Wilma Chan Highland Hospital campus, and an assignment agreement between the Authority and the trustee for the Existing Bonds (collectively, the “Highland Leases”), and are payable from rental payments made by the County under the Highland Leases.

The Authority and the County desire to issue new bonds to refinance a portion of the Existing Bonds to achieve debt service savings and to amend the Highland Leases to reflect the reduced base rental payments and other changes resulting from the issuance of the new bonds.

AHS is party to an existing subordination agreement and consent, which subordinates the lease between AHS and the County (the “AHS Lease”) to the Highland Leases, giving the Existing Bonds a preference over the rights of both AHS and the County with respect to the AHS Lease (with respect to the Highland Hospital campus). In addition, there is a subordination provision in the AHS lease itself.
An amendment and restatement of the existing subordination agreement expressly continuing such subordination and applying it to the Highland Leases, as amended in connection with the issuance of the new bonds, and to the new bonds as well as the Existing Bonds that are not refinanced as part of the transaction is necessary for the County to refinance the Existing Bonds.

**Prior Review/Action:** On November 30, 2016 the Board authorized the CEO to execute the Second Amended and Restated Subordination Agreement.

**Board Action Requested:** Staff recommends the Board adopt the attached resolution authorizing the CEO to execute the Third Amended And Restated Subordination Agreement And Consent.

**Fiscal Impact:** N/A

**Budgeted/Authorization:** N/A

**Estimated Cost Savings:** N/A

**Strategic Plan Pillar:** N/A
Authorization for Chief Executive Officer to Execute the Third Amended And Restated Subordination Agreement And Consent

WHEREAS, the Alameda County Joint Powers Authority (the “Authority”) previously issued lease revenue bonds (the “Existing Bonds”) to finance the construction of the new Acute Care Tower, the Highland Care Pavilion, and other facilities on the Highland Hospital campus;

WHEREAS, the Existing Bonds are supported by a site lease and lease agreement, both between Alameda County (the “County”) and the Authority, and an assignment agreement between the Authority and the trustee for the Existing Bonds (collectively, the “Highland Leases”), and are payable from rental payments made by the County under the Highland Leases;

WHEREAS, the Authority and the County desire to issue new bonds to refinance a portion of the Existing Bonds to achieve debt service savings and to amend the Highland Leases to reflect the reduced base rental payments and other changes resulting from the issuance of the new bonds;

WHEREAS, Alameda Health System (“AHS”) is party to a Second Amended and Restated Subordination Agreement and Consent, dated as of November 1, 2016, which subordinates the lease between AHS and the County (the “AHS Lease”) to the Highland Leases, giving the Existing Bonds a preference over the rights of both AHS and the County with respect to the AHS Lease (with respect to the property subject to the Highland Leases);

WHEREAS, the County is now requesting that AHS execute a Third Amended and Restated Subordination Agreement and Consent (the “Subordination Agreement”) among the County, the Authority and AHS, continuing such subordination and applying it to the Highland Leases, as amended in connection with the issuance of the new bonds, and to the new bonds as well as the Existing Bonds that are not refinanced as part of the transaction;
WHEREAS, the Subordination Agreement is necessary for the County to refinance the Existing Bonds under this financing structure;

NOW, THEREFORE, BE IT RESOLVED, that the Board of Trustees hereby authorizes the Chief Executive Officer to execute the Subordination Agreement in such form, and containing such terms and conditions, as is approved by the Chief Executive Officer, and such other documents as may be necessary to effect the subordination or the refinancing of the Existing Bonds, in such form as is approved by the Chief Executive Officer.

THE FOREGOING Resolution was presented the 13th day of September 2023, to wit:

I hereby certify under penalty of perjury that the President of the Board of Trustees was duly authorized to execute this document on behalf of the Alameda Health System by majority of vote of the Board on September 13, 2023 and that a copy has been delivered to the President.

ATTEST:

_____________________________________________________
Ronna Jojola Gonsalves
Clerk of the Board of Trustees
Alameda Health System

Date:__________________________

APPROVED AS TO FORM:

_____________________________________________________
Ahmad Azizi, General Counsel

Date:__________________________

THE FOREGOING Resolution was PASSED and ADOPTED by the Alameda Health System Board of Trustees this 13th day of September 2023, to wit:

_____________________________________________________
Kinkini Banerjee
President, Board of Trustees
Alameda Health System
THIS TRANSACTION IS EXEMPT FROM FILING FEES PURSUANT TO CALIFORNIA GOVERNMENT CODE SECTION 6103 AND TRANSFER TAXES PURSUANT TO CALIFORNIA REVENUE AND TAXATION CODE SECTION 11928

THIRD AMENDED AND RESTATED SUBORDINATION AGREEMENT AND CONSENT

THIS THIRD AMENDED AND RESTATED SUBORDINATION AGREEMENT AND CONSENT (this “Agreement”) is dated as of [________], 2023, among Alameda Health System (“AHS”), which is formerly known as Alameda County Medical Center (“ACMC”), the County of Alameda (the “County”), a public subdivision of the State of California, and the Alameda County Joint Powers Authority, a joint exercise of powers duly organized and existing pursuant to a Joint Exercise of Powers Agreement, dated as of April 1, 2004 (the “Authority”).

RECITALS:

Whereas, the County and AHS (at such time, known as ACMC) entered into an unrecorded Medical Facilities Lease, dated as of November 28, 2000 (the “ACMC Lease”), pursuant to which the County leased to AHS various hospitals, clinics and other medical facilities described therein (the “ACMC Lease Property”), a portion of which ACMC Lease Property is more particularly described in the attached Attachment A which is incorporated herein by this reference (as so set forth on such Attachment A, the “Facilities”);

Whereas, the Authority previously issued its $320,000,000 Lease Revenue Bonds (Multiple Capital Projects) 2010 Series A (the “2010 Bonds”) and $287,380,000 Lease Revenue Bonds (Multiple Capital Projects), 2013 Series A (the “2013 Bonds”) and used the proceeds thereof to finance and refinance all or any portion of the costs of the design, engineering, site preparation, construction, reconstruction, renovation, retrofitting, furnishing, and equipping of the Highland Hospital (the “Project”), which is operated by AHS;

Whereas, the Authority is refinancing a portion of the 2013 Bonds with the proceeds of its $______ Lease Revenue Refunding Bonds (Highland Hospital Project) 2023 Series A (the “2023 Bonds”);

Whereas, under the 2010 Bonds and 2013 Bonds financing structure, and continued in the 2023 Bonds financing structure, the County leased certain real property of the County (the
“Property”) to the Authority, pursuant to terms and conditions set forth in that certain Site Lease, dated as of October 1, 2010, and recorded in the Official Records of the County of Alameda on November 3, 2010 as instrument number 2010323064 (the “Original Site Lease”), as amended by the First Amendment to Site Lease, dated as of October 1, 2013, and recorded in the Official Records of the County of Alameda on September 30, 2013, as instrument number 2013319520 (the “First Amendment to Site Lease”) and the Second Amendment to Site Lease, dated as of November 1, 2016, and recorded in the Official Records of the County of Alameda on January 25, 2017, as instrument number 2017019132 (the “Second Amendment to Site Lease”) and the Third Amendment to Site Lease, dated as of [_________ 1, 2023] and recorded concurrently herewith (the “Third Amendment to Site Lease” and, together with the Original Site Lease, the First Amendment to Site Lease and the Second Amendment to Site Lease, the “Site Lease”), each between the County, as lessor, and the Authority, as lessee;

Whereas, the Authority subleased the Property to the County, in accordance with the terms and conditions set forth in that certain Lease Agreement, dated as of October 1, 2010, and recorded in the Official Records of the County of Alameda on November 3, 2010 as instrument number 2010323065 (the “Original Lease Agreement”), as amended by the First Amendment to Lease Agreement, dated as of October 1, 2013, and recorded in the Official Records of the County of Alameda on September 30, 2013, as instrument number 2013319521 (the “First Amendment to Lease Agreement”), the Second Amendment to Lease Agreement, dated as of November 1, 2016, and recorded in the Official Records of the County of Alameda on January 25, 2017 as instrument number 2017019131 (the “Second Amendment to Lease Agreement”), and the Third Amendment to Lease Agreement, dated as of [_________ 1, 2023], and recorded concurrently herewith (the “Third Amendment to Lease Agreement” and, together with the Original Lease Agreement, the First Amendment to Lease Agreement and the Second Amendment to Lease Agreement, the “Lease Agreement”), each between the Authority, as sublessor, and the County, as sublessee;

Whereas, the Property subject to the Site Lease and the Lease Agreement is the same real property, together with the facilities and other improvements thereon, as the Facilities;

Whereas, the Authority wishes to assign certain of its interests in and to the Lease Agreement to U.S. Bank Trust Company, National Association, as trustee (the “Trustee”), in accordance with the terms and conditions set forth in that certain Assignment Agreement, dated as of October 1, 2010, and recorded in the Official Records of the County of Alameda on November 3, 2010 as instrument number 2010323066 (the “Original Assignment Agreement”), between the Authority and the Trustee, as amended and restated by that certain Amended and Restated Assignment Agreement, dated as of October 1, 2013, and recorded September 30, 2013 as instrument number 2013319522, between the Authority and the Trustee, that certain Second Amended and Restated Assignment Agreement, dated as of November 1, 2016, and recorded January 25, 2017, as instrument number 2017019134 (the “Second Amended and Restated Assignment Agreement”), and that certain Third Amended and Restated Assignment Agreement, dated as of [_________ 1, 2023] and recorded concurrently herewith (the “Assignment Agreement”), between the Authority and the Trustee;

Whereas, pursuant to a Subordination Agreement and Consent, dated as of October 1, 2010, and recorded in the Official Records of the County of Alameda on November 3, 2010 as instrument
number 2010323063 (the “Original Subordination Agreement”), as amended and restated by the Amended and Restated Subordination Agreement and Consent, dated as of October 1, 2013, and recorded in the Official Records of the County of Alameda on September 30, 2013 as instrument number 2013319519 (the “Amended and Restated Subordination Agreement”) and the Second Amended and Restated Subordination Agreement and Consent, dated as of November 1, 2016, and recorded in the Official Records of the County of Alameda on January 25, 2017, as instrument number 2017019133 (the “Second Amended and Restated Subordination Agreement”), the parties hereto agreed to subordinate the ACMC Lease in all respects to Original Site Lease, as amended by the First Amendment to Site Lease, the Original Lease Agreement, as amended by the First Amendment to Lease Agreement, and the Second Amended and Restated Assignment Agreement;

Whereas, prior to the date hereof the County has made the Facilities described in Attachment A hereto (and only such Facilities, which comprise only a portion of the ACMC Lease Property) subject to the Site Lease and Lease Agreement to serve as the Property thereunder; and

Whereas, the parties are entering into this Agreement to amend and restate in its entirety the Amended and Restated Subordination Agreement.

NOW THEREFORE, in consideration of the foregoing premises, the sum of Ten and 00/100 Dollars ($10.00) in hand paid, and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged by each party hereto, for themselves and for their successors and assigns, it is hereby agreed as follows:

1. FOREGOING RECITALS. The foregoing recitals are hereby incorporated by reference as if fully set forth herein.

2. CONSENT. AHS hereby consents to the Site Lease, the Lease Agreement, and the Assignment Agreement and hereby subordinates the ACMC Lease in respect of the Facilities (and only in respect thereof) to the Site Lease, the Lease Agreement and the Assignment Agreement, all pursuant to this Agreement.

3. SUBORDINATION TO SITE LEASE. Subject to the terms of this Agreement, the ACMC Lease in respect of the Facilities (and only in respect thereof) is hereby made subject, junior and subordinate to the Site Lease and to all renewals, modifications, consolidations, replacements and extensions of the Site Lease so that all rights of AHS and the County under the ACMC Lease in respect of the Facilities (and only in respect thereof) shall be subject, junior and subordinate to the rights of the County and the Authority under the Site Lease and to all renewals, modifications, consolidations, replacements and extensions of the Site Lease as fully as if such instrument had been executed, delivered and recorded prior to the execution of the ACMC Lease.

4. SUBORDINATION TO LEASE AGREEMENT. Subject to the terms of this Agreement, the ACMC Lease in respect of the Facilities (and only in respect thereof) is hereby made subject, junior and subordinate to the Lease Agreement and to all renewals, modifications, consolidations, replacements and extensions of the Lease Agreement so that all rights of AHS and the County under the ACMC Lease in respect of the Facilities (and only in respect thereof) shall be subject, junior and subordinate to the rights of the County and the Authority under the Lease Agreement, and to all renewals, modifications, consolidations, replacements and extensions of the

4885-2907-3787.5
Lease Agreement as fully as if such instrument had been executed, delivered and recorded prior to the execution of the ACMC Lease.

5. **SUBORDINATION TO ASSIGNMENT AGREEMENT.** Subject to the terms of this Agreement, the ACMC Lease in respect of the Facilities (and only in respect thereof) is hereby made subject, junior and subordinate to the Assignment Agreement and to all renewals, modifications, consolidations, replacements and extensions of the Assignment Agreement so that all rights of AHS and the County under the ACMC Lease in respect of the Facilities (and only in respect thereof) shall be subject, junior and subordinate to the rights of the Trustee and the Authority under the Assignment Agreement, and to all renewals, modifications, consolidations, replacements and extensions of the Assignment Agreement as fully as if such instrument had been executed, delivered and recorded prior to the execution of the ACMC Lease.

6. **FURTHER ASSURANCES.** AHS agrees that upon request of either the County or the Authority, it will execute such further written agreements, and take such further actions, to evidence and affirm any and all of its obligations and/or agreements under this Agreement as may be reasonably requested by such parties.

7. **REPRESENTATIONS.** Each party represents and warrants that the person executing this Agreement on its behalf has full power, authority and authorization to execute this Agreement and to agree to its terms without the necessity of any consents, authorizations or approvals, or if such consents, authorizations or approvals are required they have been obtained prior to the execution hereof.

8. **SUCCESSORS AND ASSIGNS.** This Agreement shall be binding upon ACMC, the County and the Authority and their successors and assigns and shall inure to the benefit of AHS, the County and the Authority and their respective successors and/or assigns.

9. **MODIFICATIONS.** This Agreement may not be modified except by an instrument in writing executed by AHS, the County and the Authority.

10. **GOVERNING LAW.** This Agreement shall be governed by all applicable federal laws and the laws of the State of California.

11. **COUNTERPARTS.** This Agreement may be executed in counterparts and each such counterpart shall constitute an original.

[Remainder of page intentionally left blank]
IN WITNESS WHEREOF, the parties have caused this Second Amended and Restated Subordination Agreement to be executed by its duly authorized representative as of the date first written above.

COUNTY OF ALAMEDA, CALIFORNIA  ALAMEDA COUNTY JOINT POWERS AUTHORITY

By: ________________________________  By: ________________________________
   [________________________]        [________________________]  
ATTEST:

By: ________________________________  By: ________________________________
   [________________________]        [________________________]  

APPROVED AS TO FORM:

Donna R. Ziegler, County Counsel

By: ________________________________
   [________________________]  
Andrea L. Weddle
Chief Assistant County Counsel

ALAMEDA HEALTH SYSTEM

By: ________________________________
   [________________________]  

APPROVED AS TO FORM:

By: ________________________________
   [________________________]  

[Signature Page to Third Amended and Restated Subordination Agreement and Consent]
ACKNOWLEDGMENT

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

STATE OF CALIFORNIA

County of _____________________________

On ________________, before me, ____________________________ a Notary Public, personally appeared ____________________________ who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

________________________________________
Signature of Notary

(Affix seal here)
EXHIBIT A

Description of the Property
G1. Chief Financial Officer Report,
MEMORANDUM

TO: AHS Finance Committee
FROM: Kim Miranda, CFO
DATE: August 31, 2023
SUBJECT: July Financial Report

Financial Summary
Net Income for July was $1.8 million compared to a budget of $0.1 million. Operating Revenue was $116.8 million for the month and favorable to budget by $2.5 million. Operating Expense was $114.8 million for the month and unfavorable to budget by $0.8 million. Earnings before interest, depreciation, and amortization (EBIDA) was $5.1 million and the EBIDA Margin was 4.4% compared to budget EBIDA of $3.3 million and an EBIDA Margin of 2.9%. For the month, EBIDA exceeded the budget by $1.8 million.

<table>
<thead>
<tr>
<th>July 2023</th>
<th>FY 2023</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actual</td>
<td>Budget</td>
</tr>
<tr>
<td>Operating revenue</td>
<td>$116,770</td>
</tr>
<tr>
<td>Operating expense</td>
<td>$114,833</td>
</tr>
<tr>
<td>Operating income (loss)</td>
<td>$1,937</td>
</tr>
<tr>
<td>Other non-operating activity</td>
<td>$(125)</td>
</tr>
<tr>
<td>Net Income (loss)</td>
<td>$1,811</td>
</tr>
<tr>
<td>EBIDA adjustments</td>
<td>$3,289</td>
</tr>
<tr>
<td>EBIDA</td>
<td>$5,100</td>
</tr>
<tr>
<td>Operating Margin</td>
<td>1.7%</td>
</tr>
<tr>
<td>EBIDA Margin</td>
<td>4.4%</td>
</tr>
</tbody>
</table>

Operating Revenue
Operating Revenue was $116.8 million and favorable to budget for the month by $2.5 million and 2.2%. Gross Patient Service Revenue (patient charges) was $355.3 million for the month and unfavorable to budget by $0.8 million and 0.2%. Inpatient and Professional service revenue fell below budget by 0.7% and 5.3%, respectively. The case mix index, CMI, was below budget by 4.1% indicating lower complexity of patients and services. Inpatient surgeries were 16.7% below budget. Discharges were slightly higher than budget which had a positive impact on LOS over trend. The length of stay was 6.2 which exceeded budget by 3.3%.
Emergency Department volumes were below budget by 4.0%, negatively impacting professional fees. On a positive note, outpatient charges were above budget by 2.1% driven by surgery cases exceeding budget by 10.3% indicating more elective volume. Clinic visits also exceeded the budget by 1.1%.

Net Patient Revenue
Net Patient Service Revenue (NPSR) was $69.4 million for the month and favorable to budget by $2.0 million and 3.0% driven by a better than budget collection ratio and improved payor mix toward commercial insurance. The collection ratio was 19.5% and 0.6% above the budget of 18.9%. Trauma cases were 8.3% over budget in July driving the improved payer mix. Collections on fully reserved accounts were consistent with trend. AHS implemented a CDM increase on July 1, 2023 of a blended 3%. AHS is expected to collect slightly more reimbursement from commercial payers, which represents approximately 8% of AHS charges. The strong revenue estimate is based on analysis of payments to charges on fully paid or zero balance accounts (ZBA) adjusted for the CDM increase.

Other Government Program Revenue
Other Government Program Revenue for the month was $39.6 million approximating budget. Government programs were accrued at budget since no added information is available. The slight unfavorable variance was from lower Medi-Cal CalAim funding ($46.0 thousand) offset by higher Prop 56 receipts ($21.0 thousand).

Other Operating Revenue
Other Operating Revenue for the month was $3.8 million compared to a budget of $3.3 million, which is favorable to budget by $0.5 million and 13.7%. Retail pharmacy cash exceeded budget ($0.7 million) which was partially offset by timing of grant revenue ($0.3 million).

Operating Expense
Operating Expense was $114.8 million for the month and unfavorable to budget by $0.8 million and 0.7%. Labor ($2.1 million) had the most significant unfavorable variance this month and is discussed below. Most other variances were positive including Physician contract services ($0.2 million), Materials and supplies ($0.4 million), Facilities ($0.6 million) and Administration ($0.1 million). Facilities had the largest favorable
Memorandum to AHS Finance Committee  
July 2023 Operating Results

Operating Results

- Variance driven by timing for medical equipment repairs ($0.3 million), building repairs ($0.2 million), and utilities ($0.3 million). Materials and supplies had the next largest variance driven by lower surgical supplies consistent with lower surgery volume ($0.3 million) and lab reagents ($0.2 million). All other line-item variances are minor and considered timing differences across many departments.

Labor Costs are itemized below:

<table>
<thead>
<tr>
<th>Description</th>
<th>July 2023</th>
<th>FY 2023</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual</td>
<td>Budget</td>
</tr>
<tr>
<td>Labor costs</td>
<td>$86,395</td>
<td>$84,316</td>
</tr>
<tr>
<td>Physician contract services</td>
<td>3,269</td>
<td>3,484</td>
</tr>
<tr>
<td>Purchased services</td>
<td>7,755</td>
<td>7,836</td>
</tr>
<tr>
<td>Materials and supplies</td>
<td>10,171</td>
<td>10,592</td>
</tr>
<tr>
<td>Facilities</td>
<td>2,329</td>
<td>2,970</td>
</tr>
<tr>
<td>Depreciation and amortization</td>
<td>3,150</td>
<td>3,068</td>
</tr>
<tr>
<td>General and administrative</td>
<td>1,764</td>
<td>1,810</td>
</tr>
<tr>
<td><strong>Total operating expense</strong></td>
<td><strong>$114,833</strong></td>
<td><strong>$114,076</strong></td>
</tr>
</tbody>
</table>

Labor cost for the month was $86.4 million and unfavorable to budget by $2.1 million and 2.5%. Salary and wages were unfavorable by $0.8 million and 1.6% driven by overtime ($1.2 million), FTEs exceeding budget by 8 FTE ($0.1 million) offset by other pay variances. Registry exceeded budget by $0.6 million and 9.9% driven by an unfavorable FTE variance of 93 ($2.6 million) offset by lower rates ($2.0 million). The demand for registry remains high; however, rates are decreasing from pandemic levels. Physician salaries for the month are favorable $0.7 million and 7.8% across many specialties. Planned recruiting was included evenly in the budget and additional terminations have occurred. Services as needed (SANs) were utilized due to the vacancies. SAN FTEs were not included in the budget. The result is an unfavorable FTE variance of 14 FTE. Benefits for the month are $13.6 million and unfavorable $1.4 million and 11.3% driven by new union contract including housing allowance for interns and residents under GME ($0.6 million) and self-funded insurance plans ($0.6 million). Retirement approximates budget.

**FTE Trending**

For the month, Paid FTE were 4,892 compared to a budget of 4,776 which was unfavorable to budget by 116 and 2.4%. The FTE trend graph below reflects paid FTE and adjusted patient days (Total Gross Revenues /...
Inpatient Revenues = Outpatient Factor x Patient Days). Overall, adjusted patient days are recovering to pre-COVID-19 levels represented by the red line; however, LOS is driving the need for additional resources. Paid FTE and each paid component are represented by color within the bars. Registry and overtime FTE are above budget which is reflected to the far left of the graph when comparing July actual to July budget.

Balance Sheet and Financial Condition

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

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

Accounts Receivable (AR)
The Gross Days in AR decreased 2.3 days to 60.1 days and the Net Days in AR decreased 2.2 days to 36.1 days over the prior month. The calculation reflects 90 days versus actual days for the quarter to standardize. Collections were strong in July and above trend for professional and hospital billing. Patient collections are reflected in the table below. Open hospital denials decreased $35.4 million due to collaboration with Cloud Med to assist working clinical denials which resulted in revenue of $0.9 million in July. Para Rev back log of accounts over 180 days is resolved. The balance over 180 is down to $7.0 million and we have resumed the normal collections process. AHS continues to bill hospital FFS MediCal claims on paper. The state is accepting claims and July receipts were $12.1 million. The NPI Reconciliation and Consolidation kick-off meeting began last week.
## Balance Sheet Summary

<table>
<thead>
<tr>
<th></th>
<th>Jul-23</th>
<th>FY 2023</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash, unrestricted and restricted</td>
<td>$43,846</td>
<td>$36,856</td>
</tr>
<tr>
<td>Patient receivable, net</td>
<td>90,005</td>
<td>94,432</td>
</tr>
<tr>
<td>Due from third-party payors</td>
<td>330,907</td>
<td>267,447</td>
</tr>
<tr>
<td>Due from County</td>
<td>37,582</td>
<td>35,038</td>
</tr>
<tr>
<td>Other current assets</td>
<td>59,623</td>
<td>56,132</td>
</tr>
<tr>
<td>Other noncurrent assets</td>
<td>154,480</td>
<td>156,520</td>
</tr>
<tr>
<td>Deferred outflows</td>
<td>231,502</td>
<td>231,502</td>
</tr>
<tr>
<td><strong>Total Assets</strong></td>
<td>$947,945</td>
<td>$877,927</td>
</tr>
<tr>
<td>Accounts payable and payroll liabilities</td>
<td>$142,186</td>
<td>$137,432</td>
</tr>
<tr>
<td>Due to third-party payors</td>
<td>208,847</td>
<td>203,250</td>
</tr>
<tr>
<td>Due to County</td>
<td>54,417</td>
<td>15,908</td>
</tr>
<tr>
<td>Liquidity facility - County of Alameda</td>
<td>(13,765)</td>
<td>(33,490)</td>
</tr>
<tr>
<td>Other long-term payables</td>
<td>597,610</td>
<td>597,985</td>
</tr>
<tr>
<td>Deferred inflows</td>
<td>43,260</td>
<td>43,260</td>
</tr>
<tr>
<td><strong>Fund Balance</strong></td>
<td>(84,610)</td>
<td>(86,418)</td>
</tr>
<tr>
<td><strong>Total Liabilities &amp; Fund Balance</strong></td>
<td>$947,945</td>
<td>$877,927</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Jul-23</th>
<th>FY 2023</th>
</tr>
</thead>
<tbody>
<tr>
<td>Days in Cash</td>
<td>5.1</td>
<td>2.6</td>
</tr>
<tr>
<td>Gross Days in Patient Receivable</td>
<td>60.1</td>
<td>62.4</td>
</tr>
<tr>
<td>Net Days in Patient Receivable</td>
<td>36.1</td>
<td>38.3</td>
</tr>
<tr>
<td>Due from/(to) third-party payors</td>
<td>$122,060</td>
<td>$64,197</td>
</tr>
<tr>
<td>Due from/(to) County</td>
<td>$(16,835)</td>
<td>$19,130</td>
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<tr>
<td>Days in accounts payable</td>
<td>37.9</td>
<td>34.7</td>
</tr>
<tr>
<td>% of AP over 60 days</td>
<td>2.1%</td>
<td>1.5%</td>
</tr>
<tr>
<td>Net negative balance - receivable/(payable)</td>
<td>$39,086</td>
<td>$58,811</td>
</tr>
</tbody>
</table>

### Accounts Payable

Days in Accounts Payable is 37.9 at the end of the month increased 3.2 days over prior month from timing of recurring check runs versus the last day of the calendar month. The Percent over 60 Days is 2.1%. AHS cash position on the Line of Credit with the County has allowed us to maintain timely payments to vendors.
Memorandum to AHS Finance Committee  
July 2023 Operating Results

**Supplemental Program Revenue Receivable/Payable**

The information presented in the table below provides subsidiary information for Supplemental Program receivables and payables on the Balance Sheet and our best estimate of the timing of when the cash will ultimately be received or paid. The net receivable balance for Supplemental Programs is $122.1 million, which is an increase of $57.9 million over the June preliminary balance. The increase reflects IGTs for GPP, CY23, Q2 ($35.8 million) and GME, FY24, Q1 ($2.3 million) and accruals reflecting budget ($20.0 million).

Estimates are necessary to record supplemental income because the ultimate amount that may be collected under the program is uncertain, and dependent on costs for services that were ultimately provided, quality metrics achieved, Medi-Cal enrollment, and our ability to identify and claim related costs. The timing of receipts and payments is critical because these cashflows affect the NNB under our Line of Credit with the County. Nearly half of AHS annual revenue comes from supplemental funding.

AHS had significant liability for under the old Medi-Cal Waiver and Cost Report Settlements (P14) which have mostly been settled. Waiver periods FY10, FY11, FY14 and FY15 remain open. The remaining estimated amount due is $16.2 million.

### PATIENT COLLECTIONS  
(in thousands)

<table>
<thead>
<tr>
<th></th>
<th>Behavioral Legacy</th>
<th>Behavioral Health</th>
<th>Behavioral Epic</th>
<th>Total FY 2024</th>
<th>FY 2023</th>
<th>FY 2022</th>
<th>FY 2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jul</td>
<td>1</td>
<td>10,909</td>
<td>68,682</td>
<td>79,592</td>
<td>74,260</td>
<td>59,732</td>
<td>41,373</td>
</tr>
<tr>
<td>Aug</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>58,590</td>
<td>57,374</td>
<td>53,893</td>
</tr>
<tr>
<td>Sep</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>76,063</td>
<td>61,968</td>
<td>64,484</td>
</tr>
<tr>
<td>Oct</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>59,796</td>
<td>49,923</td>
<td>51,514</td>
</tr>
<tr>
<td>Nov</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>56,939</td>
<td>52,057</td>
<td>49,499</td>
</tr>
<tr>
<td>Dec</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>67,018</td>
<td>68,121</td>
<td>53,274</td>
</tr>
<tr>
<td>Jan</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>71,452</td>
<td>62,292</td>
<td>34,443</td>
</tr>
<tr>
<td>Feb</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>57,886</td>
<td>52,269</td>
<td>49,157</td>
</tr>
<tr>
<td>Mar</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>65,320</td>
<td>62,888</td>
<td>58,922</td>
</tr>
<tr>
<td>Apr</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>55,307</td>
<td>56,235</td>
<td>55,646</td>
</tr>
<tr>
<td>May</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>63,795</td>
<td>69,591</td>
<td>44,005</td>
</tr>
<tr>
<td>Jun</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>70,027</td>
<td>53,187</td>
<td>43,889</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1</strong></td>
<td><strong>10,909</strong></td>
<td><strong>68,682</strong></td>
<td><strong>79,592</strong></td>
<td><strong>776,453</strong></td>
<td><strong>705,637</strong></td>
<td><strong>600,099</strong></td>
</tr>
</tbody>
</table>

| % change between fiscal years | 7.2% | 10.0% | 17.6% |
Memorandum to AHS Finance Committee  
July 2023 Operating Results

Net County Receivable and Payable

The net County receivable and payable due under arrangements with the County are reflected as part of the Due to and Due From accounts reported on the Balance Sheet. The County receivable includes the Base HPAC contract, Measure A and Grants. The Capital Designation receivable reflects a funding arrangement to support the Sapphire project. AHS transfers $7.0 million in June of each year as required by the agreement with the County. If AHS meets the requirements to gain access to these funds, AHS will send an invoice to the County. Generally, invoicing happens once June financial statements are finalized. The Capital Cost Transfer reflects a payable based on cost report settlements associated with County owned buildings. These amounts are paid to the County once final reconciliation has occurred and the cost report has been settled. AHS has the contractual ability to benefit from these funds to help maintain and invest in County owned facilities. The current amount transferred to the County and available for use is $39.6 million. AHS transfers 90% of the estimated cost reimbursement related to County owned buildings and true up when final settled. The estimate amount due the County for cost reports not final settled is $14.5 million through FY21. Inter-government transfers (IGT) are ongoing to draw down federal supplemental funding.
Memorandum to AHS Finance Committee
July 2023 Operating Results

Net Negative Balance
The Net Negative Balance (NNB) or Line of Credit with the County is positive reflecting $39.1 million on July 31, 2023 and remains compliant with the terms of the Permanent Agreement. The Working Capital Loan is reported on the Balance Sheet as a long-term liability labeled “Gross Working Capital Loan.” To calculate the NNB, the Gross Working Capital Loan ($13.8 million receivable) is increased by the County Restricted Cash Fund ($25.3 million) which is included in Cash.

Net Position
The Net Position or Fund Balance of AHS as of July 31, 2023, is negative $84.6 million which improved $1.8 million over last month reflecting net income this month.

Status on Contingencies Related to Supplemental and Other Revenues

Highland Federally Qualified Healthcare Center (FQHC) Settlement
The State reached out to AHS inquiring about a new application that AHS submitted to establish the dental clinic located at Highland as a new FQHC. The State wanted to understand the new application request and ultimately agreed to allow AHS to resume billing all previous service locations on the Highland campus as FQHC. AHS has made the required changes in EPIC and began billing as an FQHC for these service locations on March 1, 2022. AHS and the State started negotiations on a retroactive settlement going back to the FY12 filing made by AHS to establish an FQHC rate. Once the negotiations progress to a point where a new estimate can be determined, AHS will adjust the current liability on the balance sheet. AHS currently has a pending recoupment of $40.0 million. AHS is being paid at the current Highland FQ rate for the additional service locations until the new rate is finalized.

Line of Credit (Net Negative Balance) Forecast
The NNB was technically paid off in April, 2022 and remains paid off. The NNB balance with the County is a receivable of $39.1 million.
The Line of Credit Balance or the Net Negative Balance (NNB) held with the County is forecasted in the line graph below based on estimated cash sources and uses through the end of next fiscal year, June 30, 2023. The purpose of this analysis is to provide the best “real time” information that can reasonably be quantified; however, the forecast is an estimate and subject to change. For the purposes of this projection, AHS has updated the cashflow based on the approved FY24 budget which includes performance improvement initiatives (GRIT). Additionally, FY23 capital expenditures were approved for $30.5 million. The NNB forecasted balance will be adjusted each month as better information becomes available.

Below is a table providing more detail on material cash items or events included in NNB Forecast. The items on the top table represent expected cashflow from material programs as represented in the NNB forecast. The following changes were made to the table and forecast this month.

- AB85 Realignment repayment for FY21 reduced from $38.0 million to $8.4 million based on final report submission in June 2023.

The second table reflects the three remaining prior year recoupments. The first listed is the old Waiver recoupments which were delayed in settlement and the timeline remains unknown. The Federal Qualified Health Center (FQHC) recoupment is a conservative settlement estimate based on the difference between reimbursement rates for services provided at Highland campus locations that were considered qualified and subsequently denied by the State. AHS is in current discussions with the State and once an agreement is reached with the State the FQHC liability will be adjusted. Lastly, we are seeing progress on the Physician SPA reconciliation audits. FY08 audit was finalized in June 2023 and resulted in release of the $5.0 million reserve.
Memorandum to AHS Finance Committee
July 2023 Operating Results

Material Items Included in NNB Forecast

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>HPAC amendment and AB85 realignment</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>EPP (semi-annual)</td>
<td>-</td>
<td>-</td>
<td>(8,395)</td>
<td>$40,000</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>QIP (annual)</td>
<td>20,000</td>
<td>20,000</td>
<td>70,000</td>
<td>70,000</td>
<td>70,000</td>
<td>70,000</td>
<td>70,000</td>
</tr>
<tr>
<td>GPP (quarterly)</td>
<td>26,000</td>
<td>26,000</td>
<td>26,000</td>
<td>7,300</td>
<td>26,000</td>
<td>26,000</td>
<td></td>
</tr>
<tr>
<td>Medi-Cal Managed Care Rate Range (annual)</td>
<td>45,000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

$26,000 $46,000 $(8,395) $66,000 $7,300 $116,000 $45,000

Prior Year Reimbursement Settlements

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Waiver recoupment (fy10, fy11, fy14, fy15)</td>
<td>$(16,190)</td>
</tr>
<tr>
<td>Medi-Cal FQHC recoupment (fy08 - fy13)</td>
<td>$(40,000)</td>
</tr>
<tr>
<td>Physician SPA (fy08 - fy13)</td>
<td>$(29,000)</td>
</tr>
</tbody>
</table>

Preliminary Fiscal Year End Financial Statement

Below are June and year-end preliminary financial statements for fiscal year 2023, which will be shared in a brief Power Point presentation at the Finance Committee meeting. The financial statements do not include fiscal year-end entries that will be finalized in October as part of the annual audit process.

Adjustments are expected in the following areas:

- Net Patient Revenue and Capitation
  - BHS revenue true-up for May and June payments received after June 30, 2023.
  - Look back analysis to validate AR reported for June 30, 2023, performed by auditors.
- Supplemental Program Revenue
  - No additional adjustments anticipated on other programs; however, information may change during the audit.
- Foundation true-up to mirror balances between the entities and record subsidy from AHS for June.
- Expense related items
  - Self-funded Workers’ Compensation (actuarial report).
  - Self-funded Hospital and Medical Malpractice (actuarial report).
  - AHS Defined Benefit retirement plan (actuarial report).
  - Interest for 4th quarter from County on NNB and restricted funds.
  - Any material invoicing requiring a true-up, including registry.

The final audit report and financial statements will be presented to Audit Committee on November 7, 2023. Fiscal year 2023 year-end comparisons to budget and prior year will be presented at the January 3, 2024 Finance Committee.
<table>
<thead>
<tr>
<th></th>
<th>June 2023</th>
<th></th>
<th></th>
<th>% Var</th>
<th>Year-To-Date</th>
<th></th>
<th></th>
<th>% Var</th>
<th>FY 2022</th>
<th>YTD</th>
<th>% Var</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual</td>
<td>Budget</td>
<td>Variance</td>
<td>% Var</td>
<td>Actual</td>
<td>Budget</td>
<td>Variance</td>
<td>% Var</td>
<td>Actual</td>
<td>Budget</td>
<td>Variance</td>
</tr>
<tr>
<td>Operating revenue</td>
<td>$179,706</td>
<td>$101,750</td>
<td>$77,956</td>
<td>75.6%</td>
<td>$1,426,820</td>
<td>$1,214,503</td>
<td>$214,315</td>
<td>17.8%</td>
<td>$1,370,829</td>
<td>$1,153,198</td>
<td>4.2%</td>
</tr>
<tr>
<td>Operating expense</td>
<td>$195,827</td>
<td>$98,240</td>
<td>$(97,587)</td>
<td>(99.3%)</td>
<td>$1,408,597</td>
<td>$1,168,776</td>
<td>$(237,821)</td>
<td>(20.3%)</td>
<td>$217,628</td>
<td>(99.8%)</td>
<td>(22.0%)</td>
</tr>
<tr>
<td>Operating income (loss)</td>
<td>(16,121)</td>
<td>3,510</td>
<td>(19,631)</td>
<td>(559.3%)</td>
<td>22,223</td>
<td>45,729</td>
<td>(23,506)</td>
<td>(51.4%)</td>
<td>217,628</td>
<td>(99.8%)</td>
<td>(718.6%)</td>
</tr>
<tr>
<td>Other non-operating activity</td>
<td>(170)</td>
<td>(25)</td>
<td>(145)</td>
<td>(580.0%)</td>
<td>(1,360)</td>
<td>(302)</td>
<td>(1,058)</td>
<td>(350.3%)</td>
<td>(166)</td>
<td>(718.6%)</td>
<td>(718.6%)</td>
</tr>
<tr>
<td>Net Income (loss)</td>
<td>(16,291)</td>
<td>3,485</td>
<td>(19,776)</td>
<td>(567.5%)</td>
<td>20,863</td>
<td>45,427</td>
<td>(24,564)</td>
<td>(54.1%)</td>
<td>217,628</td>
<td>(99.8%)</td>
<td>(90.4%)</td>
</tr>
<tr>
<td>EBIDA adjustments</td>
<td>60,850</td>
<td>(71)</td>
<td>60,921</td>
<td></td>
<td>65,943</td>
<td>(854)</td>
<td>65,897</td>
<td></td>
<td>27,196</td>
<td></td>
<td></td>
</tr>
<tr>
<td>EBIDA</td>
<td>44,559</td>
<td>3,414</td>
<td>41,145</td>
<td></td>
<td>85,906</td>
<td>44,573</td>
<td>41,333</td>
<td></td>
<td>100,265</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Operating Margin</td>
<td>(3.0%)</td>
<td>3.4%</td>
<td>(2.4%)</td>
<td></td>
<td>1.6%</td>
<td>3.8%</td>
<td>(2.2%)</td>
<td></td>
<td>15.5%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>EBIDA Margin</td>
<td>24.8%</td>
<td>3.4%</td>
<td>21.4%</td>
<td></td>
<td>6.0%</td>
<td>3.7%</td>
<td>2.3%</td>
<td></td>
<td>13.5%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>July 2023</td>
<td>FY 2023</td>
<td>% Variance</td>
<td>% Variance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>--------------------------------</td>
<td>----------------</td>
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<td>------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Actual</td>
<td>Budget</td>
<td>Variance</td>
<td>YTD</td>
<td>Variance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Operating revenue</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net patient service revenue</td>
<td>$69,376</td>
<td>$67,330</td>
<td>$2,046</td>
<td>$65,023</td>
<td>$4,353</td>
<td>6.7%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Capitation revenue</td>
<td>4,030</td>
<td>4,012</td>
<td>18</td>
<td>3,901</td>
<td>129</td>
<td>3.3%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other government programs</td>
<td>39,595</td>
<td>39,619</td>
<td>(24)</td>
<td>35,938</td>
<td>3,657</td>
<td>10.2%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other operating revenue</td>
<td>3,769</td>
<td>3,315</td>
<td>454</td>
<td>3,086</td>
<td>683</td>
<td>22.1%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total operating revenue</td>
<td>$116,770</td>
<td>$114,276</td>
<td>$2,494</td>
<td>$107,948</td>
<td>$8,822</td>
<td>8.2%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Operating expense</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Labor costs</td>
<td>86,395</td>
<td>84,316</td>
<td>(2,079)</td>
<td>78,586</td>
<td>(7,809)</td>
<td>(9.9%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician contract services</td>
<td>3,269</td>
<td>3,484</td>
<td>215</td>
<td>3,269</td>
<td>-</td>
<td>0.0%</td>
<td></td>
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</tr>
<tr>
<td>Purchased services</td>
<td>7,755</td>
<td>7,836</td>
<td>81</td>
<td>6,745</td>
<td>(1,010)</td>
<td>(15.0%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Materials and supplies</td>
<td>10,171</td>
<td>10,592</td>
<td>421</td>
<td>8,220</td>
<td>(1,951)</td>
<td>(23.7%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facilities</td>
<td>2,329</td>
<td>2,970</td>
<td>641</td>
<td>3,006</td>
<td>677</td>
<td>22.5%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depreciation and amortization</td>
<td>3,150</td>
<td>3,068</td>
<td>(82)</td>
<td>2,673</td>
<td>(477)</td>
<td>(17.8%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General and administrative</td>
<td>1,764</td>
<td>1,810</td>
<td>46</td>
<td>1,790</td>
<td>26</td>
<td>1.5%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total operating expense</td>
<td>$114,833</td>
<td>$114,076</td>
<td>(757)</td>
<td>$104,289</td>
<td>(10,544)</td>
<td>(10.1%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Operating income (loss)</td>
<td>1,937</td>
<td>200</td>
<td>1,737</td>
<td>3,659</td>
<td>(1,722)</td>
<td>(47.1%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-operating activity</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interest income (expense)</td>
<td>(139)</td>
<td>(80)</td>
<td>(59)</td>
<td>(118)</td>
<td>(21)</td>
<td>(18.0%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other nonoperating revenue</td>
<td>13</td>
<td>13</td>
<td>-</td>
<td>13</td>
<td>0</td>
<td>2.4%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total non-operating activity</td>
<td>(126)</td>
<td>(67)</td>
<td>(59)</td>
<td>(105)</td>
<td>(21)</td>
<td>(19.9%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net income (loss)</td>
<td>$1,811</td>
<td>$133</td>
<td>$1,678</td>
<td>$3,554</td>
<td>(1,743)</td>
<td>(49.0%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EBIDA adjustments</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interest income (expense)</td>
<td>139</td>
<td>80</td>
<td>59</td>
<td>118</td>
<td>21</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depreciation and amortization</td>
<td>3,150</td>
<td>3,068</td>
<td>82</td>
<td>2,673</td>
<td>477</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Retirement (deferred)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total EBIDA adjustments</td>
<td>3,289</td>
<td>3,148</td>
<td>141</td>
<td>2,791</td>
<td>498</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EBIDA</td>
<td>$5,100</td>
<td>$3,281</td>
<td>$1,819</td>
<td>$6,345</td>
<td>(1,245)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
# ALAMEDA HEALTH SYSTEM (consolidated)
## Balance Sheet
### As of July 31, 2023
*(In Thousands)*

<table>
<thead>
<tr>
<th>ASSETS</th>
<th>Current Month</th>
<th>FYE 2023</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash &amp; cash equivalents</td>
<td>$18,525</td>
<td>$11,535</td>
</tr>
<tr>
<td>Patient account receivables, net</td>
<td>90,005</td>
<td>94,432</td>
</tr>
<tr>
<td>Due from third-party payors</td>
<td>330,907</td>
<td>267,447</td>
</tr>
<tr>
<td>Due from County of Alameda</td>
<td>37,582</td>
<td>35,038</td>
</tr>
<tr>
<td>Due from State of California</td>
<td>27,427</td>
<td>26,912</td>
</tr>
<tr>
<td>Inventories</td>
<td>11,505</td>
<td>11,669</td>
</tr>
<tr>
<td>Other current assets</td>
<td>20,691</td>
<td>17,551</td>
</tr>
<tr>
<td><strong>TOTAL CURRENT ASSETS</strong></td>
<td>536,642</td>
<td>464,584</td>
</tr>
<tr>
<td>Restricted cash equivalents</td>
<td>25,321</td>
<td>25,321</td>
</tr>
<tr>
<td>Post employment benefit asset</td>
<td>(33,671)</td>
<td>(33,671)</td>
</tr>
<tr>
<td>Right-to-use lease assets, net</td>
<td>30,384</td>
<td>30,870</td>
</tr>
<tr>
<td>Capital assets - nondepreciable</td>
<td>9,021</td>
<td>9,021</td>
</tr>
<tr>
<td>Capital assets - depreciable, net</td>
<td>148,746</td>
<td>150,300</td>
</tr>
<tr>
<td><strong>TOTAL NONCURRENT ASSETS</strong></td>
<td>179,801</td>
<td>181,841</td>
</tr>
<tr>
<td><strong>DEFERRED OUTFLOWS OF RESOURCES</strong></td>
<td>231,502</td>
<td>231,502</td>
</tr>
<tr>
<td><strong>TOTAL ASSETS &amp; DEFERRED OUTFLOWS</strong></td>
<td>$947,945</td>
<td>$877,927</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LIABILITIES &amp; NET ASSETS</th>
<th>Current Month</th>
<th>FYE 2023</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accounts payable and accrued expenses</td>
<td>$65,942</td>
<td>$71,006</td>
</tr>
<tr>
<td>Accrued compensation</td>
<td>47,864</td>
<td>37,320</td>
</tr>
<tr>
<td>Due to third-party payors</td>
<td>208,847</td>
<td>203,250</td>
</tr>
<tr>
<td>Due to County of Alameda</td>
<td>54,417</td>
<td>15,908</td>
</tr>
<tr>
<td>Other Payables</td>
<td>28,380</td>
<td>29,106</td>
</tr>
<tr>
<td><strong>TOTAL CURRENT LIABILITIES</strong></td>
<td>405,450</td>
<td>356,590</td>
</tr>
<tr>
<td>Liquidity facility - County of Alameda</td>
<td>(13,765)</td>
<td>(33,490)</td>
</tr>
<tr>
<td>Net pension liability</td>
<td>512,879</td>
<td>512,879</td>
</tr>
<tr>
<td>Accrued compensated absences, net of current portion</td>
<td>20,869</td>
<td>20,869</td>
</tr>
<tr>
<td>Self-insurance liabilities, net of current portion</td>
<td>29,470</td>
<td>29,470</td>
</tr>
<tr>
<td>Lease obligations, net of current portion</td>
<td>27,632</td>
<td>28,007</td>
</tr>
<tr>
<td>Other long-term liabilities</td>
<td>6,760</td>
<td>6,760</td>
</tr>
<tr>
<td><strong>TOTAL LONG TERM LIABILITIES</strong></td>
<td>583,845</td>
<td>564,495</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DEFERRED INFLOWS OF RESOURCES</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Fund balance - capital contribution</td>
<td>84,764</td>
<td>84,764</td>
</tr>
<tr>
<td>Fund balance - prior years</td>
<td>(171,185)</td>
<td>(192,045)</td>
</tr>
<tr>
<td>Current year income/(loss)</td>
<td>1,811</td>
<td>20,863</td>
</tr>
<tr>
<td><strong>FUND BALANCE</strong></td>
<td>(84,610)</td>
<td>(86,418)</td>
</tr>
<tr>
<td><strong>TOTAL LIABILITIES, DEFERRED INFLOWS, &amp; FUND BALANCE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$947,945</td>
<td>$877,927</td>
</tr>
</tbody>
</table>
# ALAMEDA HEALTH SYSTEM (consolidated)  
**Statement of Cash Flows**  
For the Period Ended July 31, 2023  
(in thousands)

## CASH FLOWS FROM OPERATING ACTIVITIES

<table>
<thead>
<tr>
<th>Description</th>
<th>Current Month</th>
<th>FYE 2023</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operating income (loss)</td>
<td>$ 1,937</td>
<td>$ 22,223</td>
</tr>
<tr>
<td>Depreciation and amortization</td>
<td>3,150</td>
<td>37,604</td>
</tr>
<tr>
<td><strong>Net changes in operating assets and liabilities:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient account receivables, net</td>
<td>4,427</td>
<td>(1,552)</td>
</tr>
<tr>
<td>Due from/to third-party payors</td>
<td>(57,863)</td>
<td>(38,447)</td>
</tr>
<tr>
<td>Due from/to County</td>
<td>35,965</td>
<td>46,022</td>
</tr>
<tr>
<td>Due from State</td>
<td>(515)</td>
<td>(5,749)</td>
</tr>
<tr>
<td>Inventory</td>
<td>164</td>
<td>6,105</td>
</tr>
<tr>
<td>Other current assets</td>
<td>(3,140)</td>
<td>(73)</td>
</tr>
<tr>
<td>Accounts payable and accrued expenses</td>
<td>(5,067)</td>
<td>3,656</td>
</tr>
<tr>
<td>Accrued compensation</td>
<td>10,544</td>
<td>(5,386)</td>
</tr>
<tr>
<td>Other current payables</td>
<td>(726)</td>
<td>(5,170)</td>
</tr>
<tr>
<td>Net pension liability</td>
<td>-</td>
<td>259,933</td>
</tr>
<tr>
<td>Other postemployment benefits obligations</td>
<td>-</td>
<td>108,836</td>
</tr>
<tr>
<td>Other long-term liabilities</td>
<td>-</td>
<td>3,041</td>
</tr>
<tr>
<td>Deferred outflows/inflows</td>
<td>0</td>
<td>(343,301)</td>
</tr>
<tr>
<td><strong>Net cash provided by (used in) operating activities</strong></td>
<td>(11,124)</td>
<td>87,742</td>
</tr>
</tbody>
</table>

## CASH FLOWS FROM NONCAPITAL FINANCING ACTIVITIES

<table>
<thead>
<tr>
<th>Description</th>
<th>Current Month</th>
<th>FYE 2023</th>
</tr>
</thead>
<tbody>
<tr>
<td>Change in liquidity facility</td>
<td>19,725</td>
<td>(7,835)</td>
</tr>
<tr>
<td>Interest payments on working capital loan</td>
<td>87</td>
<td>1,244</td>
</tr>
<tr>
<td>Proceeds from grants for COVID-19 pandemic</td>
<td>-</td>
<td>0</td>
</tr>
<tr>
<td>Receipts of rental income</td>
<td>13</td>
<td>191</td>
</tr>
<tr>
<td><strong>Net cash provided by (used in) noncapital financing activities</strong></td>
<td>19,825</td>
<td>(6,400)</td>
</tr>
</tbody>
</table>

## CASH FLOWS FROM CAPITAL AND FINANCING ACTIVITIES

<table>
<thead>
<tr>
<th>Description</th>
<th>Current Month</th>
<th>FYE 2023</th>
</tr>
</thead>
<tbody>
<tr>
<td>Purchase and construction of capital assets</td>
<td>(1,110)</td>
<td>(19,440)</td>
</tr>
<tr>
<td>Repayment of other long-term liabilities</td>
<td>0</td>
<td>(7,282)</td>
</tr>
<tr>
<td>Purchase of right-to-use lease obligations</td>
<td>-</td>
<td>(7,594)</td>
</tr>
<tr>
<td>Repayment of lease obligations</td>
<td>(375)</td>
<td>1,431</td>
</tr>
<tr>
<td>Capital contributions and transfers</td>
<td>-</td>
<td>(43,730)</td>
</tr>
<tr>
<td><strong>Net cash provided by (used in) capital and financing activities</strong></td>
<td>(1,485)</td>
<td>(76,615)</td>
</tr>
</tbody>
</table>

## CASH FLOWS FROM INVESTING ACTIVITIES

<table>
<thead>
<tr>
<th>Description</th>
<th>Current Month</th>
<th>FYE 2023</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interest and investment income</td>
<td>(226)</td>
<td>(2,795)</td>
</tr>
<tr>
<td><strong>Net cash provided by (used in) investing activities</strong></td>
<td>(226)</td>
<td>(2,795)</td>
</tr>
</tbody>
</table>

## CHANGES IN CASH AND CASH EQUIVALENTS

<table>
<thead>
<tr>
<th>Description</th>
<th>Current Month</th>
<th>FYE 2023</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>6,990</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## CASH AND CASH EQUIVALENTS, beginning of period

<table>
<thead>
<tr>
<th>Description</th>
<th>Current Month</th>
<th>FYE 2023</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>$36,856</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## CASH AND CASH EQUIVALENTS, end of period

<table>
<thead>
<tr>
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<th>FYE 2023</th>
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<td><strong>$43,846</strong></td>
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## ALAMEDA HEALTH SYSTEMS Volume Reports

### Month: July 2023

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<th>Budget</th>
<th>Variance</th>
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<th>YTD Actual</th>
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<tr>
<td>Clinic Visits</td>
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<td>5,033</td>
<td>(767)</td>
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<td>104,311</td>
<td>104,776</td>
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<td>-18.0%</td>
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<td>8.7%</td>
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<td>20.6%</td>
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<td>-0.2%</td>
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<td>-2.1%</td>
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<td>7.0%</td>
<td>0.1%</td>
<td>0.7%</td>
<td>7.0%</td>
<td>7.0%</td>
<td>0.1%</td>
<td>0.7%</td>
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<td>0.9%</td>
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<td>0.8%</td>
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<td>3.6%</td>
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<td>0.8%</td>
<td>29.2%</td>
<td>4.3%</td>
<td>-0.7%</td>
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<td>2.9%</td>
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<td>3.1%</td>
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<td>100%</td>
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### ALAMEDA HEALTH SYSTEMS Volume Reports

#### Month: July

**Campus: HIGHLAND**

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<th>YTD Actual</th>
<th>YTD Budget</th>
<th>Var % Var</th>
<th>YTD PY Actual</th>
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</tr>
<tr>
<td>General Acute Days</td>
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<td>232</td>
<td>5.1%</td>
<td>4,810</td>
<td>4,578</td>
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<td>5.1%</td>
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<td>4,810</td>
<td>4,578</td>
<td>232</td>
<td>5.1%</td>
<td>4,810</td>
<td>4,578</td>
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<td>1.580</td>
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<td>0.52%</td>
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<td>0.00%</td>
<td>6.3</td>
<td>6.3</td>
<td>0.00%</td>
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<td>7,684</td>
<td>7,234</td>
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<td>1,217</td>
<td>1,247</td>
<td>30</td>
<td>2.4%</td>
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<td>0.00%</td>
<td>92%</td>
<td>87%</td>
<td>0.00%</td>
<td>0.00%</td>
</tr>
<tr>
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<td>6</td>
<td>8</td>
<td>2</td>
<td>-24.1%</td>
<td>6</td>
<td>8</td>
<td>2</td>
<td>-24.1%</td>
</tr>
<tr>
<td><strong>TOTAL FTE, HOURS, WRVU</strong></td>
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</tr>
<tr>
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<td>1,681</td>
<td>1,619</td>
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<td>33.5</td>
<td>31.6</td>
<td>1.8</td>
<td>-5.8%</td>
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<tr>
<td>Worked Hours Per AD</td>
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<td>28</td>
<td>-15.1%</td>
<td>211</td>
<td>183</td>
<td>28</td>
<td>-15.1%</td>
</tr>
</tbody>
</table>

**OTHER STATS**

- Emergency Visits: 4,083, Var %: -7.7%
- Trauma Cases: 299, Var %: 8.2%
- Left Without Being Seen: 573, Var %: -7.7%
- Deliveries: 150, Var %: 28.0%
- IP Surgeries: 253, Var %: -10.6%
- OP Surgeries: 179, Var %: 20.12%
- Total Surgeries: 432, Var %: -2.3%
- GI Procedures: 266, Var %: 7.2%
- Cardiac Procedures: 61, Var %: 55.7%
- HGH Cath Lab and IR: 346, Var %: 42.1%

**CLINIC / TELEHEALTH VISITS**

- Specialty: 1,760, Var %: 213.1%
- Behavioral Health: 683, Var %: 1.01%
- Clinic Visits: 2,443, Var %: 14.6%
- Clinic Visits Per Day: 0, Var %: 0.00%
- Telehealth Specialty: 564, Var %: 45.6%
- Telehealth Behavioral Health: 83, Var %: 44.0%
- Telehealth Visits: 647, Var %: 36.6%
- Telehealth Visits Per Day: 0, Var %: 0.00%

**TOTAL CLINIC VISITS**: 3,090, Var %: 18.6%

**PAYOR MIX**

- Insurance %: 10.23%, Var %: 2.69%
- Medi-Cal %: 26.24%, Var %: 1.51%
- Medi-Cal MC %: 31.53%, Var %: -3.92%
- Medicare %: 18.24%, Var %: 0.21%
- Medicare MC %: 7.36%, Var %: -2.5%
- Other Govt %: 3.75%, Var %: 0.48%
- Self-Pay %: 2.65%, Var %: -0.29%

Total Payor Mix %: 100.00%, Var %: 0.00%

CMI Highland: 1.607, Var %: -8.4%
### ALAMEDA HEALTH SYSTEMS Volume Reports

**Month: July**

**Campus: ALAMEDA**

<table>
<thead>
<tr>
<th>METRICS</th>
<th>MTD Actual</th>
<th>MTD Budget</th>
<th>Var</th>
<th>% Var</th>
<th>YEAR-TO-DATE</th>
<th>YTD Actual</th>
<th>YTD Budget</th>
<th>Var</th>
<th>% Var</th>
<th>PRIOR YEAR-TO-DATE</th>
<th>YTD PY Actual</th>
<th>Var</th>
<th>% Var</th>
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<td><strong>ACUTE</strong></td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General Acute Days</td>
<td>1,162</td>
<td>892</td>
<td>270</td>
<td>30.3%</td>
<td>1,162</td>
<td>892</td>
<td>270</td>
<td>30.3%</td>
<td>1,039</td>
<td>123</td>
<td>11.8%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Patient Days</td>
<td>1,162</td>
<td>892</td>
<td>270</td>
<td>30.3%</td>
<td>1,162</td>
<td>892</td>
<td>270</td>
<td>30.3%</td>
<td>1,039</td>
<td>123</td>
<td>11.8%</td>
<td></td>
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<td>1,735</td>
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<tr>
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<td>(30)</td>
<td>-77.2%</td>
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### ALAMEDA HEALTH SYSTEMS Volume Reports

**Month:** July

**Campus:** ALAMEDA

### PAYOR MIX

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<th>YTD Actual</th>
<th>YTD Budget</th>
<th>Var</th>
<th>% Var</th>
<th>YTD PY Actual</th>
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### CMI Alameda

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<th>YTD PY Actual</th>
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ALAMEDA HEALTH SYSTEMS Volume Reports
Month: July

Campus: SAN LEANDRO
MONTH
MTD
Actual
ACUTE -------------------General Acute Days
Rehab Days
Total Patient Days
General Acute Discharges
Rehab Discharges
Total Discharges
Acute OP Factor
Average Daily Census
Average Length of Stay
Adjusted Patient Days
Adjusted Discharges
Occupancy %
Observation Equiv Days
ACUTE REHAB -------------------Rehab Patient Days
Rehab Discharges
Rehab OP Factor
Average Daily Census
Average Length of Stay
Adjusted Patient Days
Adjusted Discharges
Occupancy %

MTD
Budget

Var

YEAR-TO-DATE
% Var |

YTD
YTD
Actual Budget

Var

PRIOR YEAR-TO-DATE
% Var |

881
693
1,574
287
46
333
1.780
50.8
4.7
2,802
593
81%
52

1,250 (369) -29.5%
728
(35) -4.9%
1,978 (404) -20.4%
313
(26) -8.2%
52
(6) -11.0%
364
(31) -8.6%
1.636 (0.144) -8.8%
63.8 (13.0) -20.4%
5.4
0.7 12.9%
3,237 (434) -13.4%
596
(3) -0.6%
101%
0%
0.0%
236 (185) -78.1%

881
693
1,574
287
46
333
1.780
50.8
4.7
2,802
593
81%
52

1,250 (369) -29.5%
728
(35) -4.9%
1,978 (404) -20.4%
313
(26) -8.2%
52
(6) -11.0%
364
(31) -8.6%
1.636 (0.144) -8.8%
63.8 (13.0) -20.4%
5.4
0.7 12.9%
3,237 (434) -13.4%
596
(3) -0.6%
101%
0%
0.0%
236 (185) -78.1%

693
46
1.0000
22.4
15.1
693
46
80%

728
(35) -4.9%
52
(6) -11.0%
1.0000 0.0000
0.0%
23.5
(1.1) -4.9%
14.1
1.0
6.9%
728
(35) -4.9%
52
(6) -11.0%
84%
0%
0.0%

693
46
1.0000
22.4
15.1
693
46
80%

728
(35) -4.9%
52
(6) -11.0%
1.0000 0.0000
0.0%
23.5
(1.1) -4.9%
14.1
1.0
6.9%
728
(35) -4.9%
52
(6) -11.0%
84%
0%
0.0%

YTD PY
Actual

Var

% Var |

1,063 (182) -17.1%
654
39 6.0%
1,717 (143) -8.3%
245
42 17.1%
46
0 0.0%
291
42 14.4%
1.663 (0.118) -7.1%
55.4
(4.6) -8.3%
5.9
1.2 19.9%
2,855
(52) -1.8%
484
109 22.5%
88%
0% 0.0%
49
3 6.5%

654
39
46
0
1.0000 0.0000
21.1
1.3
14.2
0.8
654
39
46
0
75%
0%

6.0%
0.0%
0.0%
6.0%
6.0%
6.0%
0.0%
0.0%

TOTAL FTE, HOURS, WRVU
METRICS
-----------------Total Paid
FTE
Total Productive FTE
Total Adjusted Patient Days
Total Adjusted Discharges
Total Paid FTE per AOB
Worked Hours Per APD
Worked Hours Per AD

442
378
3,203
678
4.28
20.9
99

442
356
3,559
656
3.85
17.7
96

(1) -0.2%
(22) -6.2%
(356) -10.0%
22
3.4%
(0.44) -11.3%
(3.2) -18.0%
(3) -2.8%

442
378
3,203
678
4.28
20.9
99

442
356
3,559
656
3.85
17.7
96

(1) -0.2%
(22) -6.2%
(356) -10.0%
22
3.4%
(0.44) -11.3%
(3.2) -18.0%
(3) -2.8%

399
335
3,188
540
3.88
18.6
110

(43)
(43)
15
137
(0.40)
(2.3)
11

-10.9%
-12.7%
0.5%
25.4%
-10.3%
-12.2%
10.1%

OTHER STATS -------------------Emergency Visits
Left Without Being Seen
(LWBS)
IP Surgeries
OP Surgeries
Total Surgeries

2,557
104
44
77
121

2,658
52
77
110
187

(101)
52
(33)
(33)
(66)

2,557
104
44
77
121

2,658
52
77
110
187

(101)
52
(33)
(33)
(66)

-3.8%
100.5%
-43.0%
-30.0%
-35.4%

2,360
165
54
110
164

197
(61)
(10)
(33)
(43)

8.3%
-37.0%
-18.5%
-30.0%
-26.2%

6.68%
16.42%
34.16%
26.21%
9.48%
4.53%
2.52%
100.00%

6.87%
19.42%
32.10%
27.57%
9.84%
1.77%
2.44%
100.00%

-0.19% -2.8%
-3.00% -15.4%
2.06%
6.4%
-1.36% -4.9%
-0.36% -3.6%
2.77% 156.7%
0.08%
3.4%
0.00%
0.0%

5.59%
22.13%
29.71%
28.90%
7.38%
2.35%
3.94%
100.00%

1.09%
-5.71%
4.44%
-2.69%
2.10%
2.18%
-1.41%
0.00%

19.6%
-25.8%
15.0%
-9.3%
28.4%
92.9%
-35.9%
0.0%

1.374 -0.089

-6.5%

PAYOR MIX -------------------Insurance %
Medi-Cal %
Medi-Cal MC %
Medicare %
Medicare MC %
Other Govt %
Self-Pay %
Total Payor Mix %
CMI San Leandro YTD

1.285

-3.8%
100.5%
-43.0%
-30.0%
-35.4%

-0.19% -2.8%
-3.00% -15.4%
2.06%
6.4%
-1.36% -4.9%
-0.36% -3.6%
2.77% 156.7%
0.08%
3.4%
0.00%
0.0%

1.374 -0.246 -16.1%

6.68%
6.87%
16.42% 19.42%
34.16% 32.10%
26.21% 27.57%
9.48%
9.84%
4.53%
1.77%
2.52%
2.44%
100.00% 100.00%
1.285

227/284

1.374 -0.246 -16.1%


## ALAMEDA HEALTH SYSTEMS Volume Reports

**Month:** July

**Campus:** FAIRMONT

<table>
<thead>
<tr>
<th>SNF -----------</th>
<th>MTD Actual</th>
<th>MTD Budget</th>
<th>Var % Var</th>
<th>YTD Actual</th>
<th>YTD Budget</th>
<th>Var % Var</th>
<th>YTD PY Actual</th>
<th>Var % Var</th>
</tr>
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<tbody>
<tr>
<td>SNF Patient Days</td>
<td>3,995</td>
<td>3,231</td>
<td>764 23.7%</td>
<td>3,995</td>
<td>3,231</td>
<td>764 23.7%</td>
<td>3,140</td>
<td>855 27.2%</td>
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<tr>
<td>SNF Discharges</td>
<td>15</td>
<td>11</td>
<td>4 36.7%</td>
<td>15</td>
<td>11</td>
<td>4 36.7%</td>
<td>6</td>
<td>9 150.0%</td>
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<tr>
<td>SNF OP Factor</td>
<td>1.0500</td>
<td>1.0612</td>
<td>0.0112 1.1%</td>
<td>1.0500</td>
<td>1.0612</td>
<td>0.0112 1.1%</td>
<td>1.0435 (0.0065)</td>
<td>-0.6%</td>
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<td>Average Daily Census</td>
<td>128.9</td>
<td>104.2</td>
<td>24.7 23.7%</td>
<td>128.9</td>
<td>104.2</td>
<td>24.7 23.7%</td>
<td>101.3</td>
<td>27.6 27.2%</td>
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<td>Average Length of Stay</td>
<td>266.3</td>
<td>294.5 (28.2)</td>
<td>-9.6%</td>
<td>266.3</td>
<td>294.5 (28.2)</td>
<td>-9.6%</td>
<td>523.3 (257.0)</td>
<td>-49.1%</td>
</tr>
<tr>
<td>Adjusted Patient Days</td>
<td>4,195</td>
<td>3,428</td>
<td>766 22.4%</td>
<td>4,195</td>
<td>3,428</td>
<td>766 22.4%</td>
<td>3,277</td>
<td>918 28.0%</td>
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<td>Adjusted Discharges</td>
<td>16</td>
<td>12</td>
<td>4 35.3%</td>
<td>16</td>
<td>12</td>
<td>4 35.3%</td>
<td>6</td>
<td>9 151.6%</td>
</tr>
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<td>95%</td>
<td>77%</td>
<td>0% 0.0%</td>
<td>95%</td>
<td>77%</td>
<td>0% 0.0%</td>
<td>75%</td>
<td>0% 0.0%</td>
</tr>
<tr>
<td>Bed Holds</td>
<td>43</td>
<td>44</td>
<td>(1) -2.3%</td>
<td>43</td>
<td>44</td>
<td>(1) -2.3%</td>
<td>24</td>
<td>19 79.2%</td>
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### TOTAL FTE, HOURS, WRVU

<table>
<thead>
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<th></th>
<th>MTD Actual</th>
<th>MTD Budget</th>
<th>Var % Var</th>
<th>YTD Actual</th>
<th>YTD Budget</th>
<th>Var % Var</th>
<th>YTD PY Actual</th>
<th>Var % Var</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Paid FTE</td>
<td>304</td>
<td>277 (26)</td>
<td>-9.5%</td>
<td>304</td>
<td>277 (26)</td>
<td>-9.5%</td>
<td>278</td>
<td>(26) -9.3%</td>
</tr>
<tr>
<td>Total Productive FTE</td>
<td>257</td>
<td>220 (37)</td>
<td>-16.9%</td>
<td>257</td>
<td>220 (37)</td>
<td>-16.9%</td>
<td>232</td>
<td>(25) -10.8%</td>
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</table>

### CLINIC / TELEHEALTH VISITS

<table>
<thead>
<tr>
<th></th>
<th>MTD Actual</th>
<th>MTD Budget</th>
<th>Var % Var</th>
<th>YTD Actual</th>
<th>YTD Budget</th>
<th>Var % Var</th>
<th>YTD PY Actual</th>
<th>Var % Var</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health</td>
<td>1,038</td>
<td>877</td>
<td>161 18.3%</td>
<td>1,038</td>
<td>877</td>
<td>161 18.3%</td>
<td>917</td>
<td>121 13.2%</td>
</tr>
<tr>
<td>Rehab</td>
<td>8</td>
<td>0</td>
<td>8 0.0%</td>
<td>8</td>
<td>0</td>
<td>8 0.0%</td>
<td>10</td>
<td>(2) -20.0%</td>
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<tr>
<td>Clinic Visits</td>
<td>1,046</td>
<td>877</td>
<td>169 19.2%</td>
<td>1,046</td>
<td>877</td>
<td>169 19.2%</td>
<td>927</td>
<td>119 12.8%</td>
</tr>
<tr>
<td>Clinic Visits Per Day</td>
<td>0</td>
<td>0</td>
<td>0 0.0%</td>
<td>0</td>
<td>0</td>
<td>0 0.0%</td>
<td>46</td>
<td>(46) -100.0%</td>
</tr>
<tr>
<td>Telehealth Behavioral Health</td>
<td>25</td>
<td>20</td>
<td>5 25.2%</td>
<td>25</td>
<td>20</td>
<td>5 25.2%</td>
<td>5</td>
<td>20 400.0%</td>
</tr>
<tr>
<td>Telehealth Visits</td>
<td>25</td>
<td>20</td>
<td>5 25.2%</td>
<td>25</td>
<td>20</td>
<td>5 25.2%</td>
<td>5</td>
<td>20 400.0%</td>
</tr>
<tr>
<td>Telehealth Visits Per Day</td>
<td>0</td>
<td>0</td>
<td>0 0.0%</td>
<td>0</td>
<td>0</td>
<td>0 0.0%</td>
<td>0</td>
<td>0 -100.0%</td>
</tr>
<tr>
<td>TOTAL CLINIC VISITS</td>
<td>1,071</td>
<td>897</td>
<td>174 19.3%</td>
<td>1,071</td>
<td>897</td>
<td>174 19.3%</td>
<td>932</td>
<td>139 14.9%</td>
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</table>

### PAYOR MIX

<table>
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<tr>
<th></th>
<th>MTD Actual</th>
<th>MTD Budget</th>
<th>Var % Var</th>
<th>YTD Actual</th>
<th>YTD Budget</th>
<th>Var % Var</th>
<th>YTD PY Actual</th>
<th>Var % Var</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insurance %</td>
<td>1.01%</td>
<td>1.52%</td>
<td>-0.51% -33.7%</td>
<td>1.01%</td>
<td>1.52%</td>
<td>-0.51% -33.7%</td>
<td>0.98%</td>
<td>0.02% 2.4%</td>
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<tr>
<td>Medi-Cal %</td>
<td>10.06%</td>
<td>76.26%</td>
<td>-66.20% -86.8%</td>
<td>10.06%</td>
<td>76.26%</td>
<td>-66.20% -86.8%</td>
<td>75.15%</td>
<td>-65.10% -86.6%</td>
</tr>
<tr>
<td>Medi-Cal MC %</td>
<td>74.21%</td>
<td>7.10%</td>
<td>67.12% 945.8%</td>
<td>74.21%</td>
<td>7.10%</td>
<td>67.12% 945.8%</td>
<td>8.39%</td>
<td>65.83% 784.7%</td>
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<tr>
<td>Medicare %</td>
<td>11.48%</td>
<td>12.60%</td>
<td>-1.12% -8.9%</td>
<td>11.48%</td>
<td>12.60%</td>
<td>-1.12% -8.9%</td>
<td>12.51%</td>
<td>-1.03% -8.2%</td>
</tr>
<tr>
<td>Medicare MC %</td>
<td>1.73%</td>
<td>1.68%</td>
<td>0.05% 3.0%</td>
<td>1.73%</td>
<td>1.68%</td>
<td>0.05% 3.0%</td>
<td>1.26%</td>
<td>0.47% 37.4%</td>
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<tr>
<td>Other Govt %</td>
<td>1.23%</td>
<td>0.74%</td>
<td>0.49% 66.9%</td>
<td>1.23%</td>
<td>0.74%</td>
<td>0.49% 66.9%</td>
<td>1.10%</td>
<td>0.13% 11.8%</td>
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<tr>
<td>Self-Pay %</td>
<td>0.28%</td>
<td>0.11%</td>
<td>0.18% 165.2%</td>
<td>0.28%</td>
<td>0.11%</td>
<td>0.18% 165.2%</td>
<td>0.61%</td>
<td>-0.32% -53.5%</td>
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<tr>
<td>Total Payor Mix %</td>
<td>100.00%</td>
<td>100.00%</td>
<td>0.00% 0.0%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>0.00% 0.0%</td>
<td>100.00%</td>
<td>0.00% 0.0%</td>
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</table>

**CMI Fairmont**

<table>
<thead>
<tr>
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<th>MTD Budget</th>
<th>Var % Var</th>
<th>YTD Actual</th>
<th>YTD Budget</th>
<th>Var % Var</th>
<th>YTD PY Actual</th>
<th>Var % Var</th>
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<tbody>
<tr>
<td>1.215</td>
<td>1.149</td>
<td>-0.157 -11.5%</td>
<td>1.215</td>
<td>1.149</td>
<td>-0.157 -11.5%</td>
<td>1.149</td>
<td>0.066 5.7%</td>
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<tr>
<td></td>
<td>MTD Actual</td>
<td>MTD Budget</td>
<td>Var</td>
<td>% Var</td>
<td>YTD Actual</td>
<td>YTD Budget</td>
<td>Var</td>
<td>% Var</td>
</tr>
<tr>
<td>--------------------------</td>
<td>------------</td>
<td>------------</td>
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<td>-------</td>
<td>------------</td>
<td>------------</td>
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<td>-------</td>
</tr>
<tr>
<td><strong>ACUTE ----------------------</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psych Days</td>
<td>2,087</td>
<td>1,972</td>
<td>115</td>
<td>5.8%</td>
<td>2,087</td>
<td>1,972</td>
<td>115</td>
<td>5.8%</td>
</tr>
<tr>
<td>Total Patient Days</td>
<td>2,087</td>
<td>1,972</td>
<td>115</td>
<td>5.8%</td>
<td>2,087</td>
<td>1,972</td>
<td>115</td>
<td>5.8%</td>
</tr>
<tr>
<td>Psych Discharges</td>
<td>242</td>
<td>229</td>
<td>14</td>
<td>5.9%</td>
<td>242</td>
<td>229</td>
<td>14</td>
<td>5.9%</td>
</tr>
<tr>
<td>Total Discharges</td>
<td>242</td>
<td>229</td>
<td>14</td>
<td>5.9%</td>
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<td>229</td>
<td>14</td>
<td>5.9%</td>
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<tr>
<td>Acute OP Factor</td>
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<td>1.180</td>
<td>1.207</td>
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<td>2.3%</td>
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<td>3.7</td>
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<td>67.3</td>
<td>63.6</td>
<td>3.7</td>
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<td>0.1%</td>
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<td>276</td>
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<td>3.5%</td>
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<td>92%</td>
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<td>0.0%</td>
<td>98%</td>
<td>92%</td>
<td>0%</td>
<td>0.0%</td>
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<tr>
<td><strong>TOTAL FTE, HOURS, WRVU</strong></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Total Paid FTE</td>
<td>376</td>
<td>355</td>
<td>(21)</td>
<td>-6.0%</td>
<td>376</td>
<td>355</td>
<td>(21)</td>
<td>-6.0%</td>
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<tr>
<td>Total Productive FTE</td>
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<td>278</td>
<td>(47)</td>
<td>-17.0%</td>
<td>325</td>
<td>278</td>
<td>(47)</td>
<td>-17.0%</td>
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<tr>
<td>Physician wRVU</td>
<td>8,827</td>
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<td>5,770</td>
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<td>8,827</td>
<td>3,057</td>
<td>5,770</td>
<td>188.8%</td>
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<td><strong>OTHER STATS ---------------</strong></td>
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<td>PES Equivalent Days</td>
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<td>725</td>
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<td>736</td>
<td>725</td>
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<tr>
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<td>17,673</td>
<td>16,151</td>
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<td>9.4%</td>
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<td>16,151</td>
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<td>21</td>
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<td>21</td>
<td>22</td>
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<tr>
<td><strong>PAYOR MIX ----------------</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td>Insurance %</td>
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<td>7.59%</td>
<td>5.47%</td>
<td>2.12</td>
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<tr>
<td>Medi-Cal %</td>
<td>13.08%</td>
<td>15.52%</td>
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<td>-15.7%</td>
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<td>15.52%</td>
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<td>Medi-Cal MC %</td>
<td>45.94%</td>
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<td>45.94%</td>
<td>49.59%</td>
<td>-3.65</td>
<td>-7.4%</td>
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<tr>
<td>Medicare %</td>
<td>24.32%</td>
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<tr>
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<td>2.40%</td>
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<td>99.4%</td>
<td>4.79%</td>
<td>2.40%</td>
<td>2.39</td>
<td>99.4%</td>
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<td>Other Govt %</td>
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<td>-60.9%</td>
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<td>3.92%</td>
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<td>60.9%</td>
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<tr>
<td>Total Payor Mix %</td>
<td>100.00%</td>
<td>100.00%</td>
<td>0.00</td>
<td>0.0%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>0.00</td>
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<td>1.233</td>
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<td>5.3%</td>
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<td>MTD Actual</td>
<td>MTD Budget</td>
<td>Var</td>
<td>% Var</td>
<td>YTD Actual</td>
<td>YTD Budget</td>
<td>Var</td>
<td>% Var</td>
</tr>
<tr>
<td>----------------------</td>
<td>------------</td>
<td>------------</td>
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<td>-------</td>
<td>------------</td>
<td>------------</td>
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<td><strong>TOTAL FTE, HOURS, WRVU</strong></td>
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<td>Total Paid FTE</td>
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<td>(44)</td>
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<td>437</td>
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<td>Total Productive FTE</td>
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<td>1,378</td>
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<td><strong>CLINIC / TELEHEALTH VISITS</strong></td>
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<tr>
<td>Primary Care</td>
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<td>8,665</td>
<td>671</td>
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<td>67</td>
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<td>394</td>
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<td>21,276</td>
<td>394</td>
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</tr>
<tr>
<td>Clinic Visits Per Day</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.0%</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Telehealth Primary Care</td>
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<td>2,651</td>
<td>(541)</td>
<td>-20.4%</td>
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<td>2,651</td>
<td>(541)</td>
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<td>(406)</td>
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<td>1,848</td>
<td>(406)</td>
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<td>1</td>
<td>32</td>
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<tr>
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<td>4,500</td>
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<td>(915)</td>
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<tr>
<td>Telehealth Visits Per Day</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.0%</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td><strong>TOTAL CLINIC VISITS</strong></td>
<td>25,255</td>
<td>25,776</td>
<td>(521)</td>
<td>-2.0%</td>
<td>25,255</td>
<td>25,776</td>
<td>(521)</td>
<td>-2.0%</td>
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<tr>
<td><strong>PAYOR MIX</strong></td>
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<tr>
<td>Insurance %</td>
<td>2.72%</td>
<td>1.94%</td>
<td>0.78%</td>
<td>39.9%</td>
<td>2.72%</td>
<td>1.94%</td>
<td>0.78%</td>
<td>39.9%</td>
</tr>
<tr>
<td>Medi-Cal %</td>
<td>13.94%</td>
<td>18.85%</td>
<td>-4.91%</td>
<td>26.0%</td>
<td>13.94%</td>
<td>18.85%</td>
<td>-4.91%</td>
<td>26.0%</td>
</tr>
<tr>
<td>Medi-Cal MC %</td>
<td>57.17%</td>
<td>55.72%</td>
<td>1.46%</td>
<td>2.6%</td>
<td>57.17%</td>
<td>55.72%</td>
<td>1.46%</td>
<td>2.6%</td>
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<tr>
<td>Medicare %</td>
<td>12.35%</td>
<td>12.44%</td>
<td>-0.09%</td>
<td>-0.7%</td>
<td>12.35%</td>
<td>12.44%</td>
<td>-0.09%</td>
<td>-0.7%</td>
</tr>
<tr>
<td>Medicare MC %</td>
<td>0.96%</td>
<td>0.59%</td>
<td>0.37%</td>
<td>63.6%</td>
<td>0.96%</td>
<td>0.59%</td>
<td>0.37%</td>
<td>63.6%</td>
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<tr>
<td>Other Govt %</td>
<td>8.53%</td>
<td>7.23%</td>
<td>1.30%</td>
<td>18.0%</td>
<td>8.53%</td>
<td>7.23%</td>
<td>1.30%</td>
<td>18.0%</td>
</tr>
<tr>
<td>Self-Pay %</td>
<td>4.32%</td>
<td>3.23%</td>
<td>1.08%</td>
<td>33.4%</td>
<td>4.32%</td>
<td>3.23%</td>
<td>1.08%</td>
<td>33.4%</td>
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<tr>
<td>Total Payer Mix %</td>
<td>100.00%</td>
<td>100.00%</td>
<td>0.00%</td>
<td>0.0%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>0.00%</td>
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</table>
## July 2023 Preliminary Financial Report

### Volume Highlights

<table>
<thead>
<tr>
<th></th>
<th>July</th>
<th>Budget</th>
<th>Variance</th>
<th>% Var</th>
<th>PY YTD Actual</th>
<th>Variance</th>
<th>% Var</th>
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<td><strong>ACUTE</strong></td>
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<tr>
<td>Patient Days</td>
<td>9,633</td>
<td>9,420</td>
<td>213</td>
<td>2.3%</td>
<td>9,626</td>
<td>7</td>
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<tr>
<td>Discharges</td>
<td>1,565</td>
<td>1,562</td>
<td>3</td>
<td>0.2%</td>
<td>1,462</td>
<td>103</td>
<td>7.0%</td>
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<tr>
<td>Average Daily Census</td>
<td>310.7</td>
<td>303.9</td>
<td>6.8</td>
<td>2.2%</td>
<td>310.5</td>
<td>0.2</td>
<td>0.1%</td>
</tr>
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<td>Average Length of Stay</td>
<td>6.2</td>
<td>6.0</td>
<td>0.2</td>
<td>3.3%</td>
<td>6.6</td>
<td>(0.4)</td>
<td>-6.1%</td>
</tr>
<tr>
<td>Adjusted Patient Days</td>
<td>15,396</td>
<td>14,894</td>
<td>502</td>
<td>3.4%</td>
<td>14,702</td>
<td>694</td>
<td>4.7%</td>
</tr>
<tr>
<td>Adjusted Discharges</td>
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<td>2,468</td>
<td>33</td>
<td>1.3%</td>
<td>2,233</td>
<td>268</td>
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<tr>
<td>CMI</td>
<td>1.466</td>
<td>1.528</td>
<td>(0.062)</td>
<td>-4.1%</td>
<td>1.528</td>
<td>(0.062)</td>
<td>-4.1%</td>
</tr>
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<td>Emergency Visits</td>
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<td>8,479</td>
<td>(340)</td>
<td>-4.0%</td>
<td>7,754</td>
<td>385</td>
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<tr>
<td>Trauma Cases</td>
<td>299</td>
<td>276</td>
<td>23</td>
<td>8.3%</td>
<td>272</td>
<td>27</td>
<td>9.9%</td>
</tr>
<tr>
<td>Observation Equivalent Days</td>
<td>31</td>
<td>329</td>
<td>(298)</td>
<td>-90.6%</td>
<td>293</td>
<td>(262)</td>
<td>-89.4%</td>
</tr>
<tr>
<td>PES Equivalent Days</td>
<td>736</td>
<td>725</td>
<td>11</td>
<td>1.5%</td>
<td>587</td>
<td>149</td>
<td>25.4%</td>
</tr>
<tr>
<td>Surgeries</td>
<td>699</td>
<td>726</td>
<td>(27)</td>
<td>-3.7%</td>
<td>672</td>
<td>27</td>
<td>4.0%</td>
</tr>
<tr>
<td>IP Surgeries</td>
<td>315</td>
<td>378</td>
<td>(63)</td>
<td>-16.7%</td>
<td>348</td>
<td>(33)</td>
<td>-9.5%</td>
</tr>
<tr>
<td>OP Surgeries</td>
<td>384</td>
<td>348</td>
<td>36</td>
<td>10.3%</td>
<td>324</td>
<td>60</td>
<td>18.5%</td>
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<tr>
<td>Deliveries</td>
<td>150</td>
<td>117</td>
<td>33</td>
<td>28.2%</td>
<td>130</td>
<td>20</td>
<td>15.4%</td>
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<tr>
<td>Patient Days</td>
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<td>8,403</td>
<td>27</td>
<td>0.3%</td>
<td>8,082</td>
<td>348</td>
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<td>Discharges</td>
<td>27</td>
<td>25</td>
<td>2</td>
<td>8.0%</td>
<td>17</td>
<td>10</td>
<td>58.8%</td>
</tr>
<tr>
<td>Average Daily Census</td>
<td>271.9</td>
<td>271.1</td>
<td>0.8</td>
<td>0.3%</td>
<td>260.7</td>
<td>11.2</td>
<td>4.3%</td>
</tr>
<tr>
<td>Average Length of Stay</td>
<td>312.2</td>
<td>331.7</td>
<td>(19.5)</td>
<td>-5.9%</td>
<td>475.4</td>
<td>(163.2)</td>
<td>-34.3%</td>
</tr>
<tr>
<td><strong>CLINIC VISITS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinic Visits</td>
<td>29,510</td>
<td>29,199</td>
<td>311</td>
<td>1.1%</td>
<td>27,898</td>
<td>1,612</td>
<td>5.8%</td>
</tr>
<tr>
<td>Telehealth Visits</td>
<td>25,244</td>
<td>24,166</td>
<td>1,078</td>
<td>4.5%</td>
<td>23,344</td>
<td>1,900</td>
<td>8.1%</td>
</tr>
<tr>
<td>Physician wRVU</td>
<td>4,266</td>
<td>5,033</td>
<td>(767)</td>
<td>-15.2%</td>
<td>4,554</td>
<td>(288)</td>
<td>-6.3%</td>
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<tr>
<td>Total Adjusted Patient Days</td>
<td>26,922</td>
<td>25,896</td>
<td>1,026</td>
<td>4.0%</td>
<td>302,285</td>
<td>21,135</td>
<td>7.0%</td>
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<td>Total Adjusted Discharges</td>
<td>2,441</td>
<td>2,361</td>
<td>80</td>
<td>3.4%</td>
<td>27,362</td>
<td>844</td>
<td>3.1%</td>
</tr>
</tbody>
</table>
Acute Care Hospitals: HGH, SLH (excludes Rehab), AH

➢ **LOS Variance Days:** The total # of actual days in a bed in excess of the allowed # of days from national and state regulatory acuity models. June: 2,393 days which is **2.4% month over month Decrease** and is **11.2% Decrease year over year** June.

➢ **LOS Variance Dollars:** The AHS estimated additional cost of resources due to the variance days for July was $3.6M (calculated at $1,500/day). Does not include the $11.7M opportunity cost of the bed being unavailable to another patient (weighted average per diem reimbursement all heads in a bed $4,883).
Operating revenue exceeded budget primarily due to improved mix of services, payer mix, and retail pharmacy.

Operating expenses exceeded budget driven by higher than budget LOS and patient days; driving up labor costs. Overtime and registry costs remain higher than plan.

Net Income and EBIDA are favorable to budget for the month.

<table>
<thead>
<tr>
<th></th>
<th>July 2023</th>
<th>FY 2023</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual</td>
<td>Budget</td>
</tr>
<tr>
<td>Operating revenue</td>
<td>$ 116,770</td>
<td>$ 114,276</td>
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<tr>
<td>Operating expense</td>
<td>114,833</td>
<td>114,076</td>
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<tr>
<td>Operating income (loss)</td>
<td>1,937</td>
<td>200</td>
</tr>
<tr>
<td>Other non-operating activity</td>
<td>(126)</td>
<td>(67)</td>
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<tr>
<td>Net Income (loss)</td>
<td>$ 1,811</td>
<td>$ 133</td>
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<td>EBIDA adjustments</td>
<td>3,289</td>
<td>3,148</td>
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<td>EBIDA</td>
<td>$ 5,100</td>
<td>$ 3,281</td>
</tr>
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<td>1.7%</td>
<td>0.2%</td>
</tr>
<tr>
<td>EBIDA Margin</td>
<td>4.4%</td>
<td>2.9%</td>
</tr>
</tbody>
</table>
Gross patient service revenue approximates budget for the month.

- The average LOS is 6.2 exceeding budget; although, reflects improvement from trend. CMI is lower than budget (4.1%) indicating less complexity of patients and services. Inpatient surgery fell below budget by 16.7%. Deliveries exceeded budget by 28.2%.
- ED visits were below budget by 4% negatively impacting professional fees. SNF census and discharges continue to trend up.
- CDM increase of a blended 3% was effective on July 1, 2023.

NPSR Collection ratio was 19.5% and above budget from improved payor mix. Commercial patient revenue was 1.5% over budget driven by Trauma cases (8.3%).
➢ Other government programs was unfavorable for the month driven by lower Medi-Cal CalAim funding offset by higher Prop 56 receipts.
➢ Other operating revenue was favorable for the month $0.5M driven by higher retail pharmacy ($0.7M) and lower grant revenue ($0.3M).
Physician contract services were favorable driven by lower GME General Surgery ($0.2M).

Purchased Services favorable with offsetting variances. Outside medical services ($0.4M) and transitional housing ($0.2M) variances were offset by lower software licenses/hosting fees ($0.2M), management consultant ($0.1M) and parking services ($0.1M).

Material and Supplies favorable driven by lower surgical supplies ($0.3M) and lab reagents ($0.2M).

Facilities favorable driven by timing for medical equipment repairs ($0.1M), building repairs ($0.2M), and utilities ($0.3M).

Depreciation and amortization favorable from higher equipment depreciation.

General and administrative is favorable from timing on outside travel/training ($0.1M).
Labor costs are unfavorable to budget driven by increased volume of acute patient days (2.3% above budget) and labor shortages requiring overtime and the use of registry at higher rates.

- Salaries and wages (staff) unfavorable driven by overtime.
- Physician Salaries were favorable with the variances spread across multiple specialties. SANs filled in vacancies, however SAN FTEs were excluded from the budget.
- Higher registry usage (month 93 FTE, $2.6M) offset by lower rates (month $2.0M), total unfavorable by $0.6M. July is lower than the April-June 2023 run rate $6.9M.

<table>
<thead>
<tr>
<th></th>
<th>July 2023</th>
<th>FY 2023 YTD</th>
<th>% Var</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Salaries and wages (staff)</strong></td>
<td>$51,191</td>
<td>$48,084</td>
<td>(6.5)%</td>
</tr>
<tr>
<td><strong>Salaries and wages (physicians)</strong></td>
<td>$8,229</td>
<td>$7,126</td>
<td>(15.5)%</td>
</tr>
<tr>
<td><strong>Registry</strong></td>
<td>$6,194</td>
<td>$7,139</td>
<td>13.2%</td>
</tr>
<tr>
<td><strong>Employee benefits (taxes, insurance)</strong></td>
<td>$13,616</td>
<td>$12,122</td>
<td>(12.3)%</td>
</tr>
<tr>
<td><strong>Retirement</strong></td>
<td>$7,165</td>
<td>$6,900</td>
<td>(3.8)%</td>
</tr>
<tr>
<td><strong>Retirement (deferred)</strong></td>
<td>-$</td>
<td>(2,785)</td>
<td>(100.0)%</td>
</tr>
<tr>
<td><strong>Total labor costs</strong></td>
<td>$86,395</td>
<td>$78,586</td>
<td>(9.9)%</td>
</tr>
</tbody>
</table>

**Compensation ratio**

- Actual: 74.0%
- Budget: 73.8%
- Variance: -0.2%

**Paid FTEs**

- Actual: 4,892
- Budget: 4,776
- Variance: (2.4%)
➢ Employee Benefits unfavorable driven by timing of self-funded health expenditures ($0.4M), other insurance plans ($0.2M), FICA ($0.1M), self-funded workers compensation ($0.1M) and new GME contract, annual payment for interns/residents FY24 housing allowance ($0.6M).

➢ Retirement at budget for the month.
 Jul 2024 shows a negative variance for Paid FTEs, driven by registry needed to staff for higher patient days and vacancies. YTD unfavorable variance is 116 FTEs.

Registry RN is low for July may due to incomplete data transferred from vendor.
Days in Cash are 5.1 and higher than year-end; typically, below 5.0 days.

Gross AR Days decreased 2.3 days and Net AR Days decreased 2.2 days. See next slide for additional detail.

Days in Accounts Payable increased due to timing of the check run. The target is 30 days.

Net Position is negative $84.6M and improved $1.8M from June 30, 2023 reflecting YTD Net Income.

Net Negative Balance is a receivable $39.1M. NNB consists of the liquidity facility (loan) of $13.8M plus the restricted cash of $25.3M; and is below the June 30, 2024 credit ceiling of $105.0M.
Hospital Revenue Cycle Key Indicators
- HB AR Days decreased 1.5 days from prior month.
- HB payments posted (collections) were $58.7M for the month above the YTD trend at $51.8M.
- Partnership with Cloudmed to assist with clinical denials. Open denials decreased from $56.4M to $21.0M in July. Clinic appeals won for $0.9M.
- Establish monthly JOC with Alameda Alliance to review denials, resulting in successful outcome. Having second JOC with Brown & Toland and starting JOC with Anthem Blue Cross in Q2.
- Candidate for Billing (CFB) increased 1.3 days to 6.5 days in July. Target is <4 CFB days. Focus group continues to focus on decreasing CFB.
- Continuous process improvement is underway in denial prevention.
  - DNFB Task Force
  - High risk, trauma, and high dollar review

Professional Revenue Cycle Key Indicators
- PB AR Days were decreased 2.7 from prior month.
- PB payments posted (collections) were $10.0M for the month above the YTD trend of $7.9M.
- Continuous process improvement is underway in denial prevention.
  - Denial trending by visit and procedure
  - Department Denial Task Force for prevention
  - Deployed new RCM Service Line Meeting with Cardiology Services. Plans to roll-out service line meetings for all other ambulatory clinics.

Hospital RCM
AR Days Target (Huron) = 57.0
July 2023 AR Days = 64.7

Professional RCM
AR Days Target (Huron) = 33.0
July 2023 AR Days = 30.2
FY23 collections were $776.5M exceeding FY22 and FY21 collections. The transition to Epic occurred in FY20 on September 29, 2019. Volumes dropped during the pandemic (3/2021); however, collections strong with improved Revenue Cycle.

FY24 Patient collections are running approximately 7.2% higher than the same time period in FY23.

<table>
<thead>
<tr>
<th></th>
<th>Behavioral Health (in thousands)</th>
<th>Total FY 2024</th>
<th>FY 2023</th>
<th>FY 2022</th>
<th>FY 2021</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Legacy</td>
<td>Health</td>
<td>Epic</td>
<td>79,592</td>
<td>776,453</td>
</tr>
<tr>
<td>Jul</td>
<td>1</td>
<td>10,909</td>
<td>68,682</td>
<td>79,592</td>
<td>74,260</td>
</tr>
<tr>
<td>Aug</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>58,590</td>
</tr>
<tr>
<td>Sep</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>76,063</td>
</tr>
<tr>
<td>Oct</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>59,796</td>
</tr>
<tr>
<td>Nov</td>
<td>-</td>
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<td>-</td>
<td>56,939</td>
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<tr>
<td>Dec</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>67,018</td>
</tr>
<tr>
<td>Jan</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>71,452</td>
</tr>
<tr>
<td>Feb</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>57,886</td>
</tr>
<tr>
<td>Mar</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>65,320</td>
</tr>
<tr>
<td>Apr</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>55,307</td>
</tr>
<tr>
<td>May</td>
<td>-</td>
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<td>-</td>
<td>-</td>
<td>63,795</td>
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<tr>
<td>Jun</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>70,027</td>
</tr>
<tr>
<td>Total</td>
<td>1</td>
<td>10,909</td>
<td>68,682</td>
<td>79,592</td>
<td>776,453</td>
</tr>
</tbody>
</table>

% change between fiscal years: 7.2% FY23, 10.0% FY24, 17.6% FY25.
The forecast is based on the FY24 Budget and is expected to be below limit of $105.0M at 6/30/24.

- Capital budget cash flow is $30.5M; YTD capital was $1.0M. The cashflow assumes another $29.5M will be spent this fiscal year.
- July 2023 activity was consistent with forecast and no material impact on NNB.
➢ AB85 Realignment repayment for FY21 reduced from $38.0 million to $8.4 million based on final report submission in June 2023.

➢ Prior year activity for the old Waiver, Medi-Cal FQHC and Physician SPA settlements are reflected in a separate table as the final settlement amount and timing are unknown.
  • Physician SPA FY08 final settled in June 2023, resulting in release of $5.0M reserves.

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>HPAC amendment and AB85 realignment</td>
<td>$ -</td>
<td>-</td>
<td>$ -</td>
<td>$ (8,395)</td>
<td>$ 40,000</td>
<td>$ -</td>
<td>$ -</td>
</tr>
<tr>
<td>EPP (semi-annual)</td>
<td></td>
<td></td>
<td>20,000</td>
<td></td>
<td>20,000</td>
<td></td>
<td></td>
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<tr>
<td>QIP (annual)</td>
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<td></td>
<td></td>
<td></td>
<td>70,000</td>
<td></td>
<td></td>
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<tr>
<td>GPP (quarterly)</td>
<td>26,000</td>
<td>26,000</td>
<td>26,000</td>
<td>7,300</td>
<td>26,000</td>
<td></td>
<td></td>
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<tr>
<td>Medi-Cal Managed Care Rate Range (annual)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>45,000</td>
</tr>
<tr>
<td></td>
<td>$ 26,000</td>
<td>$ 46,000</td>
<td>$ (8,395)</td>
<td>$ 66,000</td>
<td>$ 7,300</td>
<td>$ 116,000</td>
<td>$ 45,000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Prior Year Reimbursement Settlements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waiver recoupment (fy10, fy11, fy14, fy15)</td>
</tr>
<tr>
<td>Medi-Cal FQHC recoupment (fy08 - fy13)</td>
</tr>
<tr>
<td>Physician SPA (fy08 - fy13)</td>
</tr>
</tbody>
</table>
July 2023 Financial Statement by Entity

### Operating Revenue

<table>
<thead>
<tr>
<th></th>
<th>ALAMEDA</th>
<th>FAIRMONT</th>
<th>FQ CLINIC</th>
<th>HIGHLAND</th>
<th>JOHN GEORGE</th>
<th>SAN LEANDRO</th>
<th>SYSTEM</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net Patient Revenue</td>
<td>$9,258</td>
<td>$2,535</td>
<td>$5,135</td>
<td>$36,545</td>
<td>$7,262</td>
<td>$8,641</td>
<td>$0</td>
<td>$69,376</td>
</tr>
<tr>
<td>Capitation Revenue</td>
<td>360</td>
<td>33</td>
<td>865</td>
<td>2,317</td>
<td>18</td>
<td>436</td>
<td>0</td>
<td>4,030</td>
</tr>
<tr>
<td>Other Government Programs</td>
<td>1,734</td>
<td>49</td>
<td>52</td>
<td>8,826</td>
<td>59</td>
<td>1,877</td>
<td>0</td>
<td>12,597</td>
</tr>
<tr>
<td>Other Revenues</td>
<td>527</td>
<td>204</td>
<td>364</td>
<td>1,866</td>
<td>370</td>
<td>438</td>
<td>0</td>
<td>3,769</td>
</tr>
<tr>
<td><strong>Total Revenue - All Sources</strong></td>
<td><strong>11,879</strong></td>
<td><strong>2,821</strong></td>
<td><strong>6,417</strong></td>
<td><strong>49,554</strong></td>
<td><strong>7,709</strong></td>
<td><strong>11,392</strong></td>
<td><strong>0</strong></td>
<td><strong>89,773</strong></td>
</tr>
</tbody>
</table>

### Budget Revenue Variance

|                      | 677      | 510      | 166       | 1,913    | 249         | (1,020)     | 0      | 2,494       |

### Collection %

- **Operating Collection %**: 16.3% 18.9% 44.6% 18.2% 31.7% 17.4% 19.5%
- **Budget Collection %**: 15.6% 18.1% 42.5% 17.5% 33.7% 16.7% 18.9%

### Operating Expenses

<table>
<thead>
<tr>
<th></th>
<th>9,189</th>
<th>4,448</th>
<th>8,170</th>
<th>34,237</th>
<th>8,422</th>
<th>8,720</th>
<th>13,210</th>
<th>86,395</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salaries &amp; Benefits</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Purchased Services</td>
<td>1,044</td>
<td>357</td>
<td>357</td>
<td>3,806</td>
<td>1,050</td>
<td>707</td>
<td>3,702</td>
<td>11,024</td>
</tr>
<tr>
<td>Materials and Supplies</td>
<td>764</td>
<td>371</td>
<td>712</td>
<td>6,839</td>
<td>119</td>
<td>882</td>
<td>485</td>
<td>10,171</td>
</tr>
<tr>
<td>Facilities</td>
<td>121</td>
<td>137</td>
<td>148</td>
<td>908</td>
<td>110</td>
<td>249</td>
<td>656</td>
<td>2,329</td>
</tr>
<tr>
<td>Depreciation</td>
<td>393</td>
<td>30</td>
<td>174</td>
<td>425</td>
<td>25</td>
<td>200</td>
<td>1,904</td>
<td>3,150</td>
</tr>
<tr>
<td>General &amp; Administration</td>
<td>34</td>
<td>3</td>
<td>2</td>
<td>45</td>
<td>0</td>
<td>37</td>
<td>1,644</td>
<td>1,764</td>
</tr>
<tr>
<td><strong>Total Operating Expenses</strong></td>
<td><strong>11,544</strong></td>
<td><strong>5,345</strong></td>
<td><strong>9,563</strong></td>
<td><strong>46,259</strong></td>
<td><strong>9,726</strong></td>
<td><strong>10,795</strong></td>
<td><strong>21,601</strong></td>
<td><strong>114,833</strong></td>
</tr>
</tbody>
</table>

### Budget Expense Variance

|                      | 784      | (48)     | (787)     | (590)    | (291)       | 130         | 44     | (758)       |

### Contribution Margin

|                      | 335      | (2,524)  | (3,146)   | 3,295    | (2,017)     | 597         | (21,601) | (25,060)   |

### Budget Contribution Margin Variance

|                      | 1,461    | 462      | (621)     | 1,322    | (42)        | (891)       | 44     | 1,736       |

246/284
## July 2023 Financial Statement by Entity

<table>
<thead>
<tr>
<th>Contribution Margin</th>
<th>ALAMEDA</th>
<th>FAIRMONT</th>
<th>FQ CLINIC</th>
<th>HIGHLAND</th>
<th>JOHN GEORGE</th>
<th>SAN LEANDRO</th>
<th>SYSTEM OVERHEAD</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>335</td>
<td>(2,524)</td>
<td>(3,146)</td>
<td>3,295</td>
<td>(2,017)</td>
<td>597</td>
<td>(21,601)</td>
<td>(25,060)</td>
</tr>
<tr>
<td>Budget Contribution Margin Variance</td>
<td>1,461</td>
<td>462</td>
<td>(621)</td>
<td>1,322</td>
<td>(42)</td>
<td>(891)</td>
<td>44</td>
<td>1,736</td>
</tr>
<tr>
<td>Net Allocations incl Non Operating</td>
<td>431</td>
<td>311</td>
<td>560</td>
<td>3,231</td>
<td>494</td>
<td>244</td>
<td>21,601</td>
<td>26,871</td>
</tr>
<tr>
<td>Total Non Operating Activity</td>
<td>(7)</td>
<td>(8)</td>
<td>(13)</td>
<td>(69)</td>
<td>(14)</td>
<td>(16)</td>
<td>0</td>
<td>(126)</td>
</tr>
<tr>
<td>Net Income (Loss) After Allocations</td>
<td>766</td>
<td>(2,213)</td>
<td>(2,586)</td>
<td>6,526</td>
<td>(1,523)</td>
<td>841</td>
<td>0</td>
<td>1,811</td>
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<tr>
<td>Budget Net Income (Loss) After Allocations</td>
<td>(662)</td>
<td>(2,759)</td>
<td>(1,994)</td>
<td>4,949</td>
<td>(1,523)</td>
<td>2,123</td>
<td>0</td>
<td>134</td>
</tr>
</tbody>
</table>

### Statistics

<table>
<thead>
<tr>
<th>Statistics</th>
<th>ALAMEDA</th>
<th>FAIRMONT</th>
<th>FQ CLINIC</th>
<th>HIGHLAND</th>
<th>JOHN GEORGE</th>
<th>SAN LEANDRO</th>
<th>SYSTEM OVERHEAD</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Days / Clinic Visits</td>
<td>5,597</td>
<td>3,995</td>
<td>27,573</td>
<td>4,810</td>
<td>2,087</td>
<td>2,261</td>
<td>46,323</td>
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<tr>
<td>Patient Discharges</td>
<td>240</td>
<td>15</td>
<td></td>
<td></td>
<td></td>
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<td>1,592</td>
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<td>ED Visits / PES</td>
<td>1,499</td>
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<td>4,083</td>
<td>833</td>
<td>2,557</td>
<td>8,972</td>
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<tr>
<td>Left Without Being Seen (LWBS)</td>
<td>39</td>
<td></td>
<td>573</td>
<td>104</td>
<td></td>
<td></td>
<td>716</td>
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<tr>
<td>Surgeries</td>
<td>146</td>
<td></td>
<td>432</td>
<td>121</td>
<td></td>
<td></td>
<td>699</td>
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### Statistics Variance

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<th>Statistics Variance</th>
<th>ALAMEDA</th>
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<th>FQ CLINIC</th>
<th>HIGHLAND</th>
<th>JOHN GEORGE</th>
<th>SAN LEANDRO</th>
<th>SYSTEM OVERHEAD</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Days / Clinic Visits</td>
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<td></td>
<td></td>
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<tr>
<td>Patient Discharges</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ED Visits / PES</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Left Without Being Seen (LWBS)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Surgeries</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Entity Financial Statements

• Monthly Operating Reviews (MOR) with each entity leaders/managers underway and have identified opportunities for improvement. Implementing action plans.
  – Bridge plans to close financial gap in process

• Next Steps
  – Add entity Key Statistics
  – Allocation of Performance Improvement Initiatives
  – Complete revenue allocations
    • Validate and understand collection ratios
  – Continue work to direct cost all feasible expenses
    • Physician expense/EBMG reporting moving forward
  – Develop service line financial statements for next year FY24
    • Examples: Cardiology, Post Acute, Behavioral Health
### YTD Net Income at 5/31/23

<table>
<thead>
<tr>
<th>Description</th>
<th>Actual</th>
<th>Budget</th>
<th>Variance</th>
<th>Variance Detail</th>
<th>Cash Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost report settlements - Medi-Cal FY21 and FY22</td>
<td>18,703</td>
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<td></td>
<td></td>
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<tr>
<td>AB85 Realignment - adjustment FY21 and FY22 reserves</td>
<td>31,589</td>
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<td></td>
<td></td>
<td>no</td>
</tr>
<tr>
<td>HPAC amendment #2 - additional revenues</td>
<td>7,000</td>
<td></td>
<td></td>
<td></td>
<td>yes</td>
</tr>
<tr>
<td>Physician SPA - release of FY08 reserves</td>
<td>5,000</td>
<td></td>
<td></td>
<td></td>
<td>no</td>
</tr>
<tr>
<td>ACERA retirement - actuarial report</td>
<td>(59,308)</td>
<td></td>
<td></td>
<td></td>
<td>no</td>
</tr>
<tr>
<td>Inventory adjustment - expired product</td>
<td>(5,686)</td>
<td></td>
<td></td>
<td></td>
<td>yes</td>
</tr>
<tr>
<td>Other expense items</td>
<td>(17,074)</td>
<td></td>
<td></td>
<td></td>
<td>yes</td>
</tr>
</tbody>
</table>

**Subtotal - Material activity posted in June 2023:**

$(19,776)$

### YTD Net Income at 6/30/23 (preliminary)

<table>
<thead>
<tr>
<th>Description</th>
<th>Actual</th>
<th>Budget</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>YTD Net Income at 6/30/23 (preliminary)</td>
<td>$20,863</td>
<td>$45,427</td>
<td>$(24,564)</td>
</tr>
</tbody>
</table>

### YTD EBIDA at 5/31/23

<table>
<thead>
<tr>
<th>Description</th>
<th>Actual</th>
<th>Budget</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>YTD EBIDA at 5/31/23</td>
<td>$41,343</td>
<td>$41,159</td>
<td>$184</td>
</tr>
<tr>
<td>Change in YTD Net Income</td>
<td></td>
<td></td>
<td>$(19,776)</td>
</tr>
<tr>
<td>ACERA retirement based on actuarial report</td>
<td>59,308</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depreciation and amortization</td>
<td>1,469</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interest income (expense)</td>
<td>148</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### YTD EBIDA at 6/30/23 (preliminary)

<table>
<thead>
<tr>
<th>Description</th>
<th>Actual</th>
<th>Budget</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>YTD EBIDA at 6/30/23 (preliminary)</td>
<td>$85,906</td>
<td>$44,573</td>
<td>$41,333</td>
</tr>
</tbody>
</table>
Presentation does not include fiscal year-end entries that will be finalized by October 2023. Final audit report will be presented to Audit Committee on 11/08/23. Year end comparison to Budget and Prior Year will be presented after the audit is complete.

- **Net Patient Revenue and Capitation**
  - BHS revenue true-up for May and June payments received after 6/30/223
  - Look back analysis to validate AR reported for June 30, 2023

- **Supplemental Program Revenue**
  - Measure A revenue true-up for May and June to reconcile to total payments per County (lags 2 months)
  - No additional adjustments anticipated on other programs; however, information may change during the audit.

- **Foundation true-up to mirror balances between the entities; AHS subsidy payment for June.**

- **Expense related items**
  - Self-funded Workers’ Compensation (actuarial report)
  - Self-funded Hospital and Medical Malpractice (actuarial report)
  - AHS Defined Benefit retirement plan (actuarial report)
  - Interest for 4th quarter from County on NNB and restricted funds
  - Any material invoicing requiring a true-up
# June 2023 Preliminary Financial Report

## Volume Highlights

<table>
<thead>
<tr>
<th></th>
<th>Jun</th>
<th>Budget</th>
<th>Variance</th>
<th>% Var</th>
<th>YTD Actual</th>
<th>YTD Budget</th>
<th>Variance</th>
<th>% Var</th>
<th>PY YTD Actual</th>
<th>Variance</th>
<th>% Var</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ACUTE</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient Days</td>
<td>9,140</td>
<td>8,985</td>
<td>155</td>
<td>1.7%</td>
<td>115,203</td>
<td>105,057</td>
<td>10,146</td>
<td>9.7%</td>
<td>106,753</td>
<td>8,450</td>
<td>7.9%</td>
</tr>
<tr>
<td>Discharges</td>
<td>1,518</td>
<td>1,548</td>
<td>(30)</td>
<td>-1.9%</td>
<td>18,220</td>
<td>18,618</td>
<td>(398)</td>
<td>-2.1%</td>
<td>17,947</td>
<td>273</td>
<td>1.5%</td>
</tr>
<tr>
<td>Average Daily Census</td>
<td>304.7</td>
<td>299.5</td>
<td>5.2</td>
<td>1.7%</td>
<td>315.6</td>
<td>287.8</td>
<td>27.8</td>
<td>9.7%</td>
<td>292.5</td>
<td>23.1</td>
<td>7.9%</td>
</tr>
<tr>
<td>Average Length of Stay</td>
<td>5.9</td>
<td>5.8</td>
<td>0.1</td>
<td>1.7%</td>
<td>6.3</td>
<td>5.6</td>
<td>0.7</td>
<td>12.5%</td>
<td>5.9</td>
<td>0.4</td>
<td>6.8%</td>
</tr>
<tr>
<td>Adjusted Patient Days</td>
<td>14,897</td>
<td>14,095</td>
<td>802</td>
<td>5.7%</td>
<td>182,902</td>
<td>164,197</td>
<td>18,705</td>
<td>11.4%</td>
<td>166,747</td>
<td>16,155</td>
<td>9.7%</td>
</tr>
<tr>
<td>Adjusted Discharges</td>
<td>2,517</td>
<td>2,429</td>
<td>88</td>
<td>3.6%</td>
<td>28,927</td>
<td>29,099</td>
<td>(172)</td>
<td>-0.6%</td>
<td>28,033</td>
<td>894</td>
<td>3.2%</td>
</tr>
<tr>
<td>CMI</td>
<td>1.535</td>
<td>1.530</td>
<td>0.005</td>
<td>0.3%</td>
<td>1.464</td>
<td>1.511</td>
<td>(0.047)</td>
<td>-3.1%</td>
<td>1.511</td>
<td>(0.047)</td>
<td>-3.1%</td>
</tr>
<tr>
<td>Emergency Visits</td>
<td>7,861</td>
<td>7,981</td>
<td>(120)</td>
<td>-1.5%</td>
<td>95,812</td>
<td>95,535</td>
<td>277</td>
<td>0.3%</td>
<td>92,552</td>
<td>3,260</td>
<td>3.5%</td>
</tr>
<tr>
<td>Trauma Cases</td>
<td>254</td>
<td>230</td>
<td>24</td>
<td>10.4%</td>
<td>3,189</td>
<td>3,070</td>
<td>119</td>
<td>3.9%</td>
<td>3,024</td>
<td>165</td>
<td>5.5%</td>
</tr>
<tr>
<td>Observation Equivalent Days</td>
<td>112</td>
<td>152</td>
<td>(40)</td>
<td>-26.3%</td>
<td>2,514</td>
<td>1,720</td>
<td>794</td>
<td>46.2%</td>
<td>2,086</td>
<td>428</td>
<td>20.5%</td>
</tr>
<tr>
<td>PES Equivalent Days</td>
<td>936</td>
<td>578</td>
<td>358</td>
<td>61.9%</td>
<td>8,413</td>
<td>6,608</td>
<td>1,805</td>
<td>27.3%</td>
<td>6,582</td>
<td>1,831</td>
<td>27.8%</td>
</tr>
<tr>
<td>Surgeries</td>
<td>748</td>
<td>771</td>
<td>(23)</td>
<td>-3.0%</td>
<td>8,811</td>
<td>8,578</td>
<td>233</td>
<td>2.7%</td>
<td>8,318</td>
<td>493</td>
<td>5.9%</td>
</tr>
<tr>
<td>IP Surgeries</td>
<td>360</td>
<td>361</td>
<td>(1)</td>
<td>-0.3%</td>
<td>4,098</td>
<td>4,235</td>
<td>(137)</td>
<td>-3.2%</td>
<td>4,009</td>
<td>89</td>
<td>2.2%</td>
</tr>
<tr>
<td>OP Surgeries</td>
<td>388</td>
<td>410</td>
<td>(22)</td>
<td>-5.4%</td>
<td>4,713</td>
<td>4,343</td>
<td>370</td>
<td>8.5%</td>
<td>4,309</td>
<td>404</td>
<td>9.4%</td>
</tr>
<tr>
<td>Deliveries</td>
<td>134</td>
<td>110</td>
<td>24</td>
<td>21.8%</td>
<td>1,457</td>
<td>1,462</td>
<td>(5)</td>
<td>-0.3%</td>
<td>1,399</td>
<td>58</td>
<td>4.1%</td>
</tr>
<tr>
<td><strong>SNF</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient Days</td>
<td>8,110</td>
<td>8,231</td>
<td>(121)</td>
<td>-1.5%</td>
<td>96,926</td>
<td>99,756</td>
<td>(2,830)</td>
<td>-2.8%</td>
<td>94,862</td>
<td>2,064</td>
<td>2.2%</td>
</tr>
<tr>
<td>Discharges</td>
<td>23</td>
<td>22</td>
<td>1</td>
<td>4.5%</td>
<td>277</td>
<td>293</td>
<td>(16)</td>
<td>-5.5%</td>
<td>295</td>
<td>(18)</td>
<td>-6.1%</td>
</tr>
<tr>
<td>Average Daily Census</td>
<td>270.3</td>
<td>274.4</td>
<td>(4.1)</td>
<td>-1.5%</td>
<td>265.6</td>
<td>273.3</td>
<td>(7.7)</td>
<td>-2.8%</td>
<td>259.9</td>
<td>5.7</td>
<td>2.2%</td>
</tr>
<tr>
<td>Average Length of Stay</td>
<td>368.6</td>
<td>382.0</td>
<td>(13.4)</td>
<td>-3.5%</td>
<td>349.9</td>
<td>340.5</td>
<td>9.4</td>
<td>2.8%</td>
<td>321.6</td>
<td>28.3</td>
<td>8.8%</td>
</tr>
<tr>
<td><strong>CLINIC VISITS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinic Visits</td>
<td>33,100</td>
<td>30,276</td>
<td>2,824</td>
<td>9.3%</td>
<td>384,619</td>
<td>378,270</td>
<td>6,349</td>
<td>1.7%</td>
<td>360,649</td>
<td>23,970</td>
<td>6.6%</td>
</tr>
<tr>
<td>Telehealth Visits</td>
<td>5,070</td>
<td>4,199</td>
<td>871</td>
<td>20.7%</td>
<td>58,972</td>
<td>56,613</td>
<td>2359</td>
<td>4.2%</td>
<td>67,007</td>
<td>(8,035)</td>
<td>-12.0%</td>
</tr>
<tr>
<td>Physician wRVU</td>
<td>110,662</td>
<td>94,613</td>
<td>16,049</td>
<td>17.0%</td>
<td>1,186,263</td>
<td>1,122,475</td>
<td>73,788</td>
<td>6.6%</td>
<td>1,104,441</td>
<td>81,822</td>
<td>7.4%</td>
</tr>
<tr>
<td>Total Adjusted Patient Days</td>
<td>26,922</td>
<td>25,896</td>
<td>1,026</td>
<td>4.0%</td>
<td>323,420</td>
<td>306,849</td>
<td>16,571</td>
<td>5.4%</td>
<td>302,285</td>
<td>21,135</td>
<td>7.0%</td>
</tr>
<tr>
<td>Total Adjusted Discharges</td>
<td>2,441</td>
<td>2,361</td>
<td>80</td>
<td>3.4%</td>
<td>28,206</td>
<td>28,338</td>
<td>(132)</td>
<td>-0.5%</td>
<td>27,362</td>
<td>844</td>
<td>3.1%</td>
</tr>
</tbody>
</table>
Operating revenue continues to exceed budget due to improved patient volumes and mix of services, Supplemental funding, Revenue Cycle performance and Measure A receipts.

Operating expenses continue to exceed budget driven by higher than budget LOS and patient days; driving up labor costs and supply costs. Labor rates significantly over budget.

Non-operating is unfavorable for the month due to year-end grant adjustments.

Net Income is unfavorable for the month and below budget by $19.8M. YTD Net Income is $20.9M and below budget by $24.6M.

EBIDA is favorable and above budget for the month and YTD.
Gross patient service revenue is favorable to budget driven by patient days (1.7%), clinic visits (9.3%), and trauma cases (10.4%).

- The average LOS is 5.9 for the month and improved over YTD trend. YTD LOS is 6.3 which is above PYTD of 5.9 and 6.8%. CMI is at budget for the month. YTD CMI is below budget by 3.1% and below prior year at 1.511.

NPSR Collection ratio was 24.7% and above budget. Adjustment of FY21 and FY22 Medi-Cal P-14 reserves resulted in 5.2% improvement. YTD, at 19.1% and 0.9% better than budget; reflecting positive mix, revenue cycle performance, and cost report reserves.

Longer LOS trend is negatively impacting the Zero Balance Analysis resulting in a lower collection ratio due to medical necessity denials and lower reimbursement for administrative days.
Other government programs was favorable by $51.4M for the month driven by GPP FY16-FY18 ($4.5M), Measure A funds ($2.6M), HPAC Amendment ($7.0M), Covid Worker Retention ($5.9M), and AB85 Realignment FY21 ($37.2M) offset by FY22 ($5.6M).

YTD favorable by $117.8M driven by:
- Medi-Cal Waiver: GPP ($8.5M) and CalAIM ECM ($0.6M)
- Measure A and Parcel Tax: Measure A ($27.1M)
- Supplemental Programs: Largest positive variances are AB85 Realignment ($32.4M), QIP ($24.9M), GME ($10.6M), HPAC Amendment ($7.0M), Covid Worker Retention ($5.9M), Rate Range CY21 ($5.4M) and offset SNF Supplement recoupment ($12.3M). All other variances are less than $5.0M by program.

Other operating revenue was unfavorable for the month $1.4M driven by lower retail pharmacy ($0.4M) and grant revenue ($1.0M). YTD favorable by $2.6M and 6.3% driven by higher pharmacy revenue ($5.1M), Sutter class action settlement ($1.0M), offset by grant revenue ($2.8M) and parking revenue ($0.7M).
Physician contract services were unfavorable driven by Anesthesiology ($0.2M), Psychiatry ($0.1M), and GME General Surgery ($0.1M). YTD, unfavorable with the largest negative variances in Anesthesiology ($1.2M), Psychiatry ($0.8M), and Orthopedic ($0.5M).

Purchased Services unfavorable driven by higher outside medical services ($0.9M), clinical services ($0.4M), software licenses ($0.4M), HIM services ($0.4M), Covid related activity ($0.3M), transitional housing ($0.2M), sheriff services ($0.2M), billing/collection fees ($0.2M), and partially offset by lower Huron contingency fees ($0.9M). YTD, unfavorable driven by higher outside medical services ($2.6M), HIM services ($2.2M), clinical services ($1.9M), Covid related activity ($1.3M), security ($1.3M), patient access ($1.0M) offset by favorable consultant fees ($1.5M) and Huron contingency fees ($4.6M). The remaining variances are spread across multiple cost centers.

Material and Supplies unfavorable driven by an inventory adjustment for expired supplies ($5.6M), pharmaceuticals ($1.8M), medical supplies ($1.1M), surgical supplies ($0.9M), IT equipment ($0.8M), lab reagents ($0.4M), and non-medical supplies ($0.3M). YTD, unfavorable driven by higher pharmaceuticals ($10.0M), medical supplies ($7.1M), inventory adjustment ($5.6M), surgical supplies ($2.3M), non-medical supplies ($1.1M), food ($0.9M), lab reagent ($0.9M), and bed/gurney purchase ($0.6M).

<table>
<thead>
<tr>
<th></th>
<th>Actual</th>
<th>Budget</th>
<th>Variance</th>
<th>% Var</th>
<th>Actual</th>
<th>Budget</th>
<th>Variance</th>
<th>% Var</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>June 2023</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Labor costs</td>
<td>$149,130</td>
<td>$69,918</td>
<td>$(79,212)</td>
<td>(113.3)%</td>
<td>$1,024,500</td>
<td>$829,984</td>
<td>$(195,616)</td>
<td>(23.6)%</td>
</tr>
<tr>
<td>Physician contract services</td>
<td>3,656</td>
<td>3,284</td>
<td>(372)</td>
<td>(11.3)%</td>
<td>41,963</td>
<td>39,412</td>
<td>(2,551)</td>
<td>(6.5)%</td>
</tr>
<tr>
<td>Purchased services</td>
<td>11,474</td>
<td>8,286</td>
<td>(3,188)</td>
<td>(38.5)%</td>
<td>106,243</td>
<td>99,714</td>
<td>(6,529)</td>
<td>(6.5)%</td>
</tr>
<tr>
<td>Materials and supplies</td>
<td>19,899</td>
<td>8,605</td>
<td>(11,294)</td>
<td>(131.2)%</td>
<td>132,602</td>
<td>102,937</td>
<td>(29,665)</td>
<td>(28.8)%</td>
</tr>
<tr>
<td>Facilities</td>
<td>4,410</td>
<td>3,243</td>
<td>(1,167)</td>
<td>(36.0)%</td>
<td>37,457</td>
<td>38,918</td>
<td>1,451</td>
<td>3.7%</td>
</tr>
<tr>
<td>Depreciation and amortization</td>
<td>4,144</td>
<td>2,675</td>
<td>(1,469)</td>
<td>(54.8)%</td>
<td>37,504</td>
<td>32,098</td>
<td>(5,506)</td>
<td>(17.2)%</td>
</tr>
<tr>
<td>General and administrative</td>
<td>3,114</td>
<td>2,229</td>
<td>(885)</td>
<td>(39.7)%</td>
<td>26,118</td>
<td>26,713</td>
<td>595</td>
<td>2.2%</td>
</tr>
<tr>
<td><strong>Total operating expense</strong></td>
<td><strong>$195,827</strong></td>
<td><strong>$98,240</strong></td>
<td><strong>$(97,587)</strong></td>
<td>(99.3)%</td>
<td><strong>$1,406,597</strong></td>
<td><strong>$1,168,776</strong></td>
<td><strong>$(237,821)</strong></td>
<td>(20.3)%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>FY 2022</th>
<th></th>
<th></th>
<th></th>
<th>FY 2022</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>YTD</strong></td>
<td>$821,895</td>
<td></td>
<td></td>
<td></td>
<td>$37,781</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>% Var</strong></td>
<td>(24.7)%</td>
<td></td>
<td></td>
<td></td>
<td>(11.1)%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>YTD</th>
<th></th>
<th></th>
<th></th>
<th>YTD</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>FY 2022</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total operating expense</strong></td>
<td><strong>$1,153,198</strong></td>
<td><strong>$1,153,198</strong></td>
<td><strong>$1,153,198</strong></td>
<td>(22.0)%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
June 2023 Preliminary Financial Report
Expense Highlights excluding Labor (part 2)

- Facilities unfavorable driven by medical equipment repairs ($0.3M), building repairs ($0.3M), rental equipment ($0.4M), utilities ($0.4M), and GASB reduction in lease expense ($0.3M). YTD favorable driven by higher utilities ($2.0M) and building repairs ($0.9M) offset by lower equipment rental ($0.5M) and implementation of GASB 87 ($3.8M) which reduces lease expense and includes it as amortization expense.

- Depreciation and amortization unfavorable from amortization ($0.3M) and depreciation adjustment for recently capitalized equipment ($1.2M).

- General and administrative is unfavorable from timing on insurance costs ($0.2M). YTD, favorable consulting travel ($1.2M), legal ($1.0M), and partially offset by recruiting ($0.7M).

<table>
<thead>
<tr>
<th></th>
<th>June 2023</th>
<th>Year-To-Date</th>
<th>FY 2022</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual</td>
<td>Budget</td>
<td>Variance</td>
</tr>
<tr>
<td>Labor costs</td>
<td>$149,130</td>
<td>$69,918</td>
<td>($79,212)</td>
</tr>
<tr>
<td>Physician contract services</td>
<td>3,656</td>
<td>3,264</td>
<td>(372)</td>
</tr>
<tr>
<td>Purchased services</td>
<td>11,474</td>
<td>8,286</td>
<td>(3,188)</td>
</tr>
<tr>
<td>Materials and supplies</td>
<td>19,899</td>
<td>8,605</td>
<td>(11,294)</td>
</tr>
<tr>
<td>Facilities</td>
<td>4,410</td>
<td>3,243</td>
<td>(1,167)</td>
</tr>
<tr>
<td>Depreciation and amortization</td>
<td>4,144</td>
<td>2,675</td>
<td>(1,469)</td>
</tr>
<tr>
<td>General and administrative</td>
<td>3,114</td>
<td>2,229</td>
<td>(885)</td>
</tr>
<tr>
<td>Total operating expense</td>
<td>$195,827</td>
<td>$98,240</td>
<td>($97,587)</td>
</tr>
</tbody>
</table>
June 2023 Preliminary Financial Report
Expense Highlights – Labor (part 1)

Labor costs are unfavorable to budget driven by increased volume of acute patient days (1.7% above budget) and labor shortages requiring overtime and the use of registry at higher rates.

- Staff (non-physician) rate variances include overtime utilization ($1.9M/mo, $19.4M/yr), unrealized “BEST” savings ($1.4M/mo, $16.5M/yr), extra shift pay “CES” ($0.3M/mo, $2.6M/yr), increases to base pay rates ($0.8M/mo, $7.2M/yr), other including hiring/retention bonus and settlements ($5.3M/mo, $8.0M/yr), offset by volume variance (68 FTE $0.7M/mo, 76 FTE $9.4M/yr). Also includes Workers Retention Payment ($5.9M).

- Physician Salaries were $0.6M over budget for the month with the largest variance continuing in Hospitalists ($0.1M). YTD Physician salaries were $5.9M over budget. The largest variances were Hospitalists ($2.0M), Internal Medicine ($0.8M), OB/GYN ($0.6M), Anesthesiology ($0.5M), Podiatry ($0.5M), and Psychiatry ($0.5M) with remaining variance across many specialties.

- Higher registry usage (month 236 FTE, $3.8M; YTD 200 FTE, $39.5M) at higher rates (month $0.7M; YTD $29.4M) continues. June is lower than the July-December 2022 run rate $7.8M.
Employee Benefits unfavorable driven by timing of self-funded health expenditures ($1.7M), FICA ($0.8M), other benefit plans ($2.0M), and self-funded workers compensation ($0.3M). YTD unfavorable driven by self-funded health expenditures ($9.4M), self-funded workers compensation ($1.9M), other benefit plans ($1.6M), FICA timing ($0.9M), and remote working stipend ($0.4M).

Retirement unfavorable for ACERA ($0.6M month; $3.1M YTD), favorable for AHS and union plans (at month; $0.3M YTD), and unfavorable for AHMG plan (at month; $0.8M YTD).

<table>
<thead>
<tr>
<th></th>
<th>June 2023</th>
<th></th>
<th>Year-To-Date</th>
<th></th>
<th>FY 2022</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual</td>
<td>Budget</td>
<td>Variance</td>
<td>% Var</td>
<td>Actual</td>
</tr>
<tr>
<td>Salaries and wages (staff)</td>
<td>$55,275</td>
<td>$45,418</td>
<td>(9,857)</td>
<td>(21.7)%</td>
<td>$581,074</td>
</tr>
<tr>
<td>Salaries and wages (physicians)</td>
<td>8,084</td>
<td>7,451</td>
<td>(633)</td>
<td>(8.5)%</td>
<td>94,113</td>
</tr>
<tr>
<td>Registry</td>
<td>6,633</td>
<td>2,106</td>
<td>(4,527)</td>
<td>(215.0)%</td>
<td>94,257</td>
</tr>
<tr>
<td>Employee benefits (taxes, insurance)</td>
<td>15,633</td>
<td>11,338</td>
<td>(4,295)</td>
<td>(27.9)%</td>
<td>149,432</td>
</tr>
<tr>
<td>Retirement</td>
<td>6,982</td>
<td>6,390</td>
<td>(592)</td>
<td>(9.3)%</td>
<td>79,836</td>
</tr>
<tr>
<td>Retirement (deferred)</td>
<td>56,523</td>
<td>(2,785)</td>
<td>(59,308)</td>
<td>(129.6)%</td>
<td>25,888</td>
</tr>
<tr>
<td><strong>Total labor costs</strong></td>
<td>$149,130</td>
<td>$69,918</td>
<td>(79,212)</td>
<td>(113.3)%</td>
<td>$1,024,600</td>
</tr>
<tr>
<td>Compensation ratio</td>
<td>83.0%</td>
<td>68.7%</td>
<td>-14.3%</td>
<td></td>
<td>71.7%</td>
</tr>
<tr>
<td>Paid FTEs</td>
<td>5,033</td>
<td>4,712</td>
<td>(321)</td>
<td>(6.8)%</td>
<td>4,831</td>
</tr>
</tbody>
</table>
FTE trend includes Registry and compares staffing to adjusted patient days (Gross Patient Revenue divided by Inpatient Revenue equals Outpatient Factor, then multiplied by Total Patient Days). Vacancy to budget is represented by the space between the lines.

COVID leave of absence benefits:
- AHS provided 12 weeks COVID-related leave effective mid-April 2020 through 12/30/20; total cost $16.7M.
- COVID-related legislation, Senate Bill 95, was effective 1/01/21 and ended 9/30/21; total cost $2.1M.
- COVID-related legislation, Senate Bill 114 was effective 1/01/22 and ends 12/31/22; total cost $4.9M.

Capitalized FTEs (average of 84 FTE) used for the SAPPHIRE implementation during July through December 2019 are not included in the Paid FTE trend line.
- Days in Cash are 2.6 and slightly higher than year-end; typically, below 5.0 days.
- Gross AR Days decreased 2.9 days and Net AR Days decreased 5.3 days. See next slide for additional detail.
- Days in Accounts Payable increased due to timing of the check run. The target is 30 days.
- Net Position is negative $77.8M and declined $14.3M from June 30, 2022 reflecting YTD Net Income and a $43.9M restatement of the Capital Cost receivable from the County.
- Net Negative Balance is a receivable $58.8M consistent with prior year end. NNB consists of the liquidity facility (loan) of $33.5M plus the restricted cash of $25.3M; and is below the June 30, 2023 ceiling of $110.0M.

<table>
<thead>
<tr>
<th></th>
<th>Jun-23</th>
<th>May-23</th>
<th>FY 2022</th>
</tr>
</thead>
<tbody>
<tr>
<td>Days in cash</td>
<td>2.6</td>
<td>3.9</td>
<td>2.3</td>
</tr>
<tr>
<td>Gross days in patient receivable</td>
<td>62.4</td>
<td>65.3</td>
<td>64.6</td>
</tr>
<tr>
<td>Net days in patient receivable</td>
<td>38.9</td>
<td>44.2</td>
<td>43.8</td>
</tr>
<tr>
<td>Due from/(to) third-party payors</td>
<td>64,197</td>
<td>(3,477)</td>
<td>25,750</td>
</tr>
<tr>
<td>Due from/(to) County</td>
<td>19,130</td>
<td>24,839</td>
<td>65,152</td>
</tr>
<tr>
<td>Days in accounts payable</td>
<td>34.7</td>
<td>30.8</td>
<td>50.4</td>
</tr>
<tr>
<td>% of AP over 60 days</td>
<td>2.2%</td>
<td>2.7%</td>
<td>1.5%</td>
</tr>
<tr>
<td>Current ratio</td>
<td>1.3</td>
<td>1.2</td>
<td>1.2</td>
</tr>
<tr>
<td>Net position - fund balance/(deficit)</td>
<td>$ (86,418)</td>
<td>$ (70,132)</td>
<td>$ (63,551)</td>
</tr>
<tr>
<td>Net negative balance - receivable/(payable)</td>
<td>$ 58,811</td>
<td>$ 63,839</td>
<td>$ 50,718</td>
</tr>
</tbody>
</table>
June 2023 Preliminary Financial Report

AR Trending

Hospital Revenue Cycle Key Indicators

- HB AR Days decreased 3.9 days from prior month. Medi-Cal started processing inpatient claims related to NPI error load in state system upgrade. Related cash received in June was $5.3M.
- HB payments posted (collections) were $58.2M for the month above the YTD trend at $51.2M.
- ParaRev AR (outsourced) project made significant improvement in FY23. Remaining inventory is $12.5M.
- Partnership with Cloudmed to assist with clinical denials for $56.4M.
- Candidate for Billing (CFB) decreased 4.3 days to 5.2 days in June. Target is <4 CFB days. Focus group continues to decrease CFB.
- Continuous process improvement is underway in denial prevention.
  - DNFB Task Force
  - High risk, trauma, and high dollar review

Professional Revenue Cycle Key Indicators

- PB AR Days were decreased 2.4 from prior month.
- PB payments posted (collections) were $8.5M for the month above the YTD trend of $7.9M.
- Continuous process improvement is underway in denial prevention.
  - Denial trending by visit and procedure
  - Department Denial Task Force for prevention
  - Deployed new RCM Service Line Meeting with Cardiology Services. Plans to roll-out service line meetings for all other ambulatory clinics.
FY22 collections were $705.6M exceeding FY21 and FY20 collections. The transition to Epic occurred in FY20 on September 29, 2019. Volumes dropped during the pandemic (3/2021); however, collections strong with improved Revenue Cycle.

FY23 Patient collections are running approximately 9.8% higher than the same time period in FY22.
Projection forecasting NNB balance to be below limit for both FYs. Forecast will be updated with the FY24 budget in July.

The forecast is based on the FY23 projection with bridge plans to achieve FY23 Budget.

- Capital budget cash flow is $31.8M; YTD capital was $24.5M. FY24 forecast estimated $30.0M.
- The FY24 cashflows were adjusted 3% for patient receipts, payroll and accounts payable. Supplementals were forecasted based on run rate modified for any one-time items.
- This month, FY23 Cash Flow from Operations improved $32.4M driven by a lower repayment for FY21 AB85 Realignment, higher patient receipts and higher Measure A funding.
AB85 Realignment repayment for FY21 reduced from $38.0 million to $8.4 million based on final report submission in June 2023.

Prior year activity for the old Waiver, Medi-Cal FQHC and Physician SPA settlements are reflected in a separate table as the final settlement amount and timing are unknown.

- Physician SPA FY08 final settled in June 2023, resulting in release of $5.0M reserves.

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>HPAC amendment and AB85 realignment</td>
<td>$</td>
<td>-</td>
<td>-</td>
<td>$ (8,395)</td>
<td>$ 40,000</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>EPP (semi-annual)</td>
<td></td>
<td>20,000</td>
<td></td>
<td></td>
<td>20,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>QIP (annual)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GPP (quarterly)</td>
<td></td>
<td>26,000</td>
<td>26,000</td>
<td>26,000</td>
<td>7,300</td>
<td>26,000</td>
<td></td>
</tr>
<tr>
<td>Medi-Cal Managed Care Rate Range (annual)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>45,000</td>
</tr>
</tbody>
</table>

| Prior Year Reimbursement Settlements   |        |        |        |        |        |        |        |
| Waiver recoupment (fy10, fy11, fy14, fy15) |        |        |        |        |        |        | $ (16,190) |
| Medi-Cal FQHC recoupment (fy08 - fy13)  |        |        |        |        |        |        | $ (40,000) |
| Physician SPA (fy08 - fy13)            |        |        |        |        |        |        | $ (25,000) |
G2. Public Affairs and Community Engagement Report
TO: Board of Trustees
FROM: Alice Kinner, Administrative Director, Public Affairs & Community Engagement
DATE: September 1, 2023
SUBJECT: Public Affairs and Community Engagement Report

Public Affairs and Community Engagement (PACE) provides collaborative and integrated strategic communications and meaningful engagement with stakeholders that supports, promotes, and amplifies AHS's mission and vision while reinforcing its brand identity. PACE has four main functional areas: Government and Legislative Affairs, Community Engagement, Communications, and Media. This report provides an overview of key activities.

**Government and Legislative Affairs**
The primary responsibility of Government and Legislative Affairs is to develop and maintain relationships with elected officials at local, state, and federal levels, track and analyze the impact of legislation on AHS, and facilitate the participation of AHS's interested parties in legislative and policy development. The State Legislature reconvened from their summer recess on August 14th. Bills must make it out of the Appropriations Committees to the floor by September 1st. The Legislature can amend bills on the floor until September 8th. September 14th is the last day for the Legislature to send bills to the Governor who has until Oct. 14th to sign or veto bills.

Appendix A provides a list of State legislation that AHS is tracking.

**Community Engagement**
The Community Engagement team supports and participates in activities throughout the year that align with organizational priorities and strategies. Engagement efforts help develop and maintain relationships with key community-based organizations, local business groups, and elected officials, in addition to enhancing the health and well-being of the communities we serve. Outreach and engagement initiatives support AHS’s mission and strategic goals.

Below is a list of activities for the months of August – October 2023.

*Contact Louise Nakada, LNakada@alamedahealthsystem.org for more information.*

<table>
<thead>
<tr>
<th>Date</th>
<th>Location</th>
<th>Event</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>August</td>
<td>All AHS facilities</td>
<td>AHS Backpack and School Supply Drive</td>
<td>All AHS facilities donated backpacks and school supplies for neighborhood schools: Reach Academy (Oakland), Bella Vista Elementary (Oakland), Paden Elementary (Alameda), Halkin Elementary (San Leandro), McKinley Elementary (San Leandro),</td>
</tr>
<tr>
<td>Date</td>
<td>Time</td>
<td>Location</td>
<td>Event</td>
</tr>
<tr>
<td>------------</td>
<td>-----------------</td>
<td>---------------------------</td>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>August</strong></td>
<td><strong>12th</strong></td>
<td>Davis Street Community</td>
<td>AHS participated in this annual health fair hosted by Davis Street</td>
</tr>
<tr>
<td></td>
<td>10:00 a.m. – 2:00 p.m.</td>
<td>Health Center, San</td>
<td>Health Center. AHS joined community organizations and service</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Leandro</td>
<td>providers and offered health education and information about AHS</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>services to over 500 families in attendance.</td>
</tr>
<tr>
<td><strong>August</strong></td>
<td><strong>19th</strong></td>
<td>Wilma Chan Highland</td>
<td>In partnership with Oakland’s Adopt-a-spot program, approximately</td>
</tr>
<tr>
<td></td>
<td>9 a.m. – 11 a.m.</td>
<td>Hospital Campus,</td>
<td>15 AHS employees and their families volunteered in this clean-up</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Oakland</td>
<td>event for the neighborhood surrounding the Wilma Chan Highland Hospital</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Campus.</td>
</tr>
<tr>
<td><strong>August</strong></td>
<td><strong>26th</strong></td>
<td>Dig Deep Farms, Union</td>
<td>Dig Deep Farms is an essential partner of the Recipe4Health Program.</td>
</tr>
<tr>
<td></td>
<td>10 a.m. – 2 p.m.</td>
<td>City</td>
<td>AHS participated in this community event that honored the land and</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>our ancestors and brought together the farming community and</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>community stakeholders at a new farm location in Union City.</td>
</tr>
<tr>
<td><strong>September</strong></td>
<td><strong>1st</strong></td>
<td>Alameda Hospital,</td>
<td>In partnership with the American Red Cross, Alameda Hospital will</td>
</tr>
<tr>
<td></td>
<td>11 a.m. – 5 p.m.</td>
<td>Alameda</td>
<td>host a community blood drive. Regular drives are held throughout the</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>year.</td>
</tr>
<tr>
<td><strong>September</strong></td>
<td><strong>10th</strong></td>
<td>Downtown Oakland</td>
<td>AHS, in partnership with the LGBTQIA+ and Allies group, will</td>
</tr>
<tr>
<td></td>
<td>11 a.m.</td>
<td></td>
<td>participate in this event that celebrates the inclusiveness and</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>diversity of Oakland and AHS.</td>
</tr>
<tr>
<td><strong>September</strong></td>
<td><strong>14th</strong></td>
<td>Casa Peralta Courtyard,</td>
<td>AHS / San Leandro Hospital will participate in this</td>
</tr>
<tr>
<td></td>
<td>5:00 p.m. – 7:30 p.m.</td>
<td>San Leandro</td>
<td>multicultural networking event that brings together the San Leandro</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Chamber of Commerce Multicultural Mixer.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>September</strong></td>
<td><strong>24th</strong></td>
<td>Alameda Point, Alameda</td>
<td>AHS / Alameda Hospital is the Health and Wellness Expo sponsor of this</td>
</tr>
<tr>
<td></td>
<td>7:30 a.m. – 12 p.m.</td>
<td></td>
<td>event which includes a Half Marathon, 10K, 5K, and Family Fun Run.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Over 1,000 people are expected to participate.</td>
</tr>
<tr>
<td><strong>September</strong></td>
<td><strong>28th</strong></td>
<td>Oakland Zoo, Oakland</td>
<td>AHS in partnership with the Mobile Health Center will offer health</td>
</tr>
<tr>
<td></td>
<td>9 a.m. – 2 p.m.</td>
<td></td>
<td>and dental screenings, and health and wellness information at this</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>annual event hosted by Alameda County Supervisor Nate Miley and the</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>USOAC.</td>
</tr>
</tbody>
</table>
**COMMUNICATIONS**

The PACE Communications Team develops and implements communication strategies, plans and programs for key organizational initiatives. Updates provided are as of August 28, 2023.

**Unique Stories**
In August 2023, PACE created 23 unique stories that spotlight AHS programs and departments. These stories were shared via AHSCConnects, the AHS intranet, and the internet at alamedahealthsystem.org.

**CEO Chronicles Newsletter**
The CEO Chronicles is a monthly newsletter that is sent to nearly 6,000 staff and 645 community stakeholders including elected officials, community partners and local businesses. Note that for the month of August 2023, it was decided not to send out a CEO Chronicles Newsletter.

For every newsletter, PACE produces and features a CEO video. You can view newsletter videos on our [YouTube playlist](#).

**Leadership Desktop Chat**
PACE supports employee and physician engagement by producing Leadership Desktop Chats every Wednesday. This includes coordinating and preparing talking points, determining run of show, booking guest speakers and special presentations, coordinating follow-up on employee questions, tracking and posting frequently asked questions and posting Chat videos for those who were unable to attend.
The webinar is hosted by the PACE Administrative Director and panelists include our Chief Executive Officer, Chief Operating Officer, Chief Human Resources Officer, Chief Medical Officer, Chief Nursing Officer, Director of Security, and the Infection Prevention and Control Director. Most recently we’ve added a representative from Payroll to the panelist lineup as requested by Chat participants.

Attendees hear a report from the CEO and have an opportunity to ask questions of leadership. Periodically, guest panelists are invited to provide information about key AHS initiatives. In August staff received updates on True North Metrics, the Health Equity Diversity Inclusion and Belonging (HEDI-B) Committee, and received special presentations from AHS physicians about and the Doctor of the Day pilot program. The Chat averaged 276 unique viewers every Wednesday for the month of August 2023.

**Digital Communication**
PACE oversees digital communications for the system and manages all verified and approved AHS social media accounts, develops digital assets and videos and maintains homepages for the AHS website and intranet. PACE-produced videos can be seen on our [YouTube channel](#).

**Digital Marketing**
PACE promoted the Wilma Chan Highland Hospital Campus Farmers Market on Facebook and Instagram through digital ads on Mondays and Tuesdays for three weeks for a total reach of 19,408 views. Reach is defined as the number of times an ad is viewed by a unique user.

The Farmers Market was also promoted on LinkedIn for one week with a reach of 7,975 impressions.

The total number of unique views of our ads across all three platforms totals 27,383.

**Social Media Report**
Date Range of Report: August 1, 2023 – August 24, 2023

<table>
<thead>
<tr>
<th></th>
<th>Facebook</th>
<th>Twitter</th>
<th>Instagram</th>
<th>LinkedIn</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number of Followers/Fans Compared to Previous 30 Days</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Facebook</strong></td>
<td>2K fans</td>
<td>2.1K followers</td>
<td>628 followers</td>
<td>22K followers</td>
</tr>
<tr>
<td><strong>Twitter</strong></td>
<td>2 from 2K</td>
<td>18 from 2.1K</td>
<td>10 from 628</td>
<td>229 from 22K</td>
</tr>
<tr>
<td><strong>Instagram</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>LinkedIn</strong></td>
<td></td>
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</tr>
</tbody>
</table>
Social media engagement is the measure of interactions - comments, likes, shares, tweets, etc. that our audience has with the content AHS posts. Reactions is an umbrella term for interactions like Love/Angry on Facebook or shares/reposts on LinkedIn.

Top 5 Social Media Posts Based on Engagement Across All Social Media Platform for August

We are honored to have had Alameda County Board of Supervisors Lena Tam and Elisa Marquez touring and connecting with staff at our Wilma Chan Highland Hospital Campus and learning about public hospital finances. We look forward to continuing to serve our community together. #WeServeAll #EssentialHospitals See post.

In recognition of #WorldBreastfeedingWeek, we are partnering with the Alameda County Breastfeeding Coalition to table educational information for patients and staff at our ambulatory sites! This year's focus is "Let's make breastfeeding and work, work!" #WeServeAll #WICBreastFeeding See post.

Get health tips and more at the Davis Street Health Fair in San Leandro today from 10am to 1pm. Stop by the Alameda Health System booth and learn about high blood pressure, diabetes, cholesterol, and spin our prize wheel for giveaways. #CaringForOurCommunity #WeServeAll See post.
AHS Substance Use Disorder Treatment Manager Jasmin Canfield is profiled in the San Francisco Chronicle feature, “How seven lives were ‘forever changed’ by the overdose crisis.”

“I see substance use as a secondary issue, and the primary issue is trauma. [At AHS], we are seeing people who really are in pain and want to escape that pain. A lot of times they are tired. They’re tired of living with the suffering,” said Canfield. If you or someone you know needs substance use treatment, call 510-545-2765. See post.

Oakland high schoolers are encouraged to apply for our Health Excellence & Academic Leadership (HEAL) program, an AHS HealthPATH internship for students interested in a career in health care. HEAL students shadow practitioners throughout the Wilma Chan Highland Hospital Campus, interact with patients, and learn about the variety of health care fields they could pursue. The application period opened on August 7 and will close August 31. The next HEAL program will run after school from September 18 to January 24. Applicants must be Oakland residents or attend an Oakland Unified School District (OUSD) public or charter school. See post.

**Media and Communications**

Media and Communications is responsible for press coverage, media relations, and public relations that champion Alameda Health System (AHS) and our critical role in the community. We amplify stories that inform the public, elevate the profiles of AHS leadership, publicize the heroic acts our staff perform every day, and establish AHS as the community health pillar within Alameda County.

**Audience & Reach**

PACE uses Critical Mention, an all-in-one platform for real-time media monitoring across Television, Radio, Social Media, and Online News. Critical Mention calculates our audience and publicity values using data from industry-leading media data providers such as LexisNexis, Nielsen and Podchaser. The performance metrics below are a measure of media mentions, audience size, and publicity value associated with our target audience in California. These mentions are often picked up by national media outlets as well, therefore national reach and publicity metrics are much higher.

Mentions are the number of instances in which Alameda Health System, Alameda Hospital, Highland Hospital, John George Psychiatric Hospital, San Leandro Hospital, or The Wilma Chan Highland Hospital Campus were mentioned across all media. The audience estimate represents the number of people who potentially viewed the AHS mentions. The publicity value estimate represents the cost to advertise for a specific time, program, and/or platform used multiplied by the audience number.

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Mentions</th>
<th>Audience</th>
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<tr>
<td>July 1- Aug. 28, 2023</td>
<td>214</td>
<td>34,184,516</td>
<td>$1,809,075</td>
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The San Francisco Chronicle profiles AHS Substance Use Disorder Treatment Manager Jasmin Canfield.

Canfield was profiled in The San Francisco Chronicle’s, “How seven lives were ‘forever changed’ by the overdose crisis.” This article is part of a nationwide campaign by Hearst newspapers and Apple News to produce special coverage of the opioid crisis.

KTVU Fox 2 features Alameda Health System’s HealthPATH program.

HealthPATH provides education and training opportunities to young people in the Alameda County communities that are most impacted by health inequities.

AHS CEO James Jackson speaks to KTVU about rising gun violence.

“What we see is not only is there the immediate violence to the individual, but there are the repercussions of the violence that impact our community,” Jackson said.
## Appendix A – AHS Activities on Key State Bills – 8/24/2023

<table>
<thead>
<tr>
<th>Bill No.</th>
<th>Author</th>
<th>Title</th>
<th>Summary</th>
<th>Status</th>
<th>AHS Activities &amp; Potential Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>AB 40</td>
<td>Rodriguez</td>
<td>Emergency medical services.</td>
<td>The latest amendment removed the statewide 20-minute APOT standard and instead would require LEMSA to establish an APOT of no more than 30 minutes by March 1, 2024. A licensed general acute care hospital with an ED would develop a specific APOT time reduction protocol by June 1, 2024.</td>
<td>8/14 - At Senate Appropriations Suspense File</td>
<td>AHS is monitoring this bill</td>
</tr>
<tr>
<td>AB 48</td>
<td>Aguiar-curry</td>
<td>Nursing Facility Resident Informed Consent Protection Act of 2023</td>
<td>Would establish a new consent form that skilled-nursing facilities must complete. The form would ensure specified information has been shared with a patient prior to providing consent to administer treatments or procedures involving psychotherapeutic drugs, except in an emergency.</td>
<td>7/10 - At Senate Appropriations Suspense File</td>
<td>AHS is monitoring this bill</td>
</tr>
<tr>
<td>AB 414</td>
<td>Reyes</td>
<td>Communications: Digital Equity Bill of Rights</td>
<td>This bill would establish that it is the principle of the state to ensure digital equity for all California residents and that residents shall have equitable broadband access.</td>
<td>8/21 - Senate Floor third reading</td>
<td>AHS supports it</td>
</tr>
<tr>
<td>AB 645</td>
<td>Friedman</td>
<td>Speed Safety System Pilot Program</td>
<td>Would create a five-year pilot program to install automated speed cameras in six cities including Oakland. This bill would require cities to work collaboratively with local stakeholder organizations, specifically racial equity, privacy protection, and economic justice organizations, in developing the Speed Safety System Use Policy, which would include where the automated cameras would be located.</td>
<td>7/11 - At Senate Appropriations</td>
<td>AHS supports it</td>
</tr>
<tr>
<td>AB 689</td>
<td>Carrillo</td>
<td>Community colleges: registered nursing programs</td>
<td>Would require a community college with a limited enrollment course or program to ensure that at least fifteen percent of the admitted students, but no less than three students per incoming cohort, in the course or program are incumbent health care workers. Would require a community college that administers a priority enrollment system to grant priority in that system to students who are incumbent health care workers.</td>
<td>8/14 - At Senate Appropriations Suspense File</td>
<td>AHS is monitoring this bill</td>
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<tr>
<td>Bill No.</td>
<td>Author</td>
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<td>AB 722</td>
<td>Bonta</td>
<td>Alameda Health System Hospital Authority</td>
<td>Existing law prohibits the hospital authority, before January 1, 2024, from entering into a contract with any other person or entity to replace services being provided by physicians and surgeons who are employed by the hospital authority and in a recognized collective bargaining unit, with services provided by that other person or entity without clear and convincing evidence that the needed medical care can only be delivered cost-effectively by that other person or entity. The latest amendment would extend the sunset date to January 1, 2035, instead of prohibiting indefinitely the authority’s ability to enter into those contracts.</td>
<td>8/14 - Senate Floor third reading</td>
<td>AHS worked together with UAPD and agreed to extend the sunset date by 11 years, until 1/1/2035. The author amended the bill accordingly.</td>
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<tr>
<td>AB 762</td>
<td>Wicks</td>
<td>CA Violence Intervention and Prevention Grant Program (CalVIP)</td>
<td>The latest amendments would expand the CalVIP program to include counties that have one or more cities disproportionately impacted by community gun violence and tribal governments, and increase the maximum grant amount to $2,500,000 per year and require a grant cycle to be at least 3 years.</td>
<td>8/14 - At Senate Appropriations Suspense File</td>
<td>AHS supports AB 762. AHS' Trauma Violence Intervention Program partners with many CBOs and the City of Oakland who are recipients of CalVIP.</td>
</tr>
<tr>
<td>AB 1007</td>
<td>Ortega</td>
<td>Occupational safety and health: plume</td>
<td>Would require Cal/OSHA, by June 1,2024, to submit a proposed regulation requiring hospitals to evacuate or use a plume scavenging system in any setting where techniques are used that create plume.</td>
<td>7/10 - At Senate Appropriations Suspense File</td>
<td>AHS is monitoring this bill</td>
</tr>
<tr>
<td>AB 1060</td>
<td>Ortega</td>
<td>Health care coverage: naloxone hydrochloride</td>
<td>It would require coverage of drugs approved by the FDA for the complete or partial reversal of an opioid overdose, such as naloxone hydrochloride (NH), under a health plan contract, health insurance policy, and the Medi-Cal program. It would also prohibit a health plan contract or health insurance policy from imposing cost-sharing requirements over $10 per package and would prohibit a high deductible health plan from imposing cost-sharing. This bill would sunset by 1/1/2030.</td>
<td>7/10 - At Senate Appropriations Suspense File</td>
<td>AHS supports AB 1060</td>
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<td>Bill No.</td>
<td>Author</td>
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<td>AHS Activities &amp; Potential Impact</td>
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<td><strong>AB 1063</strong></td>
<td>Gabriel</td>
<td>Nurse to patient staffing ratios: annual report</td>
<td>Would require the California Department of Public Health (CDPH), beginning 1/1/2025, to conduct an annual review of its enforcement of regulations related to nurse-to-patient staffing ratios. The report must include data regarding the number of violations, steps that were taken in response to the reports, and outcome of investigations. CDPH would also be required to hold a public hearing to receive input from direct care nurses regarding the efficacy of the department’s enforcement of the regulations. The report would be required to be submitted to the Legislature.</td>
<td>9/1 - At Senate Appropriations Suspense File</td>
<td>AHS is monitoring this bill</td>
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<tr>
<td><strong>AB 1359</strong></td>
<td>Schiavo</td>
<td>Paid sick day: health care employees</td>
<td>Would require four days of unpaid sick leave for health care workers, in addition to paid sick leave available under existing law.</td>
<td>8/14 - At Senate Appropriations Suspense File</td>
<td>AHS is monitoring this bill</td>
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<tr>
<td><strong>AB 1392</strong></td>
<td>Rodriguez</td>
<td>Hospitals: procurement contracts</td>
<td>Would require hospitals that are part of a system with operating expenses of $25 million or more to submit annual plans to the Department of Health Care Access and Information (HCAI) detailing how the hospital plans to increase procurement from minority, women, LGBT, and disabled veteran businesses. The plans would be posted on HCAI’s website for public access. Failure to submit the plan would result in a civil penalty of $100 per day.</td>
<td>8/14 - At Senate Appropriations Suspense File</td>
<td>AHS is monitoring this bill</td>
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<tr>
<td><strong>AB 1484</strong></td>
<td>Zbur</td>
<td>Temporary public employees</td>
<td>Would allow temporary employees of a public employer who have been hired to perform the same or similar work performed by permanent employees to be represented by a recognized employee organization. The bill would require those temporary employees to be automatically included in the same bargaining unit as the permanent employees upon the request of the recognized employee organization</td>
<td>8/14 - At Senate Appropriations Suspense File</td>
<td>AHS is monitoring this bill</td>
</tr>
<tr>
<td><strong>SB 253</strong></td>
<td>Wiener</td>
<td>Climate Corporate Data Accountability Act</td>
<td>Would require businesses, including hospitals and health care providers, with annual revenue in excess of $1 billion to publicly disclose their direct greenhouse gas emissions and indirect emissions related to heating and cooling annually to the California Air Resources Board starting in 2026. Other upstream</td>
<td>8/16 - At Asm/ Appropriations Suspense File</td>
<td>AHS is monitoring this bill</td>
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<tr>
<td>Bill No.</td>
<td>Author</td>
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<td>SB 282</td>
<td>Eggman</td>
<td>Medi-Cal FQHC and RHC</td>
<td>Authorizes reimbursement, under the Medi-Cal program, for a maximum of two visits taking place on the same day at a single location if after the first visit the patient suffers illness or injury requiring additional diagnosis or treatment, or if the patient has a medical visit and a mental health visit or a dental visit, as defined.</td>
<td>8/16 - At Asm/Appropriations Suspense File</td>
<td>AHS supports SB 282</td>
</tr>
<tr>
<td>SB 302</td>
<td>Stern</td>
<td>Compassionate Access to Medical Cannabis Act or Ryan’s Law</td>
<td>Currently, “Ryan’s Law” requires health care facilities — including hospitals, skilled-nursing facilities, and assisted living centers — to allow terminally ill patients to use medicinal cannabis within the facility, subject to specified requirements. This bill would add patients who are over 65 years of age with a chronic disease to the list of those who can use medicinal cannabis within these facilities. These patients would be subject to the same requirements that are applicable to terminally ill patients.</td>
<td>8/23 - At Asm. Appropriations Suspense File</td>
<td>AHS is monitoring this bill</td>
</tr>
<tr>
<td>SB 525</td>
<td>Durazo</td>
<td>Minimum wage: health care workers</td>
<td>would require healthcare facilities and care centers to (1) increase the minimum wage for healthcare workers to $21 in 2024 and $25 in 2025, (2) require annual incremental adjustments to the minimum wage by 3.5% or the CPI, whichever is higher; and (3) require exempt, full-time employees to make 150% of the healthcare minimum wage. SEIU is the sponsor of the bill.</td>
<td>8/16 - At Asm/Appropriations Suspense File</td>
<td>AHS is monitoring this bill</td>
</tr>
<tr>
<td>SB 616</td>
<td>Gonzalez</td>
<td>Sick days</td>
<td>would require employers to provide at least 56 hours or seven days of accrued sick leave or paid time off by the 280th calendar day of employment and would require that time to be allowed to be carried over into the following year. The bill would also increase the amount of paid sick leave or paid time off an employee can accrue from 48 hours or six days to 112 hours or 14 days.</td>
<td>8/16 - At Asm. Appropriations Suspense File</td>
<td>AHS is monitoring this bill</td>
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<tr>
<td>Bill No.</td>
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<tr>
<td>SB 667</td>
<td>Dodd</td>
<td>Healing Arts: Pregnancy and Childbirth</td>
<td>Would authorize a certified nurse-midwife, pursuant to policies and protocols that are mutually agreed upon with a physician and surgeon, as specified, to provide a patient with care outside of that scope of services or to provide intrapartum care to a patient who has had a prior cesarean section or surgery that interrupts the myometrium.</td>
<td>7/13 - Asm. Floor third reading</td>
<td>AHS is monitoring this bill</td>
</tr>
<tr>
<td>AB 315</td>
<td>Bauer-Kahan</td>
<td>False advertising: abortion</td>
<td>Would prohibit and make an unfair business practice of using false or misleading advertisements or statements about the provision, or lack of provision, of abortion or pregnancy-related services.</td>
<td>Held in Asm. Appropriation suspense file.</td>
<td>AHS monitored the bill</td>
</tr>
<tr>
<td>AB 869</td>
<td>Wilson</td>
<td>Hospitals: seismic safety compliance</td>
<td>Would allow certain rural and district hospitals to apply for a five-year extension of the 2030 seismic deadline if they experienced financial hardship. Recent amendments expanded criteria allowing healthcare districts to be eligible to apply for the extension.</td>
<td>Held in Senate Health</td>
<td>AHS monitored the bill</td>
</tr>
<tr>
<td>AB 1001</td>
<td>Haney</td>
<td>Health Facilities: behavioral health emergency services</td>
<td>Would require general acute care hospitals to adopt behavioral health emergency service policies related to minimum staffing requirements, response times, and data management and reporting. This bill would establish the Behavioral Health Emergency Response and Training Fund to support staffing increases in public and non-profit general acute care hospitals.</td>
<td>Held in Senate Health</td>
<td>AHS monitored the bill</td>
</tr>
<tr>
<td>AB 1156</td>
<td>Bonta</td>
<td>Hospital workers' compensation</td>
<td>Would create a rebuttable presumption in the workers’ compensation system that an infectious disease, respiratory disease, cancer, PTSD, musculoskeletal injury, or respiratory disease, including COVID-19 and its variants, arose out of work for any hospital direct patient care worker.</td>
<td>Held in Asm. Insurance Committee</td>
<td>AHS monitored the bill</td>
</tr>
</tbody>
</table>

State Bills Not Moving Forward in 2023 Legislative Session

<table>
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<tr>
<th>Bill No.</th>
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<th>Title</th>
<th>Summary</th>
<th>Status</th>
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<td>Bill No.</td>
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<td>AB 1164</td>
<td>Lowenthal</td>
<td>Hospitals: emergency departments: crowding score</td>
<td>Would require hospitals to create a protocol for emergency department crowding. Hospitals would be required to determine the range of crowding scores that constitute each category of the crowding scale and — with some exceptions — calculate and record a crowding score every four hours, at a minimum. The bill would require implementation and filing of the protocol with the Department of Health Care Access and Information by Jan. 1, 2025.</td>
<td>Held in Asm. Appropriation suspense file.</td>
<td>AHS has shared with CHA that a crowding score system has been in place. Implementing a new crowding score system by law would not be an effective solution</td>
</tr>
<tr>
<td>AB 1644</td>
<td>Bonta</td>
<td>Medi-Cal: Medically supportive food and nutrition services</td>
<td>Would transition medically supportive food and nutrition interventions from optional services in healthcare to covered Medi-Cal benefits</td>
<td>Held in Asm. Appropriation suspense file.</td>
<td>AHS supported this bill</td>
</tr>
<tr>
<td>SB 59</td>
<td>Skinner</td>
<td>Menstrual Product Accessibility Act</td>
<td>Would require any building owned by the state, including a hospital that receives state funds, to provide menstrual products free of charge in all women’s and all-gender restrooms, as well as at least one men’s restroom.</td>
<td>Held in Sen. Appropriation suspense file.</td>
<td>AHS monitored the bill</td>
</tr>
<tr>
<td>SB 759</td>
<td>Grove</td>
<td>Hospital: seismic safety</td>
<td>Would extend the 2030 seismic mandates deadline by 10 years</td>
<td>Held in Sen. Health Committee</td>
<td>AHS monitored the bill</td>
</tr>
</tbody>
</table>
ADDENDUM 1: 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.
ADENDUM 2: Board Attendance Tracker
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<th>Date</th>
<th>Banerjee</th>
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**Color Key**

1 - Planned In person
2 - Planned Absence
3 - Planned Remote-Just Cause
4 - Planned Remote-Old Brown
5 - Attended In Person-Full
6 - Attended In Person-Partial
7 - Attended Remote-Just
8 - Attended Remote-Old
9 - Absent-excused
10 - Absent-unexcused
11 - Not Required
12 - Attended Remote Covid Rules