QUALITY PROFESSIONAL SERVICES COMMITTEE MEETING
Wednesday, November 29, 2023
5:00pm-7:00pm

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

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

Members of the public may also participate at the following ZOOM Meeting Link:1
https://alamedahealthsystem.zoom.us/j/9361457125?pwd=aUF4anZtK01lRklVMzZvQVY5NTdOZz09

Meeting ID: 936 145 7125
Password: 20200513

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

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

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

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

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

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

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

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

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

OPEN SESSION / ROLL CALL

PUBLIC COMMENT: Non-Agenda Items

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

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

   A1. ARTICLE: Big Changes Coming to Medi-Cal, the State’s Health Plan for 40% of Californians, SF Chronicle

B. ACTION: Consent Agenda (estimated 10 min)

Public comment on all Consent Agenda items may be heard prior to the Committee’s vote. To provide comment remotely, follow the “Public Comment Instructions” above. The Committee does not deliberate on Consent Agenda items. Any member of the public or the Committee may request that a Consent Agenda item get pulled from the Consent Agenda for deliberation and to be voted on separately from the Consent Agenda.
B1. **Approval of the Minutes of the October 25, 2023 Quality Professional Services Committee Meeting**

B2. **Policies and Procedures**

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

**System Wide Policies**
- Intravenous Admixture Program Policy
- Quality Assurance and Performance Improvement Annual Plan - QAPI 2024
- Complimentary Local Transportation
- Pre-Operative Anesthesia Guidelines

B3. **Medical Staff Policies**

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

**AHS and AH Medical Staff policies:**
- Medical Staff Credentialing and Privileging of Practitioners
- Medical Staff Professionalism and Conduct

**AHS Medical Staff policies:**
- Medical Staff Physician Practice Office Policy
- Facility with Medical Staff Added to Hospital Licensure

**Medical Staff Retired Policies:**
- AHS Medical Staff Division Chief & Site Director
- AHS and AH Medical Staff Medical Staff Advanced Practice Provider Categories

B4. **Revised Privilege Form(s) for AHS and AH:**

- Emergency Medicine Multifacility
- Psychiatry Multifacility
- Pulmonary and Critical Care Medicine Multifacility

**Recommendation: Motion to Approve**

**END OF CONSENT AGENDA**

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

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

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

E. **REPORT/DISCUSSION: QAPI Plan (estimated 15 min)**
   Christian Rieta, Director of Quality and Outcomes

F. **REPORT/DISCUSSION: Critical Care Update (estimated 15 min)**
   Dr. Benson Chen, Division Chief of Pulmonary and Critical Care Medicine, Vice Chair, Patient Safety and Quality, Department of Medicine

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

H. **WRITTEN REPORT: Post Acute**
   Richard Espinoza, Chief Operating Officer, Post Acute

I. **CLOSED SESSION (estimated 20 min)**
   
   Public comment on Closed Session items may take place prior to the Board adjourning to the Closed Session. To provide comment remotely, follow the “Public Comment Instructions” above. An announcement of any action taken during the Closed Session will take place prior to the end of the Open Session.

   I1. Consideration of Confidential Medical Staff Credentialing Reports
      Chief of Staff, AHS Medical Staff
      Chief of Staff, AH Medical Staff

   I2. Regulatory Affairs, Risk Management, Patient Safety
      [Health and Safety Code 101850(ai) (1)]

   *(Reconvene to Open Session)*

OPEN SESSION

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

ADJOURNMENT

**ADDENDUM ONE: ABCs of Communication**
ADDENDUM TWO: Committee Charter

Our Mission
Caring, Healing, Teaching, Serving All

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

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

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

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

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

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

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

The AHS Board of Trustees is committed to protecting the private health information (PHI) of our patients. We ask that speakers refrain from disclosing or discussing the PHI of others. Please also know that, should you decide to disclose your PHI, the Trustees will still likely refer your matter, to the extent it involves PHI, to the executive staff for a confidential review of the facts and for confidential handling. If you would like more information regarding the confidentiality of PHI as it relates to the Health Insurance Privacy and Accountability Act, please refer to 45CFR Section 164.101, et.seq.
A. QPSC Chair (estimated 10 min)
US & WORLD // CALIFORNIA

Big changes coming to Medi-Cal, the state’s health plan for 40% of Californians

By Kathleen Pender

Updated Nov 20, 2023 3:03 p.m.
Some big changes are coming to Medi-Cal, California’s Medicaid health care program for low-income people, next year.

Starting Jan. 1, two groups of people that had not been eligible for full-scale Medi-Cal will gain access: low-income adults ages 26-49 and some people who are disabled or older than 64. On the other hand, some current Medi-Cal enrollees will lose coverage as the state finishes unwinding the federal “continuous coverage” program that kept people on Medicaid in the pandemic, even if they no longer qualified.

Meanwhile, about 1.2 million Medi-Cal members in 21 counties — including more than 100,000 in Alameda and Contra Costa — will have to switch to a new managed health care plan on Jan. 1 because of a big shakeup in the state’s contracts with managed care providers.
“Full-scope” Medi-Cal provides free health, mental health, vision and dental care to low-income Californians. It also covers long-term care in the person’s home or a nursing home; Medicare generally does not. To qualify based on income, most adults can’t earn more than 138% of the federal poverty level for their household size. That’s $20,124 for an individual or $41,400 for a family of four.

About 15.3 million people, or almost 40% of the state’s population, are enrolled in Medi-Cal. That number grew by about 3 million during the pandemic.

More From Kathleen Pender

IRS to offer free, guided tax prep in 2024 for some Californians. Should you use it?
Why higher-income workers in California may get surprised by this tax hike in 2024

The surge was partly a result of continuous coverage. Additionally, since January 2020, the California Department of Health Care Services — which administers Medi-Cal — has implemented various laws that let more people qualify for full coverage.

Here’s a closer look at upcoming changes.

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**Expansion for immigrants**

Although Medicaid is a federal-state program, states cannot use federal funds to pay for full-scope Medicaid for non-citizens without what the state calls “satisfactory” immigration status. California, however, has been using state funds to phase in full-scope Medi-Cal for undocumented immigrants who meet its income and other requirements.

Coverage was expanded to children lacking permanent legal status through age 18 in 2016, to young adults 19 through 25 in 2020 and to adults 50 and older on May 1, 2022. As of August, about 670,000 people gained full coverage thanks to those three expansions combined, according to the California Legislative Analyst’s office.
Starting Jan. 1, adults between 26 and 49 will also qualify regardless of their immigration status, which could cover an estimated 700,000 more people.

Before they could get full Medi-Cal coverage, undocumented immigrants could get restricted-scope Medi-Cal, which is generally limited to emergency and pregnancy services.

Other states have expanded full Medicaid coverage to certain undocumented groups, but California will be the first to extend it to all, said Jennifer Tolbert, director of state health reform with KFF, a nonprofit organization focused on health care.

As of May, the department estimated that the age 26-49 expansion would cost the state $1.2 billion in 2023-24, nearly double the previous cost estimate of $635 million. “In the first full year of the expansion, we estimate costs to the general fund to be nearly $3 billion,” said Ryan Miller, the LAO’s principal fiscal and policy analyst. Reasons for the increase include new data showing that utilization and costs for prior expansions were higher than previously assumed, Miller added.

**Continuous coverage unwinding**

Normally Medi-Cal must make sure members still qualify every year, but for three years during the pandemic, in exchange for enhanced federal funds, states were not allowed to drop people from Medicaid.

This program ended March 31 and states gradually began unwinding continuous coverage. On April 1, Medi-Cal started to redetermine whether all 15 million members are still eligible and if they were not, disenroll them. That process will
end on May 31, 2024, and “normal operations” will resume June 1, the department said via email.

It’s too early to tell how many members ultimately will lose coverage because people who are disenrolled have 90 days to prove they are still eligible and can be reinstated.

But from June through September, about 731,000 people, or 17% of those due for redetermination, had been disenrolled. Most disenrollments have been for “procedural” reasons, such as missing or erroneous paperwork. Only 5% lost coverage because their income was too high or they didn’t live in California.

The California Health Care Foundation predicts that the “vast majority” of those disenrolled will be eligible for other types of coverage, such as Covered California or an employer plan, but may need help transitioning.

Many members will be renewed without taking action. Before contacting members to complete a renewal, their county Medi-Cal office will try to verify them using outside sources such as electronic tax data or other state programs, such as CalFresh or CalWORKs. If the county can complete the renewal this way, the member will receive a notice that they were automatically renewed.

Members who are dropped from Medi-Cal but think they are still eligible should first contact their local Medi-Cal office or a Health Enrollment Navigator in their county.

If they were discontinued because of missing information and are still within their 90-day “cure period,” the county will work with them to restore coverage. If the
county can’t reinstate them, they can [file an appeal](#) for a Medi-Cal Fair Hearing. For more information, see [KeepMediCalCoverage.org](#).

**Asset test eliminated**

Historically, Medi-Cal had both income and asset limits. The Affordable Care Act removed asset limits for most people effective Jan. 1, 2014, but retained them for some groups in certain Medi-Cal programs. These include people with disabilities, those in nursing homes or using long-term care and those who are also on Medicare. For the latter group of “dually eligible” people, Medi-Cal covers costs that Medicare does not, such as premiums and copayments.

Before 2022, the asset limit for seniors and people with disabilities was extremely low — $2,000 for one person or $3,000 for a couple. Some assets do not count toward this limit, such as a primary home, primary vehicle and retirement accounts if the person is taking required minimum distributions.

Starting July 1, 2022, these limits were raised dramatically — to $130,000 for one person and $195,000 for two. On Jan. 1, the asset test will be eliminated but there will still be income limits, which vary by program.

“The asset limit increase allowed a larger number of applicants to become eligible for Medi-Cal benefits, and allowed current Medi-Cal members to retain a larger amount of non-exempt assets and still be eligible for Medi-Cal,” the department says on its website.

It’s unclear how many more people will qualify when the asset test is eliminated. “People with limited income tend to have limited assets,” said Alice Burns, associate director of KFF’s Program on Medicaid and the Uninsured.
The change “will also help people who are already eligible to enroll in and maintain their coverage because they will not be required to document their assets during the application and renewal processes. Eligibility is renewed at least once a year,” she said.

People who might be newly eligible because of the asset test elimination can get help from their local Area Agency on Aging or their county health office.

**Managed care shakeup**

Most people enrolled in Medi-Cal are in managed care plans, which typically require members to use health care providers within their network. The state contracts with a small number of plans — some public, some commercial — in each county to serve members of that county.

As part of a managed care overhaul, Medi-Cal put its contracts in all counties up for competitive bidding. As a result, some Medi-Cal members in 21 counties will have to change plans next year because their old one is exiting. In some of these counties, new plans will enter. But in others, members will simply have fewer choices.

“There will be more counties with only one plan,” said Chris Perrone, a director with the California Health Care Foundation.

As part of a separate deal with Kaiser Permanente to increase its Medi-Cal enrollment by 25% over five years, Kaiser will be available in 10 new counties next year. It is already available in 22 counties, including all nine in the Bay Area.

Unlike other plans, however, Kaiser generally accepts new Medi-Cal members only if they have been with Kaiser (perhaps through an employer or individual plan)
within the past six or 12 months (depending on the county) or have a family member who is a Kaiser member. That won’t change next year, except the lookback will be 12 months in all counties. Also, current and former foster youth and people with both Medicare and Medi-Cal will be able to join even if they have neither prior Kaiser coverage or a family member with Kaiser.

In the Bay Area, the big change will be in Alameda and Contra Costa counties, where Anthem Blue Cross is exiting. In Alameda County, about 81,000 Anthem members will have to switch to the Alameda Alliance for Health — a public, not-for-profit agency — or to Kaiser if they meet the qualifications. In Contra Costa County, about 34,500 Anthem customers can choose the Contra Costa Health Plan or, if they qualify, Kaiser. Those losing Anthem have already been notified.

The Alliance and Anthem contract has about 92% of the same health care providers, said Matt Woodruff, the Alliance’s chief executive officer. As for the remaining 8%, if an Anthem member has seen a doctor or specialist in the past 12 months, and that provider is not in the Alliance’s network, the member may be able to continue to see that provider for up to 12 months by requesting “continuity of care.”

Medi-Cal’s managed care transition is also designed to improve patient outcomes by placing many new requirements on participating plans, such as reinvesting a portion of profits in their communities, increasing transparency, focusing more on primary care and having a chief health equity officer.

Kaiser direct

Another change is that, starting next year, Kaiser will have a direct contract with the state in all 32 counties where it offers Medi-Cal, which should help to streamline Medi-Cal members’ entry into Kaiser.
Currently, Kaiser has a direct contract with the state in five of its 22 counties, but in 17 others — including all Bay Area counties — it operates as a subcontractor through plan partners. In Alameda County, for example, Medi-Cal members would first go through the Alameda Alliance (the direct contractor) and then ask to enroll in Kaiser.

Next year, members will still have access to Kaiser doctors and facilities but will now deal directly with only Kaiser. “It streamlines entry into Kaiser Permanente,” said Kaycee Velarde, Kaiser’s executive director for Medi-Cal contracting and policy. Members won’t be getting “duplicate information or two IDs, and trying to figure out what to use.”

Existing members have been notified of the change and will get new ID cards. “It should feel like a very seamless transition,” she added.

**Correction:** A previous version of this article misstated the number of California counties in which Kaiser currently has a direct contract with the state. The correct number is five counties.

*Kathleen Pender is a freelance writer. Email: kathpender84@gmail.com X: @KathPender*

By Kathleen Pender

Kathleen Pender was a San Francisco Chronicle journalist for 36 years. After serving as a business reporter and editor, she wrote the Net Worth column from 2000 to 2021, where she explained how the big business and economic news of the day affected a household’s net worth. She majored in business journalism at the University of Missouri-Columbia and was a Knight-Bagehot fellow in business journalism at Columbia University.
SAN FRANCISCO

S.F.’s new IKEA has enlivened former downtown ‘dead spot’

IKEA has attracted enthusiastic downtown San Francisco shoppers since opening in August, although hopes that it would magically revitalize the blighted blocks around it may have been overblown.

WINE, BEER & SPIRITS

Buyers are now bidding for the future of S.F.’s Anchor Brewing

HEALTH

How to minimize COVID, flu and RSV risk this Thanksgiving

BAY AREA

BART and Muni are crowded again. Is Bay Area transit ridership finally back?
Thanksgiving forecast: Bay Area weather to shift throughout holiday weekend
B1. Approval of the Minutes of the October 25, 2023 Quality Professional Services Committee Meeting
QUALITY PROFESSIONAL SERVICES COMMITTEE MEETING
Wednesday, October 25, 2023
5:00pm-7:00pm

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

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

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

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

QUALITY PROFESSIONAL SERVICES COMMITTEE MEETING MINUTES

THE MEETING WAS CALLED TO ORDER AT 5:03 pm

Trustee Bhuket announced they would reorder the agenda. They would take roll, hear public comment, then go into closed session to hear the credentialling reports.

ROLL CALL WAS TAKEN AND THE FOLLOWING TRUSTEES WERE PRESENT: Taft Bhuket, MD, Kinkini Banerjee, Jennifer Esteen, David Sayen

ABSENT: None

PUBLIC COMMENT ON NON AGENDIZED ITEMS: None

Mr. Azizi said the Quality Professional Services Committee would meet in Closed Session to consider the credentialling items as set forth in the agenda.

A. REPORT/DISCUSSION: QPSC Chair
   Taft Bhuket, MD, Trustee

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

B1. Approval of the Minutes of the September 27, 2023 Quality Professional Services Committee Meeting

B2. Policies and Procedures

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

**System Wide Policies**
- Targeted Temperature Management Policy – TTM CONTROLLED SUBSTANCE MANAGEMENT
- GME - CLINICAL AND EDUCATIONAL WORK HOURS
- GME - KAISER OAKLAND/HIGHLAND OB/GYN RESIDENCY AHS COMMUNITY HOSPITALS
- GME - PROGRAM CLOSURE AND REDUCTION POLICY
- GME - RESTRICTIVE COVENANT POLICY
- Infusion Pump Policy
- BLOOD_PRODUCT_ADMINISTRATION_(TRANSFUSION)_33465_1
- AHS Code Status Policy
- Comfort Care Policy (CARE OF THE PATIENT AND FAMILY TRANSITIONING TO COMFORT CARE)
- Utilization Management Committee Plan
- Visiting Policy

B3. **Medical Staff Polices**

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

- Medical Staff Department Structure and Divisions

B4. **Revised Privilege Form**

- Addiction Medicine Multifacility

A motion was made by Trustee Banerjee and seconded by Trustee Esteen to approve the Consent Agenda.

**ACTION:** A motion was made and seconded to approve the Consent Agenda. A roll call vote was taken, and the motion passed.

**AYES:** Trustees Bhuket, Banerjee, Esteen, Sayen

**NAYS:** None

**ABSTENTION:** None
C. REPORT/DISCUSSION: Medical Staff Reports

- AHS Medical Staff: Lan Na Lee, MD (Chief of Medical Staff)
  Abid Mogannam, MD (SLH Leadership Committee Chair)
- AH Medical Staff: Nikita Joshi, MD (Chief of Medical Staff)

Trustee Esteen asked about the process for communicating survey ratings to doctors. Dr. Wills said part of the discussion was to work on how to disseminate information. It needed to end up at the front line, in addition to the Board.

Trustee Banerjee said they had to consider what it would take to bring our own employees and their families into AHS for care. Dr. Wills agreed. They wanted to provide the care they would provide for their families.

Trustee Esteen was out from 6:15 to 6:40

D. REPORT/DISCUSSION: Quality Reports

D1. Regulatory Affairs, Patient Safety, TNM Dashboard

Ana Torres, Vice President, Quality

Trustee Banerjee asked if the behavioral harm listed in the report was to patients and employees. Ms. Johnson confirmed that it was.

Trustee Bhuket asked if there were no goals for Ambulatory. Ms. Johnson said it was hard when there was only one event. They had opportunities to look for ambulatory sensitive harms. She wanted to try to give them more to report on to ensure the data was that low.

Trustee Bhuket said perhaps they should work with Dr. Mack and Mr. Fitzgerald to guide the selection of those goals.

Trustee Esteen asked when a patient submitted a request for a staff member to wash their hands if it would be captured. Ms. Johnson said it was more of a personal interaction. They wanted to make sure patients knew they could ask.

Trustee Bhuket asked how they know if they are hitting the handwashing goals. Ms. Johnson said they had unit-based auditing to look at staff going in and out of rooms and also secret shoppers.

Trustee Bhuket asked why the data was so high when it had been very low in the past. Ms. Johnson said there were several reasons including awareness and the auditing process.

Trustee Banerjee asked about ways they could stratify data. Ms. Johnson said they could stratify by the different screenings and also the overall, individual health screenings disaggregated by race.

Trustee Bhuket asked how the patient centered data was gathered. Ms. Johnson said the in-patients were surveyed by phone once they got home. ED, ambulatory surgery, and outpatient were reached out to via mail as well as email and text. At John George they handed out the surveys at discharge to protect the privacy of the patients.
Trustee Banerjee said it was exciting to see these data points as they heard from the community how important access was. It was great to see the work being done.

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

**E. REPORT/DISCUSSION: AHS Quality Retreat Update** (estimated 20 min)  
Felicia Tornabene, MD, Chief Medical Officer  
Ana Torres, Vice President, Quality  
Annette Johnson, Quality Analytics and PI, Director

**F. REPORT/DISCUSSION: Patient Safety Annual Report** (estimated 20 min)  
Darshawn Grewal, Patient Safety Director

Trustee Bhuket asked if the patient relations team was staffed to handle the patient behavior events. Ms. Grewal said it was important to have restoration of trust and to have those very sensitive conversations with impacted families. There was not the capacity to manage the amount of grievances they received at the level they wanted to do so. The resources were not there.

Trustee Sayen said there might be a bit of a post pandemic bounce because during the pandemic, there weren’t as many encounters happening. It took a lot of effort to manage grievances once they happened, but the more important thing was to not let them happen in the first place.

**G. INFORMATION: Planning Calendar/Issue Tracking**  
Taft Bhuket, MD, Chair

Mr. Azizi said the Quality Professional Services Committee would meet in Closed Session to consider item H2 as set forth in the agenda.

**H. CLOSED SESSION**

**H1. Consideration of Confidential Medical Staff Credentialing Reports**  
Chief of Staff, AHS Medical Staff  
Chief of Staff, AH Medical Staff

**H2. Regulatory Affairs, Risk Management, Patient Safety**  
[Health and Safety Code 101850(ai) (1)]

*(Reconvene to Open Session)*

**OPEN SESSION**

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

Mr. Azizi reported that the Committee met in Closed Session and considered credentialing reports for each of the medical staffs and approved credentials/privileges for fully qualified practitioners recommended by the medical staffs.
ADJOURNMENT:  7:30 pm

This is to certify that the foregoing is a true and correct copy of the minutes of the Quality Professional Services Committee meeting of October 25, 2023, as approved by the Quality Professional Services Committee on November 29, 2023:

_____________________________
Ronna Jojola Gonsalves
Clerk of the Board

APPROVED AS TO FORM:

Reviewed by: __________________________
Ahmad Azizi
General Counsel
B2. Policies and Procedures
<table>
<thead>
<tr>
<th>TOPIC or TITLE OF POLICY</th>
<th>Document Owners</th>
<th>Summary of Changes</th>
<th>Last Approved Date</th>
<th>Next review date after BOT approval</th>
<th>Purpose</th>
<th>History of Review Committee</th>
</tr>
</thead>
</table>
| AHS System Wide Policies & Procedures | Kruti Rawal PharmD | - Condense three site specific policies into one policy  
- Approved by System P&T 10/2023  
- Consent Item – Policy | 11/2025 | | |  
- P&T 10/2023  
- CPC 11/02/2023  
- AHS & AH MEC 11/15/2023 |
| Intravenous Admixture Program Policy | Ana Torres | - Revised | 11/2025 | | |  
- CPC 11/02/2023  
- AHS & AH MEC 11/15/2023 |
| Quality Assurance and Performance Improvement Annual Plan - QAPI 2024 | Thomishia Booker | - Revised | 11/2025 | | |  
- CPC 11/02/2023  
- AHS & AH MEC 11/15/2023 |
| Complimentary Local Transportation | Dr. Laura Lang | - Revised | 11/2025 | | |  
- CPC 11/02/2023  
- AHS & AH MEC 11/15/2023 |
02_INTRAVENOUS_ADMIXTURE_PROGRAM_POLICY_(33943_-1)
Policy Statement
The Department of Pharmacy at all acute care sites which include Wilma Chan Highland Hospital, San Leandro Hospital and Alameda Hospital shall ensure the quality, safety, and regulatory compliance of all compounded sterile preparations administered to patients within this facility.

Purpose
The Department of Pharmacy shall follow policies and procedures outlined in this document to comply with the guidelines, standards, and requirements for Compounded Sterile Preparations (CSPs) established by the United States Pharmacopeia (USP) – General Chapter <797> and the American Society of Health-System Pharmacists (ASHP) in accordance with Federal and California State Board of pharmacy laws and regulations.

Scope
This system policy encompasses all the campuses of Alameda Health System that engage in the practice of sterile compounding in accordance with Federal and California State board of pharmacy laws and regulations.

Each individual campus is responsible for creating, implementing, execution and maintenance of their own Site Specific Standard Operating Procedure (SS-SOP) to outline the campus specific guidelines as defined by this Policy.

Definitions
1. Administration = direct application of a sterile product or preparation to a single patient by injecting, infusing or otherwise providing a sterile product or preparation in its final form.
2. BSC = Biological Safety Cabinet
3. BUD = Beyond Use Date – defined as the date, or hour and date, after which a CSP must not be used. The BUD is determined from the date and time that preparation of the CSP is initiated
4. Category 1 = are compounded under the least controlled environmental conditions and therefore are assigned a BUD of 12 h or less at controlled room temperature or 24 h or less when refrigerated
5. Category 2 = require more environmental controls and testing than category 1 CSPs and may be assigned a BUD of greater than 12 hours at controlled room temperature or more than 24 hours if refrigerated, but not to exceed the limits established
6. Category 3 = preparations undergo sterility testing, supplemented by endotoxin testing when applicable and have more requirements than category 2 CSPs for personnel qualification, use of sterile garb, use of sporicidal disinfectants, frequency of monitoring, and stability determination
7. CSP = Compounded Sterile Preparations
8. Expiration Date = The time during which a product can be expected to meet the requirements of the USP-NF monograph, or maintain expected quality provided it is kept under the specified storage conditions
9. Designated Person: One or more individuals assigned to be responsible and accountable for the performance and operation of facility and personnel as related to the preparation of CSP’s.
10. GFT = gloved fingertip and thumb sampling
11. Sterile Compounding = defined as combining, admixing, diluting, pooling, reconstituting, repackaging or otherwise altering a drug product or bulk drug substance to create a sterile preparation.
2. CSPs include:
   a. Injections, including infusions
   b. Irrigations for internal body cavities
   c. Ophthalmic dosage forms
   d. Aqueous preparations for pulmonary inhalation
   e. Baths and soaks for live organs
   f. Implants
   g. Hazardous Drugs
3. Immediate Use CSPs = a sterile preparation prepared outside of an air quality less than ISO class 5, the preparation involves not more than 3 different sterile products
4. LAFW = Laminar Air Flow Workbench
5. PECs = Primary Engineering Controls; includes LAFW and BSC
6. SECs = Secondary Engineering Controls; a temperature and air flow-controlled environment in which PECs are placed
7. Preparation Per Approved Labeling = Compounding does not include mixing, reconstituting, or other such acts that are performed in accordance with directions in approved labeling provided by product's manufacturer. Preparing a manufactured sterile product per the manufacturer's approved labeling is outside the scope of USP chapter 797 only if the product is prepared as a single dose for an individual patient; and the approved labeling includes information for the diluent, resulting strength, container closure system, and storage time.
1. Proprietary bag and vial systems = Docking and activation of proprietary bag and vial systems in accordance with the manufacturer’s labeling for immediate administration to an individual patient is not considered compounding and may be performed outside of an International Organization for Standardization (ISO) Class 5 environment.
2. Repackaging: Repackaging of a sterile product or preparation from its original container and into another container must be performed in accordance with the requirements in USP Chapter <797>.

PROCEDURES
A. Pharmacist-in-Charge (PIC) Responsibility:

1. On a biennial basis, before July 1 of every odd-numbered year, the pharmacist-in-charge (PIC) shall review and complete the self-assessment form 17M-39 (Rev. 01/2022) for compounding. This may be obtained from the California Board of Pharmacy website
2. On an annual basis, the pharmacist-in-charge (PIC) shall review this Intravenous Admixture Program policy and standard operating procedures for compliance with any and all changes related to the practice of compounding sterile preparations.
3. Any changes to policy, procedures, and standard operating processes will be communicated to assigned compounding staff through any/or all of the following: email, newsletter, pharmacy huddles, training and/or additional competency testing.
4. The PIC, or designated person(s) are responsible for creating and implementing a training program for personnel and ensure that all personnel who prepare CSPs:
   • have direct oversight of compounders;
   • perform restocking or cleaning and disinfection duties;
• are initially trained and qualified by demonstrating the knowledge and competency in maintaining a sterile compounding area before being allowed to perform their job functions independently.
• Training may be performed by the designated person(s) or an assigned trainer.

B. **Pharmacy Personnel Responsibilities:**

1. Only pharmacy staff who successfully completed all required IV admixture competency training, aseptic media fill manipulation skills testing and fingertip glove sampling testing, shall be allowed to prepare compounded sterile products (CSPs).

2. Personnel allowed to perform tasks in a sterile compounding environment shall receive and complete appropriate didactic and calculation competency initially and at least every 12 months in regard to appropriate sterile compounding principles and practices.

3. Garbing and Hand Hygiene competencies are administered biannually for personnel preparing category 1 and 2 CSPs. (Please See SOP – Training of Sterile IV Compounding Staff and Support Personnel)

4. Pharmacy Technician: Each assigned technician is responsible to:
   a. Garb and perform proper hand hygiene (Refer to SOP – Garbing for Non-Hazardous and Hazardous Parenteral Compounding)
   b. Clean the BSC prior to compounding
   c. Work only on one drug preparation at a time
   d. Select appropriate drugs, additives, diluents, solutions, supplies, and other devices needed and calculate quantities for compounding based on the prescription
   e. Check the condition of the packaged items, their labels and expiration dates
   f. Any damaged or outdated items shall be removed from the area and will be returned/credited from the manufacturer or discarded.
   g. Items used in the hood are kept in direct airflow to minimize the chance of airborne contamination.
   h. Visually inspect for particulates, turbidity, or other unexpected changes during the compounding process.
   i. Place all necessary items in the work area before beginning admixture to prevent frequent interruptions and breach of aseptic technique. Keep all unnecessary items out of the hood work area.
   j. Record all drugs compounded (see Record Keeping)
   k. Notify the pharmacist immediately upon completion of a STAT or NOW medication
   l. Properly dispose of needles, syringes, and supplies used in the designated containers
   m. Stock the IV room with sufficient quantity of medications, solutions, and supplies.
   n. All exterior packaging of items and supplies must be wiped with alcohol before introduction into the IV room (i.e. IV bags, vials, etc.)
   o. Order supplies needed to replenish stock
   p. Complete and document the following:
      i. Hood cleaning (each shift)
### INTRAVENOUS ADMIXTURE PROGRAM POLICY

**LEVEL**

- [ ] System
- [ ] Site

**EFFECTIVE DATE:** Not Approved Yet

**LAST REVIEW DATE:** No Review Date

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- ii. IV room bins, racks, shelves, carts cleaning (weekly)
- iii. All temperature logs (twice daily)

- q. Abide by all compounding preparation techniques and procedures as defined by hospital policy (Please See SS-SOP – Sterile Hazardous and Non-Hazardous Compounding Preparations)

5. **Pharmacist(s) is(are) responsible to:**
   - a. Check all IV orders for incompatibilities (physical, chemical, and therapeutic), allergies, instabilities, contraindications, dosage, appropriate diluents, infusion time and rate using professional knowledge, appropriate references, etc. Contact the prescriber if problems are identified and communicate with the patient’s nurse if any delay is expected.
     - i. If physical compatibility, stability, or solubility of an admixture is dependent on solution pH, temperature, or other factors beyond the control of the pharmacy department, use of a final in-line filter may be recommended.
   - b. Enter IV orders into the pharmacy computer system accurately with appropriate administration times.
   - c. Ensure the proper storage and delivery of the product to the patient based on the drug’s package insert or manufacturer recommendations
   - d. Verify all components prepared by the technician for the compounding process BEFORE and AFTER compounding
     - i. Inspects the expiration date and integrity of each drug, diluent, and solution used.
     - ii. Inspects each vial for the appropriate amount withdrawn to ensure potency and review the appropriate calculations performed to ensure appropriate strength of the final CSP.
     - iii. Inspects each vial for the absence of harmful levels of contaminants such as particulates or discoloration to ensure quality of each drug ingredient used.
     - iv. Initial all completed CSPs labels prior to dispensing
   - e. Ensure all CSPs are labeled appropriately and include:
     - i. Hospital pharmacy name
     - ii. Minimum of 2 patient identifiers
     - iii. Patient room number
     - iv. Name and concentration/strength of ingredients of the CSP
     - v. Date/time drug is compounded
     - vi. Route and rate of administration
     - vii. Instructions for storage and handling (i.e. Refrigerate, protect from light), if applicable.
     - viii. Final expiration date/time of the CSP

6. **Personal Hygiene and Garbing**
   - a. Individuals entering a compounding area must be properly gowned and garbed.
   - b. Personnel must maintain proper personal hygiene to minimize risk of contamination to the environment and CSPs
   - c. Food and drink are not permitted within the compounding areas
   - d. Personnel must remove:
     - i. Outer garments (e.g., bandanas, coats, hats, jackets, sweaters, or vests)
     - ii. Cosmetic products
C. Training, Competencies, and Evaluation in Aseptic Manipulation Skills

1. Training Program
   a. Personnel who prepare CSPs must complete and pass competencies before being assigned to sterile compounding activities.
   b. Observation: During the fingertip and media-fill tests, the personnel’s garbing, hand hygiene, and sterile technique are validated by observation by another staff member trained in the compounding of sterile products.
   c. The following shall be assessed initially and at a minimum every 12 months:
      i. Cleaning and Disinfection
      ii. Didactic coursework, pharmacy calculations [examination questions shall be updated annually]
      iii. Aseptic technique
      iv. Documentation of compounding process
      v. Proper use of PECs
      vi. Principles of movement of materials and personnel within the compounding area
   d. Personnel must score at least 90% on all didactic examinations to pass.
   e. Results of all competency evaluations and corrective actions performed for failures must be documented and documentation maintained to provide a record and assessment of personnel competency. Documentation shall include:
      i. Name of Person Evaluated
      ii. Evaluation date/time
      iii. Media components used including manufacturer, lot/expiration dates
      iv. Temperatures for each interval of incubation
      v. Dates of incubation
      vi. Results
      vii. Name or identifier of competency observer and documenter of results

2. Garbing and Hand Hygiene Competency
   a. Compounding personnel must successfully complete an initial garbing competency evaluation with no fewer than 3 separate garbing processes in succession - failure of any
of the 3 initial garbing competency evaluations requires repeat testing until personnel completes 3 garbing evaluations successfully in a row.

i. Each garbing competency consists of a visual observation and a gloved fingertip and thumb (GFT) sampling of both hands

ii. Failure is indicated by visual observation of improper hand hygiene and/or garbing procedures

iii. Failure of gloved fingertip/thumb testing is sampling results that exceed the action levels described below in section d.v:

b. After successful initial competency demonstration, personnel shall complete the garbing competency every 6 months for compounding of category 1 and category 2 CSPs

c. Personnel who have direct oversight of compounding personnel, but do not compound, may complete garbing competency every 12 months. Personnel who have direct oversight of compounding are not allowed to compound unless they successfully complete the garbing competency at the same requirement for compounding personnel.

d. Competency in garbing and hand hygiene shall be assessed by means of:
   i. Finger-tip glove testing for aseptic manipulative skills initially and every 6 months.
   ii. A qualified evaluator will have each personnel sample the glove fingertips onto a TSA with lecithin and polysorbate 80 agar media after proper garbing and hand hygiene but prior to applying any disinfectant.
   iii. Three sets of gloved fingertips samples should be performed before initial compounding is allowed.
   iv. Plates are covered, inverted, and placed into an incubator at 30-35°C for no less than 48 hours and then at 20 to 25 °C for no less than 5 days.
   v. Personnel must have a result of zero (0) colony forming units (CFUs) at the end of the incubation period to pass.

3. Aseptic Manipulation Competency
   a. Pharmacy personnel shall successfully complete an aseptic manipulation competency prior to beginning the compounding of category 1 and category 2 CSPs.
   b. The aseptic manipulation competency evaluation consists of visual observation, media fill testing, followed by post compounding gloved fingertip and thumb sampling, as well as surface sampling of the direct compounding area.
   c. Personnel compounding category 1 and category 2 CSPs shall successfully complete an aseptic manipulation competency initially and every 6 months.
   d. Personnel who have direct oversight of compounding personnel, but do not compound, may complete aseptic manipulation competency every 12 months. Personnel who have direct oversight of compounding are not allowed to compound unless they successfully complete the aseptic manipulation competency at the same requirement as for compounding personnel.
   e. Media-fill testing for aseptic manipulative skills shall be performed initially and every 6 months.
      i. Immediately following completion of the media-fill test, GFT sampling must be performed on both hands inside of an ISO class 5 PEC.
ii. Surface sampling of the direct compounding area must occur after compounding completion. A failure in the media fill, GFT, or surface sample constitutes an overall failure of the aseptic manipulation competency.

iii. Bags are examined daily for turbidity. Turbidity indicates positive growth of microorganisms which fails the test.

iv. If the minibag is clear, the test is negative, and the compounding personnel has passed the test.

v. Successful completion of GFT post compounding is defined as less than or equal to 3 CFU as a total from both hands. Microbial identification is not required for gloved fingertip and thumb sampling.

f. Media fill tests shall simulate the most difficult and challenging aseptic compounding procedures encountered; the components shall be replaced with the use of soybean-casein digest media. The media fill test must capture factors that may affect sterility of a CSP including but not limited to:

i. Length of the process that can create contamination risk (e.g., operator fatigue, quality of equipment)

ii. Number of aseptic additions or transfers

iii. Number, type, and complexity of manipulations

iv. Number of personnel in the buffer room or SCA

g. If commercial sterile microbial growth media is used, a certificate of analysis must be on record from the supplier stating that the lot of growth media will support the growth of microorganisms.

h. Growth media shall be stored according to manufacturer instructions.

4. Any employee who fails any of the above competencies will be unable to work in the IV compounding room until competence is certified and will be placed on a performance improvement plan. The employee will be retrained and re-evaluated to assure correction of all aseptic practice deficiencies and will repeat the competency testing in 6 months.

5. Records of training and demonstrated competence shall be available for each individual and retained for three years beyond the period of employment.

D. Facilities and Equipment Controls

1. Facility Design

a. The surfaces, ceilings, walls, floors, doors, door frames, fixtures, shelving, work surfaces, counters, and cabinets in the classified clean room area must be smooth, impervious, free from cracks and crevices, and non-shedding so they may be cleaned and disinfected and to minimize spaces in which microorganisms and other contaminants can accumulate.

b. Surfaces should be resistant to damage by cleaning agents, sporicidal and other types of disinfectants and tools used to clean.

c. Seals and sweeps should not be installed at doors between buffer rooms and anterooms. Access doors should be hands free. Tack mats must not be placed within ISO classified areas.

d. Junctures between the ceiling and the walls and between the walls and the floor must be sealed to eliminate cracks/crevices where dirt can accumulate.
e. If ceilings consist of inlaid panels, panels must be caulked around each panel to seal them to the support frame.

f. Walls must be constructed of durable material and integrity must be maintained. Panels must be joined together and sealed to each other and the support structure.

g. Floors must include coving to the sidewall, or the juncture between the floor and the wall must be caulked.

h. Ante rooms must have a line of demarcation to separate the clean side from the dirty side. The anteroom shall be entered through the dirty side, and the clean side is closest to the buffer room.

i. Classified areas should minimize dust collecting overhangs such as ledges and windowsills. If present, the overhangs, and windowsills must be easily cleanable.

j. Surfaces within an SCA should be smooth, impervious, free from cracks and crevices, and non-shedding so that they can be easily cleaned and disinfected to minimize microorganisms and other contaminant accumulation.

k. Surfaces in an SCA should be resistant to damage by cleaning agents, sporicidal and other types of disinfectants and tools used to clean.

l. SCA areas should minimize dust collecting overhangs such as ledges and windowsills. If present, the overhang and windowsills must be easily cleanable.

m. Water Sources and Sink Placement: The facility where CSP’s are prepared must be designed so that activities such as hand hygiene and garbing will not adversely affect the ability of the PEC to function as designed. Sinks should enable hands-free use.

   i. If the sink is located outside of the anteroom, it must be located in a clean space to minimize the risk of bringing contaminants into the anteroom
   ii. If the sink is located outside of the anteroom, it may be placed on either the clean or the dirty side of the anteroom.
   iii. The buffer room must not contain plumbed water sources.
   iv. The anteroom must not contain floor drain(s)
   v. In a facility with an SCA design, a hand-washing sink must be placed not closer than 1m to the PEC and may be either inside the SCA or in close proximity to the SCA.

2. Ante-area
   a. Environmental services (EVS) staff will clean floors daily when no aseptic operations are in progress and document the cleaning on the EVS cleaning log.
   b. Racks, bins, equipment, and shelving will be cleaned weekly and documented on the EVS cleaning log.
   c. Ceilings and walls will be cleaned weekly by EVS staff and documented on the EVS cleaning log.
   d. Air quality testing will be done every 6 months and surface quality testing will be done every month by a qualified certification company.

3. Buffer Area
   a. Environmental services (EVS) staff will clean floors daily when no aseptic operations are in progress and document the cleaning on the EVS cleaning log.
b. Racks, bins, equipment, and shelving will be cleaned weekly and documented on the EVS cleaning Log.

c. Ceilings and walls will be cleaned weekly by EVS staff and documented on the EVS cleaning log.

d. Air quality testing will be done every 6 months and surface quality testing will be done every month by a qualified certification company.

e. Air pressure gradients between the buffer area and the ante area will be monitored daily.

4. Equipment Controls

a. All intravenous (IV) solutions with additives made in the pharmacy shall be prepared in a PEC, either a horizontal laminar airflow workbench (LAFW) or in a vertical LAFW which is also known as a Class II Biological Safety Cabinet type B2 (BSC) and dispensed by the pharmacy department.

b. Compounded sterile products shall be prepared in an ISO Class 5 environment (LAFW or BSC) located within an ISO Class 7 buffer area and separated from the pharmacy proper by an ante-area.

c. The exception to this shall be for “Immediate Use” products which may be prepared by trained registered nurses or providers in an urgent/emergent situation.

d. The PECs shall be located in a buffer room of a clean room suite or SCA that minimizes conditions that may increase risk of microbial contamination.

e. A PEC may be located within an unclassified area without an anteroom or buffer room; this design is referred to as a segregated compounding area (SCA). The SCA must be located away from unsealed windows, doors that connect to outdoors, and traffic flow. The area within 1 meter of the PEC should be dedicated only for sterile compounding.

f. ISO classified anterooms and buffer rooms must be separated from surrounding unclassified areas by fixed walls and doors. Classified rooms must be equipped with a pressure-differential monitoring system.

Summary of Minimum Requirements for Placement of PECs for Compounding of Non-Hazardous CSPs

<table>
<thead>
<tr>
<th>PEC Type</th>
<th>Device Type</th>
<th>Placement for Compounding Only Category 1 CSPs</th>
<th>Placement for Compounding Category 2 and 3 CSPs</th>
</tr>
</thead>
<tbody>
<tr>
<td>LAFS</td>
<td>LAFW</td>
<td>Unclassified SCA</td>
<td>ISO Class 7 positive pressure buffer room with ISO class 8 positive pressure anteroom</td>
</tr>
</tbody>
</table>
5. Air Quality, Air Exchanges, Air Pressure Differential and Monitoring
   a. Clean room suites are required to maintain adequate HEPA filtered airflow to buffer rooms and ante rooms. Air supplied to the cleanroom suite must be introduced through HEPA filters that are located in the ceiling of the buffer and anteroom. Air quality standards are listed in the table below:

   b. A minimum of 30 total HEPA filtered air changes per hour (ACPH) must be supplied to ISO class 7 rooms
      i. The total HEPA filtered air change rate must be adequate to maintain ISO class 7 during dynamic operating conditions.
      ii. At least 15 ACPH of the total air change rate must come from the HVAC through HEPA filters located in the ceiling
      iii. The HEP filtered air from PECs when added to the HVAC-supplied HEPA filtered air must increase the total air changes to at least 30 ACPH

   c. A minimum of 20 total HEPA filtered ACPH must be supplied to ISO Class 8 rooms
      i. The total HEPA filtered air change rate must be adequate to maintain ISO class 8 during dynamic operating conditions.
      ii. At least 15 ACPH of the total air change rate in a room must come from the HVAC through HEPA filters located in the ceiling

   d. Air Returns in the cleanroom must be low on the wall unless a visual smoke study demonstrates absence of stagnant airflow.

### Summary of ISO Classification and Particulate Matter in Room Air

<table>
<thead>
<tr>
<th>ISO Class</th>
<th>Particle Count per Cubic Meter</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>35.2</td>
</tr>
<tr>
<td>4</td>
<td>352</td>
</tr>
<tr>
<td>5</td>
<td>3520</td>
</tr>
<tr>
<td>6</td>
<td>35,200</td>
</tr>
<tr>
<td>7</td>
<td>352,000</td>
</tr>
<tr>
<td>8</td>
<td>3,520,000</td>
</tr>
</tbody>
</table>

### Summary of ACPH Requirements for Non-Hazardous Sterile Compounding Areas

<table>
<thead>
<tr>
<th>Compounding Area</th>
<th>ACPH Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unclassified SCA</td>
<td>No requirement</td>
</tr>
<tr>
<td>ISO Class 7 room(s)</td>
<td>Greater than or equal to 30 ACPH</td>
</tr>
<tr>
<td>ISO Class 8 room (s)</td>
<td>Greater than or equal to 20 ACPH</td>
</tr>
</tbody>
</table>
6. Air Pressure Differential Monitoring:
   a. Air pressure gradients between the buffer room, ante-area, and the pharmacy proper shall be
      monitored continuously using a pressure differential monitoring device and documented at
      least daily when compounding is occurring.
   b. Continuous air pressure differentials are required to minimize airflow from an area with
      lower air-quality classification to an area of higher air quality classification.
   c. No pressure differential is required between an SCA and the surrounding areas.

   ![Air Pressure Differential Monitoring Chart]

   **Air Pressure Differential Range Requirements**
<table>
<thead>
<tr>
<th>Type of Pressure Gradient</th>
<th>Range</th>
<th>Alarm Set Point</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive (+)</td>
<td>0.02 to 0.05 &quot;WC</td>
<td>Less than (+) 0.02</td>
</tr>
<tr>
<td>Negative (-)</td>
<td>-0.01 to -0.03 &quot;WC</td>
<td>More than (-) 0.01</td>
</tr>
</tbody>
</table>

7. Temperature and Humidity Monitoring:
   a. The cleanroom suite should be maintained at a temperature of 20 °C (68 F) or cooler and a
      relative humidity of 60% or below.
   b. Temperature and humidity must be monitored and documented daily for each day that
      compounding activities are performed.
   c. Temperature and humidity in the cleanroom suite must be controlled through a heating,
      ventilation, and air conditioning (HVAC) system.
   d. Free standing air conditioners, humidifiers, and dehumidifiers must not be used within the
      classified areas or the SCA.

8. Primary Engineering Controls (PECs) and Equipment:
   a. Horizontal Laminar Airflow Workbench (LAFW):
      i. Refer to SOP – Cleaning & Disinfecting Sterile Compounding Area – for guidance
         on cleaning procedures and requirements
      ii. Refer to SOP – Quality Assurance of Compounded Sterile Products and
           Certification of Sterile Compounding Area – for guidance on certification
            procedures and requirements
   b. Biological Safety Cabinet (BSC):
      i. Refer to SOP – Cleaning & Disinfecting Sterile Compounding Area – for guidance
         on cleaning procedures and requirements
      ii. Refer to SOP – Quality Assurance of Compounded Sterile Products and
           Certification of Sterile Compounding Area – for guidance on certification
            procedures and requirements
   c. Refrigerators
      i. Temperatures will be recorded and maintained in accordance with hospital policy.
         (Please See AHS Medication Storage policy)
   d. Incubators
      i. Temperatures will be recorded and maintained in accordance with hospital policy.
         (Please See AHS Medication Storage policy)
   e. (If applicable) Measuring equipment will be calibrated and certified annually by the
      California Department of Weights and Measures.
E. Sterile Compounding Area Certification and Recertification

1. Designated Person(s) Responsibilities:
   a. The designated person(s) must ensure that each area and PEC meet the classified air quality standard(s) for appropriate activities to be conducted in those areas.
   b. A corrective action plan must be implemented and documented in response to any out-of-range results.
   c. Data collected in response to corrective actions must be reviewed to confirm that the actions taken have been effective.

2. PEC, SEC Certification and Frequency:
   a. Certification of the classified areas including the PEC must be performed initially, and at least every 6 months. Testing must include:
      i. Airflow testing
      ii. HEPA Filter Integrity Test
      iii. Total Particle Count
      iv. Dynamic Airflow Smoke Patter Test
   b. Classified areas must be recertified if there are changes to the areas including, redesign, construction, replacement, or relocation of any PEC
   c. Classified areas must be recertified if there are alterations in the configuration of the room that may affect airflow or air quality
   d. Number of persons present in PEC and SEC during total particle count testing and dynamic airflow pattern certification testing must be documented
   e. All records must be reviewed by designated person(s) to ensure that the classified environments meet the minimum requirements.
      a. Documentation of review must occur. Any corrective action must also be documented.

3. Microbiological Air and Surface Monitoring
   a. The monitoring program involves collection and evaluation of samples from various air and surface locations. Results of microbiological air and surface sampling shall be reviewed in conjunction with personnel data to assess the state of control and identify potential risks of contamination.
   b. Microbiological air and surface sampling must be conducted in all classified areas during dynamic operating conditions
   c. The microbiological air and surface monitoring program must be clearly described in the facility’s SOP, which must include a diagram of sampling locations, procedures for collecting samples, frequency of sampling, size, time of day of sampling in relation to activities in the compounding area, and action levels that will trigger corrective action.
   d. Air and surface sampling must be incubated in an incubator at the temperatures specified.
   e. Incubator must be placed in a location outside of the of the sterile compounding area.
   f. The incubator temperature must be monitored during incubation using either manual or continuous recording device.
g. Results must be reviewed and documented for air and surface sampling.
h. Sampling must include:
   i. Viable impact volumetric airborne particulate sampling
   ii. Surface sampling

i. Viable Air Sampling must be performed at least every 6 months
j. Sterile Compounding Areas that compound category 1 and 2 CSPs must perform viable surface sampling at least monthly.

<table>
<thead>
<tr>
<th>Compound Type</th>
<th>Viable Sample Type</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category 1 &amp; 2</td>
<td>Air</td>
<td>Every 6 months</td>
</tr>
<tr>
<td>Category 1 &amp; 2</td>
<td>Surface</td>
<td>Every 1 month</td>
</tr>
</tbody>
</table>

4. Microbiological Sampling Data Evaluation and Action Levels
   a. Evaluation of the CFU counts against the action levels referenced and previous data shall occur to identify any adverse results or trends in environmental monitoring.
   b. If two sampling media devices are collected at a single location, all recovered growth on each must be documented and action levels applied to each sampling media device separately.
   c. If action levels are exceeded, the cause must be investigated, and corrective action taken.
   d. Data collected as part of a corrective action plan must be reviewed to confirm effectiveness. Corrective action plan must be dependent and responsive to the CFU count and types of microorganisms recovered. The investigation should include an evaluation of trends.
   e. If measured levels exceed the action limits, an attempt must be made to identify microorganisms to the genus level.
   f. The corrective action plan must be documented.

**Action Levels for Surface Sampling**

<table>
<thead>
<tr>
<th>ISO Class</th>
<th>Surface Sampling Action Levels (CFU/media device)</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>&gt;3</td>
</tr>
<tr>
<td>7</td>
<td>&gt;5</td>
</tr>
<tr>
<td>8</td>
<td>&gt;50</td>
</tr>
</tbody>
</table>

**Action Levels for Air Sampling**

<table>
<thead>
<tr>
<th>ISO Class</th>
<th>Air Sampling Action Levels [CFU/Cubic Meter (1000 liters) of air/media device]</th>
</tr>
</thead>
</table>
F. Cleaning of Sterile Compounding Area(s)
1. Refer to SOP – Cleaning & Disinfecting Sterile Compounding Area for Pharmacy & Supporting Personnel
   a. All cleaning and disinfecting activities must be performed by trained and appropriately garbed personnel using facility approved agents and procedures.
   b. Cleaning must be performed in the direction of cleanest to dirtiest areas.
   c. Floor Mops may be used to clean a non-hazardous buffer room and ante room but in that order to ensure areas are being cleaned from most clean to dirty.
   d. Cleaning equipment used in HD compounding areas may not be used to clean any other areas.
   e. All documentation logs for cleaning shall be maintained and stored in the pharmacy for three years from when it was created.
   f. Cleaning of surfaces in classified areas used to prepare category 1 and 2 CSPs must be:
      i. Cleaned
      ii. Disinfected
      iii. Sporicidal Disinfectants applied
   g. Environmental services (EVS) staff will perform the following when no aseptic operations are in progress and document in the EVS cleaning log
      i. Clean and sanitize IV room floors and empty trash daily
      ii. Clean racks, bins, equipment, exterior workbench surfaces, ceilings and walls shelving weekly with approved disinfectant solution
      iii. Non-shedding wipes and mops are dedicated for Pharmacy use only
   h. Pharmacy staff will perform and document the following in the cleaning log:
      i. Clean sink area, IV room counters, work-top surfaces, and baskets daily
      ii. Clean IV hood(s) each shift and as needed.

G. Storage and Handling of CSPs
1. Compounding personnel are responsible for ensuring that CSPs are accurately identified, measured, diluted, mixed, and are packaged, sealed, labeled, stored, dispensed, and distributed appropriately.
2. Solutions, medications, supplies, and equipment used to prepare sterile products will be stored in accordance with manufacturer or USP requirements.
3. When CSPs are known to have been exposed to storage or temperatures outside of the recommended parameters, the manufacturer will be contacted for specific lot and expiration information and instructions for shortened dating or disposal.
4. Temperatures in refrigerators and/or freezers used to store medications and compounded sterile products will be monitored and documented twice daily if such monitoring is not done through the Pyxis Smart Remote System.

5. When a temperature falls out of range, engineering will be contacted, and documentation of out-of-range temperatures will be recorded.

6. Cytotoxic drugs (if any) shall be handled and safely disposed of in accordance with the AHS policy on Medications: Hazardous Drugs Preparation and Handling.

7. Spills of hazardous drugs shall be handled and cleaned up using chemo spill kits, material safety data sheets (MSDS) and in accordance with Occupational Safety and Health Administration (OSHA) laws and regulations.

8. Medications, supplies, and compounding equipment will be stored on shelves, cabinets, and carts to facilitate appropriate cleaning.

9. Products that have exceeded their expiration date will be removed from active storage areas and will be placed in a segregated, clearly defined area of the pharmacy.

10. Before any item is brought into the clean side of an anteroom, placed into a pass-through, or brought into the SCA, it must be wiped with a sporidical disinfectant, EPA-registered disinfectant, or sterile 70% IPA using low-lint wipes by personnel wearing gloves.
    a. The wiping procedure should not compromise the packaging integrity or render the product label illegible.

11. Before any item is introduced into the PEC, it must be wiped using sterile 70% IPA using low-lint wipes and allowed to dry before use.
    a. The wiping procedure should not compromise the packaging integrity or render the product label illegible.

12. Before use, each medication, ingredient, and container will be visually inspected for damage, defects, and expiration date.

13. Critical sites must be wiped with sterile 70% IPA in the PEC to provide both a chemical and mechanical action to remove contaminants. The sIPA must be allowed to dry before entering the package.

H. Record Keeping of Compounded Sterile Products

1. Master Formula Records
   a. No drug product may be compounded until the pharmacy has first prepared a written master formula record that includes at least the following elements:
      i. Name and Strength of the compounded drug preparation
      ii. Active ingredients to be used
      iii. Equipment to be used
      iv. Inactive ingredients to be used.
      v. Process and/or procedure used to prepare the drug.
      vi. Quality reviews required at each step-in preparation of the drug.
      vii. Post-compounding process or procedures required, if any.
      viii. Expiration dating/Beyond Use dating requirements.
      ix. Instructions for product labeling, storage, and handling.

2. Where a pharmacy does not routinely compound a particular drug product, the master formula record for that product may be recorded on the prescription document itself.
3. The pharmacy maintains formula record(s) for each compounded drug product. These records are maintained and readily retrievable for at least three years from the date the record was created. The record shall include:
   a. The master formula record
   b. Active ingredient used
   c. Inactive ingredient used
   d. IV solution or diluents
   e. Date the drug product is compounded
   f. Drug lot number, manufacturer, expiration date and quantity or volume of each component used in preparing the drug product
   g. Two patient identifiers and order number
   h. The quantity or amount of the final compounded drug product
       i. Pharmacy shall maintain records of the proper acquisition, storage, and destruction of chemicals, bulk drug substances, drug products and components used in compounding
       ii. Chemicals, bulk drug substances, drug products, and components used to compound drug products shall be obtained from reliable suppliers. The pharmacy shall acquire and retain any available certificates of purity or analysis for chemicals, bulk drug substances, drug products, and components used in compounding. Certificates of purity or analysis are not required for products that are approved by the Food and Drug Administration
   j. Equipment used in compounding the drug product
   k. Pharmacy assigned reference or lot number for the compounded drug product
   l. Technician initial who prepared the drug product
   m. Pharmacist initial who reviewed the final drug product
   n. Beyond Use Date (BUD) of the final compounded drug product

I. Beyond Use Date Determination

1. CSPs prepared by the pharmacy department will have appropriate beyond use dates clearly indicated on the label.
2. Beyond-use dates are assigned according to the chemical and physical stability of the medication and based on USP <797> guidelines established for category 1, 2, and 3 products for sterility. The dates shall be supported by references, literature searches, written documentation, and/or published studies from reliable sources.
3. Product labels shall be legible and accurate indicating the date and time of beyond use or expiration.
4. Beyond-Use Dating will apply to the following:
   a. Compounded Intravenous Admixtures – beyond use dating is based on USP <797> guidelines and is determined by the risk level assigned to the product.
   b. Category 1: must be prepared in an ISO Class 5 or better primary engineering control that may be placed in an unclassified segregated compounding area. Beyond use dating is determined by medication stability, but cannot exceed the following:
       i. 12 hours at CRT (controlled room temperature)
       ii. 24 hours in a refrigerator
c. **Category 2:** CSPs must be prepared in a cleanroom suite. Beyond use dating is determined by medication stability, but depending on the following factors, cannot exceed the following:
   i. If aseptically processed, no sterility testing, and only sterile starting components:
      1. 4 days at CRT
      2. 10 days in a refrigerator
      3. 45 days in a freezer
   ii. If aseptically processed, no sterility testing and one or more nonsterile starting component(s)
      1. 1 day at CRT
      2. 4 days in a refrigerator
      3. 45 days in a freezer

d. **Proprietary bag and vial system** -
   i. Docking for immediate use is not considered compounding
   ii. Docking for future activation and administration is considered compounding
      a. Cannot exceed BUD specified in manufacturer’s labeling

### J. Compounded Sterile Product Recall
Steps to be taken in the event of a drug recall. Based upon California Business and Professional Code Section No. 4127.9(a):
A pharmacy licensed pursuant to Section 4127.1 or 4127.2 that issues a recall notice regarding a sterile compounded drug shall, in addition to any other duties, contact the recipient pharmacy, prescriber, or patient of the recalled drug and the board as soon as possible within 12 hours of the recall notice if both of the following apply:
- (1) Use of or exposure to the recalled drug may cause serious adverse health consequences or death.
- (2) The recalled drug was dispensed, or is intended for use, in this state for more details please refer to Medication – Drug Recall policy.

### K. Adverse Drug Reaction
Adverse effects reported or potentially attributable to a pharmacy’s sterile drug product shall be reported to the board within 12 hours and immediately reported to the MedWatch program of the federal Food and Drug Administration

### L. Quality Assurance Program
1. The CSP QA Program is intended to provide a mechanism for monitoring, evaluating, correcting, and improving the activities and processes described in USP 797.
2. The following must be documented:
   a. Training and competency of compounding and checking employees
3. The following tests will be performed to ensure sterility in compounding sterile room.
   a. Glove fingertip testing biannually for employees who compound CSPs.
   b. Media Fill Testing biannually for employees who compound CSPs.
   c. End product evaluation that includes endotoxins, sterility and potency testing will be performed on two compounded samples every six months.
   d. Results from end product evaluations will be reviewed and documented by the pharmacist-in-charge or a designated pharmacist
   e. In the event a sample product is discovered to be outside the appropriate threshold or below the minimum standards for sterility, potency, or endotoxin, the following actions will be implemented:
      i. Designated person(s) will investigate and formalize an action plan.
      ii. A different staff member will perform the same test and a new sample product will be sent in for repeated testing
      iii. If the new sample product meets standards, the staff who initially performed the below standards will repeat training and aseptic technique competencies with a designated pharmacist. Staff must pass competencies prior to resuming any compounding activities.
      iv. If the new sample product does not meet standards on the repeated test, the IV room will be sanitized and cleaned immediately before any patient care activities resume. A qualified certification company will be scheduled to come in for IV room and hood re-certifications.
   f. Results from end product evaluations will be reviewed and documented by the pharmacist-in-charge or a designated pharmacist.
   g. If an action plan must be implemented, it will include the following:
      i. Designated pharmacist will investigate and formalize an action plan.
      ii. Both pharmacy management and EVS management will be alerted and will immediately terminate the area.
      iii. Testing will be redone by a qualified company, and if the new sample does not meet testing standards, the area will be sanitized and cleaned immediately before any patient care activities resume.

4. A summary report on the QA program will be presented to the Medication Safety Committee and Quality Council quarterly.

References

1. USP<797> 2022
2. California Pharmacy Lawbook 2023
3. ASHP Guidelines on Compounding Sterile Preparations 2014
## Intravenous Admixture Program Policy

**Policy**

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### Approvals

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| **Departmental**                    | **Date:**    | **10/2023** |
| System Pharmacy and Therapeutics Committee (P&T) | **Date:**    | **10/2023** |
| Clinical Practice Committee (CPC)    | **Date:**    | **11/2023** |
| Medical Executive Committee         | **Date:**    | **11/2023** |
| Board of Trustees                   | **Date:**    | **11/2023** |
Quality Assurance and Performance Improvement (QAPI) Plan
FY 2024

GOAL: The Quality Assurance and Performance Improvement (QAPI) Plan describes the integrated system-wide continuous process of identifying, evaluating, prioritizing, and implementing quality and performance improvement activities throughout the continuum of care at Alameda Health System (AHS).

OBJECTIVE: The QAPI plan describes AHS’s approach to ensuring compliance with the Centers for Medicare and Medicaid Services (CMS) QAPI Conditions of Participation. Through continuous collection and analysis of quality indicators and data, self-audits, facility staff, patient/resident, and family input; performance improvement action plans and corrective actions will be created to appropriately remedy and change processes, operations, and services in ways that will ultimately improve patient care and outcomes on a sustainable basis.

Performance improvement activities will focus on high-risk, high-volume, or problem-prone areas and their effects on health outcomes, patient safety, and quality of care. It will also consider Patient/Resident, Family, and staff input for resident/family satisfaction and process improvement. Prevention of hospital adverse events through reporting and tracking of these events will be included in these activities. Data gathered for quality indicators will be used to determine if the services provided by the hospital are effective and sustainable, meet regulatory compliance and support our patient, resident and family input and provide high quality care outcomes.

This plan will assure an effective, ongoing system is in place for identifying opportunities for improvement, problematic events, policies, or practices, and is taking sustainable actions to remedy these opportunities, including following up on action plans to determine if they were effective in improving performance and quality.

Alameda Health System is comprised of the following facilities:

- AHS (Highland Hospital, Fairmont Hospital, John George Psychiatric Hospital, San Leandro Hospital and Wellness Clinics)
- Alameda Hospital and systemwide Post-acute Skilled Nursing Facilities.

Our Mission: Caring, Healing, Teaching, Serving All
Our Vision: Alameda Health System will be recognized as a world-class patient and family centered system of care that promotes wellness, eliminates disparities, and optimizes the health of our diverse communities.
Our Values: Commitment, Teamwork, Excellence, Respect, Integrity, Compassion.

AHS aims to consider Equity while promoting Quality Assurance and Performance Improvement. Equity will be a focus of the QAPI plan and will align with the AHS Health Equity, Diversity, and Inclusion (HEDI) Pledge:

Health equity, diversity and inclusion commitments will be facilitated by system level, multi-site clinical and operational leaders who will:

- Cultivate a workforce culture that embraces and advances inclusiveness and belonging
- Embed equity into the design of clinical services, research, and assessment of quality outcomes
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- Strengthen existing partnerships, and build new ones to support strategic and community priorities
- Actively advocate with and for groups who represent historically marginalized communities

**GOVERNANCE:** Quality and Safety Committee (QSC) is responsible for the oversight of the QAPI Plan through its periodic review of the program, including, the development of a plan to implement and maintain the QAPI program, the review of the progress of QAPI projects, the determination of annual QAPI projects, and the evaluation of the effectiveness of improvement actions that the organization has implemented. QSC is also responsible for ensuring that clear expectations for safety are established and communicated hospital-wide, as well as allocating adequate resources to carry out the functions of the QAPI program requirements.

In the Post-Acute setting, QAPI has oversight from the facility leadership with interdisciplinary input, including but not limited to physicians, lab, pharmacy, infection control, finance, EVS, Engineering, FNS, Rehabilitation Services, nursing and administration.

The Board of Trustees is the governing body for Alameda Health System. The Board has delegated the day-to-day management of the system to the Executive Leadership Team.

Medical staff governance is provided for each licensed entity (AHS and Alameda Hospital) by the Medical Executive Committee with oversight from the Chief of Staff.

Daily oversight for the safety and quality of facility operations and related improvement efforts are provided by Chief Administrative Officers (CAOs) and Vice Presidents of Patient Care Services (Nursing practice). There are CAOs for the following entities within AHS:

- Highland Hospital
- San Leandro Hospital and Alameda Hospital
- John George Psychiatric Hospital
- Post-Acute Care (systemwide Skilled Nursing Facilities)
- Ambulatory Care (Wellness Clinics and Highland Outpatient clinics, including Outpatient Behavioral Health)

The Quality Department is overseen by the VP of Quality who reports to the Chief Medical Officer and is also the designated Patient Safety Officer for AHS. The Quality Department supports system-wide performance improvement efforts prioritized by the Board of Trustees and Executive Leadership Team.

For Post-Acute, Quality and Regulatory compliance is overseen by the CAO of Post-Acute Services and the Director of Clinical Executive Operations Team.

In addition, the Quality Department supports the following activities for the organization:

- Continuous Survey Readiness
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- Culture of Safety Survey implementation
- Facility and Unit Level dashboards
- Focused Professional Practice Evaluation (For-Cause)
- Infection Prevention Audits/Tracers and Healthcare Associated Infection (HAI) Surveillance
- Just Culture methodology implemented system wide
- Ongoing Professional Practice Evaluation
- Peer Review
- Proactive Risk Assessment
- Quality Assurance Monitoring
- Quality Improvement Strategies
- Regulatory Compliance
- Root Cause Analyses/Root Cause Investigations (RCA and RCI)
- Simulation Center
- Valid metric development and data interpretation

Governance Structure (See Appendix A for QAPI Governance Structure)

1. **Quality Professional Services Committee (QPSC):** QPSC is a committee of the Board of Trustees, the governing body ultimately responsible for the implementation of a comprehensive and effective quality and performance improvement plan throughout the system. The Committee is comprised of at least three Trustees and the chiefs of staff from each of the Medical Staffs. The Chiefs of Staff present regular updates on quality and safety activities for each of the licensed entities at QPSC.

   In addition, the activities included in the Quality Assurance and Performance Improvement Plan are reported to the QPSC at least annually and at regular intervals via the Patient Safety and Regulatory Affairs report, and True North Metric Quality Report.

2. **Quality and Safety Committee (QSC):** This Committee for each licensed entity has a central role in the initiation and oversight of the quality and performance improvement activities for each licensed entity. All chartered Performance Improvement projects will report progress and updates to the Quality and Safety Committee. QSC is co-chaired by an AHS provider and a representative from the Quality Department. The membership consists of representatives from Medical Staff, Patient Care Services, Operational Leaders, Quality, and administrative staff from various clinical areas in inpatient, ambulatory, and ancillary areas.

   The QSC has a reporting calendar which outlines the cadence for reporting of the quality and performance improvement activities of various clinical areas, departments (i.e., Patient Care Services), and/or programs (i.e., Infection Prevention and Control).
   Please see **Appendix B for QSC Reporting Calendar**.

3. **Medical Staff:** The Chief Medical Officer (CMO) in collaboration with the Chief of Staff is
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responsible for providing leadership and oversight of quality and safety of care provided by members of the Medical Staff. The management of these functions may be delegated to Department Chairs, Chiefs of Service, or Medical Staff Committees.

Peer Review Committees, known as Quality Review Committees (QRC) at AHS, enhance the quality and safety of patient care by providing active review and evaluation of care provided by the Medical Staff. The QRC review process together with Ongoing Professional Practice Evaluation (OPPE) and Focus Professional Practice Evaluation (FPPE) ensure providers are meeting performance expectations and standard of care. The QRC Chair, who is designated by the Department Chair identifies trends in provider performance and recommends follow-up actions for ensuring providers deliver standard of care. System issues identified in review are referred to Department or Operational Leaders for resolution. Both provider and system follow-ups are discussed and tracked at the Interdisciplinary Professional Practice Committee (IPPC), the oversight Committee for peer review at AHS and the Medical Executive Committee at Alameda Hospital. Department Chairs are responsible for ensuring the standard of care is delivered by providers within the Department and driving departmental performance improvement activities which are reported out annually to the MEC (Medical Executive Committee) during Departmental Reports.

4. Executive Leadership Team (ELT): responsible for defining, communicating, and gaining approval for the strategies for the System from the Board of Trustees. Additionally, ELT is responsible for deploying the strategies to the various campuses/divisional entities, evaluating and sponsoring system-wide improvement initiatives, and ensuring alignment and feedback through governance.

PROCEDURE: Establishing clear expectations for safety will include informing all staff of their specific roles and responsibilities within the QAPI Plan. Clear expectations for safety will also be set and communicated to those providing services under arrangements or contracts and should be documented in the contracts. AHS will demonstrate evidence of the QAPI plan through Quality Assurance activities as reported to governing bodies i.e., QSC.

Selection of Metrics

On an annual basis, the Board of Trustees, through QPSC and with input from ELT, Quality, and Operational leaders identify the True North Metrics which set system-wide priorities for the year. In addition, each of the CAOs identify prioritized metrics for their site-specific dashboards which can include utilizing information from CMS for state and federal metrics and benchmarking.

Metrics are identified for the Quality pillar:

- Quality Care – AHS provides Safe, Timely, Effective, Efficient, Equitable and Patient-Centered care that is accessible to all. Quality health care is defined by the Institute of Medicine (IOM) as care that is “safe, effective, patient-centered, timely, efficient and equitable.” It is based on scientific and medical evidence. To support the delivery of quality care, AHS has implemented
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an electronic health record and other information systems to help prevent medical errors, improve treatment decisions, and increase the quality and efficiency of care. In this pillar, there are important targets and efforts spread across the work in quality and population health-oriented metrics and focus on improvements in additional metrics such as All-Cause 30 Day Re-Admit Rate, and Hospital Acquired Infection Rate (HAI). We will also continue to monitor Patient Safety Indicators and Hospital Acquired Harms (PSI/HAC) to further improvement on provider documentation and harm prevention.

- Quality Roadmap – AHS strives to communicate a shared understanding of the Quality Pillar of the Strategic Plan and will develop roadmap / plan to “Improve Quality Metrics” alignment with the Strategic Plan. Please see Appendix D for Fiscal Year 2024 Quality Pillar Roadmap

A coordinated evaluation and assessment of metrics is completed which includes the following activities:

1. Review and analysis of the following information
   a. National Quality Reporting Programs - Centers for Medicare and Medicaid Services (CMS), The Joint Commission (TJC), Promoting Interoperability (PI), Merit-based Incentive Payment System (MIPS) for Providers, and Leapfrog Safety Grade
   b. Hospital acquired conditions (HAC), Hospital Acquired Infections (HAI) as defined by National Healthcare Safety Network (NHSN), and Patient Safety Indicators (PSI).
   c. Payor quality performance programs such as Medi-Cal’s Quality Incentive Program (QIP).
   d. Patient Safety trends including MIDAS Safety Alert tracking and trending, Root Cause Analyses, total harm rates, FMEAs, and performance improvement initiatives.
   e. Regulatory and Survey findings, reportable adverse events, sentinel events, and efficacy of corrective action plans
   f. Culture of Safety Survey implementation with frontline staff/provider debriefings and development of a management and staff’s collective action plan with monitoring for areas of opportunity of improvement
   g. Just Culture algorithm and guideline implementation to promote a fair and just culture that improves patient safety by empowering employees to proactively monitor the work setting and participate in safety efforts to reduce or prevent patient harm.
   h. Development of the AHS System, Facility, and Unit Level dashboards of MIDAS safety alerts and create transparency related to harm events and solicit actions for improvement.
   i. Patient Experience data

2. Consultation with System Leaders to prioritize any quality and or safety issues in their respective areas.
3. Assessment of True North Metric data on a monthly and annual frequency for ongoing improvement opportunities.
4. Goal setting based on national benchmarks and internal stakeholder analysis.

Please see Appendix E for Fiscal Year 2024 True North Metrics.
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Measurement and Performance Improvement

The True North Metrics dashboards define strategic goals to meet our Mission and Vision. They are used to assess the ongoing performance of the organization.

- System goals and targets are set through analysis of past performance; identification of best practices; and review of national, regional, or local benchmarks.
  Areas for improvement are identified routinely and systematically by assessing quality of care from actual and/or potential events.

Quality and performance improvement projects may be identified from clinical service area self-assessments, patient reported data, or formal organizational review that identifies gaps in services for targeted goals or outcomes and may be assigned by Executive, Operational, and/or Functional Leaders. Contracted Services are also to be monitored. Clinical contracted services will participate in the QAPI Plan and contribute any Quality Assurance indicators and collect, analyze, and improve all contracted services throughout the organization.

Performance Improvement (PI) projects that are undertaken should align with the organization's mission, strategic plan and HEDI pledge. Equity should be proactively considered when designing performance improvement projects and PDSA cycles. Projects designed without an intentional focus on equity may worsen inequities. The table below contains some equity considerations when designing and conducting performance improvement projects.

<table>
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<tr>
<th>Key Performance Improvement Step</th>
<th>Equity Considerations</th>
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| Identify the issue              | • What populations are impacted by the problem you are targeting?  
                                  | • Does the team feel comfortable discussing bias and structural inequities?  
                                  | • What training has the team received around ingraining equity into their performance work?  
                                  | • Does the team composition and structure promote inclusivity?  
                                  | • How will the patient voice be incorporated into program design?  
                                  | • What are potential structural barriers to success? |
| Define the aim                  | • Are the targeted populations clearly articulated in the aim statement?  
                                  | • Does the specified timeframe match patient needs?  
                                  | • What bias exists in current data sets? |
| Assess the current state        | • What inequities already exist? |
# Quality Assurance and Performance Improvement (QAPI) Plan

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| Plan tests of change | • What types of tests of change have been previously conducted to address these inequities?  
|                     | • What policies, procedures, and practices are currently in place?  
|                     | • What strategies will help mitigate bias in data collection/analysis?  
|                     | • What is the local culture surrounding the issues?  
|                     | • Does the infrastructure needed for the project exist?  
|                     | • Will the test of change impact those most vulnerable?  
|                     | • Are materials readily available in the language(s) and formats necessary?  
|                     | • Will the planned test of change address the root cause of inequity?  
|                     | • How can we ensure that those impacted by a test of change will have input into the process?  
| Learn from tests of change | • Were any inadvertent intervention-generated disparities created? If so, which tests of change can address those disparities?  
|                     | • Do the target populations believe the project outcome?  
|                     | • Did stratified data demonstrate that gains were experienced equally by all?  
| Modify and scale up | • What are potential structural barriers to spread and sustainability?  
|                     | • What best practices helped to achieve this?  
|                     | • How will best practices be shared?  
|                     | • Are we keeping up with the dynamic discussions about health equity and are future projects updated appropriately?  
|                     | • Are there newly identified healthcare disparities that warrant performance improvement efforts?  

Source: NYC Health + Hospitals. “Weaving Equity into Every Step of Performance Improvement.” IHI.org, April 14, 2022

The performance improvement projects will be chartered by the QSC. Progress and results for any of these projects will be reported to QSC and/or MEC.

The Quality Department is responsible for driving and monitoring system level initiatives. In addition, the Operational Leaders (Service Units, and Clinical Departments) can pursue other quality and performance improvement projects based on Department identified priorities, Safety Alert trends, and other factors.

Below are examples of performance improvement activities in various areas:
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1. Population Health and Care Management activities through the QIP Medi-Cal Waiver program involving multiple interdisciplinary teams responsible for driving the performance of each measure to meet specific targets.

2. Prevention and analysis of hospital associated infections with indwelling devices, Surgical Site Infection, and event-related HAIs, such as C. diff laboratory and MRSA BSI identified events (see Annual Infection Control Plan for specific interventions set an approved by the Infection Prevention Control Committee). The metrics are weighted and ranked to determine the performance improvement focus each year.

3. Prevention and review of Hospital Acquired Conditions (HAC) or Patient Safety Indicators (PSI) such as perioperative PE/ DVT, hemorrhage/ hematoma, accidental laceration, iatrogenic pneumothorax, and other HAC/ PSIs.

4. Provider Quality Monitoring – through Peer Review, OPPE, and FPPE processes which may include review of complications, unexpected mortality, behaviors impacting quality of care, and others.

5. Identified focus areas in Safety Alerts, Complaints, Grievances, Compliments, and Environment of Care (EOC) concerns. Harm events require a thorough and credible RCA process that may generate systemic deviations in processes. Efforts to improve systemwide processes for standardization and best practice throughout AHS.

6. Ongoing regulatory compliance tracers and survey readiness activities at each facility.

7. Comprehensive corrective action plans implemented to remediate deficiencies identified by regulatory and accreditation bodies.

8. Multidisciplinary workgroups to address regulatory non-compliance and promote sustainable standard work.

9. Purposeful hourly rounding by nursing to improve Patient Experience scores.

10. Reducing readmissions led by Care Management team.

11. CMS metrics in the MDS for post-acute services.

Methodology
AHS utilizes the Plan-Do-Study-Act (PDSA) cycle to improve a process or carry out system change. The PDSA cycle is an iterative, four-stage problem solving model which is also referred to as Rapid Cycle Improvement.

1. **Plan**: Plan the test/ improvement including a plan for collecting data.
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2. **Do:** Run the test/ improvement on a small scale.

3. **Study/Check:** Analyze the results and compare them to your predictions.

4. **Act:** Based on what you learned, plan for your next step or PDSA cycle.

**Monitoring**

The activities of the Quality Assurance and Performance Improvement Plan are reported to the Quality and Safety Committee and ultimately the Board. Reports will include the following:

1. Summary of Reportable/ Sentinel events and related trends to those events. Performance Improvement projects or “Action Plans” will be developed, monitored, and reported as an outcome of each Root Cause Analysis for any reportable adverse events/sentinel events.

2. Summary of Safety Alerts event reports and resulting outcomes to patients, as well as actions taken to improve safety proactively, retrospectively and/or in response to actual and/or potential near miss events identified through Safety Alerts events.

3. Summary of regulatory findings and status of corrective actions

4. Identified strategic performance improvement projects reported by Chief Administrative Officers and VP of Quality related to True North Metrics dashboard metrics

5. Pay-for-performance quality program or publicly reported program such as Core Measures and QIP

6. Data will be collected by each department i.e., coding/billing, documentation, chart audits or database reporting.

7. For Post-Acute, QAPI meets on a monthly basis at the facility sites.

The Quality and Safety Committee will collaborate with the Board to monitor QAPI activities delegated to each department and will make recommendations on plans for improvement.
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Patient Safety Program

The Patient Safety Program ensures the quality and safety of patient care by utilizing a process to identify, reduce, mitigate, and eliminate actual or potential risks to patients. This is accomplished through the following activities:

1. All internal occurrence reporting is captured in the MIDAS web-based confidential reporting application referred to as the Safety Alert System. See Occurrence Reporting policy for additional detail.

2. The Safety Alert System identifies, quantifies, monitors, and reports relevant data concerning important risks to the safety of patients, staff, and visitors.

3. The Safety Alert System is a confidential database of AHS occurrences or near misses to assess the organization’s risk management, patient safety, and performance improvement programs.

4. The Safety Alert system allows internal reporting of any events, near misses, or unsafe conditions affecting patients, staff, and providers. Patient Relations events are entered as well, including complaints, grievances, as well as compliments.

5. Early identification of occurrences or near misses allows the organization to immediately investigate the circumstances of the occurrence; consult Regulatory Affairs to determine if an event is reportable to regulatory agencies; and if an event necessitates further investigation with a Root Cause Analysis/Root Cause Investigation.

6. Investigation of adverse occurrences, sentinel events, near miss events, potentially compensable events (PCE’s), and claims occurs prospectively, concurrently, and retrospectively to determine how similar events may be averted and to control the loss related to the occurrence. See Appendix C for Patient Safety Investigations for a description of these various types of investigations and the delegation of responsibility for the investigations among operational leaders and the Patient Safety team.

7. Collaboration with the Regulatory Affairs Department occurs to assure that potential adverse events are tracked and reviewed for potential reportability.

8. The operational leaders will be responsible to ensure compliance with all action plans, monitoring, and sustainability plans. Results of all audits will be reviewed by the Operational Leadership for ongoing compliance or mitigation of performance. Each instance of error or non-compliance will be brought to the attention of responsible employees. The employee will be coached by his/her manager; with subsequent errors regarded as a performance issue and progressive coaching and/or performance management will be instituted per Alameda Health Systems Human Resources policy. In case of repeated
Quality Assurance and Performance Improvement (QAPI) Plan

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occurrences, system vulnerabilities will be explored and corrected. Results of the audits will be submitted to the Quality and Safety Committee (QSC).

9. The Patient Safety Program promotes a Just Culture to enable a practice that embodies an atmosphere of mutual trust in which providers and staff members can talk freely about safety problems and potential solutions without fear of retribution.

10. The Patient Safety Program collaborates with and facilitates participation in the BETA HEART risk reduction safety programs:
   a. ED Quest for Zero at Highland (Tier II), Alameda (Tier I), and San Leandro (Tier I) Emergency Departments
   b. OB Quest for Zero at Highland Maternal Child Services (Tier II).
   c. BETA HEART Programs:
      i. Culture of Safety Re-Validation Survey (Annual requirement)
      ii. Just Culture Re-Validation Survey (Annual requirement)
      iii. Rapid Event Response and Analysis (Annual requirement)
      iv. Communication and Transparency (Validation Survey for FY 2024)
   d. Ad-Hoc Risk Assessments in areas requiring additional evaluations.

11. The Patient Safety Program collaborates with other departments in change projects, assessments and training that promote all aspects of the Risk Management and Patient Safety Plan, the Mission, and the Vision of AHS.

12. The Patient Safety Program conducts interval rounding with a focus on Patient Safety and National Patient Safety Goals in collaboration with AHS, Strategic Business Units, Campus, and department leadership to share responsibility and demonstrate a commitment to patient, staff, and visitor safety; however, daily rounding to ensure the safety of patients and staff is completed by local operational leaders.

13. The Patient Safety Program maintains appropriate confidentiality of all risk management program activities and data under applicable statutes, policies and procedures and rules and regulations.

14. The Patient Safety Program maintains a system for the management of complaints and grievances by patients, families, and visitors, to improve patient care, resolve disputes, and minimize the risks of liability.

15. The Patient Safety Program organizes and implements Risk Management and Safety education, in-services, and/or relevant materials designed to increase awareness, and an understanding of issues, trends, and activities.

   The Patient Safety Program provides consultative services on risk, safety or medical-legal issues as requested or needed.
Quality Assurance and Performance Improvement (QAPI) Plan
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Monitoring and analysis of Patient Safety events may include the following as described prior:

1. Identification of trends, patterns, and variations in patient care
2. Risk assessments and identifying opportunities for improvement
3. Root Cause Analysis and Root Cause Investigations
4. Culture of Safety surveys with actionable improvements in teamwork and safety climate domains
5. Implementation of a Just Culture Policy and algorithm for a fair, just, and learning culture
6. Patient Experience data including complaints and grievances
In the largest sense, regulatory compliance in healthcare is about providing high-quality patient care.

The role of the Regulatory Affairs team assures compliance with laws, standards and regulations designed to keep patients safe and provide a safe environment for the provision of the highest quality care possible. Regulatory Affairs acts as an advocate and support for both the patient and staff. All the work of Regulatory Affairs with outside entities and internal departments is to assure AHS demonstrates its best “every day, every patient, every encounter”. Regulatory Affairs supports ongoing regulatory compliance at Alameda Health System with the following regulatory bodies:

- **California Department of Public Health (CDPH), Alameda County Public Health Department**
  
  1. Regulatory Affairs manages AHS facility licenses for adherence to the state requirements under the California Code of Regulations (including Title 8, 16, 22 and 24), Health and Safety Code, Business and Professions Code.
  
  2. Regulatory Affairs helps assure adherence to local Alameda County Public Health (ACPHD) ordinances, requirements, or Emergency Orders.
  
  3. Regulatory Affairs ensures timely reporting to CDPH and ACPHD of adverse events as stipulated by state statutes and regulations.
Quality Assurance and Performance Improvement (QAPI) Plan
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4. When there is any patient complaint or adverse event self-reported to CDPH, an investigator must visit the hospital to review the case. Regulatory Affairs acts as the AHS liaison with CDPH to facilitate any investigation and coordinate information gathering with operations and system departments as needed. Any site visit or investigation that results in a deficiency or citation requires a comprehensive plan of correction with monitoring.

5. Regulatory Affairs collaborates with operational leaders to prepare for CDPH surveys including GACH, Patient Safety Licensing MERP, and other unannounced visits.

6. Regulatory Affairs performs proactive risk assessments and analysis of adverse events to identify opportunities for quality assurance, performance improvement and prevention of future events and/or patient harm.

7. For Post-Acute, the site Administrators, Directors of Nursing, CAO of Post-Acute Services and the Director of Clinical Executive Operations Team have oversight of Regulatory Affairs.

- The Joint Commission (TJC) Hospital Accreditation and Certification Programs

1. Regulatory Affairs manages AHS accreditation programs under the Joint Commission, including the preparation, coordination, and facilitation of on-site unannounced surveys.

2. AHS facilities participating in Joint Commission Accreditation or Certification programs include:
   - Alameda Hospital
   - Fairmont Hospital – outpatient services
   - Highland Hospital
   - John George Psychiatric Hospital
   - San Leandro Hospital

3. AHS Accreditation and Certification programs:
   - Alameda Hospital – Hospital Accreditation, Primary Stroke Certification & Laboratory Accreditation
   - Fairmont Hospital, outpatient services – Hospital Accreditation
   - Highland Hospital - Hospital Accreditation
   - John George Psychiatric Hospital - Hospital Accreditation
   - San Leandro Hospital - Hospital Accreditation, & Laboratory Accreditation

4. Ongoing standards compliance is supported by various activities throughout the year including:
   - mock surveys
   - patient and system tracers
   - daily/weekly compliance monitoring (metrics)
Quality Assurance and Performance Improvement (QAPI) Plan
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- in-services, education on standards, best practices, e.g., “Lunch ‘n Learn,” “Breakfast Briefings”

- **Centers for Medicare & Medicaid Services Certification Programs**
  1. Regulatory Affairs oversees AHS activities to demonstrate compliance and adherence to the federal Conditions of Participation for certification.
  2. Regulatory Affairs facilitates CMS survey activities and the response plan of correction for any deficiency notices.
  3. Oversight of ongoing compliance is maintained in conjunction with department leaders

**CELEBRATION OF ACHIEVEMENTS:** In acknowledgement of the organization’s fantastic work, AHS will choose departments each quarter to present with the AHS Quality and Safety Innovation Award. This award will recognize departments that created and implemented action plans to improve teamwork and safety at AHS. We will also share learnings generated from the selected action plans organization wide. Departments are encouraged to submit applications each quarter to qualify for the award.
Quality Assurance and Performance Improvement (QAPI) Plan
FY 2024

APPROVAL:

<table>
<thead>
<tr>
<th>Committee</th>
<th>AHS</th>
<th>Alameda Hospital</th>
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<tbody>
<tr>
<td>Quality and Safety Committee</td>
<td>10/2019, 09/2020</td>
<td>10/2019, 09/2020</td>
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<tr>
<td>Quality Professional Services Committee</td>
<td>10/2019, 11/2020, 11/2023</td>
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Quality Assurance and Performance Improvement (QAPI) Plan
FY 2024

Appendix A: Quality Assurance and Performance Improvement Governance Structure
## Appendix B: Sample QSC Reporting Calendar

### Quality and Safety Committee Reporting Calendar

<table>
<thead>
<tr>
<th>January 31st</th>
<th>February 14th</th>
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<tbody>
<tr>
<td><strong>Annual</strong></td>
<td><strong>Annual</strong></td>
</tr>
<tr>
<td>2023 Reporting Calendar</td>
<td>Graduate Medical Education (GME)</td>
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<tr>
<td>PS2 QSC COP &amp; TSC Responsive Events &amp; Complaints</td>
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<tr>
<td><strong>Semi-Annual</strong></td>
<td><strong>Semi-Annual</strong></td>
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<tr>
<td>Environmental Services</td>
<td>Cardiology/Cath Lab</td>
</tr>
<tr>
<td>Emergency Program</td>
<td>Abdominal Services</td>
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<tr>
<td><strong>Quarterly</strong></td>
<td><strong>Quarterly</strong></td>
</tr>
<tr>
<td>Patient Care Services (PCS) Report</td>
<td>Pharmacy and Med Safety/Medication Error Reduction Plan</td>
</tr>
<tr>
<td>Perioperative Services Report</td>
<td>Sepsis Committee</td>
</tr>
<tr>
<td>Quality Innovation Award</td>
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<tr>
<td>Pharmacy &amp; Therapeutics Committee</td>
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### Monthly

| Performance Improvement Workgroups (CLABIS, SS) | Performance Improvement Workgroups (CLABIS, SS) |
| OPSC Patient Safety | OPSC Patient Safety |
| EM/ACIA Workgroup Update | OPSC Regulatory Affairs |
| True North Metrics Dashboard | True North Metrics Dashboard |
| PEPFRA Workgroup Update | |

### Root Cause Analysis (RCA)

| RCA Follow-up: OGH Event (PS Triggers, Patient w/ 72 hours, Patient to Staff Assault) | RCA Follow-up: OGH Event (PS Triggers, Patient w/ 72 hours, Patient to Staff Assault) |
| RCA Follow-up: ED & ICU Patient Fall (Impact on Patient) | RCA Follow-up: ED & ICU Patient Fall (Impact on Patient) |
| RCA Follow-up: OGH Event (PS Triggers, Patient w/ 72 hours, Patient to Staff Assault) | RCA Follow-up: OGH Event (PS Triggers, Patient w/ 72 hours, Patient to Staff Assault) |
| RCA Follow-up: OGH Event (PS Triggers, Patient w/ 72 hours, Patient to Staff Assault) | RCA Follow-up: OGH Event (PS Triggers, Patient w/ 72 hours, Patient to Staff Assault) |
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### Consent Agenda

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<thead>
<tr>
<th>Consent Agenda</th>
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<tbody>
<tr>
<td>Environment of Care &amp; Emergency Management</td>
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<td>Infection Prevention &amp; Control</td>
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<tr>
<td>Pharmacy &amp; Therapeutics Committee</td>
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### March 14th

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<tr>
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<td><strong>Annual</strong></td>
<td><strong>Semi-Annual</strong></td>
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<tr>
<td>Patient Experience</td>
<td>Care Management</td>
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<td>Health Information Management</td>
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<tr>
<td>Transfusion Committee &amp; Laboratory Services</td>
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<tr>
<td>Quality Incentive Program</td>
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### April 11th

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<tr>
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<td><strong>Semi-Annual</strong></td>
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<tr>
<td>Patient Experience</td>
<td>Care Management</td>
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<td>Health Information Management</td>
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<tr>
<td>Transfusion Committee &amp; Laboratory Services</td>
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<td>Quality Incentive Program</td>
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### Root Cause Analysis (RCA)

| RCA Follow-up: OGH Event (PS Triggers, Patient w/ 72 hours, Patient to Staff Assault) | RCA Follow-up: OGH Event (PS Triggers, Patient w/ 72 hours, Patient to Staff Assault) |
| RCA Follow-up: OGH Event (PS Triggers, Patient w/ 72 hours, Patient to Staff Assault) | RCA Follow-up: OGH Event (PS Triggers, Patient w/ 72 hours, Patient to Staff Assault) |
| RCA Follow-up: OGH Event (PS Triggers, Patient w/ 72 hours, Patient to Staff Assault) | RCA Follow-up: OGH Event (PS Triggers, Patient w/ 72 hours, Patient to Staff Assault) |
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### Consent Agenda

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<td>Infection Prevention &amp; Control</td>
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<tr>
<td>Pharmacy &amp; Therapeutics Committee</td>
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</table>
## Definitions of Investigations

<table>
<thead>
<tr>
<th>Type and timeline</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td><strong>Manager Follow up:</strong></td>
<td>A local review of the event, conducted by the department manager of the area where the event occurred and other responsible leaders if there are systems, processes or errors that cross more than one department, in collaboration with Patient Safety team.</td>
</tr>
<tr>
<td>For this timeline see Occurrence Reporting policy.</td>
<td></td>
</tr>
<tr>
<td><strong>Causal Investigation:</strong></td>
<td>A systematic, timely, thorough, and credible investigation identifying the basic or causal factors of an event or near miss. The investigation should include consideration of gaps in the healthcare process, cognitive bias and patient characteristics or social determinants of health that may have contributed to the event or affected the outcome. The process would include development of an action plan designed to implement improvements to reduce risk; implementing the improvements; and monitoring the effectiveness of the improvements. Causal investigations are led by the Patient Safety team.</td>
</tr>
<tr>
<td>Causal investigations will be complete within 90 days of the event</td>
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</tr>
<tr>
<td><strong>Root Cause Analysis (RCA):</strong></td>
<td>A systematic process for identifying the basic or causal factors that underlies variation in performance, including the occurrence or possible occurrence of a sentinel event. A root cause analysis focuses primarily on systems and processes, not on individual performance. It progresses from special causes in clinical processes to common causes in organizational processes and systems and identifies potential improvements in processes or systems that would tend to decrease the likelihood of such events in the future or determines. Root Cause Analyses are led by the Patient Safety team.</td>
</tr>
<tr>
<td>Root cause analyses will be completed within 45 calendar days for all reportable sentinel events.</td>
<td></td>
</tr>
<tr>
<td><strong>Failure Mode Event Analysis (FMEA):</strong></td>
<td>This is a step-by-step approach for identifying all possible failures in a design, process, or service. “Failure modes” means the ways, or modes, in which something might fail. A Lean method of process mapping is usually used to develop the processes being analyzed. The intent of the FMEA is to develop a preventive analysis to identify potential failure modes and enact process to avoid these failure modes such that harm does not reach patients. FMEAs are led by the Patient Safety Team.</td>
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<tr>
<td>The duration taken to complete an FMEA varies.</td>
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</table>
### QUALITY ROADMAP, FY 2024

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<tr>
<th></th>
<th>FY2024</th>
<th>FY 2025</th>
<th>FY 2026</th>
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<tbody>
<tr>
<td>1</td>
<td>Develop foundations for centering equity and SDOH in quality-driven</td>
<td>Expand processes for centering equity and SDOH in quality-driven</td>
<td>Expand processes for centering equity and SDOH in quality-driven</td>
<td>Expand processes for centering equity and SDOH in quality-driven</td>
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<td></td>
<td>Simulation Center programming</td>
<td>programming.</td>
<td>programming.</td>
<td>programming.</td>
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<tr>
<td>Q1</td>
<td>Conduct needs assessment to identify HEDI</td>
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<td></td>
<td>simulation-based education opportunities within AHS</td>
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<tr>
<td>Q2</td>
<td>Develop After Action Report for in-situ simulation-based education</td>
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<tr>
<td>findings &amp; begin PDSA of new report</td>
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<tr>
<td>Q3 Finalize After Action Report for in-situ simulation-based education findings &amp; begin using new version report</td>
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<tr>
<td>Q4 Collect data on effectiveness of new process &amp; revise if necessary.</td>
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<tr>
<td>2. Stratify each applicable TNM by REAL to identify disparities</td>
<td>Prioritize identified disparities and develop improvement plans</td>
<td>Reduce identified disparities</td>
<td>Reduce identified disparities</td>
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<tr>
<td>Q1 Source &amp; mockup TNM dashboard with REAL cascades</td>
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<tr>
<td>Q1 Begin Equity Analytics Training for Analytics &amp; Performance Improvement staff</td>
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<tr>
<td>Q1 Develop Power BI Dashboard with REAL cascades</td>
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<tr>
<td>Q2 – Q4 Evaluate &amp; improve REAL collection at registration</td>
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<tr>
<td>Q2 – Q4 Distribute, promote &amp; educate clinical and operational leadership on dashboard and equity analytics</td>
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<tr>
<td>3. Provide disaggregated quality (sepsis, stroke, IPFQR,</td>
<td>Ensure 25% of QSC reports contain</td>
<td>Ensure 50% of QSC reports contain</td>
<td>Ensure 100% of QSC reports contain</td>
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<td>FY2024</td>
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<tr>
<td>perinatal care, mortality, PSI/HAC) data to QSC.</td>
<td>disaggregated data</td>
<td>disaggregated data</td>
<td>disaggregated data</td>
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<tr>
<td>Q1 Identify what metrics are available in disaggregated form</td>
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<tr>
<td>Q2 Present disaggregated quality data to QSC</td>
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<tr>
<td>Q4 Develop plan for QSC reports to include disaggregated data in reports that are presented</td>
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<tr>
<td>Q2 Obtain reaccreditation of provisional accreditation of AHS Simulation Program</td>
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<tr>
<td>Q3 Conduct gap analysis to achieve full accreditation</td>
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<tr>
<td>Q4 Develop plan to achieve full accreditation</td>
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<tr>
<td>5. Implement Rapid Event Response &amp; Analysis Program (SOS Program)</td>
<td>Implement Communication &amp; Transparency program</td>
<td>BETA – Implement Care for the Caregiver program</td>
<td>BETA - Implement Early Resolution program</td>
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<tr>
<td>Q1 Present the Rapid Response Event Response (SOS) to</td>
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<tr>
<td>Q2</td>
<td>Pilot the SOS program &amp; make adjustments as needed.</td>
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<tr>
<td>Q3</td>
<td>Educate all parties on the SOS program</td>
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<tr>
<td>Q4</td>
<td>Conduct education and fully implement SOS</td>
<td></td>
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<tr>
<td>6.</td>
<td>Sustain Culture of Safety program per BETA HEART requirement</td>
<td>Sustain Culture of Safety &amp; Rapid Event Response programs per BETA HEART requirement</td>
<td>Sustain Culture of Safety, Rapid Event Response &amp; Communication programs per BETA HEART requirement</td>
<td>Sustain Culture of Safety, Rapid Event Response, Communication, &amp; Care for the Caregiver programs per BETA HEART requirement</td>
</tr>
<tr>
<td>Q1</td>
<td>Conduct ongoing internal assessment of domains.</td>
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<tr>
<td>Q2</td>
<td>Identify any potential deviations in criteria.</td>
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<tr>
<td>Q3</td>
<td>Make necessary corrections and bring domain(s) in compliance.</td>
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<tr>
<td>Q4</td>
<td>Prepare and conduct revalidation survey(s) for ongoing compliance.</td>
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<tr>
<td>7.</td>
<td>Implement an ongoing regulatory compliance program</td>
<td>Maintain an ongoing regulatory compliance education</td>
<td>Maintain an ongoing regulatory compliance education</td>
<td>Maintain an ongoing regulatory compliance education</td>
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<tr>
<td>Q1</td>
<td>Ongoing education on new and</td>
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<tr>
<td>Problematic standards</td>
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<tr>
<td><strong>Q1</strong></td>
<td>Communication campaign rechanging standards/statues/regulatory requirements and expectations for demonstration of compliance</td>
<td></td>
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<tr>
<td><strong>Q2-Q3</strong></td>
<td>Address high risk regulatory standards via workgroups (procedural fire safety; patient rights, clinical documentation, and human resources)</td>
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<tr>
<td><strong>Q3</strong></td>
<td>Conduct systemwide mock surveys</td>
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<tr>
<td><strong>Q4</strong></td>
<td>Conduct system tracers &amp; gap assessments</td>
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<tr>
<td>8.</td>
<td>Achieve a green TNM</td>
<td>Maintain a green TNM</td>
<td>Maintain a green TNM</td>
<td>Maintain a green TNM</td>
</tr>
<tr>
<td><strong>Q1</strong></td>
<td>Identify triads for system and campus level work</td>
<td></td>
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<tr>
<td><strong>Q2</strong></td>
<td>Finalize goals and develop cascades for each TNM to support improvement</td>
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<tr>
<td><strong>Q2-Q4</strong></td>
<td>Develop A3 and action plans for improvement</td>
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<tr>
<td><strong>Q2-Q4</strong></td>
<td>Report progress monthly at MOR meetings</td>
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<td>FY2024</td>
<td>FY 2025</td>
<td>FY 2026</td>
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<td><strong>9.</strong></td>
<td>Identify opportunities for improvement with Leapfrog and Star Rating. Prioritize opportunities, develop &amp; implement improvement plans.</td>
<td>Identify opportunities for improvement with Leapfrog and Star Rating. Prioritize opportunities, develop &amp; implement improvement plans.</td>
<td>Identify opportunities for improvement with Leapfrog and Star Rating. Prioritize opportunities, develop &amp; implement improvement plans.</td>
<td>Identify opportunities for improvement with Leapfrog and Star Rating. Prioritize opportunities, develop &amp; implement improvement plans.</td>
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<tr>
<td>Q1</td>
<td>Identify leads and develop Leapfrog Survey Improvement Plan</td>
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<tr>
<td>Q2</td>
<td>Create monthly progress dashboard and present quarterly at QSC</td>
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<tr>
<td>Q3-Q4</td>
<td>Present Leapfrog action plan quarterly at QSC</td>
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<tr>
<td><strong>10.</strong></td>
<td>Reduce CLABSI, CAUTI, SSI by 30%</td>
<td>Reduce CLABSI, CAUTI, SSI by 50%</td>
<td>Reduce / eliminate CLABSI, CAUTI, SSI</td>
<td>Maintain performance</td>
</tr>
<tr>
<td>Q1</td>
<td>Implement CLABSI &amp; CAUTI prevention bundles</td>
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<tr>
<td>Q1</td>
<td>Post “days without infection” for CLABSI &amp; CAUTI</td>
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<tr>
<td>Q2</td>
<td>Provide CLABSI &amp; CAUTI SIR and SUR feedback to unit leadership</td>
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<tr>
<td>Q4</td>
<td>Implement SSI prevention bundle</td>
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<td>Q4</td>
<td>Increase utilization of midlines, where indicated</td>
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<td>FY2024</td>
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<tr>
<td>11. Implement hand hygiene (HH) program to meet evidence based (EB) guidelines</td>
<td>Maintain HH program to meet EB guidelines</td>
<td>Maintain HH program to meet EB guidelines</td>
<td>Maintain HH program to meet EB guidelines</td>
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<tr>
<td>Q2 Coordinate use of materials that invite patients and visitors to remind individuals to perform hand hygiene</td>
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<tr>
<td>Q2 Conduct annual hand hygiene competency</td>
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<tr>
<td>Q3 Develop a process for physician demonstration of hand hygiene</td>
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</tbody>
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Appendix E: Fiscal Year 2024 Tue North Metrics

**Alignment:** Metrics should align with AHS’s key strategic priorities
- Dashboard should then drill down to site/setting level TNM dashboard
- Each metric should have drill-down dashboard of key driver

**Accessibility:** Metrics should be understandable to a lay person, including our patients
- Note: Tradeoff between accessibility and benchmarking

**Accountability:** Most metrics should be attributed to Operational, Performance Improvement, or Physician leader

**Aspiration:** Target setting, and display should incorporate state and national benchmarks

**Achievability:** Annual targets should represent achievable improvement in one year

**Clinical Relevance:** Metric performance improvement should improve the quality & safety of patient care.

**Equity:** Metrics should be stratified by Race, Ethnicity and Language (REAL), Sexual Orientation and Gender Identity (SOGI) and Social Determinants of Health (SDOH) to identify current / future equity gaps and guide program/improvement design

**Inclusion:** Metrics should be inclusive of all AHS care settings, when possible and appropriate

**Specificity:** Dashboard should have a blend of broad, overarching metrics and specific, actionable metrics
<table>
<thead>
<tr>
<th>Metric</th>
<th>Base Line FY24 Goal</th>
<th>All FY蒂 24</th>
<th>Worst REAL FY蒂 24</th>
<th>Performance Trend</th>
<th>Accountable Team (Op Leader/PI Lead/MD Champion)</th>
<th>Current and Planned Actions to Drive Improvement</th>
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<tr>
<td>Safety</td>
<td>Patient Harm ALL</td>
<td>Inpatient Associated Harms</td>
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<td></td>
<td>Skilled Nursing &amp; Sub Acute Associated Harms</td>
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<td>Outpatient Associated Harms</td>
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<td>Behavioral Health Associated Harms</td>
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<td>Safety</td>
<td>Handwashing Compliance</td>
<td>Inpatient Compliance</td>
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<td>Outpatient Compliance</td>
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<tr>
<td>Timely</td>
<td>Days from appointment request to appointment for existing specialty care patients</td>
<td>Adult</td>
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<tr>
<td>Effectiveness</td>
<td>All-cause 30-day Readmissions for Black/African American Patients</td>
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<td>Effectiveness</td>
<td>Patient with up to date preventative health screenings</td>
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<tr>
<td><strong>STEP</strong></td>
<td><strong>Metric</strong></td>
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<td>All FY蒂 24</td>
<td>Worst REAL FY蒂 24</td>
<td>Performance Trend</td>
<td>Accountable Team (Op Leader/PI Lead/MD Champion)</td>
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<tr>
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<td>Time in ED from Admission Decision to Inpatient Bed</td>
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<td></td>
<td>Behavioral Health</td>
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<td>Equity</td>
<td>Rate of inpatients screened for health-related social needs (food, housing, transportation, safety, utilities)</td>
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<tr>
<td>Equity</td>
<td>Rate of inpatients who screened positive for health-related social needs (food, housing, transportation, safety, utilities)</td>
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<tr>
<td>Patient Experience</td>
<td>Rate of inpatients who reported that their nurses “always” communicated well</td>
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<tr>
<td>Patient Experience</td>
<td>Rate of patients who reported they would “definitely” recommend AHS (Composite)</td>
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<tr>
<td><strong>STEP</strong></td>
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Alameda Health System

COMPLIMENTARY LOCAL TRANSPORTATION

<table>
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<th>Department</th>
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<th>Effective Date</th>
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<tr>
<td>Campus</td>
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<tr>
<td>Unit</td>
<td>All</td>
<td>Next Scheduled Review</td>
<td>10/2026</td>
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<tr>
<td>Manual</td>
<td>Author</td>
<td></td>
<td>Director, Care Management</td>
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Replaces the following Policies: N/A

Responsible Person
Inpatient Director, Care Management, VP Patient Care Services

Purpose

The purpose of this policy is to ensure that Alameda Health System (AHS) provide complimentary local transportation in a manner that (a) promotes greater access to medical care for patients living in AHS’s permitted transportation area; (b) promotes patient safety and ease of care; and (c) complies with all applicable state and federal rules and regulations (e.g., the federal Anti-Kickback Statute, Stark, etc.). Consistent with this commitment, this policy outlines AHS’s policy and procedures for providing complimentary transportation to eligible patients.

Policy

It is the policy of AHS that patients are responsible for their own transportation arrangements. Accordingly, with the exception of complimentary local transportation authorized by this policy, AHS shall not offer or provide free or discounted transportation services to patients. As authorized by this policy, AHS may provide complimentary local transportation uniformly and consistently (e.g., bus tickets, taxi vouchers, BART tickets, etc.) when the following requirements are met: (1) Clinical staff or designated person have determined that no alternate means of safely transporting the patient exist and have reasonably concluded that complimentary transportation services as described in this policy are necessary; (2) complimentary local transportation is offered to an Eligible Patient, as defined below, to and from an AHS facility for the specific purpose of obtaining medically necessary services from AHS; (3) the complimentary transportation is limited to transportation within AHS’s Permitted Transportation Area, as defined below; (4) the transportation service provided to the patient is the most cost efficient service available to safely transport the patient to his/her destination based on the patient’s condition and mobility; and (5) the cost is not, directly or indirectly, shifted to any Federal health care program and/or a State health care program, others payers, or individuals.

Procedure

1. Eligibility and Limitations
   a. Complimentary Local Transportation – AHS may provide complimentary local transportation of low value to an Eligible Patient and, under limited circumstances, to their immediate family members or caregivers, to and from an AHS facility for the specific purpose of obtaining medically necessary services from AHS.

Printed copies are for reference only. Please refer to electronic copy for the latest version.
i. **Eligible Patient (Established Patient)** – is a person who has selected and initiated contact to schedule an appointment with AHS, or who previously has attended an appointment with AHS. Put simply, a patient is eligible to receive complimentary local transportation if (1) he or she has received services from AHS in the past; or (2) he or she (or a representative) initiated contact with AHS to schedule an appointment for the purpose of obtaining medically necessary services. In the latter scenario, AHS may provide complimentary local transportation regardless of whether the patient has received services from AHS in the past. (3) An Eligible Patient is a patient who screens as eligible under the Transportation Prioritization Algorithm (attached as Appendix A).”

ii. **Immediate Family and Caregivers** – AHS may provide complimentary local transportation to an immediate family member or caregiver of an Eligible Patient if the family member or caregiver is actually accompanying the Eligible Patient to assist the patient obtain medical care at an AHS facility.

iii. **Geographical Limit (Permitted Transportation Area)** – AHS’s complimentary local transportation is limited to transportation within AHS’s permitted transportation area. For purposes of this policy, AHS’s permitted transportation area is an area that is within twenty-five (25) miles to or from an AHS facility, except for patients located in rural areas, in which case the permissible transportation area is (75) miles from an AHS facility.

iv. **Specialized Transportation** – Complimentary local transportation does not include luxury or specialized transportation (e.g., air, luxury, ambulance, etc.).

b. **Non-Discrimination** – Complimentary local transportation must be made available uniformly and consistently to all Eligible Patients.

c. **Marketing** – AHS may not (1) publicly market or advertise the availability of its complimentary local transportation; and (2) publicly market, advertise or otherwise promote health care services available from AHS or other providers to any person during transportation provided in accordance with this policy. For purposes of this policy, informing patients that AHS offers complimentary local transportation is not marketing, if it is done in a targeted manner.

d. **Cost** – AHS shall bear the cost of the local transportation services provided pursuant to this policy and may not, directly or indirectly, shift the cost onto any Federal or State health care program, other payers, or individuals.

e. **Documentation and Record Retention** – When complimentary local transportation is provided to an Eligible Patient, a designated staff shall document in the patient’s chart the clinical guidelines that were considered, the address the Eligible Patient was transported to, and the type of transportation service that was provided. Each department shall also retain all documentation relating to the provision of complimentary local transportation provided to Eligible Patients and Immediate Family and Caregivers (if applicable). Such documentation may include copies of transportation vouchers. – including immediate family members and/or caregivers.

f. **Managed Medi-Cal Benefit** – Patients with a Managed Medi-Cal plan are not eligible for complimentary transportation as described in this policy. Patients with Managed Medi-Cal have access to a transportation benefit through Modivcare. Modivcare can be reached at 1-866-529-2128
2. **Modes of Public Transportation and Clinical Guidelines**

Unless otherwise authorized by law, complimentary transportation offered to an Eligible Patient under this policy is strictly limited to the following modes of transportation:

a. **Taxi Vouchers** – Taxi Vouchers shall be used when bus tickets are inappropriate based on the assessment of the Eligible Patient’s condition and mobility, and when Lyft through Royal Ambulance cannot be utilized. Taxi Vouchers should be provided on a limited basis. Vouchers are printed in triplicate. They must be filled out completely in a legible manner, including the date issued, the name of the person issuing the voucher, the patient’s name, and the authorized trip information. The first two copies of the triplicate will be given to the taxi driver and the last copy will be filed with the Care Management department. The following clinical guidelines should be considered when issuing a taxi voucher:

i. Eligible Patient does not meet criteria for Lyft;
ii. Eligible Patient is able to sit independently for the duration of the trip;
iii. Eligible Patient can enter the home destination to which Eligible Patient has a house key or someone is home to receive the Eligible Patient;
iv. Eligible Patient can independently ambulate from taxi to home entrance; and
v. Eligible Patient is alert, stable, and ambulatory.

b. **Bus Tickets** – Bus Tickets should be utilized when the Eligible Patient has independent mobility and is able to independently navigate the bus system. The following clinical guidelines should be considered when issuing a bus ticket:

- Eligible Patient is cognitively intact and can manage the bus system;
- Eligible Patient does not require medical supervision;
- Eligible Patient is independent with mobility and is able to maintain standing balance or use wheelchair;
- Eligible Patient can be transported with portable O2 and nasal cannula (if needed);
- Eligible Patient’s personal belongings are portable and easy to carry; and
- Eligible Patient can enter the home destination to which Eligible Patient has a house key or someone is home to receive the Eligible Patient,

c. **LYFT/Royal Ambulance** – Royal Ambulance through Lyft shall be utilized when Paratransit is not necessary and bus tickets are inappropriate based on the clinical assessment of Eligible Patient’s condition and mobility. Royal Ambulance provides passenger car transportation through a partnership with Lyft. Royal Ambulance offers curb-to-curb or door-through-door/companion rides. Lyft (Passenger Car) transportation is arranged through the Onward ordering platform. Companion rides are accompanied by a trained medical professional who will assist patients with getting in and out of the vehicle and into their home. All patients must be alert, oriented, and do not pose a flight risk.

1 (Clinical Guidelines are recommended from ACMA)
The following clinical guidelines should be considered when contacting Royal Ambulance for passenger car transportation through Lyft:

i. Eligible Patient is able to sit independently for the duration of the trip;
ii. For curb-to-curb transportation, Eligible Patient must be able to enter the home destination to which Eligible Patient has a house key or someone is home to receive the Eligible Patient;
iii. Eligible Patient can independently ambulate from car to home entrance;
iv. Eligible Patient is alert, stable, and ambulatory;; and
v. Eligible Patient does not need behavioral monitoring.

3. **Policy Administrator**
   a. Transportation shall be billed to each department. The Manager/designee will be responsible for assessing the patient’s transportation needs and exploring all other options prior to requesting transportation (taxi vouchers, bus tickets, BART tickets, etc.).

**References**

1. Anti-Kickback Law, 42 U.S.C. § 1320a-7b(b)
2. Beneficiary Inducement Law, 42 U.S.C. § 1320a-7a(A)(5)

**Approvals**

<table>
<thead>
<tr>
<th>Departmental</th>
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<tr>
<td>Clinical Practice Council</td>
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<tr>
<td>Medical Executive Committee</td>
<td>Date: 11/2023</td>
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<tr>
<td>Board of Trustees</td>
<td>Date: 11/2023</td>
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</tbody>
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Appendix A
Transportation Prioritization Algorithm

The following questions should be used to determine if a patient is eligible for complimentary transportation.

1. **Does the patient have a managed medical plan?**

   *If yes-* Call Modivcare
   *If no,* proceed to the next question.

2. **Does the patient have access to transportation on a regular basis?**

   Screening questions to consider:
   - How do you get to and from the grocery store? Bank?
   - Do you have friends/family who support you?
   - Who would you call if you had an emergency?
   - How have you made it to and from appointments before?

   *If yes-* support the patient with accessing transportation resources they have used in the past.
   *If no,* proceed to the next question.

3. **Is the patient ambulatory, alert, oriented, and can safely utilize public transportation?**

   *If yes-* consider public transportation or paratransit.
   *If no,* proceed to the next question.

4. **Based on the answers to the questions above, can you confirm there are no alternate means of safely transporting the patient and therefore complimentary transportation is necessary?**

   *If yes-* proceed with confirming eligibility.
   *If no,* patient is not eligible for complimentary transportation.

5. **Is the transportation need for the specific purpose of obtaining medical services to and from an AHS facility?**

   *If yes-* proceed with confirming eligibility.
   *If no,* patient is not eligible for complimentary transportation.

6. **Is this transportation service being offered to the patient the most cost efficient service available to safely transport the patient to his/her destination based on the patient’s condition and mobility?**

   *If yes-* proceed with confirming eligibility.
   *If no,* consider a more cost effective option.
7. *Is the* cost of the transportation, directly or indirectly, shifted to any Federal health care program and/or a State health care program, others payers, or individuals?

*If yes, patient is not eligible for complimentary transportation. If no, proceed with arranging transportation for the eligible patient.*

*Staff must document the outcome of their screening in the patient’s medical record*
Pre-Operative Anesthesia Guidelines

I: NPO Guidelines
- Applies to all elective surgery whether under general, regional or MAC anesthesia.
- For urgent or emergent procedures, discuss directly with anesthesiologist.

<table>
<thead>
<tr>
<th>Ingested Material</th>
<th>Minimum Fasting Period</th>
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<tbody>
<tr>
<td>Clear Liquids (water, juice w/o pulp, carbonated drinks, clear tea, black coffee)</td>
<td>2 hours</td>
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<tr>
<td>Non-human milk (cow, soy, oat, creamer), non-clear liquids*</td>
<td>6 hours</td>
</tr>
<tr>
<td>Light, non-fatty meal (toast and clear liquids, no fried/fatty foods or meat)</td>
<td>6 hours</td>
</tr>
<tr>
<td>Regular solid meal (meat, fried or fatty food)</td>
<td>8 hours</td>
</tr>
<tr>
<td>Continuous enteral tube feeds</td>
<td>6 hours</td>
</tr>
<tr>
<td>Continuous enteral tube feeds in patients with an existing advanced airway (ETT or cuffed tracheostomy tube)</td>
<td>6 hours for any procedure involving the airway (ie: ETT/DLT exchange, tracheostomy, planned extubation), GI tract, or in the prone position. Do not hold tube feeds for non-airway and non-GI procedures (ie: ortho procedures, wound vac change, I&amp;Ds) - RN should stop tube feeds on call to OR and suction out stomach.</td>
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</tbody>
</table>

* Consider the amount ingested and any risk factors for delayed gastric emptying

II: Routine Pre-operative Diagnostic Testing
- Always use clinical judgement and adjust care appropriately.
- Obtain urine or serum HCG testing within 24 hours of procedure for all female patients unless >50 y/o, amenorrheic for >1yr, or s/p hysterectomy.
- Normal lab tests drawn within 6 months do not need to be repeated unless clinically indicated due to changes in health status and/or plan for major surgery (see below).
- Routine cardiac testing is not recommended for minor surgeries (ie: cataract surgery).
- Normal or unchanged EKGs within 12 months do not need to be repeated.
  - Exception: Patient with known cardiac disease such as CAD (h/o stents, MI, CABG, NSTEMI, or angina): recommend EKG within 4 months.

<table>
<thead>
<tr>
<th>Testing Criteria</th>
<th>EKG</th>
<th>CBC</th>
<th>BMP</th>
<th>CMP</th>
<th>PTT/INR</th>
<th>T/S</th>
<th>Pre-op FBS</th>
<th>Extra Testing/Consults</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age ≥ 65 or METs &lt;4*</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<td></td>
<td>If METS&lt;4, consider cardiac stress-testing</td>
</tr>
</tbody>
</table>

Last edited: 10/26/23
**Major Surgery** includes procedures with potential for >500cc blood loss or major fluid shifts, involving free flap, or case length > 4 hours.

- **Major vascular surgery**
- **Craniotomy/intracranial procedure**
- **Spine surgery with fusion/instrumentation (≥2 level decompression, laminectomy, discectomy, ACDF)**
- **Thoracotomy/open thoracic procedures**
- **Major orthopaedic reconstruction (lengthy ORIF or revision arthroplasty)**
- **Pelvic surgery**
- **Whipple procedure**
- **Open abdominal procedure or resection of major organs (including debulking, reoperating, or multi-surgeon procedures)**
- **Major genitourinary surgery (radical prostatectomy)**

***For all ESRD patients, check K+ on arrival to pre-op. If iSTAT K+ is ≥6.0 mmol/L, confirm with lab BMP STAT. If the patient’s lab potassium level is ≥6.0mmol/L, scheduled case should not proceed to OR with anesthesia. Nephrology should be consulted for urgent HD. If needed, alternative HD access (ie: Quinton catheter, trialysis line) can be obtained by a vascular surgeon in the PACU or by an intensivist in the ICU under local only without need for anesthesia.

**III: Summary of Peri-op Substance Use Guidelines**

(Refer to the Anesthesia Peri-Op Substance Use Policy for more details or discuss with anesthesiologist)

- Patient should be advised to abstain from all illicit substances for at least 3 days prior to their scheduled procedure.
- Urine toxicology screen is not routinely ordered in patients with substance use disorders. Case delay and/or cancellations should be based on patient history and/or clinical signs of intoxication, respiratory symptoms, vital signs, and mental status.

---

**Major Surgery**

<table>
<thead>
<tr>
<th>Condition</th>
<th>X</th>
<th>X</th>
<th>X</th>
<th>X</th>
<th>Labs within 1 month</th>
</tr>
</thead>
<tbody>
<tr>
<td>HTN (uncontrolled, on &gt;3 meds, or dx &gt;10 yrs)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>Continue beta-blocker on day of surgery</td>
</tr>
<tr>
<td>Stable cardiac disease (CAD, MI, Afib/flutter, CHF, PH)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>Echo within 1 year if EF&lt;35% or h/o valvular heart disease (ie: AS) or PH</td>
</tr>
<tr>
<td>PPM/AICD</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td>Interrogated within last 6 months</td>
</tr>
<tr>
<td>Cirrhosis, liver disease</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>Labs within 1 month</td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td>X</td>
<td></td>
<td>X</td>
<td>Refer to last HbA1C if available</td>
</tr>
<tr>
<td>ESRD on HD***</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td>AM K+ &lt;6.0 and stable EKG, recommend last HD no more than 1 day prior to surgery</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>On diuretic/ACEi/digoxin</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>On lithium</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td>Refer to last TSH if available</td>
</tr>
<tr>
<td>On coumadin</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td>Labs within 2 weeks</td>
</tr>
</tbody>
</table>

*METs ≥ 4: able to climb a flight of 15 stairs without chest pain or dyspnea.*

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Last edited: 10/26/23
Recommendations by substance:
1. **Cocaine:** Last reported use at least 24hrs hours prior to scheduled procedure.
2. **Methamphetamines:** Last reported use at least 72hrs prior to scheduled procedure. Chronic users should have an echocardiogram prior to surgery if time allows (ie: elective procedures), to rule out severe cardiomyopathies.
3. **Heroin/fentanyl/prescription opioids:** Patients on chronic long-acting opioids should take their usual morning dose prior to their scheduled surgery.
4. **Buprenorphine:** Refer to the Anesthesia Peri-Op Substance Use Policy for recommendations/tapering. Consider chronic pain service consult post-operatively.
5. **Marijuana/THC:** Chronic users may have need for more anesthesia and increased post-op pain.

**IV: Medication Management:**
- General recommendations for common outpatient medications, not a comprehensive list.
- If specific medication or medication category is not listed, please contact anesthesiologist for further clarification as needed.
- Some specialty-specific medications will require referral to prescribing physician for pre-op optimization (ie: immunosuppressants/biologics, chemotherapeutics, PH meds, etc).
- For peri-op management of **antiplatelet agents** (ie: aspirin, clopidogrel (Plavix), ticagrelor (Brilinta), prasugrel) and **anticoagulants** (ie: warfarin (Coumadin), DOACs (apixaban (Eliquis), rivaroxaban (Xarelto), dabigatran (Pradaxa)), Lovenox / heparin), please contact surgeon and/or prescribing provider. Management varies depending on medication indications and surgical bleeding risk.

**Home medications to continue as prescribed: (including the morning of surgery, if medication usually taken in AM)**

<table>
<thead>
<tr>
<th>Medication Class</th>
<th>Examples</th>
<th>Special Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beta-Blockers</td>
<td>Metoprolol (Lopressor, Toprol XL)</td>
<td>Continue as scheduled until time of surgery</td>
</tr>
<tr>
<td></td>
<td>Carvedilol (Coreg)</td>
<td></td>
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<td></td>
<td>Atenolol</td>
<td></td>
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<td></td>
<td>Bisoprolol</td>
<td></td>
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<tr>
<td></td>
<td>Propranolol</td>
<td></td>
</tr>
<tr>
<td>Antiarrhythmics, Cardiac glycosides</td>
<td>Amiodarone (Cordarone)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dronedarone (Multaq)</td>
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<tr>
<td></td>
<td>Dofetilide (Tykosyn)</td>
<td></td>
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<td></td>
<td>Sotalol</td>
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<tr>
<td></td>
<td>Digoxin</td>
<td></td>
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<tr>
<td>Alpha-2 agonists</td>
<td>Clonidine (Catapress)</td>
<td></td>
</tr>
<tr>
<td>Vasodilators</td>
<td>Hydralazine</td>
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<tr>
<td></td>
<td>Isosorbide dinitrate (Isordil)</td>
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<tr>
<td></td>
<td>Isosorbide mononitrate (Imdur)</td>
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<tr>
<td>Calcium channel blockers</td>
<td>Amlodipine (Norvasc)</td>
<td></td>
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<tr>
<td></td>
<td>Nifedipine (Procardia)</td>
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<td></td>
<td>Diltiazem (Cardizem)</td>
<td></td>
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<tr>
<td></td>
<td>Verapamil</td>
<td></td>
</tr>
<tr>
<td>Category</td>
<td>Medications</td>
<td></td>
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<tr>
<td>----------------------------------------------</td>
<td>------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Alpha-1 antagonists (BPH meds)</td>
<td>Doxazosin (Cardura)</td>
<td></td>
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<tr>
<td></td>
<td>Terazosin (Hytrin)</td>
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<td></td>
<td>Tamsulosin (Flomax)</td>
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<tr>
<td>Thyroid medications</td>
<td>Levothyroxine (Synthroid)</td>
<td></td>
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<tr>
<td></td>
<td>Methimazole</td>
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<tr>
<td></td>
<td>Propylthiouracil (PTU)</td>
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<tr>
<td>Steroid medications</td>
<td>Prednisone</td>
<td></td>
</tr>
<tr>
<td></td>
<td>If &gt;20mg for &gt;3 weeks in last year, consider stress dose steroids peri-operatively.</td>
<td></td>
</tr>
<tr>
<td>Immunomodulators *</td>
<td>Methotrexate</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Plaquenil</td>
<td></td>
</tr>
<tr>
<td>Proton pump inhibits, H2 blockers</td>
<td>Pantoprazole, omeprazole, esomeprazole</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Famotidine, cimetidine, ranitidine</td>
<td></td>
</tr>
<tr>
<td>Respiratory inhalers (for asthma or COPD)</td>
<td>Albuterol (Proventil, Ventolin)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Budesonide/formoterol (Symbicort)</td>
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<tr>
<td></td>
<td>Fluticasone/salmeterol (Advair)</td>
<td></td>
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<td></td>
<td>Tiotropium (Spiriva)</td>
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<td></td>
<td>Ipratropium (Atrovent)</td>
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<tr>
<td></td>
<td>Montelukast (Singular)</td>
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<tr>
<td>SSRI, SNRI</td>
<td>Fluoxetine (Prozac)</td>
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<td></td>
<td>Sertraline (Zoloft)</td>
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<td></td>
<td>Paroxetine (Paxil)</td>
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<tr>
<td></td>
<td>Citalopram (Celexa)</td>
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<td></td>
<td>Escitalopram (Lexapro)</td>
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<td></td>
<td>Duloxetine (Cymbalta)</td>
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<tr>
<td></td>
<td>Venlafaxine (Effexor)</td>
<td></td>
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<tr>
<td>Tricyclic antidepressants (TCAs), Monoamine</td>
<td>Amitriptyline (Elavil)</td>
<td></td>
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<tr>
<td>oxidase inhibitors (MAOIs)</td>
<td>Nortriptyline (Pamelor)</td>
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<td></td>
<td>Doxepin</td>
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<td></td>
<td>Selegiline</td>
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<tr>
<td>Anti-epileptic medications (AEDs)</td>
<td>Levetiracetam (Keppra)</td>
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<td></td>
<td>Phenytoin (Dilantin)</td>
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<td></td>
<td>Lamotrigine (Lamictal)</td>
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<td></td>
<td>Gabapentin (Neurontin)</td>
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<td></td>
<td>Carbamazepine (Tegretol)</td>
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<td></td>
<td>Zonisamide (Zonegran)</td>
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<td></td>
<td>Oxcarbazepine (Trileptal)</td>
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<td></td>
<td>Topiramate (Topamax)</td>
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<tr>
<td></td>
<td>Valproic acid derivatives</td>
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<tr>
<td>Antipsychotics, Mood stabilizers</td>
<td>Risperidone (Risperdal)</td>
<td></td>
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<tr>
<td></td>
<td>Clozapine (Clozaril)</td>
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<tr>
<td></td>
<td>Aripiprazole (Abilify)</td>
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</tr>
</tbody>
</table>

Last edited: 10/26/23
<table>
<thead>
<tr>
<th>Medication Class</th>
<th>Examples</th>
<th>Special instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACE inhibitors, ARBs</td>
<td>Lisinopril</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Enalapril (Vasotec)</td>
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<td></td>
<td>Ramipril</td>
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<tr>
<td></td>
<td>Losartan (Cozaar)</td>
<td></td>
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<tr>
<td></td>
<td>Valsartan (Diovan)</td>
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<tr>
<td></td>
<td>Irbesartan</td>
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<tr>
<td></td>
<td>Sacubitril-valsartan (Entresto)</td>
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</tr>
<tr>
<td>Diuretics</td>
<td>Furosemide (Lasix)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Bumetanide (Bumex)</td>
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<td></td>
<td>HCTZ</td>
<td></td>
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<tr>
<td></td>
<td>Chlorthalidone</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Metolazone</td>
<td></td>
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<tr>
<td></td>
<td>Acetazolamide (Diamox)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Spironolactone (Aldactone)</td>
<td></td>
</tr>
<tr>
<td>Long-acting insulin (once a day dosing)</td>
<td>Glargine (Lantus)</td>
<td>Take ½ usual PM dose the night before surgery. No insulin day of surgery unless Type 1 DM. Notify anesthesiologist if patient on insulin pump.</td>
</tr>
<tr>
<td></td>
<td>Detemir (Levemir)</td>
<td></td>
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<tr>
<td></td>
<td>Insulin degludec (Tresiba)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Insulin glargine U-300 (Toujeo)</td>
<td></td>
</tr>
</tbody>
</table>

* Some immunomodulators require holding up to 1-4 weeks before major surgery (ie: leflunomide (Arava), azathioprine (Imuran)/6MP, etanercept (Enbrel), adalimumab (Humira), infliximab (Remicade)). Please consult prescribing physician for appropriate peri-op plan for when to stop before surgery and when safe to resume post-op.

Home medications to hold the day of surgery:
(last dose day/night prior to surgery, depending on usual schedule)

<table>
<thead>
<tr>
<th>Medication Class</th>
<th>Examples</th>
<th>Special instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parkinson’s disease medications</td>
<td>Carbidopa/Levodopa (Sinemet)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Entacapone</td>
<td></td>
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<tr>
<td></td>
<td>Amantadine</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pramipexole, ropinirole, rotigotine</td>
<td></td>
</tr>
<tr>
<td>Statins</td>
<td>Atorvastatin (Lipitor)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rosuvastatin (Crestor)</td>
<td></td>
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<tr>
<td></td>
<td>Simvastatin</td>
<td></td>
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<tr>
<td></td>
<td>Pravastatin</td>
<td></td>
</tr>
</tbody>
</table>
## Mixed/intermediate-acting insulin

<table>
<thead>
<tr>
<th>Medication Class</th>
<th>Examples</th>
<th>Last dose prior to surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td>NPH/aspart (Novolog)</td>
<td>Take ½ usual PM dose the night before surgery. No insulin day of surgery.</td>
<td></td>
</tr>
<tr>
<td>NPH/lispro (Humalog)</td>
<td></td>
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<tr>
<td>Humulin-N</td>
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<td></td>
</tr>
</tbody>
</table>

## Sulfonylureas

<table>
<thead>
<tr>
<th>Medication Class</th>
<th>Examples</th>
<th>Last dose prior to surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Glipizide</td>
<td>Last dose the day/ evening before surgery, hold on the day of surgery</td>
<td></td>
</tr>
<tr>
<td>Glyburide</td>
<td></td>
<td></td>
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<tr>
<td>Glimepiride (Amaryl)</td>
<td></td>
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</tr>
</tbody>
</table>

## DPP-4 inhibitors

<table>
<thead>
<tr>
<th>Medication Class</th>
<th>Examples</th>
<th>Last dose prior to surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sitagliptin (Januvia)</td>
<td></td>
<td></td>
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<tr>
<td>Linagliptin (Trajenta)</td>
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</tbody>
</table>

## SGLT-2 inhibitors

<table>
<thead>
<tr>
<th>Medication Class</th>
<th>Examples</th>
<th>Last dose prior to surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Empagliflozin (Jardiance)</td>
<td></td>
<td></td>
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<tr>
<td>Canagliflozin (Invokana)</td>
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<td></td>
</tr>
</tbody>
</table>

## Alpha-glucosidase inhibitors

<table>
<thead>
<tr>
<th>Medication Class</th>
<th>Examples</th>
<th>Last dose prior to surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acarbose</td>
<td></td>
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<tr>
<td>Miglitol</td>
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<td></td>
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</tbody>
</table>

## Thiazolidinediones (TZDs)

<table>
<thead>
<tr>
<th>Medication Class</th>
<th>Examples</th>
<th>Last dose prior to surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pioglitazone (Actos)</td>
<td></td>
<td></td>
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<tr>
<td>Rosiglitazone (Avandia)</td>
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</tbody>
</table>

## Meglitinides

<table>
<thead>
<tr>
<th>Medication Class</th>
<th>Examples</th>
<th>Last dose prior to surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Repaglinide (Prandin)</td>
<td>Hold evening before and day of surgery</td>
<td></td>
</tr>
<tr>
<td>Nateglinide</td>
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<td></td>
</tr>
</tbody>
</table>

## Biguanides

<table>
<thead>
<tr>
<th>Medication Class</th>
<th>Examples</th>
<th>Last dose prior to surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metformin, Metformin XL</td>
<td>Last dose the day before surgery, hold on the day of surgery</td>
<td></td>
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</tbody>
</table>

## Daily/BID-dosed GLP-1 agonists

<table>
<thead>
<tr>
<th>Medication Class</th>
<th>Examples</th>
<th>Last dose prior to surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exenatide (Byetta)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Liraglutide (Victoza, Saxenda)</td>
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<td></td>
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<tr>
<td>Lixisenatide (Adlyxin)</td>
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<tr>
<td>Semaglutide (Rybelsus)</td>
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</tr>
</tbody>
</table>

## Home medications to hold 1 week (7 days) prior to surgery:

<table>
<thead>
<tr>
<th>Medication Class</th>
<th>Examples</th>
<th>Last dose prior to surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td>NSAIDS</td>
<td>Celecoxib (Celebrex)</td>
<td>If holding other antiplatelets or anticoagulants, hold NSAIDs concurrently</td>
</tr>
<tr>
<td>Ibuprofen (Motrin)</td>
<td></td>
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<tr>
<td>Meloxicam (Mobic)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Naproxen (Aleve)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Herbal supplements, Vitamins, Fish Oils</td>
<td>Hold 7 days prior to surgery</td>
<td></td>
</tr>
<tr>
<td>Weekly-dosed GLP-1 agonists</td>
<td>Dulaglutide (Trulicity)</td>
<td>Hold 7 days prior to surgery</td>
</tr>
<tr>
<td>Exenatide-ER (Bydureon BCise)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Semaglutide (Ozempic, Wegovy)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

References:
Practice Guidelines for Preoperative Fasting and the Use of Pharmacologic Agents to Reduce the Risk of Pulmonary Aspiration: Application to Healthy Patients Undergoing Elective Procedures: An Updated Report by the American Society of Anesthesiologists Task Force on
Preoperative Fasting and the Use of Pharmacologic Agents to Reduce the Risk of Pulmonary Aspiration. Anesthesiology 2017; 126:376–393 doi: https://doi.org/10.1097/ALN.0000000000001452


B3. Medical Staff Polices
November 29, 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: November 29, 2023

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

COMMITTEE ACTION: Recommend Approval of Medical Staff Policies and Procedures

Background:
The Alameda Health System (AHS) and Alameda Hospital (AH) Medical Staff align policies and procedures to provide continuity across the two Medical Staffs.

The Medical Staff policies provide alignment of credentialing and privileging processes by offering a systematic approach to assessment across our facilities.

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

Prior Board Action: n/a

Board Action Requested: Approval

AHS and AH Medical Staff policies:
- Medical Staff Credentialing and Privileging of Practitioners
- Medical Staff Professionalism and Conduct

AHS Medical Staff policies:
- Medical Staff Physician Practice Office Policy
- Facility with Medical Staff Added to Hospital Licensure

Medical Staff Retired Policies:
- AHS Medical Staff Division Chief & Site Director
- AHS and AH Medical Staff Medical Staff Advanced Practice Provider Categories

Fiscal Impact: n/a

Budgeted/Authorized: n/a

Estimated Cost Savings: n/a

Strategic Plan Pillar: n/a
Alameda Health System

MEDICAL STAFF CREDENTIALING AND PRIVILEGING OF PRACTITIONERS

<table>
<thead>
<tr>
<th>Department</th>
<th>Medical Staff</th>
<th>Effective Date</th>
<th>5/2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unit</td>
<td>Medical Staff</td>
<td>Next Scheduled Review</td>
<td>11/2026</td>
</tr>
<tr>
<td>Manual</td>
<td>Medical Staff</td>
<td>Author</td>
<td>VP, Physician Services</td>
</tr>
<tr>
<td>Replaces the following Policies:</td>
<td>Responsible Person</td>
<td>Chief of Staff</td>
<td></td>
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</tbody>
</table>

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

Purpose
As an extension of the Alameda Health System (AHS) and Alameda Hospital (AH) Medical Staff Bylaws to establish mechanisms for gathering relevant data, which involves the collection, verification and assessment of applicant information that will serve as the basis for decisions regarding credentialing and privileging of licensed independent practitioners and advanced practice providers who provide patient care services at Alameda Health System and/or Alameda Hospital.

Policy Statement
It is the policy of the AHS and AH Medical Staff to ensure that licensed health care providers meet minimum credentialing, privileging and performance standards for Medical Staff membership/Advanced Practice Provider as outlined in the Medical Staff Bylaws. Credentialing is performed jointly for all physicians, podiatrists, psychologists, dentists, and Advanced Practice Providers for appointment to the AHS and/or AH Medical Staff/Advanced Practice Provider prior to approval by the Governing Body. Credentials and Clinical Privileges are approved separately by the AHS Medical Staff and AH Medical Staff to which the practitioner is applying. Privileging forms and/or Standardized Procedures are completed as appropriate. Members of the Medical Staff or clinical privilege holders may be granted delineated clinical privileges as specified in the Medical Staff Bylaws for each independent Medical Staff or Advanced Practice Provider.

All applications for appointment and/or reappointment to the Medical Staff/Advanced Practice Provider, and requests for clinical privileges, will be evaluated based on critical parameters: current licensure; education and relevant training; and experience, ability, and current competence to perform the requested privilege(s). Any applications that meet the application criteria during the verification process shall be categorized using the Application Criteria. Files will be flagged as outlined in the Application-Level policy and procedure.
The applicants will provide an attestation that all information submitted for credentialing and privileging is accurate and agree to report immediately any change in status of the information maintained in the Credentials files. If any submitted items differ from documentation disclosed through the verification process, the Department Chair or Division Chief consults with the provider to resolve discrepancies. All documents for any applicant or re-applicant must be no more than 180 days old at the time of Credentials Committee review.

Nondiscriminatory Statement and Audit Process
The AHS and AH Medical Staff credentialing, and privileging process acts in compliance with all federal and state and local laws and regulations governing discrimination involving patients, employees, vendors, visitors and other individuals and entities associated or involved with AHS. This policy reaffirms the commitment of the AHS Medical Staff and AH Medical Staff to maintaining a discrimination-free credentialing and privileging process.

The AHS and AH Medical Staff will not engage in discrimination or harassment of any person employed or seeking employment or medical staff credentialing or patient care within AHS on the basis of race, color, natural origin, age, disability, religion, sexual orientation, gender identity, gender expression, physical or mental disabilities, medical condition, pregnancy, HIV status, ancestry, marital status, citizenship, or status as a covered veteran or the type of procedure patients in which the practitioner specializes. The Medical Staff does not retaliate against a person for pursuing their right under this policy and/or for the purpose of investigatory proceedings. Non-discriminatory information is available in alternative forms of communication to meet the needs of persons with sensory impairments.

On an annual basis, each member of the AHS and AH Credentials Committee will sign a confidentiality statement that will also include an affirmative statement that all decisions are made in a non-discriminatory manner.

The Medical Staff Services Department will monitor through periodic audits of credentials files and practitioner complaints about possible discrimination, by performing audits of decisions recommended by the Credentials Committee. The findings will be reported to the Credentials Committee and the Medical Executive Committee on an annual basis to protect against discrimination and to maintain a nondiscriminatory credentialing process.

Procedure
All applications for appointment, reappointment, and requests for clinical privileges are processed as described below. Telemedicine credentialing by proxy will be processed in accordance with policy.

Pre-Application
A pre-application will be released via email to potential applicants requesting staff membership and/or clinical privileges at Alameda Health System. The pre-application will be used to determine if the applicant meets the basic qualification for medical staff membership/advanced practice professional status as delineated in the Medical Staff Bylaws, Rules, and Policies.
Individuals requesting to be credentialed and privileged will be provided an email outlining the basic requirements to apply for membership and/or privileges to the AHS and/or AH Medical Staff and a separate email with a link to a pre-application. Once the preapplication is completed a cursory review of the applicants’ qualifications will be performed including review of the following:

1. Professional license(s); including all states and other jurisdictions
2. California License Verification System (LVS) - Verification of 805 Reporting
3. DEA (if applicable)
4. NPI
5. NPDB (National Practitioner Data Bank self-query)
6. OIG Exclusion
7. Sam Exclusion
8. MediCal Exclusion
9. CA Secretary of State
10. CMS Opt Out List
11. Internet search query

If the applicant does not meet criteria, the Department Chair/designee will be notified, and an application will not be released. The applicant will be notified via letter and/or email that the eligibility criteria was not met, therefore an application for membership and/or privileges will not be released. Such action shall not give rise to hearing and appeal rights pursuant to the Medical Staff Bylaws. This action is not reportable to the National Practitioner Data Bank and/or Pre-Applicant’s licensing body. If a potential applicant would believe that they meet the criteria, that individual must submit to the Medical Staff within thirty (30) days after notice that the individual did not meet criteria a letter in writing that includes all information and documents that substantiate the individual meets the criteria.

If the applicant meets criteria, an email will be sent with a link to the Practitioner Portal to access the application packet and privilege forms approved by the Medical Executive Committee. The email will outline the time frame and basic requirements for processing the request.

Initial Application for Appointment
For a practitioner who meets criteria to become credentialed and privileged, they must submit a complete application along with copies of other documents as applicable including, but not limited to, the following:

1. California Medical License (copy required)
2. Out of State License, if applicable
3. Drug Enforcement Agency (“DEA”) certificate, if applicable
4. Certificates or permits (PALS, BLS/ACLS, Fluoroscopy, etc.)
5. MD Diploma, Education and Training Certificates
6. Curriculum vitae (CV) / Resume
7. ECFMG Certificate
8. Board Certification or Advanced Practice Provider National Certification
9. NPI Number
10. Evidence of current malpractice coverage of $1 million per occurrence/$3 million aggregate
11. Malpractice Insurance Declaration of Coverage for the past 10 years (recent graduates must provide malpractice during their residency)
12. Copy of government issued photo identification (i.e., driver’s license)
13. Privilege Form(s)
14. Procedure or Clinical Case log for the last two years
15. Application fee
16. Medical Health Clearance
17. Immunization/Vaccines Gaps in education, practice and work history of 90 days or more will require written documentation

The following forms must be completed and signed:
1. Background Investigation Acknowledgement Form
2. Information Release/Acknowledgment
3. Professional Sanctions and/or Allegations Explanation Form, if applicable
4. AHS/AH Medical Staff Sharing Agreement
5. Confidentiality and Security Agreement
6. Medical Staff Quality and Assessment and Peer Review Agreement
7. Continuing Medical Education (CME) attestation
8. Attestation Questionnaire: including applicant attesting to perform privileges as requested, lack of present illegal drug use, history of loss of license and/or felony convictions, and history of loss of limitation of privileges or disciplinary activity.

Applicants identity must be verified via presentation of an original government-issued identification document prior to appointment/granting of privileges.

Applications for Medical Staff membership and clinical privileges will be processed and verified as indicated below. The established processing time is estimated at 60-90 days following receipt of completed application. Applications for Behavioral Health providers will be assessed for completion and verification of qualifications within 60 days of receipt of an application. Such applicants will be notified within seven (7) business days of receipt and confirmation of whether the application is complete.

Reappointments
Reappointment to the Medical Staff and requesting of clinical privileges shall occur within a period not to exceed 24 months.

The practitioner shall be required to submit copies of documents including, but not limited to, the following:
1. Board Certification or Advanced Practice Providers Certification
2. Evidence of current malpractice coverage of $1 million per occurrence/$3 million aggregate
3. Malpractice Insurance Declaration of Coverage for the past 2 years (recent graduates must provide malpractice during their residency)
4. Privilege Form(s)
5. Reappointment application fee

The following forms must be completed and signed.
   1. Background Investigation Acknowledgement
   2. Information release/acknowledgment
   3. Professional Sanctions and/or Allegations Explanation Form, if applicable
   4. Sharing agreement
   5. Confidentiality and Security Agreement
   6. Medical Staff Quality and Assessment and Peer Review Agreement
   7. Continuing Medical Education (CME) attestation
   8. Attestation Questionnaire: including applicant attesting to perform privileges as requested, lack of present illegal drug use, history of loss of license and/or felony convictions, and history of loss of limitation of privileges or disciplinary activity.

The following competencies must be completed as part of the reappointment application process:
   - Procedural Sedation (if applicable w/privileges)

Reappointment Applications will be sent via the Practitioner Portal to provider approximately four (4) months prior to their appointment expiration date and are expected to be completed online and submitted within 60 days.

Medical Staff Services sends reappointment applications as outline in the Medical Staff Bylaws. Email communication templates are within Attachment A and will be used by Medical Staff Services for correspondence with applicants.

If the provider fails to submit a completed application by the date as stated on written notice, a final reminder will be made to the provider by telephone requesting communication with Medical Staff Services within 24 hours. Failure to do so shall be deemed to have voluntarily resigned his/her Medical Staff membership. The procedural rights set forth in the Medical Staff Bylaws shall not apply to voluntary resignation.

Verification and Processing
When the application for appointment or reappointment is submitted, a review for completeness is performed by Medical Staff Services. If additional information is required, or if questions are left blank, the applicant is contacted and informed that processing will not begin until the application is entirely complete. The applicant is responsible for providing the information to satisfy the process. Failure to submit the requested information within thirty (30) days shall be considered a withdrawal of the application. Such withdrawal shall not give rise to hearing and appeal rights pursuant to the Bylaws.

All information gathered on the application will be verified by the primary source (when applicable). Primary source may include oral verification which requires a dated, signed note in the credentialing file stating who at the primary source verified the item, and the date and time of verification.
In addition, queries will be made to the National Practitioner Data Bank (“NPDB”), the Medical Board of California (“MBC”) and the Office of Inspector General (“OIG”) regarding any adverse actions against the practitioner. The practitioner will be contacted regarding any discrepancies and will be expected to provide an explanation for any of these issues. Sources used for verifications include:

1. **California Professional License/Professional Licenses from Other States**
   Current California State professional licensure must be obtained by direct confirmation from the appropriate licensing board. Other State Medical and Professional Boards for active professional licenses.

2. **DEA Certification**
   All providers must have a valid DEA certificate, with a California address, with the exception of Pathologists. For Advanced Practice Providers, DEA requirements are based on scope of service. Providers who are required to have a DEA, must have an unexpired DEA, without limited schedules or an out of state address, otherwise privileges shall be suspended until evidence of a valid DEA is provided to Medical Staff Services.

3. **Fluoroscopy or Radiography Certification**
   A copy of the permit/certification is required for all radiologists and non-radiologists who will be using fluoroscopy equipment in the operating rooms or other procedure areas. Radiography Certificate is not acceptable as a Fluoroscopy Certificate.

   Medical Staff Services shall provide a monthly report to Radiology and Perioperative Services of all providers with a valid Fluoroscopy certificate.

4. **Hospital Affiliations and/or Work History**
   Written verification of ten (10) years of clinical work history from hospitals or other health care organization affiliations is required for initial appointment and the prior two (2) years for reappointment. Verifications of clinical privileges in good standing at the hospital designated by the practitioner as the primary admitting facility should be confirmed in writing or orally and include the date of appointment, scope of privileges, restrictions, and recommendations. A request of the practitioners’ quality and performance profile/data may be accepted in lieu of a “good standing letter” for initial appointments and reappointments.

   If verification of an affiliation is not obtained after three attempts with the applicant’s assistance, including a phone call to the facility, a file note will be created. If verification cannot be obtained due to extraordinary circumstances this needs to be documented in the file for the Department Chair/designee to review. The file may then move through the evaluation process without verification.

5. **Graduation from Medical/Professional School and Completion of Residencies and Fellowships**
   Verification of medical/professional school graduation and completion of residency and fellowship training may be obtained from the institution(s) where the training was completed, and/or an agency that is deemed a primary source verification, such as the American Medical
Association (AMA) Physician Masterfile or American Osteopathic Association (AOA) Physician Database, National Student Clearing House (NSCH) (upon confirmation the organization uses NSCH as their 3rd party) or Federation of State Medical Boards (FSMB) for closed residency programs or state licensing agency, if the state verifies.

Foreign Medical Graduates from schools of medicine other than those in the United States and Canada must present evidence of certification by the Education Commission for Foreign Medical Graduates (ECFMG) or successful completion of a fifth pathway, or successful passing of the Foreign Medical Graduate Examination in the Medical Sciences (FMGEMS). Verification of foreign graduation will be conducted.

6. **Board Certification**
   Board Certification is verified by the provider's listing in published ABMS compendium, through querying the ABMS on-line database (CertiFACTS), or primary source verification directly from the certification board. Board certification is verified at time of initial appointment, at time of reappointment, and at expiration.

In order to be considered for privileges all Advanced Practice Registered Nurses and Physician Assistants are required to have national certification when applying for credentialing and privileging. Maintenance of certification is required by any of the following bodies:

- American Academy of Nurse Practitioners (AANP)
- American Nurses Association – American Nurses Credentialing Center (ANCC)
- Pediatrics Nursing Certification Board (PNBC)
- National Certification Corporation (NCC) for Nurse Practitioner certification
- American Association of Critical-Care Nurses (AACN)
- American Midwifery Certification Board (AMCB)
- National Board of Certification & Recertification for Nurse Anesthetist (NBCRNA)
- National Commission on Certification of Physician Assistants (NCCPA)

7. **Current, Adequate Malpractice Insurance**
   Professional Liability Insurance coverage and the amount of coverage must be confirmed directly with the carrier.

8. **Professional Liability Claims History**
   Verification of ten (10) years of claims history for new appointments and the previous two (2) years for reappointments must be obtained from the current and/or previous carriers. If after three (3) attempts with the applicants’ assistance, including a phone call to the facility, the insurance carrier does not respond NPDB will be used as primary source verification. The NPDB query may be used as evidence of settlement and judgment history.

9. **Background Checks**
   Background checks will be conducted on all applicants at the time of initial appointment and reappointment in accordance with state and federal laws. Applicants must consent to this process by signing and submitting the Notice Regarding Background Check Investigation. Failure to complete this form shall result in the application being deemed incomplete.
Signature on the Notice Regarding Background Investigation acknowledges and authorizes Medical Staff Services to search the following databases:

- Social Security Number (SSN) Trace and Death Index
- Maiden & Alias Name Search
- Criminal Records Search – Federal, State and County Levels
- National Warrants and Warrants
- National Sex Offender Registry
- Office of Inspector General (OIG)
- General Services Administration (GSA)
- Medi-Cal sanctions list search
- U.S. Government Terrorist List

10. National Practitioner Data Bank (NPDB)
   The NPDB must be queried for all new appointments, reappointments and at the time of the request for additional privileges. Each query to the NPDB is facility specific therefore there will be one (1) NPDB query for AHS and one (1) query for AH if the provider is applying at both facilities. All providers will be enrolled in the NPDB Continuous Query and will be reviewed at initial appointment, reappointment, temporary privileges, and request for additional privileges.

11. Medicare/Medicaid Sanctions
   Sanction verifications for Medicare and Medicaid will be obtained via Sanctions Exclusions Report published by the Office of Inspector General (OIG) and Excluded Parties List System (EPLS). Ongoing monitoring of sanctions to Medicare and Medicaid is performed on a monthly basis by the AHS Compliance Department.

12. Professional References
   Three (3) professional references for providers with the same credentials are required for new applicants and two (2) for reappointments. For reappointments, the Department Chair or an AHS Division Chief may serve as the peer reference. These references must be from individuals familiar with a provider’s work, either via direct clinical observations or through a close working relationship within the prior two years. For an Advanced Practice Provider (APP) one of the references should be from a physician within the same department that has direct observation of care provided.

13. Medical Health Clearance
   In addition to providing documentation of the required vaccines/immunizations, providers must seek medical clearance, which includes favorable results of an appropriate Pre-Employment physical examination (via an occupational health clinic), Ishihara color blind test and a 10-panel drug test.

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

15. **Provider Enrollment**

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

16. **Ongoing Professional Practice Evaluation (OPPE)**

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

17. **Additional Information**

Other information as deemed necessary may also be collected and considered with the approval of the Medical Executive Committee.

Departments and Clinical Services may also require additional documentation or standards.

18. **Timeliness of Information**

All required verifications, signatures, and requested documents for any applicant or re-applicant must be no more than 180 days old at the time of Credentials Committee review.

**Requests for Modification of Privileges**

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

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

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

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

4. The privileges request and supportive documentation is sent to the appropriate Department Chair/designee for review and recommendation to the Credentials Committee with final review and recommendation for approval by the Medical Executive Committee (MEC) to the Governing Board).
Appointment/Privilege Approval Notifications
Providers will be issued a Board approval notification letter outlining the approved membership and privileges within ten (10) business days of the Quality Professional Services Committee (QPSC) of the Board determination.

Application Fees
Providers are required to submit an application fee for membership and/or privileges. An application is incomplete if payment has not occurred. Application fees are non-refundable once the submitted application has been received and processing has started. Reappointment fees are applied in full, regardless of the reappointment term.

1. Medical Staff Fees:
   a. AHS/AH application fee for Temporary Privileges ONLY of $100.00.
   b. AHS application fee of $300.00 and reappointment fee of $500.00.
   c. AH application fee of $300.00 and reapplication fee of $500.00.

2. Advanced Practice Provider (APP) e.g., PA, NP, etc. Fees:
   a. AHS application fee of $150.00 and a reappointment fee of $150.00.
   b. AH application fee of $200.00 and a reappointment fee of $200.00.

3. Providers who apply for membership or privileges at more than one Medical Staff within Alameda Health System the provider will receive a 50% discount of their initial application and/or reappointment fees at the second facility.

AHS and AH Category Assessments
Clinical activity for a Medical Staff member shall be consistent with the criteria outlined in the AHS and AH Medical Staff Bylaws. Qualifying activity includes patient care contacts at an Alameda Health System facility including admissions, surgeries, consultations, and other patient care procedures or consultations. The number(s) of patient care activities for the various clinical privilege associated status categories are within the AHS/AH Medical Staff Bylaws. During the reappointment process, each applicant’s OPPE report and clinical care activity reports will be reviewed to determine accurate category assignment. If an applicant no longer qualifies to continue in the current category, the Credentialing Coordinator will notify the applicant and the applicant will be given the opportunity to clarify inaccuracies. This will be considered by the Department Chair, Credentials Committee, and Medical Executive Committee as appropriate.

Voluntary Resignation
Providers who wish to resign their Medical Staff membership and/or privileges shall complete a Voluntary Resignation form (Attachment B).

Medical Staff Services will process the voluntary resignation and complete the necessary steps for deactivation of Alameda Health System computer access. The provider will attest that their charting and medical records for any care provided will be completed on or before their voluntary resignation (H&Ps, procedure notes, orders, discharge summaries). In addition, they will acknowledge that their AHS network logon and all application access will be automatically deactivated on the indicated date of their voluntary resignation. Any changes to the voluntary
resignation date or a desire to rescind this resignation MUST be communicated verbally and in writing to the Medical Staff Office and the Department Chair. Failure to communicate any changes in dates will result in the resignation being effective as of the date on the Voluntary Resignation Form and all systems access will cease as outlined in the deactivation process.

**PROVIDER RIGHTS TO AMEND APPLICATION AND REVIEW CREDENTIALS FILE**

Providers have the right to correct erroneous information obtained throughout the credentialing process. If any submitted items differ substantially from documentation disclosed through the verification process, the provider will be notified, asked to resolve this discrepancy, and expected to do so within thirty (30) days of the request. All identified and/or requested amendments will be forwarded to the Credentials Committee(s) for review and action.

Providers are allowed access to their own credentials files as outlined in the respective Medical Staff Bylaws relating to Confidentiality of the Credential File.

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

**Approvals:**

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<tr>
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<td>Date:</td>
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</tr>
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<td>QPSC</td>
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Medical Staff Credentialing and Privileging of Practitioners
Attachment A

The email templates below will be used at the point where the Credentials Coordinators stop any additional work on collecting an application for reappointment.

The provider will receive two courtesy reminder emails with language in the second reminder as follows:

---

**Subject Line:** **Action Needed** Application for Reappointment AHS / AH

**Reappointment Failure to Submit Application Reminder:** Used for the second notice that a reappointment application was not submitted.

Dear (insert provider’s name),

This is a second reminder to notify that your application for reappointment to the <Alameda Health System/Alameda Hospital> Medical Staff has not been received. It has been 20 days since the initial notification to apply for reappointment was sent. Your application for reappointment is due within 35 days from the date of initial notification. Should your application not be submitted, it will be considered a voluntary resignation of medical staff membership and privileges at <Alameda Health System/Alameda Hospital>.

Following voluntary resignation, you will be required to reapply for membership and privileges via initial application for appointment. If you have any questions, please contact the Medical Staff Services Department at <Alameda Health System/Alameda Hospital>.

Sincerely,

Medical Staff Services
AHS Phone: 510-437-6535
SLH Phone: 510-297-5404
AH Phone: 510-814-4035
Email: medicalstaff@alamedahealthsystem.org

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If the provider fails to submit a completed application in the timeframe outlined on the written notice, a final reminder will be made to the provider by telephone requesting communication with Medical Staff Services within 24 hours. Failure to do so shall be deemed to have voluntarily resigned their Medical Staff membership. The procedural rights set forth in the Medical Staff Bylaws shall not apply to a voluntary resignation under this section.

The following two email templates would be the standard work when sending email communication to address applications for reappointment which have not been submitted after three (3) automated efforts. If an application for reappointment has been started and is in progress, the applicant will be sent The Partial Action on Application for Reappointment notification.

---

**Subject Line:** **Final Notice** Application for Reappointment AHS / AH

**Cc:** Department Chair, Division Chief (if applicable), Credentials Committee Chair(s), MSS Director, Manager

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

Dear (insert provider’s name),

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

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

- First reminder – month/date/year
- Second reminder - month/date/year
- Third reminder – month/date/year

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

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

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

Please contact your Department Chair, regarding the above.

---

**Partial Action on Application for Reappointment:** Used only if the Department Chair wants them to stay on staff or they are close to having the application completed.

**Subject Line:** **Final Notice Requiring Action** Application for Reappointment AHS / AH

Cc: Department Chair, Division Chief if applicable, Credentials Committee Chair(s), MSS Director, Manager

Dear (insert provider’s name),

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

The invitation to the online application portal was sent on month/date/year, and the application remains at 14% complete. The following reminders were sent to your email(s) on file, on the below dates:

- First reminder – month/date/year
- Second reminder - month/date/year
- Third reminder – month/date/year

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

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

Please consider this our final attempt to collect your application for reappointment for processing, which if not received by COB month/date/year, will result in expiration of Medical Staff Membership and/or Privileges.

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

Please contact your Department Chair, regarding the above.
Medical Staff Credentialing and Privileging of Practitioners
Attachment B
Medical Staff Voluntary Resignation Form

I am formally submitting my voluntary resignation from the Medical Staff(s) listed below.

☐ *Alameda Health System  ☐ Alameda Hospital

Requested Voluntary Resignation Date (must be a date after this form is submitted to the Medical Staff Office):

Date: ____________

I attest that my charting and medical records and any care I provided will be completed on or before my voluntary resignation as above (H&Ps, procedure notes, orders, discharge summaries).

I acknowledge and agree that I continue to be bound by the Medical Staff Bylaws until my voluntary resignation date, including but not limited to assuring that I maintain professional liability coverage through that date.

I acknowledge that my AHS network logon and all application access will be automatically deactivated on the date of my voluntary resignation documented above.

Any request to change my voluntary resignation date or a desire to rescind this resignation MUST be communicated verbally and in writing to the Medical Staff Office and your Department Chair prior to the date specified above for my voluntary resignation and you must request a date after the requested change is submitted in writing to the Medical Staff Office.

Failure to communicate any changes in dates will result in the resignation being effective as of the date above and all systems access will cease as outlined on this form.

Reason(s) (please select all that apply):

☐ Layoff / Reduction in Workforce
☐ Resignation / Termination of Employment
☐ No longer with contracted group
☐ No longer utilize AHS Facilities
☐ Moved out of state
☐ Retired from practice
☐ Other _______________________

Practitioner’s Printed Name ___________________________ Department / Specialty ___________________________ Medical Group Name ___________________________

(if applicable)

Practitioners Signature ___________________________ Date ___________________________

Please submit your completed form via email or fax: medicalstaff@alamedahealthsystem.org Fax: (510) 379-7440

You will receive a letter that confirms your voluntary resignation of membership and/or privileges after the resignation has been accepted by the Board. For any questions, please contact Medical Staff Services at Alameda Health System (510) 437-4292 or Alameda Hospital (510) 813-4035.

*Highland Hospital, San Leandro Hospital, John George Psychiatric Hospital, Fairmont Hospital, Wellness Clinics
Alameda Health System

MEDICAL STAFF PROFESSIONALISM AND CONDUCT

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<tr>
<td>Manual</td>
<td>Medical Staff</td>
<td>Author</td>
<td>Immediate Past Chief of Staff</td>
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</tbody>
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Replaces the following Policies: Responsible Person: Chief of Staff

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

Purpose

The purpose of this policy is to encourage a fair approach and “Just Culture” which facilitates high standards of safety and quality in health care. Alameda Health System (AHS) Medical Staff and Alameda Hospital (AH) Medical Staff have adopted this Code of Conduct to support the principles in our Medical Staff Bylaws, which shall be the primary means for reviewing and disciplining providers for inappropriate behavior that may be detrimental to patient safety or the delivery of medical care or may become detrimental to patient safety or the delivery of care if it would continue. A high standard of professional behavior, ethics, and integrity are expected of each individual member or licentiate credentialed by the Medical Staff of AHS and/or AH (individually, “Provider” and collectively, “Providers”). This code is a statement of the expectations and guidelines for professional behavior of the Medical Staffs in all dealings with patients, their families, other health professionals, employees, students, vendors, government agencies and others aiming for high levels of patient care, trust, integrity, and honesty.

This policy will emphasize the necessity for all individuals working in Alameda Health System or Alameda Hospital to treat others with respect, courtesy, and dignity, and to conduct oneself in a professional manner. This policy protects individuals from behavior that does not meet these standards. Behaviors, including but not limited to intimidation, discrimination, retaliation, harassment and sexual harassment, are prohibited and will not be tolerated.

The Medical Staff Professionalism and Conduct policy supports a fair and respectful environment across Alameda Health System’s and Alameda Hospital’s Medical Staffs, with high standards of professional behavior, ethics, and integrity. All Providers are expected to conduct themselves at all times, while in Alameda Health System facilities or rendering services as a Provider, in a courteous, professional, respectful, collegial and cooperative manner. This applies to interactions and communications with or relating to Medical Staff and APP colleagues, nursing and technical personnel, other care-givers, other hospital personnel, vendors, patients, patients’ family members, friends, and
visitors. Safety and quality of patient care is dependent on teamwork, communication and a collaborative work environment.

Policy

The procedures described in this policy are to provide a system of progressive reviews and progressive interventions with referral to the Medical Executive Committee for intervention, potential corrective action and/or summary action if the reported Unprofessional Behavior recurs despite Tier 1 and Tier 2 interventions or if egregious behavior is reported.

When a member is found to have fallen short of the expectations in this policy, the Medical Staff supports tiered, non-confrontational intervention strategies focused on restoring trust with, placing accountability on, and rehabilitating the offending Provider. However, the safeguarding of patient care and safety is paramount, and the Medical Staff will enforce this policy with disciplinary measures whenever necessary.

The evaluation, monitoring and regulation of professional behavior are essential elements of the Ongoing Professional Practice Evaluation (“OPPE”) policy which provides continuous monitoring of professional practice trends of providers.

Behavior that may be detrimental to patient safety or the delivery of patient care, including but not limited to intimidating behavior, inappropriate conduct, retaliation, discrimination, and sexual harassment by Providers is prohibited and a “zero tolerance” practice is followed. Failure to follow Medical Staff Bylaws, Rules and Regulations or health system policy may be identified by multiple sources, including but not limited to the following:

1. Verbal or written reports from members of the Medical Staff or hospital employees.
2. MIDAS System via Patient Safety.
3. Reports from external sources including but not limited to Health Services Advisory Group (HSAG) the Centers for Medicare and Medicaid Services, the Medi-Cal Program, or other payers or agencies.
4. Information identified by health system committees.
5. Information reported by patients, their families, or caregivers.
6. Information otherwise brought to the attention of the Chief Executive Officer, the Chief of the Medical Staff, or the Medical Executive Committee.

Pursuant to the Medical Staff Bylaws, Rules and Regulations, and policies, the failure to follow such requirements may result in disciplinary action imposed against medical staff membership and/or privileges as stated in the signed Medical Staff Professionalism and Code of Conduct Agreement (Attachment A).

The Professional Standards Committee Chair (“PSC”) shall report to Alameda Health System and Alameda Hospital Medical Executive Committees on only matters pertaining to that medical staff and shall report in Executive Session to the applicable medical staff
matters pertaining to individual providers on that medical staff. Reports in Executive Session shall include Tier 2 interventions. Minutes of the PSC shall include a joint session for matters and Providers affecting both medical staffs and separate minutes for each medical staff that include for matters affecting only that one medical staff, such as actions regarding a Provider who only is a member of one medical staff.

**Definitions**

A) **Acceptable Professional Behavior** – Acceptable Professional Behavior are defined as conduct that is in keeping with the Medical Staff Bylaws, this policy and the standards for health care professionals as evidenced by the Hippocratic Oath, the Code of Ethics of the American Medical Association (AMA) and other applicable professional societies that promote a high standard of professional behavior, ethics and integrity. Acceptable behavior includes but is not limited to conduct that:

I. Adhere to the ethics of their respective professions by providing patients with high quality of care. Encourage a “Just Culture” which further reinforces the commitment of the Medical Staff and Alameda Health System to the highest standards of safety and quality. *(Just Culture Algorithm- Attachment B)*

II. Facilitate consistent, active, and cooperative patient care at all times.

III. Recognize the individual responsibilities of all members of the patient care team and respect the right of all members to independently advocate on behalf of the patient.

IV. Maintain respect for the dignity and sensitivities of patients and families as well as colleagues, health system employees, and all other participating Medical Staff and support staff.

V. Maintain confidentiality, as required by law, of all information and records received in the provider-patient relationship.

VI. Be willing to participate in and properly discharge those responsibilities determined by the Medical Staff and outlined in the Bylaws.

VII. Participate in Medical Staff Quality assessment and peer review activities, participate in organizational performance improvement activities, and contribute to the overall educational mission of the health system.

VIII. Reflect positively upon the reputation of the health care profession, the Medical Staff, and Alameda Health System in their language, action, attitude and behavior.

B) **Unprofessional Behavior** - Unprofessional Behavior is conduct that is overt or passive behavior, whether verbal, physical, in documentation or social media, that negatively affects, or that has the potential to negatively affect patient safety or the delivery of patient care. Examples of Unprofessional Behavior include but are not limited to:

I. Intentional damage to medical center property, theft and other fraudulent acts;

II. Use of language, physical contact, or gestures that may be offensive, threatening, degrading and/or abusive towards patients and their family, nurses, hospital personnel, or other providers;

III. Use of profanity or similarly offensive language while in the hospital and/or while speaking with nurses, patients or other hospital personnel;
IV. Disparaging comments while in the healthcare setting that undermines a culture of safety;

V. Inappropriate medical record entries or statements regarding the quality of care being provided at the hospital;

VI. Refusal to abide by Medical Staff requirements as delineated in the Medical Staff Bylaws and Regulations;

VII. Sexual Harassment - Unwanted sexual advances, requests for sexual favors, or other verbal, visual or physical conduct of a sexual nature;
  i. Behavior which occurs in or outside of the work setting and hours when:
      1. Submission to such conduct is made either explicitly or implicitly a term or condition of an individual’s employment;
      2. Submission to or rejection of such conduct is used as the basis for employment decisions affecting an individual;
      3. Conduct that has the purpose or effect of unreasonably interfering with an individual’s work performance or of creating an intimidating, hostile or offensive work environment.
  ii. Types of sexual harassment:
      1. Verbal: innuendoes, epithets, derogatory slurs, off-color jokes, propositions, graphic commentaries, threats, and/or suggestive or insulting sounds
      2. Visual/Non-Verbal: derogatory posters, cartoons, or drawings; suggestive objects or pictures; leering; and/or obscene gestures
      3. Physical: unwanted physical contact including touching, interference with an individual’s normal work movement, and/or assault
      4. Other: threatening or carrying out retaliation as a result of an individual’s negative response to harassing conduct

VIII. Physical or threatened physical assault;

IX. Harassment;

X. Discrimination;

XI. Social media misconduct.

C) Department Chair - The Department Chair will be deemed to include the Chair’s designee’s who may be a Division Chief, or another Department member appointed by the Chair to fulfill the Chair’s functions hereunder or may be designated by the Chief of Staff if the Department Chair is unavailable to appoint a designee or may have a conflict.

D) Egregious behavior - Egregious behavior is reported Unprofessional Behavior that may be grounds for a summary action, as such grounds for a summary action are described in the Medical Staff Bylaws.

E) Tiers - Tiers I, II and III are the progressive processes to review reported Unprofessional Behavior that are based upon the policy of progressive reviews and progressive interventions for reported Unprofessional Behavior. By way of example
and only for guidance but not limitation, Tier 1 reviews and interventions are for the first reported incident of reported Unprofessional Behavior; Tier 2 is for reported recurrence of reported Unprofessional Behavior after a Tier 1 review of similar nature within the prior twelve months or concerns there may have been a pattern of Unprofessional conduct; and Tier 3 is for reported egregious behavior or reported recurrence of Unprofessional Behavior after a Tier 2 review and intervention.

F) Record Maintenance - The records regarding Unprofessional Behavior will be maintained by Medical Staff outside of the credentials file for no longer than 10 years. Records older than 2 years may be used to identify a pattern, if needed.

Procedure
Any medical staff member, employee, patient, or visitor may report potentially Unprofessional Behavior. The identity of the individual reporting medical staff misconduct should not be disclosed to the individual who is the subject of the reported Unprofessional Behavior unless required as part of the medical staff hearing procedures in the Medical Staff Bylaws. The following procedure will be shown in the Professionalism and Conduct Policy Flow Chart (Attachment C).

Disciplinary intervention or a recommendation for formal corrective action to address Unprofessional Behavior will be in accordance with the Medical Staff Bylaws. If the Medical Executive Committee (also referred to herein as “MEC”) initiates a corrective action investigation, it shall comply with the Medical Staff Bylaws.

If the failure to immediately act may pose a risk of imminent danger to any person, including but not limited to zero tolerance behaviors of assault or other criminal acts, any person authorized in the Medical Staff Bylaws may impose summary restrictions or a summary suspension of the Practitioner’s membership and privileges in accordance with the Bylaws. The provisions of the Bylaws shall be followed for review of summary restrictions and summary suspensions.

A) Allegation / Concern Raised
Anyone who believes that they are being subjected to Unprofessional Behavior, has had Unprofessional Behavior reported to them, or has witnessed Unprofessional Behavior by a Provider is authorized and directed to take the following actions:

I. File a written report of the alleged incident via the MIDAS event reporting system or directly with the Medical Staff Services Office. Where possible, reports shall, to the extent possible include:
   i. Date and time of the reported event or behavior.
   ii. The medical record number of any patient present or involved with the event which is being reported.
   iii. A detailed factual description of the event or behavior observed. The description should include the names of all parties involved or who witnessed the behavior, a description of the behavior observed, and a description of any observed or potential effects on quality and patient safety or hospital operations.
iv. A description of any actions taken or attempts to remedy the situation, including the date, time and place of actions taken and the names of those intervening.

II. The Medical Staff Office will report all allegations of Unprofessional Behavior received from any source as described above to the Provider’s Department Chair.

III. If it appears the initially reported Unprofessional Behavior may pose a threat to patient safety or to the delivery of patient care, the Chief of Staff and Department Chair shall be immediately notified of the reported Unprofessional Behavior to timely assess if summary action may be reasonable and warranted pending further review. Unprofessional Behavior that is determined should be addressed via a summary action pending investigation is processed in accordance with the Medical Staff Bylaws.

IV. Absent the reported Unprofessional Behavior that will be addressed via a summary action or the corrective action process in the Medical Staff Bylaws, the Department Chair will review the allegation and make an initial determination whether the reported Unprofessional Behavior should be reviewed pursuant to Tier 1 or Tier 2 of this policy. Absent a preliminary determination by the Department Chair that the reported Unprofessional Behavior appears to be egregious, in general, Tier 1 reviews are for a Provider’s first reported Unprofessional Behavior and Tier 2 reviews are for what the Department Chair is preliminarily concerned may be a second incident of a similar nature within the prior twelve (12) months or a pattern of Unprofessional Behavior. The Department Chair may consult with the Chief of Staff or Professional Standards Committee Chair regarding such initial determination.

B) Tier 1 Review and Interventions
   I. Allegation Review
      i. If an allegation is submitted through MIDAS, the Patient Safety Department reviews the reported allegation, and at their discretion consults with the Department Chair to determine whether the incident reported could have occurred and if it may represent Unprofessional Behavior.

      ii. If the Department Chair preliminarily believes the reported Unprofessional Behavior could have occurred and may represent Unprofessional Behavior, the Chair triages the allegation as described in Section A.

      iii. At any time, an assigned Tier may be changed or referred for corrective action or summary action if, in the course of the review, the
change is deemed appropriate by the individual or committee reviewing the allegation.

II. Tier I Intervention
   i. If the Department Chair determines that the intervention meets the criteria for Tier I review, then the following steps should be followed:

   - The Department Chair shall contact the Provider and describe the nature of the behavior that has been reported. The Department Chair shall:
   - Attempt to the extent reasonably possible contact the reporting individual to acknowledge receipt of the allegation and its review.
   - Attempt to the extent reasonably possible under the circumstances to protect the identity of those individuals reporting the event and those individuals providing additional information regarding the event.
   - Either (i) engage in a verbal dialog or conversation with the Provider and give them an opportunity to describe their account of the event or (ii) provide a summary of allegations to the Provider in writing and request the Provider respond within 10 days.
   - If the Department Chair engages in a verbal dialog or conversation with the Provider, the Department Chair shall document the conversation with the Provider on the Tier 1 Conversation (“Coffee Talk”) Form - Attachment D).
   - If requested by the Department Chair, other Members of Medical staff may participate in the interview or review process.
   - The Department Chair may request additional information regarding the reported Unprofessional Behavior from the person(s) who reported the Unprofessional Behavior, witnesses and/or others, as the Department Chair deems appropriate.

   ii. Based on the findings of Tier I review, actions that may be taken include but are not limited to and may include one or more such actions:

   - Determine that no action is warranted at this time.
   - Discuss the matter with the Provider, emphasizing that the behavior is inappropriate and must cease.
   - Coaching or mentoring by Department Chair or a designee.
   - Letter of counseling.
   - Referral to Provider Wellbeing Committee.
   - Recommend Educational course or external counseling at the Provider’s expense.
iii. Documentation of the Tier 1 review shall be maintained as confidential peer review information.

C) Tier 2 Review and Intervention
   I. If the Department Chair determines that the intervention meets the criteria for Tier 2, then the following steps should be followed:
      i. Department Chair refers allegation to PSC along with documentation regarding previous allegations, any interventions, and any preliminary review of this allegation.
      ii. Any Medical staff member or AHS employee can refer an allegation to PSC if it meets criteria for Tier 2.
      iii. MEC or Chief of Staff can refer an allegation to PSC.
      iv. Chair of PSC reviews allegation with the PSC members. As a part of the review;
         a. The PSC can assess and close the case with no further review at this time if it determines the allegations are not substantial enough to warrant further inquiry;
         b. The PSC will determine the means to obtain a response from the Provider, which may include but not be limited to requiring a written response to the reported Unprofessional Behavior within ten calendar days, requiring the Provider discuss the reported Unprofessional Behavior with one or more designees of the PSC, and/or the Provider required to meet with the PSC. If there is a discussion or interview, either minutes or a memo to the file that includes the date and time of the meeting and what was discussed, including but not limited to the Provider’s responses, shall be prepared as minutes of such discussion.
         c. The PSC can determine whether a subcommittee needs to be formed to facilitate conducting interviews and gathering necessary information. All interviews will be documented by committee members.
      v. The Provider’s written response shall be maintained as a Medical Staff document and be placed in the confidential credentials file.
      vi. Documentation and findings from the review shall be considered if there are further incidents and considered at the time of appointment/reappointment.
      vii. If no written response is received within the allotted time or the Provider declines presenting in front of the committee the Provider may be required to attend a meeting following the processes in the Bylaws.
      viii. Based on the findings of Tier 2 review by the PSC, actions that may be taken include but are not limited to and may include one or more such actions:
         a. Determine that no action is warranted at this time;
         b. Implement any of the actions listed as options for a Tier 1 intervention;
c. Discuss the matter with the Provider, emphasizing that the behavior is inappropriate and must cease AND
d. Issue a written warning;
e. Refer the event to the Physician Well-Being Committee. The Physician Well-Being Committee shall be available to provide consultation for issues related to a Provider's psychological or physical health.
f. Strongly recommend educational course, with the option of a warning of referral to the MEC if the Provider fails to timely comply with recommendation.
g. Refer the Provider’s behavior to the Chief of Staff/Medical Executive Committee for evaluation.
h. Refer the Provider’s behavior to the Chief of Staff/Medical Executive Committee for corrective action to be conducted in accordance with the Medical Staff Bylaws.

vi. A copy of the complaint and documentation of the outcome and intervention will be documented. The Department Chair shall be advised of the outcome and intervention.
vii. The PSC may recommend MEC to include documented summary of the event in the provider’s OPPE. MEC will make the final decision.
viii. Repeated Tier 2 behavior and/or failure to comply with recommended Tier 2 interventions may warrant escalating the intervention to Tier 3 intervention or requesting corrective action in accordance with the Bylaws.

D) Tier 3 Review and Intervention

I. If the allegation may be considered an egregious incident, action will be taken promptly.

II. Department Chair, Chief of Staff/Designee and/or MEC must be promptly alerted about the allegation;
   i. One or more leader with the authority to impose summary action will promptly attempt to speak with the Provider to ask about the incident to help determine if a summary action pending investigation should be immediately imposed in accordance with the Bylaws.
   ii. If a summary action is imposed, the processes in the Bylaws shall be followed.
   iii. If a summary action is not imposed, but it appears the reported Unprofessional Behavior may be grounds for corrective action and potential disciplinary action, Chief of Staff in consultation with the Department Chair and/or MEC will review the allegation and determine the appropriate next steps to review the allegations in compliance with Medical Staff Bylaws and this policy.
      a. The involved Provider may be required to meet with the Medical Executive Committee, the PSC or an ad hoc
committee of either the MEC or PSC to promptly review/investigate the allegation.
b. Findings will be promptly reported to Chief of Staff and/or MEC.

III. Based on the findings of Tier 3 review, the MEC’s actions may include but not be limited to:
   i. No action is warranted at this time;
   ii. Discuss the matter with the Provider, emphasizing that the behavior is inappropriate and must cease AND
   iii. Issue a written warning and document a summary of the event in the provider’s credentials file and their OPPE.
   iv. Refer the event to the Physician Well-Being Committee. The Physician Well-Being Committee shall be available to provide consultation for issues related to a Provider's psychological or physical health.

IV. Letter of reprimand
The Medical Executive Committee may elect to send the Provider a letter of reprimand, particularly in cases where the alleged violation of Medical Staff Bylaws, Rules or Regulations presented either actual or potential risk to patient health and safety and/or actual or potential disruption of health system operations, or both. The reprimand will state that any further violation by the Provider may result in additional corrective action in accordance with the Medical Staff Bylaws, Rules and Regulations, and these guidelines.

V. Commence a corrective action investigation.
If a corrective action investigation is commenced, in addition to the foregoing, options for the MEC to impose are as stated in the Medical Staff Bylaws and include but are not limited to, and may include more than one of the foregoing and/or the following:
   i. Mandatory Educational course acceptable to the Medical Staff at the Provider’s expense.
   ii. Mandatory Counseling and/or Anger Management Therapy acceptable to the Medical Staff at the Provider’s expense.
   iii. Restriction of privileges.
   iv. Suspension of privileges or Medical Staff membership.
   v. Summary suspension of privileges or Medical Staff membership.
   vi. Revocation of privileges or Medical Staff membership.

At any time during a Tier 3 review, corrective action investigation may be requested and commenced and/or a summary action may be imposed pending further investigation if deemed reasonable and warranted in accordance with the Medical Staff Bylaws.

E) Compliance with Allegation
Efforts shall be made to ensure that involved individuals are not retaliated against and are treated respectfully.

I. Providers shall be cautioned about the prohibition on intimidating, harassing, or retaliating against persons the Provider believes may have reported or witnessed reported behavior or who participated in the review process.

II. Neither the Provider nor their designee, shall attempt to contact the reporting individual(s) or witnesses regarding the reported event or reported Unprofessional Behavior and may not discuss the reported event or reported Unprofessional Behavior with the reporting individual(s) or others providing information regarding the event, except as may be authorized by this policy or the Medical Staff Bylaws or in accordance with the formal medical staff hearing process hospital administrative review process.

III. Any intimidation, retaliation or harassment by the Provider or persons acting on behalf of the Provider against a person who is believed to have reported or witnessed reported behavior or who participated in the review process will not be tolerated and should be immediately reported to either the Chief of Staff, Department Chair or Medical Staff Services Office. Such activity may be the basis for corrective action and discipline by the Medical Staff, including but not limited to summary action.

F) Confidentiality
All records and proceedings of the Medical Staff’s review, including but not limited to any witness statements, minutes, recordings and transcripts, shall be maintained as confidential, peer review documents.

Note: reporting Patient’s Written Allegation of Sexual Misconduct
If the Medical Staff receives a written allegation from a patient or a patient’s representative that alleges sexual abuse or sexual misconduct by a member of the Medical or Advance Practice Provider, or a licensee with privileges to practice or provide care for patients, an 805.8 report must be filed with the applicable California licensing agency (e.g. Medical Board of California) within 15 days after receiving the written allegation. Sexual misconduct means inappropriate contact or communication of a sexual nature. The report must be filed even if the Medical Staff has not completed its review or has determined during the 15-day time frame that the allegation is unsubstiantiated or not credible.

Approvals

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ALAMEDA HEALTH SYSTEM MEDICAL STAFF
and
ALAMEDA HOSPITAL MEDICAL STAFF

PROFESSIONALISM AND CODE OF CONDUCT AGREEMENT

☐ Application for Initial Appointment
☐ Application for Reappointment

As an applicant for appointment to the Medical Staff(s) of Alameda Health System and Alameda Hospital please review and familiarize yourself with the enclosed Medical Staff Professionalism and Conduct Policy.

You must read, sign and date this document in order to proceed with the processing of your application.

Please sign, date and return this form with your completed medical staff application.

1. I understand that my appointment to the Medical Staff and my continued clinical privileges remain contingent upon my ongoing demonstration of clinical competence and professional behavior.

2. Pursuant to the Medical Staff Bylaws, Rules and Regulations, and policies, the failure to follow such requirements may result in disciplinary action imposed against my privileges or medical staff membership.

3. I have received a copy of the Medical Staff Professionalism and Conduct Policy (enclosed). I understand that it is my responsibility to familiarize myself with the contents of this document. I agree, as a condition of my appointment, to abide by the Medical Staff Professionalism and Conduct Policy.

__________________________________________________________________________
Printed Name                      Signature

__________________________________________________________________________
Date

Medical Staff Professionalism and Code of Conduct Policy- Attachment A
119/240
Medical Staff Professionalism and Conduct Procedure – Just Culture Algorithm

(Attachment B; Use for investigating any allegation regardless of Tier classification)

Adapted from https://www.slideshare.net/daisyjiang/policymedical-webinar-policies-and-procedures-for-patient-safety (accessed 11/15/2023)
Medical Staff Professionalism and Conduct Procedure Process Overview

Flow Chart (Attachment C; Investigate allegation in accordance with the “Just Culture Algorithm” Attachment B)
Date of Conversation: __________

Starting Time: ________  Ending Time: ________

Chair/Chief Name: ____________________  Provider Name: ____________________

Brief description of the allegation lapse in professionalism:
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

The gap identified was:
______________________________________________________________________________
______________________________________________________________________________

The behavior and conduct had an impact on the following:

☑ Patient care
☑ Communication
☑ Teamwork
☑ Policy Violation(s)
☑ Other ________________

Providers response:
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Department Chair/Designee Follow-up Actions:

☑ Determine that no action is warranted at this time.
☑ Coaching or mentoring
☑ Letter of counseling
☑ Referral to Provider Wellbeing Committee
☑ Recommend educational course or external counseling at the Provider’s expense
☑ Other ________________

Provider Response (please check all that apply):

☑ Agreement with the plan
☑ Other ________________

Additional comments:
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

*Forward completed document to Medical Staff Services.  A copy may be provided to the provider.*
Alameda Health System

MEDICAL STAFF PHYSICIAN PRACTICE OFFICE POLICY

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<th>Department</th>
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Purpose

To establish mechanism and define the process for maintaining current office address with the Medical Staff Office as part of the requirements for membership and privileges as a member of the Alameda Health System (AHS) Medical Staff.

Policy

It is the policy of the AHS Medical Staff to require current office addresses be on file with the Medical Staff Office. To protect patient care and safety, Practitioners (as defined below) must have an office address where they can see patients to provide services as routinely provided for patients post-discharge and post-referral from ambulatory care.

Procedure

1. Medical Staff members with clinical privileges, not including members with “assist only” privileges or only telemedicine privileges. (as used herein, “Practitioners”) must timely notify the Medical Staff office of their office address where they see patients and can receive notices from the Medical Staff. If a Practitioner fails to provide within ten (10) days after notice from the Medical Staff an office address that includes facilities, equipment and patient services of a medical office where the Practitioner has made arrangements to see his/her patients who are discharged from the hospital or referred from the hospital’s ambulatory care, the Practitioner’s privileges will be automatically suspended pursuant to Medical Staff Bylaws Section 7.3-8 pending receipt of such information, with an automatic resignation pursuant to Section 7.3-13 if the automatic suspension remains in effect for sixty (60) days.

2. If the Practitioner has a home office that includes facilities, equipment and staff to provide the same facilities, equipment, staff and patient services as customarily provided in an office, the Practitioner may provide information and documentation that confirms this for the Practitioner’s Department Chair to review and confirm the home office meets the standards described in this paragraph to protect patient care and safety.
3. Upon receipt of the update address, Medical Staff Services will update the office address which interfaces into the health systems electronic health record to provide continuity of patient care.

4. Members with “assist only” privileges or only telemedicine privileges must provide an address where they can receive notices from the Medical Staff within the time frames and be subject to the same automatic administrative actions for not timely responding as described in Section 1 above. However, members with “assist only” privileges are not required to have an office as described in Sections 2 or 3 above.

5. Members with clinical privileges will notify the Medical Staff Office of a change in office address within thirty (30) days following such change in address.

**Approvals**

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Alameda Health System

Facility with Medical Staff Added to Hospital License

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<td>Director, Medical Staff Services</td>
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<td>Chief Medical Officer</td>
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Printed copies are for reference only. Please refer to electronic copy for the latest version.

PURPOSE

To implement Medical Staff procedures when the Alameda Health System adds another, separately licensed facility with an independent Medical Staff to their license to assure continuous availability of duly credentialed providers at the added facility by providers who are currently affiliated in good standing.

The Alameda Health System Medical Staff may recommend that the Governing Board approve special procedures (a) to facilitate the timely application for membership and clinical privileges, credentialing and proctoring of individuals who were members in good standing of the other facility who meet criteria that is established by this Medical Staff, and (b) to enable providers to continue to exercise the same clinical privileges at the other facility as they provided prior to the change in license, “grandfather” members in good standing of the other medical staff to be able to apply for membership and clinical privileges that they held at such other facility by waiving a criteria for a clinical privilege or membership, provided (i) there is no right to such waiver, (ii) no right to a hearing for failure to grant a waiver, and (iii) such “grandfathering” is to limited individuals who held membership and/or clinical privileges in good standing and meet criteria that may be established by the Medical Staff for such “grandfathering.”

POLICY

1. An expedited appointment process, including waiver of dues or fees may be approved by the Medical Executive Committee to help assure a sufficient number of qualified and competent persons to provide care, treatment and services at the site which is to be added to Alameda Health System’s license.

2. If the other facility’s medical staff’s credentialing files, peer review and quality data are provided to this Medical Staff, individuals may be excused from certain requirements such as proctoring or Board Certification, if they meet other required criteria.

3. Given the goal of minimal disruption of at the other facility and pending further review, the staff category assignments at the other facility may be recognized, if different than existing categories defined in current Bylaws.
PROCEDURE

1. The Medical Staff Office may modify its application for appointment to enable members of the other medical staff who are not currently members of the AHS medical staff to apply for AHS medical staff membership and clinical privileges.

2. To facilitate the transition and expedite processing for the new site, credentialing may be performed in stages.

3. If it is determined there may be a shortage of a particular specialty for the new site, other AHS credentialed providers may be permitted to perform their current privileges at the other facility.

4. The MEC will determine the applicable fees and dues, if any, for applications for membership and/or clinical privileges.

5. If the other medical staff’s application and privileging information are available to feasibly do so, the Medical Staff Office will send pre-populated applications and pre-populated privilege forms to individuals on the other medical staff who are not members of the AHS Medical Staff.

6. The prepopulated application and request for privileges must be signed, dated and returned to the Medical Staff Office and include require execution of a (i) Attestation Questionnaire, (ii) Release/Acknowledgment form, (iii) Confidentiality and Security Agreement form, (iv) Medical Staff Quality and Assessment and Peer Review Agreement form and (v) Consent to the release of information and documents to AHS, including but not limited to any and all background checks.

7. An AHS credentials file will be established and will include the information and documents from the other medical staff’s credentials file and quality information.

8. The Medical Staff Office shall primary source verify:
   a. CA Medical or Professional License(s)
   b. Federation of State Medical Boards (if applicable)
   c. National Practitioner Data Bank (NPDB)
   d. LVS 805 Report
   e. Current DEA certificate (if applicable)
   f. Radiology/fluoroscopy certificate (if applicable)
   g. ECFMG (if applicable)
   h. Board Certification
   i. Background Check (if not previously conducted in the prior 24 months)
   j. Medical Sanctions and CMS Opt Out

9. The Medical Staff Office shall confirm that the credentials file from the other medical staff includes:
   a. Evidence of current professional liability insurance.
b. Evidence of a background check performed within the prior twenty-four (24) months.
   i. If a background check has not be performed within the prior twenty-four (24) months, the Medical Staff Office shall follow the processes to request a background check.

c. Current DEA Certificate (if applicable to specialty)

d. BLS/ACLS (if required for membership and/or privileges)

e. Fluoroscopy Certificate (if applicable)

f. Statement or other documentation of continuing medical education activities

g. Either (i) documentation of FPPE/Proctoring satisfactorily completed within the prior two years for the requested clinical privileges, (ii) OPPE and activity logs that demonstrate the individual competently performed the requested clinical privileges, and/or (iii) a statement from the Chair of the applicable Department that attests to the individual’s current clinical competence to perform the requested clinical privileges.

h. Evidence of Board Certification or Eligibility. If there is no evidence of Board Certification or Eligibility, but (i) the individual held clinical privileges at the new site and was not been subject to adverse action or a recommendation for adverse action based on the individual’s care or conduct that was grounds for requesting a hearing, and (ii) the former applicable Department Chair or designee of the applicant submits a peer reference that states the individual demonstrated competence through the credentialing and peer review processes comparable to a Board Certified provider, then the applicant may be “grandfathered” to be excused from the AHS Board Certification or Eligible requirements to apply to hold clinical privileges that will be limited to other facility. There is no right to such waiver.

10. If any required information or documents are not included with the application or not included in the credentials file, the applicant shall be notified and given thirty (30) days to submit such information and documents as the Medical Staff requires. Failure to timely provide such information and documents automatically will result in the incomplete application being deemed withdrawn, which is not grounds for a hearing.

11. Notwithstanding the foregoing,
   a. If an individual executed and returned to the Medical Staff within the prior ninety (90) days a complete application for membership and privileges, the individual may not be required to complete and submit all of the forms attached to the application; provided, however, if information or concerns are identified that may indicate information may have changed from what was submitted or other new concerns are identified, the applicant may be required to execute and submit all of the forms again.

   b. To facilitate the transition, individuals (i) who held membership and clinical privileges at the other site but did not have AHS membership and clinical privileges, and (ii) whose membership at the other site would have expired during the six (6) months following the merger, may be appointed for a term that expires one (1) year from when their membership at the other site would have expired. In no event will an individual be appointed for more than two (2) years.
12. An expedited approval process of individuals who held membership and clinical privileges at the other site in order to be appointed to the AHS medical staff and maintain the same clinical privileges at the other site as the applicant held at the other site prior to the change in the Hospital’s license may be followed that includes approvals by the applicable Department Chair, Medical Executive Committee and at least two voting members of the Board of Trustees, for applicants who:
   a. Have complete applications.
   b. Have not had a current challenge or previously successful challenge to licensure or registration.
   c. Have not received an involuntary termination of medical staff membership at another hospital.
   d. Have not received involuntary limitation, reduction, denial or loss of clinical privileges.
   e. Have not been determined to have either an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant.

There is no right to the expedited approval process and no right to a hearing to challenge a decision not to process an application via the expedited approval process.

11. If the AHS Medical Staff receives access to recent activity, quality and peer review data, such as OPPE and FPPE, the initial appointees to the AHS Medical Staff and those who are granted clinical privileges previously held at the other facility, may be excused from routine FPPE/proctoring upon the recommendation of the applicable Department Chair if (a) the individual holds such privileges at AHS that are not subject to proctoring, and/or (b) the Department Chair reviews of the activity, quality and peer review data from the other facility’s former medical staff and confirms the individual exercised such privileges without triggering a non-routine focused review based on questions or concerns with care or conductor and had no adverse recommendation/action. There is no right to the waiver of routine FPPE/proctoring and no right to a hearing to challenge a decision not to waive routine FPPE/proctoring.

12. Non-substantive revisions may be made to the AHS privilege forms, applications, policies and other medical staff documents to address the additional facility being added as an AHS license, including but not limited to adding, deleting and/or clarifying the applicable medical staff’s subject to the forms, applications and policies and assuring privileges are site specific.

APPROVALS

<table>
<thead>
<tr>
<th>Committee</th>
<th>Date</th>
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</thead>
<tbody>
<tr>
<td>Bylaws Committee</td>
<td>11/9/2023</td>
</tr>
<tr>
<td>Medical Executive Committee</td>
<td>11/15/2023</td>
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<tr>
<td>QPSC</td>
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</tbody>
</table>
Alameda Health System

MEDICAL STAFF ADVANCED PRACTICE PROVIDER CATEGORIES

<table>
<thead>
<tr>
<th>Department</th>
<th>Medical Staff</th>
<th>Effective Date</th>
<th>1/2022</th>
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</thead>
<tbody>
<tr>
<td>Campus</td>
<td>AHS, AH</td>
<td>Date Revised</td>
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</tr>
<tr>
<td>Unit</td>
<td>Medical Staff</td>
<td>Next Scheduled</td>
<td>1/2024</td>
</tr>
<tr>
<td>Manual</td>
<td>Medical Staff</td>
<td>Author</td>
<td></td>
</tr>
</tbody>
</table>

Replaces the following Policies: Responsible Person
Director, Medical Staff Services
Chief of Staff

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

Purpose

The Alameda Health System Medical Staff Bylaws define Advanced Practice Providers (APP) to establish mechanisms regarding who provide patient care services at Alameda Health System (AHS) and Alameda Hospital (AH).

Policy Statement

It is the policy of the AHS Medical Staff and AH Medical Staff that Advanced Providers (APPs) are not eligible for Medical Staff membership. APPs who demonstrate evidence of current licensure, relevant training and/or experience, professional competence, and continuously meet the qualifications, standards, and requirements set forth in this policy and the including the APP policies and procedures, may be granted clinical privileges or practice prerogatives by the Health System.

Categories of APPs

The types of APPs granted clinical privileges or practice prerogatives in the Health System are determined by the Board of Trustees, based on feedback from the Committee on Interdisciplinary Practice, Credentials Committee, Medical Executive Committee, and such other information as may be available to the Board of Trustees.

Eligible Categories

Independent APPS

APPs, who practice in categories that have been accepted for admission to this Health System by the Board of Trustees, are eligible for appointment to APP status. The Medical Staff and Board of Trustees has approved the following categories of Independent APPs:

- Acupuncturist
- Audiologist (AH Medical Staff)
- Optometrist

Dependent APPS
The Medical Staff and Board of Trustees has approved the following categories of Dependent Advance Practice Providers:

a. Nurse Practitioner  
b. Certified Registered Nurse Anesthetist (AHS Medical Staff)  
c. Certified Nurse Midwife (AHS Medical Staff)  
d. Physician Assistant

Non-Eligible Categories
An APP who does not have licensure or certification in an APP category identified as eligible to apply for practice prerogatives in Section 6.2 of the Medical Staff Bylaws may not apply for practice prerogatives but may submit a written request to the Chief Medical Officer asking that the Board of Trustees consider identifying the relevant category of APPs as eligible to apply for practice prerogatives. The Board of Trustees may refer the request to the Medical Executive Committee for recommendation.

Voting, Privileges and Committee Meetings
APPs shall not be entitled to vote on AHS/AH Medical Staff matters or to satisfy any AHS/AH Medical Staff attendance requirements. They shall, however, be expected to attend and participate actively in the clinical meetings of their respective departments to the extent permitted by the Department Chair. APPs may be invited to the Annual Medical Staff meeting as guest with no voting rights.

Approvals:

<table>
<thead>
<tr>
<th>Medical Executive Committee</th>
<th>AHS</th>
<th>Alameda</th>
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</thead>
<tbody>
<tr>
<td>Date:</td>
<td>1/19/22</td>
<td>1/21/22</td>
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<tr>
<td>QPSC</td>
<td>Date:</td>
<td>1/26/22</td>
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<tr>
<td>Board of Trustees</td>
<td>Date:</td>
<td>2/9/22</td>
</tr>
</tbody>
</table>
Alameda Health System

MEDICAL STAFF DEPARTMENT DIVISION CHIEF / SITE DIRECTOR

<table>
<thead>
<tr>
<th>Department</th>
<th>Medical Staff</th>
<th>Effective Date</th>
<th>10/2021</th>
</tr>
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<tbody>
<tr>
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<td>AHS</td>
<td>Date Revised</td>
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</tr>
<tr>
<td>Unit</td>
<td>Medical Staff</td>
<td>Next Scheduled Review</td>
<td>10/2024</td>
</tr>
<tr>
<td>Manual</td>
<td>Medical Staff</td>
<td>Author</td>
<td></td>
</tr>
</tbody>
</table>

Replaces the following Policies: Responsible Person

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

Purpose

The Alameda Health System (AHS) Medical Staff Bylaws define requirements for the Alameda Health System Division Chief or Site Director role. This policy describes the Medical Staff Division Chief or Site Director duties, responsibilities, and procedure for appointments.

Policy Statement

It is the policy of the AHS Medical Staff that the role of Division Chief or Site Director is in alignment with the AHS Medical Staff Bylaws. Division Chiefs or Site Directors shall be provided administrative time by the hiring entity (e.g., EBMG, UCSF, AHS, etc.)

Qualifications

Each Division and Site may have a Chief who at all times while holding office must be an Active Staff member or a Provisional Staff member in good standing and a member of the appropriate division. The Division Chief or Site Director must be qualified by training, experience, and demonstrated current ability in the clinical area covered by the Division. All Division Chiefs or Site Directors shall be board certified or be board eligible as outlined in the Medical Staff Bylaws.

Appointment

A Division Chief or Site Director shall be appointed by the Chair of the Department after careful review of the candidate's qualifications. Such appointments shall be made with the advice of the Chief of Staff and reported to the Medical Staff Department.

The Division Chief’s or Site Director’s performance shall be reviewed by the Chair of the Department and reported to the Medical Executive Committee, and the appointment shall continue, if performance is satisfactory and the Chair so recommends.
**Removal**

A Division Chief or Site Director will immediately cease being the Division Chief or Site Director upon any of the following:

a. They resign.
b. They cease to be an Active or Provisional Medical Staff member in good standing.
c. They are removed by the Chair of the Department with the concurrence of the Chief of Staff and reported to the Medical Executive Committee.
d. Such removal shall have no effect on the individual's clinical privileges or Medical Staff membership and is not subject to hearing procedures described in the Medical Staff Bylaws.

**Duties**

Each Division Chief or Site Director shall:

a. act as presiding officer at Division or Site meetings;
b. assist in the development and implementation, in cooperation with the Chair of the Department, of programs to carry out the quality review, and evaluation and monitoring functions assigned to the Division or Site;
c. evaluate the clinical work performed in the Division or Site;
d. conduct investigations and submit reports and recommendations to the Chair of the Department regarding the clinical privileges to be exercised within the Division or Site by members or applicants to the Medical Staff;
e. recommend to the Chair of the Department, specific clinical privileges for each Medical Staff member holding or requesting clinical privileges in the department both at the time of initial appointment and reappointment; and perform such other duties commensurate with the office as may from time to time be reasonably requested by the Chair of the Department, the Chief of Staff, or the Medical Executive Committee.

**Approvals:**

<table>
<thead>
<tr>
<th>Medical Executive Committee</th>
<th>AHS Core Date: 10/20/2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>QPSC</td>
<td>Date: 10/27/2021</td>
</tr>
<tr>
<td>Board of Trustees</td>
<td>Date:</td>
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</tbody>
</table>

\[132/240\]
B4. Revised Privilege Form(s) for AHS and AH_
November 29, 2023

TO: Quality Professional Services Committee

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

SUBJECT: Agenda Item: B4
Meeting Date: November 29, 2023
Item Description: Medical Staff Specialty Privilege Forms

COMMITTEE ACTION: Approval of revised Medical Staff Privilege Form

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

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

Prior Board Action: n/a

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

Revised Privilege Forms for AHS and AH:
• Emergency Medicine Multifacility
• Psychiatry Multifacility
• Pulmonary and Critical Care Medicine Multifacility

Fiscal Impact: n/a

Budgeted/Authorized: n/a

Estimated Cost Savings: n/a

Strategic Plan Pillar: Access, Quality, Experience
Emergency Medicine Multifacility Privileges
Delineation of Privileges

Applicant's Name:

Instructions:

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

<table>
<thead>
<tr>
<th>Required Qualifications</th>
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<tbody>
<tr>
<td><strong>Membership</strong></td>
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<tr>
<td><strong>Education/Training</strong></td>
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<td><strong>Continuing Education</strong></td>
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<td><strong>Certification</strong></td>
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<tr>
<td><strong>Clinical Experience (Initial)</strong></td>
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<tr>
<td><strong>Clinical Experience (Reappointment)</strong></td>
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</tbody>
</table>
Primary Privileges in Emergency Medicine

**Description:** Immediate recognition, evaluation, care, stabilization and disposition of a generally diversified population of patients in response to acute illness and injury. Focus on the immediate decision making and action necessary to prevent death or any further disability.

<table>
<thead>
<tr>
<th>Request</th>
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<tbody>
<tr>
<td><strong>Request all privileges listed below.</strong></td>
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<thead>
<tr>
<th>AHS Core</th>
<th>AH</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>- Currently granted privileges</td>
</tr>
<tr>
<td></td>
<td>Perform history and physical examination</td>
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<td></td>
<td>Attend, evaluate, diagnose, and initially treat patients who present to the emergency department with any symptom, illness, injury or condition, and provide services necessary to ameliorate minor illnesses or injuries; stabilize patients with major illnesses or injuries and assess all patients to determine if additional care is necessary.</td>
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<tr>
<td></td>
<td>Inpatient admission</td>
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<td></td>
<td>Admit and attend adolescents (14-21) years of age</td>
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</tbody>
</table>

**Procedures**

| | Diagnostic procedures including arthrocentesis; lumbar puncture; slit lamp examination; tonometry; pulse oximetry; arterial blood gas sampling and analysis; EKG; preliminary X-ray interpretation; and occult blood testing. |
| | Techniques utilized to stabilize the airway including use of airway adjuncts, rapid sequence intubation with paralytic agent, image-guided and video assisted laryngoscopy |
| | Cricothyrotomy |
| | Mechanical ventilation - all modes |
| | Skeletal procedures including stabilization of fractures and dislocations; immobilization techniques; reduction techniques; backboard and cervical immobilization techniques. |
| | Excision of thrombosed hemorrhoids |
| | Foreign body removal |
| | Gastric lavage |
| | Jejunostomy and gastrostomy tube replacement |
| | Wound management and closure including management of burns, nail removal, I&D abscess, and evacuation of hematoma |
| | Laryngoscopy, control of epistaxis, posterior packing, and chemical cautery |
| | Emergent delivery of newborns; Doppler fetal heart tones; pelvic exam; perimortem C-Section; and removal of IUD |
| | Thoracentesis |
| | Thoracostomy |
| | Pericardiocentesis |
| | Emergent thoracotomy |
| | Paracentesis and lavage |
| | Suprapubic tap and catheterization |
| | Urethral dilation |
| | Lateral canthotomy |
| | Vascular access including arterial catheter insertion; central venous access; venous cutdown |
Intraosseous infusion
Thrombolytic administration
Insertion of temporary pacemaker or use of external pacemaker and elective cardioversion

FPPE Requirements

AHS Core

AH

Ten (10) retrospective case reviews that are representative the scope and complexity of privileges requested.

Special Privilege Cluster: Emergency Limited Ultrasound

Description: Limited ultrasound for trauma or other indication.

Qualifications

Education/Training

- Documentation of training and experience during residency in accordance with ACEP Ultrasound Guidelines
- Emergency medicine physicians who did not receive training during residency should demonstrate at a minimum 25 proctored ultrasounds per primary indication or a minimum of 150 ultrasounds for general emergency ultrasound privileges
- Letter from Emergency Department Ultrasound Director certifying training and experience that meet ACEP Guidelines.

Clinical Experience (Initial)

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

Clinical Experience (Reappointment)

Applicant must provide evidence of ongoing clinical practice representative of the scope of privileges requested during the past 24 months.

Request

Request all privileges listed below.

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

- Currently granted privileges

Perform and interpret emergent, limited, or investigational ultrasound
## FPPE Requirements

### AHS Core

<table>
<thead>
<tr>
<th>AH</th>
<th>AHS Core</th>
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- Five (5) retrospective case reviews

### Privilege Cluster: Stroke Care

#### Qualifications

**Education/Training**

For recent graduates of Emergency Medicine Residency program, physician must have completed at least a 1-month Neurology rotation during Emergency Medicine residency or must attest to supervised management of acute stroke patients (10 cases) during residency.

**Clinical Experience (Initial)**

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

**Clinical Experience (Reappointment)**

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

### Request

Request all privileges listed below.

- Currently granted privileges
- Stroke care
- Thrombolytic Therapy - Standard Protocol

**Description:**

Directly visualized, focused TEE in cardiac arrest patients with tracheal intubation.

**FPPE Requirements**

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<th>AHS Core</th>
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</table>

- Ten (10) retrospective case reviews that are representative of the scope and complexity of the privileges requested.

**Description:**

Directly visualized, focused TEE in cardiac arrest patients with tracheal intubation.
Qualifications

Education/Training

Providers seeking credentialing in transesophageal echocardiography of cardiac arrest applications should have completed training and met competency standards in transthoracic echocardiography and:

- Completed a minimum of 2-4 hours of TEE-specific CME or didactics;

  AND

- Performed a minimum of 10 cardiologist proctored TEE examinations (including probe insertion) on live patients and simulation models;

  AND

- Completed a standardized assessment by a credentialed TEE provider

Clinical Experience (Initial)

10 procedures performed during previous 12 months (waived for applicants who completed training within the previous year)

Clinical Experience (Reappointment)

10 procedures performed per year (average over 2 years)

Request

Request all privileges listed below.

AHS Core

AH

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

- [ ] Currently granted privileges

- [ ] Focused Transesophageal Echocardiography (TEE) including probe placement, image acquisition and interpretation.

FPPE Requirements

AHS Core

AH

- [ ] Retrospective review of 3 cases

**TELEMEDICINE PRIVILEGES INPATIENT OR OUTPATIENT CARE**

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

**Qualifications**

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

Request

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

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<th>AHS Core</th>
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</table>

- Currently granted privileges

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

Acknowledgment of Applicant

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

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

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

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

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

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</table>

Signature of Department/Service Chair or Designee

Date

Submit
Applicant's Name:

Instructions:

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

### Required Qualifications

<table>
<thead>
<tr>
<th>Membership</th>
<th>Meet all requirements for medical staff membership.</th>
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</thead>
<tbody>
<tr>
<td>Education/Training</td>
<td>For initial applicants, effective January 1, 2020, completion of an ACGME or AOA accredited residency training program in psychiatry. <strong>OR</strong> Completion of at least three (3) years of training in an ACGME or AOA approved psychiatry residency training program and active participation as a resident or fellow in an ACGME or AOA approved training program. Moonlighting will require authorization from the training program director.</td>
</tr>
<tr>
<td>Continuing Education</td>
<td>Applicant must have 25 Category I CME credits per year directly related to the practice of critical care medicine (waived for applicants who have completed, or are currently in, training during the previous 24 months). <strong>OR</strong> Applicant must be active in the MOC program in psychiatry by the relevant American Board of Psychiatry &amp; Neurology or in Psychiatry by the American Osteopathic Board of Neurology &amp; Psychiatry or its equivalent.</td>
</tr>
<tr>
<td>Certification</td>
<td>Current certification or board eligibility in the examination process leading to certification in psychiatry by the American Board of Psychiatry &amp; Neurology or in Psychiatry by the American Osteopathic Board of Neurology &amp; Psychiatry or its equivalent. <strong>OR</strong> Enrollment in an ACGME or AOA approved residency or fellowship training program in psychiatry or a psychiatric sub-specialty.</td>
</tr>
<tr>
<td>Clinical Experience (Initial)</td>
<td>Applicant must provide documentation of provision of psychiatry services (3 cases) representative of the scope and complexity of the privileges requested during the previous year (waived for applicants who completed, or are currently in, training during the previous year).</td>
</tr>
<tr>
<td>Clinical Experience (Reappointment)</td>
<td>Applicant must provide documentation of provision of clinical services (6 cases) representative of the scope and complexity of the privileges requested during the past 24 months.</td>
</tr>
</tbody>
</table>
**Psychiatry Privileges**

*Description:* Diagnosis, treatment and prevention of the following types of disorders: mental, emotional, psychotic, mood, anxiety, developmental disabilities, behavioral, sexual and gender identity, and adjustment. Biologic, psychological, and social components of illnesses are explored and understood in treatment of the whole person.

<table>
<thead>
<tr>
<th>Request all privileges listed below.</th>
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<td><strong>Request</strong></td>
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### FPPE Requirements

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<td>□ Five (5) retrospective case reviews that are representative of the scope and complexity of privileges requested.</td>
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### TELEMEDICINE PRIVILEGES INPATIENT OR OUTPATIENT CARE

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

#### Qualifications

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

#### Acknowledgment of Applicant

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

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

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

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<td>E-Visits</td>
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Practitioner’s Signature __________________________ Date __________

### Department/Svc Chair Recommendation - Privileges

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

<table>
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<tr>
<th>Privilege</th>
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Published: 10/26/2021 1:18:03 PM Psychiatry - Multifacility Page 3 of 5
### Department/Svc Chair Recommendation - FPPE Requirements

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<tr>
<th>Requirement 1</th>
<th>Requirement 2</th>
<th>Requirement 3</th>
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</table>

Signature of Chief/Desigee: ___________________________ Date: ____________

Signature of Department or Service Chair/Desigee: ___________________________ Date: ____________

[Submit]
Pulmonary and Critical Care Medicine
Delineation of Privileges

Applicant's Name:

Instructions:

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

<table>
<thead>
<tr>
<th>Required Qualifications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Membership</td>
</tr>
<tr>
<td>Meet all requirements for medical staff membership</td>
</tr>
<tr>
<td>Education/Training</td>
</tr>
<tr>
<td>For initial applicants, effective November 1, 2023, completion of a minimum of two years of an ACGME or AOA accredited fellowship training in Pulmonary and/or Critical Care Medicine.</td>
</tr>
<tr>
<td>Continuing Education</td>
</tr>
<tr>
<td>Applicant must have 25 Category I CME credits per year directly related to the practice of Pulmonary and/or Critical Care Medicine (waived for applicants who are in or have completed training during the previous 24 months).</td>
</tr>
<tr>
<td>OR</td>
</tr>
<tr>
<td>Applicant must be active in the MOC program in Pulmonary and/or Critical Care Medicine.</td>
</tr>
<tr>
<td>Certification</td>
</tr>
<tr>
<td>Current certification or board eligibility in the examination process leading to certification in Pulmonary and/or Critical Care Medicine.</td>
</tr>
<tr>
<td>Clinical Experience (Initial)</td>
</tr>
<tr>
<td>Applicant must provide documentation of provision of Pulmonary and/or Critical Care services (50 cases) representative of the scope and complexity of the privileges requested during the previous year (waived for applicants who are in or completed training during the previous year).</td>
</tr>
<tr>
<td>Clinical Experience (Reappointment)</td>
</tr>
<tr>
<td>Completion of Pulmonary and/or Critical Care Medicine Fellowship. Applicant must provide documentation of provision of clinical services (50 cases) representative of the scope and complexity of privileges requested during the previous 24 months.</td>
</tr>
<tr>
<td>Additional Qualifications</td>
</tr>
<tr>
<td>Fluoroscopy Privileges: Current California Fluoroscopy Certificate/Permit, in accordance with Title 17, Article 1, section 30463, required for fluoroscopy use any time in or outside of operating area; radiology technician cannot be used in lieu of individual licensed provider.</td>
</tr>
</tbody>
</table>
## Core Privileges in Pulmonary and Critical Care Medicine

**Description:** Diagnosis, treatment, and support of patients in need of Pulmonary and/or Critical Care for life threatening disorders. Coordination of patient care among the primary physician, Pulmonary and/or Critical Care staff, and other specialists.

### Request all privileges listed below.

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

<table>
<thead>
<tr>
<th>Privilege</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admitting/Attending Privileges (including adolescents 14-21 years of age)</td>
<td>Evaluate, diagnose, provide consultation, medically manage, and treat patients with pulmonary disease. Privileges include medical management of general medical conditions which are encountered in the course of caring for patients with pulmonary disease.</td>
</tr>
<tr>
<td>Perform history and physical examination</td>
<td></td>
</tr>
<tr>
<td>Evaluate, diagnose, treat, manage, and provide consultation to patients presenting with organ dysfunction and in need of critical care for life threatening disorders.</td>
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<tr>
<td>Interpretation of Pulmonary Function Tests (PFTs)</td>
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<tr>
<td>Procedures</td>
<td></td>
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<tr>
<td>Airway maintenance including intubation, laryngoscopy</td>
<td></td>
</tr>
<tr>
<td>Fiberoptic bronchoscopy, without fluoroscopy</td>
<td></td>
</tr>
<tr>
<td>Fiberoptic bronchoscopy, with fluoroscopy (current California Fluoroscopy Certificate/Permit required)</td>
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<tr>
<td>Ventilator management -- all modes</td>
<td></td>
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<tr>
<td>Cavity drainage including thoracentesis, without fluoroscopy</td>
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</tr>
<tr>
<td>Cavity drainage including thoracentesis, with fluoroscopy (current California Fluoroscopy Certificate/Permit required)</td>
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<tr>
<td>Wound care including wound closure; selection of specialized dressings; drain insertion and removal; I&amp;D abscess; and the use of local anesthetics, basic and regional blocks, debridement, minor surgical excisions, and skin biopsy</td>
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<tr>
<td>Lumbar puncture with or without intrathecal injection, without fluoroscopy</td>
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<tr>
<td>Lumbar puncture with or without intrathecal injection, with fluoroscopy (Current California Fluoroscopy Certificate/Permit required)</td>
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<tr>
<td>Placement and management of arterial lines, central venous lines, dialysis catheters, and pulmonary artery catheters, without fluoroscopy</td>
<td></td>
</tr>
<tr>
<td>Placement and management of arterial lines, central venous lines, dialysis catheters, and pulmonary artery catheters, with fluoroscopy (Current California Fluoroscopy Certificate/Permit required)</td>
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<tr>
<td>Needle and tube thoracostomy</td>
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<tr>
<td>Elective cardioversion</td>
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<tr>
<td>Placement of temporary transvenous pacemaker</td>
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<tr>
<td>Percutaneous Dilatational Tracheostomy (PDT)</td>
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<td>IV immunoglobulin therapy</td>
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<tr>
<td>Abdominal paracentesis</td>
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<tr>
<td>Hyperalimentation</td>
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<tr>
<td>Use of thrombolytic agents</td>
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</tbody>
</table>
### Focused Professional Practice Evaluation (FPPE)/Routine Proctoring

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

- Five (5) retrospective case reviews that are representative of the scope and complexity of privileges requested (for applicants who have prior experience). OR Five (5) concurrent case reviews that are representative of the scope and complexity of privileges requested (for applicants who completed training during the previous year).

---

### Advanced Bronchoscopy

#### Qualifications

**Education/Training**

- Applicant must have training in EBUS or attend a dedicated course in EBUS that included hands-on training.

**Certification**

- Current certification in Pulmonary and/or Critical Care Medicine, or hold Bronchoscopy privileges.

**Clinical Experience (Initial)**

- Requires documentation of the performance of 10 Endobronchial Ultrasound Bronchoscopy procedures in the past 24 months (waived for applicants who completed training during the previous year).

**Clinical Experience (Reappointment)**

- For Endobronchial Ultrasound Bronchoscopy, must have performed a minimum of five (5) procedures within the past 24 months.

**Additional Qualifications**

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

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### Request

**Request all privileges listed below.**

- **AHS Core**

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- **Endobronchial Ultrasound, without fluoroscopy**

- **Endobronchial Ultrasound, with fluoroscopy (Current California Fluoroscopy Certificate/Permit required)**
Three (3) retrospective case reviews that are representative of the scope and complexity of privileges requested.
**Moderate (Procedural) Sedation**

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

**Qualifications**

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

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

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

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

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**Request**

*Request all privileges listed below.*

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**eICU Core**

*Request all privileges listed below.*

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<td>Click <strong>shaded blue check box</strong> to Request all privileges.</td>
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<td>Uncheck any privileges you do not want to request.</td>
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Published: 2/23/2023 12:34:26 PM
Pulmonary and Critical Care Medicine
Page 5 of 8
<table>
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<tr>
<th>AHS Core</th>
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<tr>
<td>☐ ☐</td>
<td>- Currently granted privileges</td>
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<tr>
<td>☐ ☐</td>
<td>Continuous surveillance of the electronic console utilized in patient monitoring</td>
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<td>☐ ☐</td>
<td>Direction of bedside care provided by the MD, PA, NP, RN or other healthcare provider(s) for bedside evaluations and interventions/procedures.</td>
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<td>☐ ☐</td>
<td>Communication with appropriate on-site intensivists, emergency room physician, or other physician/surgeon involved in the patient's care</td>
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<tr>
<td>☐ ☐</td>
<td>Direction of Category II Ventilator Management</td>
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<td>☐ ☐</td>
<td>Two (2) retrospective case reviews that are representative of the scope and complexity of privileges requested.</td>
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**TELEMEDICINE PRIVILEGES INPATIENT OR OUTPATIENT CARE**

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Practitioner's Signature ___________________________ Date ____________

Department Chair Recommendation - Privileges

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Signature of Chief/Designee

Date

Signature of Department Chair/Designee

Date

Submit
C. Medical Staff Reports (estimated 20 min)
Alameda Hospital Medical Executive Committee (MEC)
and
Alameda Health System Medical Executive Committee (MEC)

Report to the Quality Professional Services Committee of the Board
November 29, 2023

A. Community
Alameda Hospital

- Alameda Hospital Status Report and Planning for the Future
  - Joint Powers Affiliation Agreement (JPA) November 7th meeting Option 3b presented which expanded to options 3b 1, 2, 3

B. Quality

Alameda Hospital and Alameda Health System

- Root Cause Analysis (RCA) Process
  - Pilot of a new process referenced as RCA2 – Improved framework for the review of adverse event responses to prevent future harms and support an objective and non-intimidating approach
  - Physician participation and representation on the team piloting RCA2 from both medical staffs

- Continuing Medical Education
  - Continuing Medical Education (CME) activities and participation maintains growth
  - Awarding American Board of Pediatrics (ABP) MOC Part 2 credits for Pediatric Grand Rounds; plan to roll out American Board of Internal Medicine (AFIM) past 2 MOC points for qualifying CME sessions in 2024

- Medical Staff Governance
  - Approval of Medical Staff Medical Staff policies and procedures
    - Quality Assurance & Performance Improvement Plan (QAPI)
  - Approval of the revised Medical Staff Professionalism and Conduct policy and procedure that supports the standards and expectations set by our MECs around professional behavior, ethics, and integrity. The P&P has been significantly improved with revisions that include a progressive review process and interventions. Changes were made to include the following:
    - Definitions: Tiers 1, 2, 3 with the Review Process and Interventions
    - Medical Staff Professionalism and Code of Conduct Agreement
    - Just Culture Algorithm
    - Professionalism and Conduct Policy Flow Chart
    - Tier 1 Conversation (“Coffee Talk”) Form

- FY 2024 QPSC True North Metric Dashboard
  - Includes 46 measures spread across 5 domains related to STEEEP- safety, timely effective, efficient, equity, patient centered
  - Metrics reviewed by domain with action items for areas of opportunity
• Disaster Action Response Team (DART)
  o Multidisciplinary Task Force and multi-level team of clinical leaders and executive team focused on development of an integrated system response within AHS
    ▪ Preparation, planning, prehospital, procedures for hospital management, physician leaders
  o Preparation to respond to mass casualty incidents; drills have been identified as a critical component in the response process

Alameda Health System
• Graduate Medical Education
  o Semiannual report provided (attached)

C. Staff/Patient Experience

Alameda Hospital
• Patient Centeredness (Pt. Experience Data) FY2023 Quarter 4
  o Improved performance for Likely to Recommend (LTR)
  o Improved metric performance was observed across all HCAHPS and TNM domains/metrics
    ▪ Communication with Physicians 75.6%
    ▪ Responsiveness of Hospital Staff 56.8%
    ▪ Communication about Medicines 58.4%

Alameda Health System
• Patient Centeredness (Pt. Experience Data)
  o Performance with the strategic goals include a focus is on metrics including Hospital Nursing/Doctor Communication, Likelihood of recommending.
  o Review of metrics for both Highland and San Leandro Hospitals
    ▪ Likely to recommend HCAHPS Rate the hospital 9-10
      Current performance for Highland 74.8% and San Leandro Hospital 70.1%

• Search Committees / Department Chair Recruitment
  o Imaging and Radiology
  o Obstetrics, Midwifery and Gynecology
  o Psychiatry

D. Sustainability

• Alameda Hospital Department Report(s)
  o Medicine

• Alameda Health System Primary Care Task Force
  o Patient Access, Supply/Demand Assessment, EHR In-basket Management
## Graduate Medical Education Board Report

<table>
<thead>
<tr>
<th>Quality &amp; Patient Safety</th>
<th>Operations</th>
</tr>
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<tbody>
<tr>
<td><strong>ACGME:</strong></td>
<td><strong>Recruitment and Retention:</strong></td>
</tr>
<tr>
<td>• ACGME Survey-March 2024</td>
<td>• GMEC DEI Subcommittee</td>
</tr>
<tr>
<td>• Institutional Site Visit-May 2024</td>
<td>• Events &amp; Affinity Groups</td>
</tr>
<tr>
<td><strong>QI &amp; Patient Safety</strong></td>
<td>• Conference exhibitor</td>
</tr>
<tr>
<td>• GME/Administration Town Halls</td>
<td>• Medical Student Scholarship Program</td>
</tr>
<tr>
<td>• Patient Safety Quarterly Report to GMEC</td>
<td><strong>Grants:</strong> Song Brown/CalMedForce</td>
</tr>
<tr>
<td>• QI forum-June 2024</td>
<td><strong>Well-Being</strong></td>
</tr>
<tr>
<td>• Needle Sticks</td>
<td>• Wellness Psychologist</td>
</tr>
<tr>
<td></td>
<td>• Events &amp; Affinity Groups</td>
</tr>
</tbody>
</table>

### Strengths

**Our Graduates**- pipeline to med staff  
**Institutional Support:**  
• Town Halls with Administration  

**Culture of Learning:**  
• *GMEC  
• GMEC DEI  
• Quality Forum  
• Speaker Series  

**Curriculum:**  
• Eliminating Health Care Disparities  
• Preparation for careers working with underserved populations  

### Opportunities

**Clinical Experience and Education:**  
• Addiction Medicine Fellowship  
• Build research capacity  
• Diverse Faculty Recruitment  

**Patient Safety and Teamwork:**  
• Communication between nursing and residents (good progress and support thus far)  

**Well-Being:**  
• Build capacity to meet mental health needs
Graduate Medical Education

GOALS:

1. Addiction Medicine Fellowship
   (2 fellows starting July 2024)

2. Build research support capacity for
   Institution housed under GME umbrella
   (Planning underway with Chief Strategy Officer)

3. Support recruitment of diverse faculty.
   (Pipeline to medical staff, program with AHMG to offer perks to commit to AHS)

4. Continue to build on communication progress
   with nursing staff and residents.
   (Nursing participation in orientation, ongoing cross training)

5. Continue to build capacity to support mental health/well-being needs.
   (GME psychologist, as well as access to all other support MD and staff at AHS has)

Opportunities

Clinical Experience and Education:
- Addiction Medicine Fellowship
- Build research capacity
- Diverse Faculty Recruitment

Patient Safety and Teamwork:
- Communication between nursing and residents
  (good progress and support thus far)

Well-Being:
- Build capacity to meet mental health needs
D. Quality Reports (estimated 10 min)
In this report we will review the FYTD 2024 performance (October 1-31, 2023)

I. Patient & Staff Harm Events and Complaints/Grievances:

- In the month of October 2023, the Patient Harm Rate improved and was below the target of 2.5%. The overall harm rate for October 2023 was 1.8%, and a YTD rate of 2.5%. *(AHS target for Patient Harm rate of ≤ 2.5%).*
- October 2023: All 9 of the 513 Safety Alerts resulted in an “E” risk significance resulting in temporary and minor patient harm.
- Patient Relation events continue to increase over the past 24 months, with an increase of 33% from FY2022 to FY2023. Drill down report attached in Annual Patient Safety Report for FY 2023.

**FYTD Patient Harm Rate – 2.5%**

**Monthly Patient Harm Rate for October 2023 – 1.8%**

II. 2023 Culture of Safety Survey:


- CONGRATULATIONS AHS – 74% Culture of Safety Survey Response Rate
- Improvement in ALL 15 Cultural and Engagement Domains
- Action Plans Developed and Implemented in almost 100% of the 160 Departments

<table>
<thead>
<tr>
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</tr>
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<td>Culture of Safety Survey Steps 1-5:</td>
<td></td>
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<th>Due July 31, 2023</th>
<th>Aug – Oct 2023</th>
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<td>12/12</td>
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</tr>
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<td>22</td>
<td>22/22</td>
<td>22/22</td>
<td>22/22</td>
</tr>
<tr>
<td>Highland Hospital</td>
<td>25</td>
<td>25/25</td>
<td>25/25</td>
<td>25/25</td>
</tr>
<tr>
<td>JGPH</td>
<td>9</td>
<td>9/9</td>
<td>9/9</td>
<td>9/9</td>
</tr>
<tr>
<td>Physicians &amp; APPs</td>
<td>23</td>
<td>23/23</td>
<td>23/23</td>
<td>22/23</td>
</tr>
<tr>
<td>Post-Acute</td>
<td>8</td>
<td>8/8</td>
<td>8/8</td>
<td>8/8</td>
</tr>
<tr>
<td>San Leandro Hospital</td>
<td>10</td>
<td>10/10</td>
<td>10/10</td>
<td>10/10</td>
</tr>
<tr>
<td>Systemwide Services</td>
<td>51</td>
<td>51/51</td>
<td>51/51</td>
<td>51/51</td>
</tr>
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</table>

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**CERTIFICATE OF AWARD**

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Congratulations to the 2023 AHS Culture of Safety Innovation Award Winners!

The 2023 AHS Culture of Safety Innovation Awards are being presented to departments:

1. The greatest percentage improvement from 2022 to 2023 results

2. Action plans that demonstrate a commitment to improve the Teamwork, Safety Climate, & Burnout in their work settings resulting in significant improvements in the score from 2022 to 2023

160 departments across AHS have developed creative and innovative ways to improve the teamwork, culture, morale, communication, and burnout within their departments. Congratulations to Everyone!!!

Thank you for everyone’s active engagement in this valuable investment in our workforce and strengthening our culture at AHS.
A. **Key Point #1 – Site Visits**
   1. One EMTALA re-survey was conducted by the California Department of Public Health, representing CMS, at Highland Hospital.
   2. Three (3) licensing visit were conducted, one at Highland Hospital, one at San Leandro Hospital both on behalf of Imaging Services, and one at Southshore Skilled Nursing Facility, Alameda campus.
   3. One facility reported incident (FRI) complaint investigation at San Leandro Hospital, Radiology department.

B. **Key Point #2 – CDPH Reportable Events**
   1. Two (2) adverse events at Highland Hospital were self-reported.
   2. Two (2) adverse events at John George Psychiatric Hospital were self-reported.

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

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

E. **Key Point #5 – Joint Commission 2023 Triennial Survey**
   1. AHS corrective action plans (ESCs) and monitoring which have not met four (4) consecutive months of compliance continue to be in progress.

F. **Key Point #6 – CMS EMTALA SURVEY**
   1. CMS EMTALA re-survey conducted in October at Highland.
   2. Corrective actions implemented and monitored. Waiting for CMS response.
QPSC Executive Summary: Care Quality True North Metrics FY203 Year Results
Annette Johnson, MBA – Director of Quality Analytics

November 29, 2023

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

**Key Point 1: Hospital Acquired Harms**

AHS is targeting a minimum reduction of 50% in Fiscal Year 2024 as compared to Fiscal Year 2023. The harm index includes following 8 harm types: Central Line Associated Blood Stream Infections (CLABSI), Catheter Associated Urinary Tract Infections (CAUTI), MRSA Blood Stream Infections (MRSA BSI), C. Difficile infections, surgical site infections (SSI), patient falls with injury, hospital acquired pressure injuries (HAPI) and behavior events that result in injury.

Reported harms decreased in August to 20 but remain higher than AHS’ monthly target of 16 per month. AHS was experiencing a downward trend in harms during the final quarter of FY23 that continued into FY24. The most common harm type year to date is behavior events that resulted in injury (26) the majority of which occurred at John George Psychiatric Hospital (17). This campus actively reviews all events for improvement opportunities in Violence Reduction Committee incorporating learnings into the Assault Reduction Plan. Performance improvement teams have been developed to address CLABSI, CAUTI, SSI, Falls and HAPI. This focuses on device necessity for CAUTI and CLABSI removing unnecessary lines/catheters to reduce infection. All HAI undergo a deep dive with includes Infection Control and Prevention as well as providers and staff directly involved in the care with goal of sharing lessons learned at facility and unit huddles. Falls and HAPI unit specific champions are being recruited to co-design improvements as serve as on unit support.

**Key Point 2: Hospital and Post-Acute Handwashing Compliance**

In fiscal year 2024 AHS is targeting a hand hygiene compliance equal to greater than 95%. AHS started out FY24 with strong results (August 92%). In FY25 AHS will extend hand hygiene auditing to our Ambulatory clinics. To help further promote hand hygiene AHS’ campaign to empower patients, family, providers and nurses to speak up for hand hygiene is conducting a slogan contest in December, the intent is to engage staff in hand hygiene improvement and increase awareness.

**Key Point 3: Third Next Available Primary and Specialty Care (Return Patients)**

This fiscal year AHS has set our target equivalent to the timely access to care standards established by California Department of Health Care Services: Primary (10 days) and Specialty care (15 days). Adult Medicine exceeded target for the month of August while Pediatrics and Specialty Care met target. All three areas are on target for the fiscal year.

**Key Point 4: Acute All-Cause 30-day Readmission Rate**

This Fiscal Year 2024 readmission rate will focus specifically on African American/Black patients with the goal of bring their readmission rate consistent with overall readmission rate 10.7%. Recently AHS has seen an overall rise in readmissions, as result African American/Black rate also increased is above target for the month and fiscal year. A deep dive review is underway to understand the root causes of this increase. The team is exploring utilization of risk modeling to predict a patient’s readmission risk and develop targeted interventions to decrease/eliminate the risk.
**Key Point 5: Adult Health Maintenance Up to Date**
AHS targeted a 10% gap closure to 90th percentile for preventative screenings which are up to date for AHS assigned patients (includes screening/counseling for: breast/cervical/colon cancer, depression, tobacco, chlamydia, HIV, influenza immunization). The target is based on QIP and results needed to achieve performance targets under this program. New specifications for tobacco, depression screening and influenza vaccination have recently been implemented and the composite metric needs to be rerun to reflect these changes and goal setting adjusted to reflect the rate changes. Improvement work will continue to focus on patient outreach, maximization of every patient touchpoint to encourage health care screenings and preventive care, and special events to promote cancer screenings.

**Key Point 6: Median Time from Decision to Admit to Inpatient Bed**
In Fiscal Year 2024 AHS will target 4 hours for median time from decision to admit to inpatient bed. While still far from goal decision to admit to Inpatient bed wait times have been improving for the last 4 months. To continue the promising results of the August Doc of the Day Pilot a workgroup has been assigned to create a scalable solution and address all opportunities identified. In addition, space allotment in Highland is under review to determine if it is possible to convert administrative space into treatment areas. This would increase treatment capacity and offer staff better sightlines on waiting patients allowing staff the opportunity to discourage patients from leaving without being seen.

**Key Point 7: Rate of Inpatients Screened for Health-Related Social Needs and Rate of Inpatients Positive for Health-Related Social Needs:**
To better address unmet needs that can negatively affect a patient's health and well-being, AHS is targeting screening 90% of inpatient acute admissions for food, housing, transportation, safety, and utilities security. Measurement will begin in late December and results from the first year of measurement will be used to establish a baseline rate of need amongst AHS’ patient population.

**Key Point 8: Patient Experience Metrics**
Nursing Communication is the number one driver of patient satisfaction in the acute inpatient care setting. AHS is targeting the national 50th percentile (76.53%) as per Centers for Medicare and Medicaid Services (CMS). Performance was less than 0.5% away from achieving goal in August.

The Likelihood of Recommending Composite target of 80.3% represents a 10% improvement at the composite level and National 50th percentile for each service line. AHS has yet to achieve the target, though performance continues to make steady improvement for the second month this fiscal year with results better than FY23 (73.0%).

Improvement efforts continue to focus on both completing and quality of purposeful hourly and nurse leader rounding allowing staff to connect with patients, conduct real time service recovery. AHS is working on spreading leader recovery rounds to all applicable service areas with pre-surgery rounds launched, simulation trainings in develop to help charge nurses update waiting family/visitors of patients undergoing surgery, and the Emergency Service is currently developing a rounding template specific to their setting. Lastly unit and clinic specific reports have been developed to keep staff informed of their performance, including response scale distribution allowing for quantification of the effort needed to improve performance.
# Patient Safety

## AHS PATIENT SAFETY REPORT – SYSTEM WIDE

### I. RISK EVENTS

<table>
<thead>
<tr>
<th>AHS Pillar</th>
<th>Safety Alert Focus Areas</th>
<th>Metrics</th>
<th>FY 21</th>
<th>FY 22</th>
<th>FY 23</th>
<th>FYTD 2024</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality: Patient Safety, Risk Mgmt</td>
<td>Safety Alert Reporting - Risk Events</td>
<td>Total Reported Events</td>
<td>5,722</td>
<td>5,694</td>
<td>5,779</td>
<td>1,939</td>
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<tr>
<td></td>
<td>Safety Alert Risk Event Follow Up</td>
<td>Total SA Events</td>
<td>2.5%</td>
<td>3.2%</td>
<td>2.7%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Target 2.5%)</td>
<td>149 Pt.</td>
<td>186</td>
<td>154</td>
<td>49 Total Events</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Harm Events</td>
<td></td>
<td></td>
<td></td>
<td>2.5% Patient Harm Rate</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Median Time Event to Close</td>
<td>7</td>
<td>3</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Target 7 days)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Charts:

- **All Risk Event Volume by Month**: Graph showing the number of events by month from July 2022 to October 2023.
- **Top 5 Risk Event Classes by Volume for the Last 3 Months**: Bar chart showing the top 5 classes with Patient Behavior leading, followed by Staff/Provider Clinical Practice /Behavior, Treatment / Test / Non-Surgical Procedures, Medication / Other Substance, and Patient Fall.
- **Risk Events by Significance for the Last 3 Months**: Stacked bar chart showing the number of events by significance from A to I.
## II. PATIENT RELATION EVENTS

<table>
<thead>
<tr>
<th>AHS Pillar</th>
<th>Safety Alert Focus Areas</th>
<th>Metrics</th>
<th>FY 21</th>
<th>FY 22</th>
<th>FY 23</th>
<th>FYTD 2024</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Experience</td>
<td>MIDAS Safety Alert Reporting - Patient Relations Events</td>
<td>Total Patient Relation Events</td>
<td>621</td>
<td>773</td>
<td>998</td>
<td><strong>315</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Complaints</td>
<td>278</td>
<td>259</td>
<td>324</td>
<td><strong>85</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Grievances</td>
<td>338</td>
<td>509</td>
<td>674</td>
<td><strong>230</strong></td>
</tr>
<tr>
<td></td>
<td>Grievance Follow Up</td>
<td>Median Time Event to Close (Target 30 days)</td>
<td>38</td>
<td>34</td>
<td>29</td>
<td><strong>22</strong></td>
</tr>
</tbody>
</table>

**Patient Relations Event Volume by Month**

**Patient Relations Events by Volume for the Last 3 Months**

**Patient Relations Events by Significance for the Last 3 Months**
III. CULTURE OF SAFETY

2023 Culture of Safety Survey Update
Step 5 (Final Step) Action Plans Implemented, Monitored, and Sustained

<table>
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<td>51/51</td>
<td>51/51</td>
<td>51/51</td>
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Certificate of Award

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160 departments across AHS have developed creative and innovative ways to improve the teamwork, culture, morale, communication, and burnout within their departments. Congratulations to Everyone!!!

Thank you for everyone’s active engagement in this valuable investment in our workforce and strengthening our culture at AHS.
The 2023 AHS Culture of Safety Innovation Award is being presented to the following departments for their innovative, creative and engaging efforts to improve Teamwork, Safety Climate & Burnout in their work settings.

And the Winners Are...

Highest % Improvement from 2022 to 2023

Alameda Hospital: Inpatient Pharmacy - 10%
Ambulatory Care: Marina Specialty Staff - 17%
Behavioral Health: JGPH Unit D - 17%
Highland Hospital: Same Day Surgery - 16%

Physicians & APPs:
- SLH Internal Medicine (87th Percentile)
- AHS Gastroenterology (87th Percentile)

Post-Acute: Leadership Team - 36%
San Leandro Hospital: Respiratory Therapy - 22%
Systemwide Services: Quality Outcomes - 20%

2023 Action Plans Focused on Improving Teamwork, Safety Culture, & Burnout

Alameda Hospital: OR/PACU/SDS - 9%
Ambulatory Care: Bridge Clinic - 17%
Behavioral Health: PES - 12%
Highland Hospital: Staffing - 16% & Operating Room - 15%

Physician & APPs:
- HGH Internal Medicine - 83rd Percentile
- HGH Palliative Care - 74th Percentile
- HGH Pathology & Laboratory Medicine - 71st Percentile

San Leandro Hospital: Clinical Laboratory - 17%
Systemwide Services:
- IS – Desktop Support - 19%
- HR OLE - 19%
- PACE - 18%

Green denotes % improvement from 2022 to 2023
I. Regulatory Events Summary – Open Session

A. CDPH Site Visits and Complaints

1. 10/02/23 – Wilma Chan Highland Hospital, K3 Radiology – licensing survey for 1.5T MRI successfully completed.
2. 10/10/23 to 10/11/23 – Wilma Chan Highland Hospital Emergency Department – CMS EMTALA resurvey
3. 10/10/23 – San Leandro Hospital, Radiology – licensing survey for stationary CT machine, successfully completed.
4. 10/18/23 – Southshore Skilled Nursing Facility – licensing survey to reopen, post construction repair, successfully completed with same day approval.
5. 10/26/23 – San Leandro Hospital, Radiology – Facility reported investigation (FRI) regarding allegation of sexual assault, staff-to-patient, Complaint investigation still open.

B. CDPH Self-Reported Events

1. 10/2/23 – Wilma Chan Highland Hospital, 8ACT – Patient fall adverse event that occurred 09/24.
2. 10/18/23 – John George Psychiatric Hospital, PES Lobby – Patient-to-staff assault.
3. 10/20/23 - Wilma Chan Highland Hospital, 7ACT – Hospital acquired unstageable pressure injury.
4. 10/27/23 – John George Psychiatric Hospital, Unit C – Patient-to-staff assault.

C. Joint Commission Complaints

1. None

D. Joint Commission Sentinel Events

1. None

E. Follow-up: The Joint Commission 2023 Triennial Survey, 04/18/23 -04/21/23

1. AHS corrective action plans continue to be implemented and monitored by operational leaders and are ongoing. Non-compliant results shared on an ongoing basis with AHS Quality Services Committee (QSC).

F. CMS EMTALA SURVEY – UPDATE

CMS EMTALA Resurvey was conducted on October 10 to October 11 at Wilma Chan Highland Hospital
• The summary of their observations and findings will be submitted to CMS Regional Office within the following two weeks. Waiting for a response from CMS.
• The EMTALA workgroup/taskforce will move forward to collect data and monitor the elements of the plan of correction for sustainability and ongoing compliance.
<table>
<thead>
<tr>
<th>STEEEP</th>
<th>Metric</th>
<th>FY23 Base Line</th>
<th>FY24 Goal</th>
<th>Current Month All</th>
<th>FYTD 24</th>
<th>Accountable Team</th>
<th>Performance Trend</th>
<th>Action Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety</td>
<td>Patient Harm ↓</td>
<td>32 Month 386 Year</td>
<td>16 month 193 Year</td>
<td>20</td>
<td>96</td>
<td>Asian</td>
<td>11</td>
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<tr>
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<td>Acute</td>
<td>245</td>
<td>10 month 122 Year</td>
<td>14</td>
<td>59</td>
<td>African American/Black</td>
<td>14</td>
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<tr>
<td>Safety</td>
<td>Post Acute</td>
<td>23</td>
<td>&lt;1 Month 11 Year</td>
<td>2</td>
<td>2</td>
<td>White</td>
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<td>0</td>
<td>All</td>
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<tr>
<td>Safety</td>
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<td>118</td>
<td>5 Month 59 Year</td>
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<td>Safety</td>
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<td>82.5%</td>
<td>95%</td>
<td>92%</td>
<td>93%</td>
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<tr>
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<tr>
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<td>Days between appointment request and appointment : Primary Return ↓ (TNAA)</td>
<td>27</td>
<td>10</td>
<td>11</td>
<td>4</td>
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<td>N/A</td>
<td>Porshia Mack, Terrance Fitzgerald-Shaw</td>
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<td>Timely</td>
<td>Adult</td>
<td>28</td>
<td>10</td>
<td>14</td>
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<td>N/A</td>
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<td>Pediatrics</td>
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<td>FY23 Base line</td>
<td>FY24 Goal</td>
<td>Current Month All</td>
<td>FYTD 24</td>
<td>Accountable Team</td>
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<td>Days between appointment request and appointment : Specialty Return ↓ (TNAA)</td>
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<td>15</td>
<td>9</td>
<td>10</td>
<td>N/A</td>
<td>N/A</td>
<td>Performance shifted to improved results after records clean up and is on track for month and fiscal year.</td>
</tr>
<tr>
<td>Effective</td>
<td>All-cause 30 day Readmissions for Black/African American Pts ↓</td>
<td>14.40%</td>
<td>10.70%</td>
<td>19%</td>
<td>15%</td>
<td>N/A</td>
<td>N/A</td>
<td>Readmission Committee exploring rise in readmits. Readmission Committee aligned with Care and Utilization Committees</td>
</tr>
<tr>
<td>Effective</td>
<td>Patient with up-to-date preventive health screenings ↑</td>
<td>70.20%</td>
<td>71.36%</td>
<td>65.91%</td>
<td>65.76%</td>
<td>White</td>
<td>60.20%</td>
<td>Results shifted downward in June. Data under review as QIP PY6 build underway.</td>
</tr>
<tr>
<td>Efficient</td>
<td>ED Boarding Time</td>
<td>Time in ED from Decision to Admit to Inpatient Bed ↓</td>
<td>6:35</td>
<td>4:00</td>
<td>6:16</td>
<td>6:35</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Equity</td>
<td>Rate of inpatients screened for health-related social needs (food, housing, transportation, safety, utilities) ↓</td>
<td>N/A</td>
<td>90%</td>
<td>Pending</td>
<td>Pending</td>
<td>Pending</td>
<td>Pending</td>
<td>The Epic infrastructure to survey patients and store responses is in development. Track date for first data release is January 2024.</td>
</tr>
<tr>
<td>Equity</td>
<td>Rate of inpatients who screened positive for health related social needs (food, housing, transportation safety, utilities) ↑</td>
<td>N/A</td>
<td>N/A</td>
<td>Pending</td>
<td>Pending</td>
<td>Pending</td>
<td>Pending</td>
<td>The Epic infrastructure to survey patients and store responses is in development. Track date for first data release is January 2024.</td>
</tr>
<tr>
<td>Patient Centered</td>
<td>Rate of patients who reported that their nurses “always” communicated well ↑</td>
<td>71.40%</td>
<td>76.53%</td>
<td>76.27%</td>
<td>74.55%</td>
<td>White</td>
<td>66.90%</td>
<td>Performance improvement trend continues. Unit specific reports including response distribution now available. Continue to reinforce hourly and leadership rounding.</td>
</tr>
<tr>
<td>Patient Centered</td>
<td>Rate of patients who reported they would “definitely” recommend AHS (Composite) ↑</td>
<td>73.00%</td>
<td>80.3%</td>
<td>75.57%</td>
<td>74.63%</td>
<td>Native American</td>
<td>64.20%</td>
<td>Performance Improvement trend continues. Leadership and service recovery rounds expanded to include Inpatient, Emergency Department and Same Day Surgery.</td>
</tr>
<tr>
<td>Acute</td>
<td></td>
<td>61.61%</td>
<td>69%</td>
<td>65.07%</td>
<td>64.19%</td>
<td>White</td>
<td>55.70%</td>
<td>Performance improved for the 3rd month in row. Training and reinforcement of GIFT service standard continues as well as hourly rounding.</td>
</tr>
<tr>
<td>Post Acute (Acute Rehab Only)</td>
<td></td>
<td>68%</td>
<td>75%</td>
<td>66.67%</td>
<td>73.08%</td>
<td>Asian</td>
<td>50.00%</td>
<td>Sample size less than 15 per month. YTD results indicate improvement over baseline FY23.</td>
</tr>
<tr>
<td>Ambulatory</td>
<td></td>
<td>85.50%</td>
<td>86.80%</td>
<td>84.97%</td>
<td>85.83%</td>
<td>Native American</td>
<td>65.20%</td>
<td>FY24 performance thus far is consistent with FY23. Clinical specific results report now available including response distribution to determine low hanger fruit for improvement.</td>
</tr>
</tbody>
</table>
## Fiscal Year 2024
### True North Metric Definitions for QPSC

<table>
<thead>
<tr>
<th>Metric</th>
<th>Definition</th>
<th>GOAL</th>
</tr>
</thead>
</table>
| **Patient Harm**                                 | The number of potential health-care acquired patient harms  
Includes: CLABSI, CAUTI, MRSA BSI, C-Diff, SSI for Acute Med-Surg/Critical Care, and Patient Falls with injuries, Hospital Acquired Pressure Injuries and Behavior Events that result in injury for all areas (practically, not inclusive of ambulatory)                                                                                                                           | CMS 50th Percentile                       |
| **Handwashing Compliance**                       | Percentage of observed encounters where handwashing was completed                                                                                                                                                                                                                                                                                                                                             | 95%                                       |
| **Days to Primary Care**                         | The average length of time in days between the day a patient makes a request a Primary Care appointment and the third next available appointment.                                                                                                                                                                                                                                                                 | Based on DMHC Timely Access of Care        |
| **Days to Specialty Care**                       | The average length of time in days between the day a patient makes a request a Specialty Care appointment and the third next available appointment.                                                                                                                                                                                                                                                                  | Based on DMHC Timely Access of Care        |
| **All-cause 30 day Readmissions for Black/African American Pts ↓** | Percentage of Black/African American patient encounters, regardless of payer type, with an unplanned readmission to any AHS facility within 30 days for any cause among encounters for acute care inpatients with a principal discharge diagnosis/procedure for a clinical classification category in the Cardiorespiratory, Cardiovascular, Medicine, Neurology, or Surgery/Gynecology cohort. Note: This measure approximates, but likely does not match, the value of the corresponding CMS readmission measure. | Close the performance gap between overall rate and African American/Black rate.            |
| **Patient with up-to-date preventive health screenings ↑** | Percentage of preventative screenings which are up to date for AHS patients (includes screening/counseling for: breast/cervical/colon cancer, depression, tobacco, chlamydia, HIV, influenza immunization)  
Note: Patients can get "partial" credit if some, but not all, screenings complete                                                                                                                   | Composite Rate equal to all screening metrics reaching QIP Targets | 176/240|
| **ED Boarding Time**                             | Median time from Decision to Admit to departure from the emergency department for admitted patients.  
Decision to Admit = First Admit Disposition  
Admit = Time patient admitted to Inpatient Unit  
Per the Joint Commission ED patients who wait more than 4 hours for an inpatient bed are considered boarders                                                                                                                                         | Establish consistent screening practice    |
| **Rate of Inpatients screened for health-related social needs (food, housing, transportation, safety, utilities) ↑** | The percentage of inpatient acute medical/surgical admissions where the patient is screened for social determinants of health: food insecurity, housing, transportation, safety and utilities  
Establish consistent screening practice                                                                                                                                             | No goal establishing a baseline in first year of measurement                                      |
| **Rate of inpatients who screened positive for health-related social needs (food, housing, transportation, safety, utilities) ↓** | The percentage of inpatient acute medical/surgical admissions that screened positive for at least one social determinant of health: food insecurity, housing, transportation, safety and utilities  
No goal establishing a baseline in first year of measurement                                                                                                                             | CMS 50th Percentile                       |
| **Rate of patients who reported that their nurses “always” communicated well** | Percentage of patients who rated nursing communication top box. Nurse Communication is a composite composed of three questions related to nursing care, attitude, attention paid to personal needs, and how well the nurses explained the care they were providing                                                                                     | Composite rate where servicelines are at or above the national 50th Percentile | 176/240|
| **Rate of patients who reported they would “definitely” recommend AHS** | Percentage of patients who would recommend AHS (includes rehab, acute, ambulatory, ED, outpatient surgery, dental, radiology)                                                                                                                                       | Composite rate where servicelines are at or above the national 50th Percentile | 176/240|
November 29th, 2023

True North Metric
Dashboard Review
Care Quality

Annette Johnson, MBA
DIRECTOR OF QUALITY ANALYTICS
Care Quality Pillar
There are 11 True North Metrics in fiscal year 2024 under the Care Quality Pillar, which are balanced across IOM STEEP dimensions of quality: Safe, Timely, Effective, Efficient, Equitable, and Patient Centered. The menu of metrics is inclusive of all service lines and is intended to improve efficiency, workflows, and to support patient flow across the system.

Hospital Acquired Harms:
Alameda Health System is continuously driving towards the goal of zero preventable harm. As an incremental step towards this goal AHS targeted a minimum reduction of 50% in Fiscal Year 2024 as compared to Fiscal Year 2023. The harm index includes following 8 harm types: Central Line Associated Blood Stream Infections (CLABSI), Catheter Associated Urinary Tract Infections (CAUTI), MRSA Blood Stream Infections (MRSA BSI), C. Difficile infections, surgical site infections (SSI), patient falls with injury, hospital acquired pressure injuries (HAPI) and behavior events that result in injury.

Reported harms decreased in August to 20 but remain higher than AHS’ monthly target of 16 per month AHS was experiencing a downward trend in harms during the final quarter of FY23 that continued into FY24. The most common harm type year to date is behavior events that resulted in injury (26) the majority of which occurred at John George Psychiatric Hospital (17). This campus actively reviews all events for improvement opportunities in Violence Reduction Committee incorporating learnings into the Assault Reduction Plan. Of the five Hospital Acquired Infections, C. difficile, CLABSI, and CAUTI present the greatest opportunities for improvement. To address the rise in C. difficile infections stool collection and appropriate cleaning techniques were reviewed with the staff. Additionally, ATP testing is being utilized to validate the effectiveness of cleaning. ATP verifies and counts the number of living cells on a sample you take from the surface. By testing the ATP levels on a surface, it can be determined whether it is safe for human contact or not Efforts around CLABSI and CAUTI events continue to focus on device necessity and maintenance. CLABSI and CAUTI events are reviewed with staff directly involved in the care. Lessons learn are then summarized and shared at all Facility and Unit Safety Huddles. In addition, Infection Prevention and Control has developed Micro Minutes which are one-page job aids highlighting relevant best practices and care bundles related to recent HAI events. These job aids are shared simultaneously with event summaries during huddles.

Hospital and Post-Acute Handwashing Compliance
Practicing hand hygiene is a simple yet effective way to prevent infections and can prevent the spread of germs, including those that are resistant to antibiotics and are becoming difficult, if not impossible, to treat. In fiscal year 2024 AHS is targeting a hand hygiene compliance equal to greater than 95%. Throughout Fiscal Year 2023 AHS saw system wide improvement in both volume of audits collected and compliance rates. AHS performance remains 93% for fiscal year to date. To help further promote hand hygiene AHS will be launching an informational campaign empowering staff, providers, patients, and their families to speak up and hold each other accountable for hand washing. AHS will run a Slogan Contest for this campaign in December to encourage staff to share in designing the future state and generate by in speaking up for hand hygiene. In FY24 AHS will extend hand hygiene auditing to our Ambulatory clinics.

Third Next Available Appointment Primary and Specialty Care (Return Patients):
Third Next Available Appointment (TNAA) is the industry standard measure of the patient’s ability to seek and receive care with the provider of their choice, at the time they choose, and indicates how long a patient waits to be seen. This measure is used to assess the average number of days to the third next available appointment for an office visit. In contrast to first and second available appointments (often the
result of last-minute cancellations, working patients into the schedule, or other events), the TNAA best represents the performance of the appointment access system. This fiscal year AHS has set our target equivalent to the timely access to care standards established by California Department of Health Care Services: Primary (10 days) and Specialty care (15 days). Adult Medicine exceeded target for the month of August while Pediatrics and Specialty Care met target. All three areas are on target for the fiscal year.

**Acute All-Cause 30-Day Re-admit:**
Over the last three fiscal years AHS has made significant progress in decreasing acute all cause 30 day readmissions. However a disaggregation by race shows that all populations have been improving but our African American/Black population remains consistently higher than our overall rate and other groups. To address this phenomenon, this Fiscal Year’s readmission rate will focus specifically on African American/Black patients with the goal of bring their readmission rate consistent with overall readmission rate 10.7%.

The Readmission Team led by Dr. Borneo in coordination with the Utilization Management Team are actively engaged in decreasing this gap and understanding the root cause. The team is exploring utilization of risk modeling to predict patients’ risk and develop targeted interventions to decrease/eliminate the risk. Care Management Team continues drive early identification and referral for patients who need Health Advocates, Substance Use support, and/or Community Health Workers to address post-acute care needs and decrease likelihood or re-admission. Recently AHS has seen an overall rise in readmissions, as result African American/Black rate also increased is above target for the month and fiscal year. A deep dive review is underway to understand the root causes of this increase.

**Adult Health Maintenance Up to Date**
AHS targeted a 10% gap closure to 90th percentile for preventative screenings which are up to date for AHS assigned patients (includes screening/counseling for: breast/cervical/colon cancer, depression, tobacco, chlamydia, HIV, influenza immunization). The target is based on QIP and results needed to achieve performance targets underthis program. Patients can get “partial” credit if some, but not all, screenings are complete. The results of this metric are currently under review. New specifications for tobacco, depression screening and influenza vaccination have recently been implemented and the composite metric needs to be rerun to reflect these changes and goal setting adjusted to reflect the rate changes. Improvement work will continue to focus on patient outreach, maximization of every patient touchpoint to encourage health care screenings and preventive care, and special events to promote cancer screenings.

**Median Time from Decision to Admit to Inpatient Bed:**
In Fiscal Year 2024 AHS will target 4 hours for median time from decision to admit to inpatient bed. AHS recognizes this is an ambitious goal but feels strongly that it is necessary for the safety of our patients and staff. Per Joint Commission any patient that waits longer than 4 hours for inpatient bed after the decision to admit is made is considered an “Emergency Department Boarder.” Fiscal Year 2023 proved to be a challenging year for
emergency room throughput, but work is already underway to decrease admission wait times

While still far from goal decision to admit to Inpatient bed wait times have been improving for the last 4 months There was a pilot in August where Emergency Physicians were designated to identify patients that were eligible for transfer from Highland to our community hospitals. The results were promising and increased the number by transfers. To continue the gains seen during the pilot a workgroup has been assigned to analyze these results and create a scalable solution. In addition, space allotment in Highland is under review to determine if it is possible to convert administrative space into treatment areas. This would increase treatment capacity and offer staff better sightlines on patients to allow staff the opportunity to discourage patients from leaving without being seen.

Rate of Inpatients Screened for Health-Related Social Needs and Rate of Inpatients Positive for Health-Related Social Needs:
Social determinants of health (SDOHs) are the conditions in the environments where people are born and live that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Many health conditions and diseases can be improved by simple behavioral changes, such as eating nutritious food, safe and secure housing, managing stress and getting enough sleep. To better address unmet needs that can negatively affect a patient's health and well-being, AHS is targeting screening 90% of inpatient acute admissions for food, housing, transportation, safety, and utilities security. Measurement will begin in late December and results from the first year of measurement will be used to establish a baseline rate of need amongst AHS' patient population.

Hospital Nursing Communication (HCAHPS) Experience
Industry wide Nursing Communication is the number one driver of patient satisfaction in the acute inpatient care setting. AHS is targeting the national 50th percentile (76.53%) as per Centers for Medicare and Medicaid Services (CMS). While AHS did not meet its goal last fiscal year results were trending upward and this upward trend continues for in the second month of the fiscal year. Performance was less than 0.5% away from achieving goal. Improvement efforts continue to focus on improving the quality of purposeful hourly and nurse leader rounding through the use of simulation training labs allowing staff to practice connecting with patients and conducting real time service recovery. Medication communication sheets have been revised to help patients better understand the purposes of their medications, prepare them for a successful discharge, and allow an opportunity to address any of their concerns prior to discharge.

Likelihood of Recommending (Composite)
In Fiscal Year 2023 AHS expanded monitoring of patient experience beyond inpatient HCAHPS and Ambulatory CG-CAHPS to include all service lines with the creation of the Likelihood of Recommending Composite metric. This metric measures the percentage of patients willing to recommend AHS to others and includes survey results from Inpatient Acute Rehabilitation, Acute Inpatient, Ambulatory, Emergency Department, Outpatient Services, Dental and Radiology. The first year of monitoring saw promising improvement and monitoring will continue in FY24. The composite target of 80.3% represents a 10% improvement at the composite level and National 50th percentile for each service line. AHS has yet to achieve the target, though performance continues to make steady improve for the second month this fiscal year with results better than FY23 (73.0%). This is driven by sustained improvement in Acute patient satisfaction (Emergency, Ambulatory Surgery, Inpatient Med-Surg). AHS is working on spreading leader
recovery rounds to all applicable service areas with pre-surgery rounds launched, simulation trainings in
develop to help charge nurses update waiting family/visitors of patient undergoing surgery, and the
Emergency Service is currently developing a rounding template specific to their setting. It is too early to
access Post Acute Rehabilitation satisfaction has a limited sample size of less than 10 per month (due to
this service being a single unit with length of stays up to 14 days and only patients discharged home
eligible for survey the pool is limited) once a quarter of results are in AHS will be better able to assess
performance. Performance in Ambulatory is declining slightly to help combat this clinic specific results are
now available and routinely reviewed with staff and include response distribution to help quantify the
effort required to improve.
E. QAPI Plan (estimated 15 min)
OIG and CMS Focus on QAPI

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland   21244-1850

Center for Clinical Standards and Quality/Quality, Safety & Oversight Group

Ref: QSO-23-09-Hospital

DATE: March 9, 2023

TO: State Survey Agency Directors

FROM: Director, Quality, Safety & Oversight Group (QSOG)

SUBJECT: Revision to State Operations Manual (SOM), Hospital Appendix A - Interpretive Guidelines for 42 CFR 482.21, Quality Assessment & Performance Improvement (QAPI) Program
Major Focus of the QAPI Guidelines

In response to the OIG study and the growing number of adverse-events-related State Agency Findings, CMS has made it very clear that the hospital is expected to demonstrate a comprehensive, data-driven QAPI program that reduces medical error and ensures compliant performance for all hospital services and departments.

- Although interpretive guidelines are, in theory, for surveyors, CMS encouraged hospitals to implement these expectations BEFORE the survey team arrives to investigate a complaint or self-reported adverse event.
- The Governing Body must play an active role in the development and implementation of the data-based QAPI program … broadening its focus beyond Hospital Compare, US News, or other benchmarks.
- The QAPI program must collect, analyze and improve performance data for the ENTIRE scope of care and services, including services rendered at off-campus locations and services rendered through contract or agreement.
- QAPI data must demonstrate sustained compliance and measurable improvements in service-specific functions.
- Preventable harm events (not just “sentinel events”) must be identified and meaningful steps to prevent or reduce recurrences must be implemented, monitored, and sustained.
Quality Assurance and Performance Improvement (QAPI) Plan FY 2024

• **GOAL:** The Quality Assurance and Performance Improvement (QAPI) Plan describes the integrated system-wide continuous process of identifying, evaluating, prioritizing, and implementing quality and performance improvement activities throughout the continuum of care at Alameda Health System (AHS).

• **OBJECTIVE:** The QAPI plan describes our approach to ensuring compliance with the Centers for Medicare and Medicaid Services (CMS) QAPI Conditions of Participation. Through continuous collection and analysis of quality indicators and data, corrective actions will be appropriate to remedy and change processes, operations, and services in ways that will ultimately improve patient care and outcomes on a sustainable basis.

• **GOVERNANCE:** Quality and Safety Committee (QSC) is responsible for the oversight of the QAPI Plan through its periodic review of the program, including, the development of a plan to implement and maintain the QAPI program, the review of the progress of QAPI projects, the determination of annual QAPI projects, and the evaluation of the effectiveness of improvement actions that the organization has implemented. QSC is also responsible for ensuring that clear expectations for safety are established and communicated hospital-wide, as well as allocating adequate resources to carry out the functions of the QAPI program requirements.
Updated Key Activities

- Continuous Survey Readiness
- Culture of Safety Survey implementation
- Facility and Unit Level dashboards
- Focused Professional Practice Evaluation (For-Cause)
- Infection Prevention Audits/Tracers and Healthcare Associated Infection (HAI) Surveillance
- Just Culture methodology implemented system wide
- Ongoing Professional Practice Evaluation
- Peer Review
- Proactive Risk Assessment
- Quality Assurance Monitoring
- Quality Improvement Strategies
- Regulatory Compliance
- Root Cause Analyses/Root Cause Investigations (RCA and RCI)
- Simulation Center
- Valid metric development and data interpretation
Governance Structure

Purpose: Visually demonstrate the governance structure and information flow of quality and performance improvement activities to the Board of Trustees.

- **Board of Trustees (BOT)**
- **Quality Professional Services Committee (QPSC)**
  - Chief of Staff (CQS) reports to QPSC
- **Executive Leadership Team (ELT)**
  - AH Medical Executive Committee (MEC)

- **AHS Medical Executive Committee (MEC)**
  - Interdepartmental Professional Practice Committee (IPPC)
    - Continuing Medical Education (CME) Committee
  - AHS Quality Review Committees (QRC)
  - Infection Prevention & Control Committee (IPCC)
  - Code Blue Committee
  - Transfusion Committee
  - AHS Pharmacy & Therapeutics
  - AHS Stroke Committee

- **AH Quality and Safety Committee (QSC)**
  - AH Quality and Safety Committee (QSC)
  - AH Quality Review Committees (QRC)
    - *Reports directly to MEC*
    - *Credentials Committee*
    - *Ethics Committee*

- **Non-Medical Staff Committees**
  - Ambulatory Quality
  - Environment of Care
  - Nursing Quality Review Committee
  - Post-Acute QAPI Committees
  - Simulation Committee

- **Quality Incentive Program (QIP)**

- **Other Medical Staff Committees**
  - Utilization Management
  - Graduate Medical Education
  - Credentialing Committee
  - Ethics Committee
  - San Leandro Leadership

**IPPC:** Oversight for QRCs. Refers system and operational issues to QSC or MEC.

**QRC:** Conducts active peer review of cases to evaluate practitioner performance and clinical practices of care.

**M & M:** educational forum and refers cases for QRC review.

**QSC:** Has a central role in the initiation, review, performance and maintenance of the organization’s quality, performance improvement, root-cause analyses (RCA), patient safety and regulatory activities and events.

**MEC:** Receives monthly reports from QSC and from various Medical Staff Committees and Departments. Approve policies and procedures. Reviews and approves clinically impactful contracts. Chief of Staff reports monthly to QPSC.
Governance

- **Quality Professional Services Committee (QPSC):** Committee of the Board of Trustees, responsible for effective quality and performance improvement plan throughout the system

- **Quality and Safety Committee (QSC):** Committee for each licensed entity responsible for the quality and performance improvement activities

- **Medical Staff:** The Chief Medical Officer (CMO) in collaboration with the Chief of Staff is responsible for leadership and oversight of care provided by the Medical Staff. i.e., Peer Review Committees

- **Executive Leadership Team (ELT):** responsible for strategizing system-wide improvement initiatives, and ensuring alignment and feedback through governance
Selection of Metrics

• **Quality Care** – AHS provides Safe, Timely, Effective, Efficient, Equitable and Patient-Centered care that is accessible to all

• **Quality Roadmap** – AHS strives to communicate a shared understanding of the Quality Pillar of the Strategic Plan and will develop roadmap / plan to “Improve Quality Metrics” alignment with the Strategic Plan.

• **True North Metrics** - Selected with specific objectives: Alignment, Accessibility, Accountability, Aspiration, Achievability, Clinical Relevance, Equity, Inclusion, Specificity
# True North Metrics Dashboard

<table>
<thead>
<tr>
<th>STEEP</th>
<th>Metric</th>
<th>Base Line</th>
<th>Fy24 Goal</th>
<th>All</th>
<th>Worst REAL</th>
<th>Performance Trend</th>
<th>Accountable Team (Op Leader/PI Lead/MD Champion)</th>
<th>Current and Planned Actions to Drive Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety</td>
<td>Patient Harm All↓</td>
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<td></td>
<td>Inpatient Associated Harms</td>
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<td>Skilled Nursing &amp; Sub Acute Associated Harms</td>
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<td>Behavioral Health Associated Harms</td>
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<tr>
<td>Safety</td>
<td>Handwashing Compliance ↑</td>
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<td></td>
<td>Outpatient Compliance</td>
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<tr>
<td>Timely</td>
<td>Days from appointment request to appointment for existing specialty care patients↓</td>
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<td>Adult</td>
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<td>Pediatrics</td>
<td></td>
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<td>Baseline</td>
<td>Fy24 Goal</td>
<td>All Current Month</td>
<td>All FYTD 24</td>
<td>Worst REAL Current Month</td>
<td>Worst REAL FYTD 24</td>
<td>Performance Trend</td>
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<td>Current and Planned Actions to Drive Improvement</td>
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The True North Metrics dashboards define strategic goals to meet our Mission and Vision. They are used to assess the ongoing performance of the organization.

Quality and performance improvement projects may be identified from clinical service area self-assessments, patient reported data, or formal organizational review that identifies gaps in services for targeted goals or outcomes and may be assigned by Executive, Operational, and/or Functional Leaders.

Contracted Services are also to be monitored. Clinical contracted services will participate in the QAPI Plan and contribute any Quality Assurance indicators and collect, analyze, and improve all contracted services throughout organization.

Performance Improvement (PI) projects that are undertaken should align with the organization's mission, strategic plan and HEDI pledge. Equity should be proactively considered when designing performance improvement projects and PDSA cycles. Projects designed without an intentional focus on equity may worsen inequities. The table below contains some equity considerations when designing and conducting performance improvement projects.
# Equity Considerations

<table>
<thead>
<tr>
<th>Key Performance Improvement Step</th>
<th>Equity Considerations</th>
</tr>
</thead>
</table>
| Identify the issue               | • What populations are impacted by the problem you are targeting?  
• Does the team feel comfortable discussing bias and structural inequities?  
• What training has the team received around ingraining equity into their performance work? |
| Define the aim                   | • Are the targeted population clearly articulated in the aim statement?  
• Does the specified timeframe match patient needs?  
• What bias exists in current data sets? |
| Assess the current state         | • What inequities already exist?  
• What types of tests of change have been previously conducted to address these inequities?  
• What policies, procedures, and practices are currently in place? |
| Plan tests of change             | • Will the test of change impact those most vulnerable?  
• Are materials readily available in the language(s) and formats necessary?  
• Will the planned test of change address the root cause of inequity? |
| Learn from tests of change       | • Were any inadvertent intervention-generated disparities created? If so, which tests of change can address those disparities?  
• Do the target populations believe the project outcome? |
| Modify and scale up              | • What are potential structural barriers to spread and sustainability?  
• What best practices helped to achieve this?  
• How will best practices be shared? |

Source: NYC Health + Hospitals. “Weaving Equity into Every Step of Performance Improvement.” IHI.org, April 14, 2022
Performance Improvement Activities

- **Population Health and Care Management** activities through the QIP (Quality Incentive Pool) Diabetes Management, Immunizations, Cancer Screenings
- **Prevention of Hospital Acquired Infections (HAI)** (see Annual Infection Control Plan for specific interventions) C.diff, SSI, CAUTI, CLABSI
- **Prevention of Hospital Acquired Conditions (HAC)** or Patient Safety Indicators (PSI) DVT, HAPI, Retained Foreign Objects
- **Provider Quality Monitoring** Peer Review, Ongoing Professional Practice Evaluations (OPPE) and Focused Professional Practice Evaluations (FPPE)
- **Safety Alerts** Events, Complaints, Grievances, Compliments, and Environment of Care (EOC) concerns
- **Root Cause Analysis** (RCA) of Harms or potential harms
- **Ongoing Regulatory Compliance** and survey readiness activities at each facility
- **Plan of Corrections** to remediate deficiencies identified by regulatory and accreditation bodies
- **Purposeful Hourly Rounding** by nursing to improve Patient Experience
- **Reducing Readmissions** led by Care Management team
Methodology

AHS utilizes the Plan-Do-Study-Act (PDSA) cycle to improve a process or carry out system change. The PDSA cycle is an iterative, four-stage problem solving model which is also referred to as Rapid Cycle Improvement.

1. **Plan**: Plan the test/improvement including a plan for collecting data.
2. **Do**: Run the test/improvement on a small scale.
3. **Study/Check**: Analyze the results and compare them to your predictions.
4. **Act**: Based on what you learned, plan for your next step or PDSA cycle.
## Quality and Safety Committee Calendar

<table>
<thead>
<tr>
<th>January 10th</th>
<th>February 14th</th>
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<tbody>
<tr>
<td><strong>Annual</strong></td>
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<tr>
<td>2023 Reporting Calendar</td>
<td>Graduate Medical Education (GME)</td>
</tr>
<tr>
<td>FY22 QPSC CDPH &amp; TJC Reportable Events &amp; Complaints</td>
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<tr>
<td><strong>Semi-Annual</strong></td>
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<tr>
<td>Environmental Services</td>
<td>Cardiology/Cath Lab</td>
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<td>Stroke Program</td>
<td>Ambulatory Services</td>
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<td>CMS Performance Improvement Programs</td>
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<tr>
<td><strong>Quarterly</strong></td>
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<tr>
<td>Patient Care Services (PCS) Report</td>
<td>Pharmacy and Med Safety/Medication Error Reduction Plan</td>
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<tr>
<td>Perioperative Services Report</td>
<td>Sepsis Committee</td>
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<td>Quality Innovation Award</td>
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<td>Nurse Quality Review Committee</td>
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<td>Performance Improvement Workgroups (CLABSI, SSI)</td>
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<td>QPSC Patient Safety</td>
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<td>EMTALA Workgroup Update</td>
<td>QPSC Regulatory Affairs</td>
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<td>True North Metrics Dashboard</td>
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<td>EMTALA Workgroup Update</td>
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<td>Infection Prevention &amp; Control</td>
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<td>Pharmacy &amp; Therapeutics Committee</td>
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# Quality and Safety Committee Calendar

## March 14th

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## April 11th

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<td>JGPH: TJC - Create Safer Environment</td>
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Patient Safety Program

The Patient Safety Program ensures the quality and safety of patient care. This is accomplished through the following activities:

- **Incident Reports** via MIDAS Safety Alert System,
- **Early identification & Investigation** of adverse occurrences, sentinel events, near miss events, potentially compensable events (PCE’s)
- **Collaboration with the Regulatory Affairs** Department, operational leaders, department leaders
- **Collaboration with BETA Healthcare** (Malpractice Carrier) on programs to reduce or eliminate i.e., Quest for Zero (OB and ED), BETA Heart, Just Culture, Risk Assessments
- **Interval Rounding** Risk and Safety Education
- **Consultation Services** on risk, safety or medical-legal issues
Regulatory Affairs Program

The Regulatory Affairs Program ensures quality and safety by:

- Assuring compliance with laws, standards and regulations designed to keep patients safe and provide a safe environment.

- Managing ongoing regulatory compliance, certification and licensure at Alameda Health System i.e., CDPH, Alameda County Public Health Department, The Joint Commission and CMS.

Celebration of Achievements

Quality and Patient Safety Innovation Awards!

The Innovation Award recognizes organizational excellence in Quality and Patient Safety; and celebrates the efforts of healthcare professionals in quality and patient safety across AHS.
# Celebration of Achievements

## Quality and Patient Safety Innovation Awards!

<table>
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<tr>
<th>FY'23 Quarter 1</th>
<th>Highland Hospital Inpatient Pharmacy Sterile Compounding Dose Error Reduction</th>
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<td>FY'23 Quarter 2</td>
<td>Highland Hospital Department of Anesthesia - Improved Pain Management, Pain Reduction</td>
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<tr>
<td>FY'23 Quarter 3</td>
<td>Highland Hospital ICU - CLABSI and CAUTI Reduction</td>
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<td>Alameda Hospital Stroke Committee - Improvements to Stoke Patient Care and Outcomes</td>
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<tr>
<td>FY'23 Quarter 4</td>
<td>System - Regulatory Affairs Team</td>
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Celebration of Achievements
BETA Symposium 2023!

Quest for Zero: ED
Quest for Zero: OB
Just Culture
Questions?

Felicia Tornabene, MD, FACHE
Chief Medical Officer, Alameda Health System
ftornabene@alamedahealthsystem.org

Ana M Torres, MPH, CPHQ, CPSP, CJCP, HACP, LSSBB
VP of Quality, Alameda Health System
antorres@alamedahealthsystem.org

Christian Rieta, MS-HCA, BSN, RN-BC, CPHQ
System Director of Quality and Outcomes
crieta@alamedahealthsystem.org
F. Critical Care Update (estimated 15 min)
AHS Critical Care

Tze-Ming (Benson) Chen, MD, FCCP
Medicine/Pulmonary and Critical Care Medicine
Outline

1. Outcomes
2. Code Blue Committee
3. Organ Donation
4. Additional QI projects
Q2 2023 ICU Outcomes via A.P.A.C.H.E.

- **ICU Readmissions** system-wide at AHS are 4.9%, below the Ntl benchmark of 5.8%.
- **Acuity** system-wide is reflected by an APACHE score of 56, which is higher than the Ntl benchmark of 54.
- Average **ICU Mortality** ratio (observed/expected) was 0.91, an improvement over preceding quarters.
- Average **ICU Length Of Stay** ratio system-wide is 1.08. And wait times for a transfer bed at Highland continues to be in excess of 24 hours, or 1.1 days.
- **Ventilator Days** decreased from 5.2 days to 4.6 days at Highland, for 2023 YTD.
- **Top 2 Diagnoses** for AHS in Q2 are Sepsis, Pulmonary at #1, and Cardiac Arrest at #2.
AHS average Q2 acuity exceeds the Ntl benchmark for APACHE score.
Readmissions

- Alameda ICU readmissions were highest at 9.2%. Each of the 13 readmissions were reviewed for opportunities for prevention, and found to have been primarily hypothermia that led to readmission.
Mortality Trends

### ICU Mortality Ratios

<table>
<thead>
<tr>
<th></th>
<th>Highland</th>
<th>Alameda</th>
<th>San Leandro</th>
<th>Avg. AHS Q2 2023</th>
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<tbody>
<tr>
<td>Pred ICU Mort</td>
<td>14.4%</td>
<td>15.4%</td>
<td>13.8%</td>
<td>10.1%</td>
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<tr>
<td>Actual ICU Mort</td>
<td>16.3%</td>
<td>18.4%</td>
<td>12.5%</td>
<td>9.2%</td>
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<tr>
<td>ICU MORT RATIO</td>
<td><strong>1.13</strong></td>
<td><strong>1.19</strong></td>
<td><strong>0.90</strong></td>
<td><strong>0.91</strong></td>
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</table>

### Hospital Mortality Ratios

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<tbody>
<tr>
<td>Pred HOSP Mort</td>
<td>18.6%</td>
<td>19.8%</td>
<td>18.0%</td>
<td>14.0%</td>
</tr>
<tr>
<td>Act HOSP Mort</td>
<td>19.9%</td>
<td>23.4%</td>
<td>18.2%</td>
<td>13.4%</td>
</tr>
<tr>
<td>HOSP MORT RATIO</td>
<td><strong>1.07</strong></td>
<td><strong>1.18</strong></td>
<td><strong>1.01</strong></td>
<td><strong>0.95</strong></td>
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</table>
AHS ICU Length of Stays

Highland ICU LOS: 1 year period

For 3 consecutive quarters, the orders to transfer were written prior to the predicted LOS, but the extended wait times prior to transfer are causing the avg. LOS ratio to be > 1.0 at Highland.
Project: Ventilator Days

Kramer, AA, et al (2017). The Impact of Mortality on Total Costs Within the ICU, Critical Care Medicine, 45(9), 1457-1463.

### Highland Ventilator Days

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Days Saved since previous year</th>
<th># Pts</th>
<th># Pt days</th>
<th>Cost /day</th>
<th>Savings vs previous year</th>
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</thead>
<tbody>
<tr>
<td>Apr 2017-Dec 2017</td>
<td>0.5</td>
<td>397</td>
<td>182.62</td>
<td>4067</td>
<td>$742,716</td>
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<tr>
<td>2018</td>
<td>-0.3</td>
<td>563</td>
<td>-140.75</td>
<td>4067</td>
<td>$-572,430</td>
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**Note:**

- **Actual Vent Days** vs. **Predicted Vent Days**
- **Highland Ventilator Days**
- **Actual Vent Days**
- **Predicted Vent Days**
- **Days Saved since previous year**
- **# Pts**
- **# Pt days**
- **Cost /day**
- **Savings vs previous year**

**Source:**

Kramer, AA, et al (2017). The Impact of Mortality on Total Costs Within the ICU, Critical Care Medicine, 45(9), 1457-1463.
QI: Decreasing ICU Length of Stay and Ventilator Days

1. ABCDEF Bundle
   A. Assess, Prevent, and Manage Pain
      i. Analgesia and Sedation Orderset Revision
   B. Both Spontaneous Awakening Trials and Spontaneous Breathing Trials
      i. Staff education / multidisciplinary rounding
   C. Choice of analgesia and sedation
      i. Analgesia and Sedation Orderset Revision
   D. Delirium: Assess, Prevent and Manage
      i. Analgesia and Sedation Orderset Revision
   E. Early mobility and Exercise
      i. Staff education / Mobility Team / Repairing equipment / Purchasing equipment
   F. Family Engagement and empowerment
      i. Reinforcing with clinical team importance of involving family in patient’s care

Acknowledgements: PCCM Division members, Physical Therapy Department, ICU Nursing and Respiratory Therapy Department with special recognition of Lori Foidl, Shonta Archie, Dawn Hughes, Theresa Randall, Craig Cole, Kelley Bullard, Tiffany Lee, Michael Wu, Praveen Belur, Amandeep Singh, Wendy Anderson, Kristen Pappen, Karla Huerta, Linne Almer
QI: Improving Patient Throughput at Highland Hospital: ICU Component

1. Systems approach towards inpatient care
   A. Issues:
      i. Highland Hospital chronically overflowing with patients
      ii. SLH and AH chronically underutilized
   B. Solution:
      i. Admit patients to AHS Hospitals based on patient’s clinical needs and personal preferences
      ii. Throughput Steering Committee: HUGE multidisciplinary effort led by Andrea Wu, Chitra Akileswaran, Indhu Subramanian, Brandon Boesch, Charlotte Wills, Youssef Youssef, Ro Lofton, Dusty Gilleland, Dana Littlepage, Mark Fraztke, Hospitalist Divisions, PCCM Division, ED Department, Transfer Center
      iii. Doc of the Day Pilot
**QI: Improving Interdisciplinary Communication**

1. Daily multidisciplinary rounding  
   A. Ensures all aspects of patient care are addressed  
   B. Fosters “Team”

2. Rounding sheets  
   A. Provides quick reference for daily management plan for each patient  
   B. Ensures consistency in addressing patient care needs

3. Evening attending intensivist to attending hospitalist signout  
   1. Ensures clear communication regarding concerns, plans, and goals for ICU patients to overnight team

Acknowledgements: Tiffany Lee, Kelley Bullard, Brandon Boesch, Lori Foidl, ICU Nursing, PCCM Division, Hospitalist Division
## Disease-specific Outcomes

<table>
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<th>Diagnosis #1</th>
<th>HGH 2022</th>
<th>HGH 2023 YTD</th>
<th>ALH 2023 YTD</th>
<th>SLH 2023 YTD</th>
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<td>121</td>
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<td>18.8%</td>
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<td>24.9%</td>
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<tr>
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<td>63.6%</td>
<td>59.0%</td>
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<td>1.09</td>
<td>1.29</td>
<td>0.74</td>
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<table>
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<th>COVID-19</th>
<th>SEPSISPULM</th>
<th>CHF</th>
<th>EMPHYSBRON</th>
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<td>National Predicted Hospital</td>
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<tr>
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<td>36.6%</td>
<td>0</td>
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<td>1.05</td>
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Code Blue Committee
Highland Hospital
2023-Q2 Code Blue Report

Graph 1: Code Blue Events by Location

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<tbody>
<tr>
<td># of Codes All Units (excluding ED)</td>
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<td>11</td>
<td>28</td>
<td>19</td>
<td>69</td>
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<tr>
<td># of Codes Outside ICU</td>
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<td>4</td>
<td>7</td>
<td>8</td>
<td>22</td>
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<td>% Codes Outside ICU</td>
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<td>36.4%</td>
<td>25.0%</td>
<td>42.1%</td>
<td>31.9%</td>
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<td>39.0%</td>
<td>39.0%</td>
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## Graph 5: In Hospital Mortality

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<td># of Patients with Code Blue Events</td>
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<td>10</td>
<td>46</td>
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<tr>
<td># Expired</td>
<td>6</td>
<td>8</td>
<td>16</td>
<td>5</td>
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<tr>
<td>% Expired</td>
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<td>80.0%</td>
<td>84.2%</td>
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<td>66.0%</td>
<td>66.0%</td>
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</tr>
</tbody>
</table>
1. Destigmatizing semi-elective intubation
   A. Multiple cardiac arrests associated with delays in intubation
      i. Salvage therapies
      ii. False sense of success
2. Reviewing out-of-ICU cardiac arrests
3. Exploring Deterioration Index
   A. New concept being explored and implemented across hospitals nationwide
   B. Utilizing EPIC to provide early warning system

Acknowledgements: PCCM Division, ICU Nursing, Anesthesia, ED Department with special thanks to Tyronda Elliott, Michael Wu, Linne Almer, and Gerrie Teo
Graph 6: Neuro Outcome at Discharge

- CPC 1: Good Cerebral Performance
- CPC 2: Moderate Cerebral Disability
- CPC 3: Severe Cerebral Disability
- CPC 4: Coma, Vegetative state

<table>
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<tr>
<th>Period</th>
<th>CPC 1</th>
<th>CPC 2</th>
<th>CPC 3</th>
<th>CPC 4</th>
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<td>Oct - Dec 2022</td>
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<tr>
<td>Jan - Mar 2023</td>
<td>100.0%</td>
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<td>Apr - Jun 2023</td>
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<tr>
<td>12-month rolling</td>
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<td>48.1%</td>
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</tbody>
</table>

**CPC 1.** Good cerebral performance: conscious, alert, able to work, might have mild neurologic or psychologic deficit.

**CPC 2.** Moderate cerebral disability: conscious, sufficient cerebral function for independent activities of daily life. Able to work in sheltered environment.

**CPC 3.** Severe cerebral disability: conscious, dependent on others for daily support because of impaired brain function. Ranges from ambulatory state to severe dementia or psychosis.

**CPC 4.** Coma or vegetative state: any degree of coma without the presence of all brain death criteria. Unawareness, even if appears awake (vegetative state) without interaction with environment; may have spontaneous eye opening and sleep/awake cycles. Cerebral nonresponsiveness.

**CPC 5.** Brain death: apnea, areflexia, EEG silence, etc.
Improving Post-cardiac Arrest Outcomes

1. Performed retrospective analysis of all out of hospital cardiac arrests in 2022
   A. Identified a number of issues but mostly with inadequate post-arrest temperature management
      i. 2021-2022 AHS changed post-arrest TTM protocol to fever avoidance
   B. Recommendations
      A. Revised TTM protocol: target 36C for initial 24 hrs and then aggressive fever prophylaxis for subsequent 48 hrs
      B. Replacing current hypothermia equipment in the ICU
      C. Purchased new intravascular temperature management system

Acknowledgements: Adeline Goss, Tyronda Elliott, Amandeep Singh, Wendy Anderson, Marina Trilesskaya, Oluwayemisi Adejumo, Linne Almer, Lori Foidl, Dawn Hughes
Organ Donation
**Hospital Scorecard**
Wilma Chan Highland Hospital Year to Date 2023

### YTD Donation Rates

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<tr>
<th></th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>YTD</th>
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</thead>
<tbody>
<tr>
<td>Effective Referral Rate</td>
<td>68%</td>
<td>91%</td>
<td>90%</td>
<td>100%</td>
<td>62%</td>
<td>100%</td>
<td>98%</td>
<td>90%</td>
<td>94%</td>
<td>90%</td>
<td>94%</td>
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<td>50%</td>
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<td>67%</td>
<td>100%</td>
<td>90%</td>
<td>67%</td>
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<td>100%</td>
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<td>90%</td>
<td>100%</td>
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<tr>
<td>Organ Referral Rate</td>
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<td>90%</td>
<td>100%</td>
<td>100%</td>
<td>90%</td>
<td>100%</td>
<td>N/A</td>
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<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
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<td>90%</td>
<td>100%</td>
<td>100%</td>
<td>90%</td>
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<td>98%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>95%</td>
<td>90%</td>
<td>100%</td>
<td>98%</td>
<td>100%</td>
<td>95%</td>
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<td>Tissue Timeliness Rate</td>
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<td>88%</td>
<td>100%</td>
<td>88%</td>
<td>95%</td>
<td>89%</td>
<td>92%</td>
<td>90%</td>
<td>90%</td>
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<td>95%</td>
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<td>91%</td>
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### YTD Donation Performance

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<th>Apr</th>
<th>May</th>
<th>Jun</th>
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<th>Aug</th>
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<th>Oct</th>
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### YTD Compliance Events

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<th>Nov</th>
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**Conversion Rate** = Actual Donors/All Patients with organ donation potential

**Timely Organ Referral Rate** = The patient was referred within one hour of meeting clinical cues

**Timely Tissue Referral Rate** = Timely Tissue Referrals / Tissue Referral

**Planned Discussion Rate** = Collaborative efforts made by care team and DNW to provide the donation discussion to authorizing party with no preliminary mention of donation by care team.
Highland CLABSI CY Data
Highland CY2023 Infection Count and SIR

Highland CY2023 Infection Count By Unit

Highland CY2023 SIR By Unit

230/240
QI: Decreasing HAI: CLABSI and CAUTI

1. Indwelling Device Management
   A. Avoid insertion if not indicated
   B. Ensure sterile insertion
   C. Ensure sterile technique for maintenance
   D. Removal as soon as possible

2. Multipronged approach
   A. Education
   B. Monitoring for indication
   C. Monitoring for appropriate device management / care
   D. Multimodal outreach for device removal
   E. Nursing driven protocol for foley removal
   F. Providing alternatives
   G. Drill down on every CLABSI and CAUTI for OFIs
      i. TPN and single lumen PICC line recommendation

Acknowledgements: Debra Culmer, Tyronda Elliott, Kelley Bullard, Deborah Ellis, Dusty Gilleland, Robert McCabe, Infection Prevention Team
1. Sepsis is a significant contributor to patient morbidity and mortality in the U.S.
2. CMS guidelines recommend sepsis bundle management
3. Questions raised regarding effectiveness of bundle management
   A. Performed retrospective study of 200 patients admitted to Highland Hospital in 2021 and 2022
      i. Results showed lack of bundle benefit on patient mortality as a whole
      ii. But potential benefit seen in patients with high acuity level
      iii. Implications:
          a) Targeted approach towards bundle application
      iv. Submitted as an abstract for the 2024 American Thoracic Society International Meeting

Acknowledgements: Ghita Bouzarif, Linne Almer, Lisa Chikovani, Kylie Chen, Sepsis Harm Reduction Team
1. **Issue**: inadequate nutritional support for AHS patients due to lack of enteral access or frequent NPO status for procedures and surgeries
   
   A. **Issue**: Inadequate enteral access
      
      i. Prior to 2023, AHS patients could not undergo naso-gastric feeding tube placement unless done in IR or OR
      
      ii. Starting in 2023, AHS purchased CorTrak system and currently in use in the HGH ICU with plans to expand to SLH ICU and other HGH floors
   
   B. **Issue**: Frequent nutrition interruption
      
      i. Adjusting NPO requirement for surgery / procedures to align with current guidelines and recommendations

Acknowledgements: Tyronda Elliott, Tiffany Lee, Lori Foidl, Dawn Hughes
Thank You

Questions?
CMS Quality Star Rating

All AHS Post Acute SNF/SA continue with:
5-star Quality Rating
Alameda SNF’s/SA Quality Measures

Alameda Hospital D/P Snf

Quality measures

Learn more about quality measures
Find out why these short-stay measures are important
Find out why these long-stay measures are important
Get current data collection period

Quality measures rating

★ ★ ★ ★ ★
Much above average
Fairmont Quality Measures

Alameda County Medical Center D/P Snf

Quality measures

Learn more about quality measures

Find out why these short-stay measures are important

Find out why these long-stay measures are important

Get current data collection period

Quality measures rating

★ ★ ★ ★ ★

Much above average
CDPH Visits

- CDPH/ACPHD visit to Park Bridge for outbreak
  - Visit went very well – minor suggestions given:
    - Upon exiting, a sign to discard all PPE so they do not take to their car (face shields, etc.)
    - PPE cart in breakroom so they do not need to go in the hall for new
    - AHS may collaborate with ACPHD on new items: Covid sniffing dogs, Blue light EVS cleaning training

- All AHS SNF/SA have been in Covid Response testing
  - working closely with CDPH and ACPHD
CARF Survey Acute Rehab

About CARF
We are an independent, nonprofit organization focused on advancing the quality of services you use to meet your needs for the best possible outcomes.

CARF provides accreditation services worldwide at the request of health and human service providers. Whether you are seeking rehabilitation for a disability, treatment for addiction and substance abuse, home and community services, retirement living, or other health and human services, you can have confidence in your choice. Providers that meet our standards have demonstrated their commitment to being among the best available.

• Commission on Accreditation of Rehabilitation Facilities
• Survey occurred 9/28 and 9/29
• Preliminary findings suggest another 3-year accreditation will be achieved for:
  – Rehab program
  – Stroke program
• 3-year highest accreditation granted
• Would be third time the unit achieved the 3-year accreditation
November 20, 2023

Lizette Taylor, OTR, WCC
Alameda Health System - San Leandro Hospital Acute Rehabilitation
13865 East 14th Street, 3rd and 4th floor
San Leandro, CA 94578

Dear Ms. Taylor:

It is my pleasure to inform you that Alameda Health System - San Leandro Hospital Acute Rehabilitation has been issued CARF accreditation based on its recent survey. The Three-Year Accreditation applies to the following program(s)/service(s):

- Inpatient Rehabilitation Programs - Hospital (Adults)
- Inpatient Rehabilitation Programs - Hospital: Stroke Specialty Program (Adults)

This accreditation will extend through September 30, 2026. This achievement is an indication of your organization’s dedication and commitment to improving the quality of the lives of the persons served. Services, personnel, and documentation clearly indicate an established pattern of conformance to standards.

The accreditation report is intended to support a continuation of the quality improvement of your organization’s program(s)/service(s). It contains comments on your organization’s strengths as well as any consultation and recommendations. A Quality Improvement Plan (QIP) demonstrating your organization’s efforts to implement the survey recommendation(s) must be submitted within the next 90 days to retain accreditation. The QIP form is posted on Customer Connect (customerconnect.carf.org), CARF’s secure, dedicated website for accredited organizations and organizations seeking accreditation. Please log on to Customer Connect and follow the guidelines contained in the QIP form.

Your organization should take pride in achieving this high level of accreditation. CARF will recognize this accomplishment in its listing of organizations with accreditation and encourages your organization to make its accreditation known throughout the community. Communication of the accreditation to your referral and funding sources, the media, and local and federal government officials can promote and distinguish your organization. Enclosed are some materials that will help you publicize this achievement.
CARF Areas of Strength shared by Surveyors

Areas of Strength

CARF found that Alameda Health System - San Leandro Hospital Acute Rehabilitation demonstrated the following strengths:

- The commitment of AHS as a safety net hospital strengthens the program’s advocacy for underinsured persons in the area and strengthens the community overall.
- Both the longevity and history of services to the community demonstrated by the Acute Rehabilitation Unit (ARU) program are embedded in the culture of the staff.
- The relocation of the program from the old rehabilitation unit to the new accommodation on the third and fourth floors of the San Leandro Hospital has proven to be a benefit to the persons served.
- The leadership teams of both AHS and LifePoint Health strengthen the program, with a wide variety of resources for both knowledge and support systems to ensure the success of the program.
- The integration of Health Equity Diversity and Inclusion (HEDI) in the strategic initiatives of AHS’s rehabilitation unit demonstrate a significant commitment to equity for persons served and staff.
CARF Areas of Strength shared by Surveyors

- The medical director and rehabilitation physicians are well qualified and actively involved in the provision of care on the unit. A consultation service has been developed to assist the level one trauma service with rehabilitation planning for persons served. The medical director has advocated in a variety of ways to advance knowledge of the program with various stakeholders in the community. Review of medical records of the persons served reveals strong documentation of items related to each diagnosis and meets the requirements to justify the need for comprehensive integrated inpatient rehabilitation admission.

- The staff members of the ARU are engaged and clearly enthusiastic about the work that they perform each day. The staff members were welcoming and friendly and, when working with persons served, were respectful and professional.

- The team communicates through various methods. A therapy huddle is held daily to discuss and coordinate care. Team members can discuss the progress and goals of the persons served and any changes in condition, which provides a consistent approach in caring for the person served. The electronic medical record has features that allow the providers to communicate with one another. Weekly interdisciplinary team meetings and family conferences are documented in the medical record with the persons served, providing input and preferences of treatment and disposition planning.

- Outcomes are predicted, measured, and achieved for persons served. Despite a relatively high case mix index, the program has a low percentage of acute care transfers.
Thank you

Questions?
ADDENDUM ONE: ABCs of Communication
Agreements for Better Communications and Processes

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

QUALITY AND PROFESSIONAL SERVICES COMMITTEE CHARTER

1. Membership.

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

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

2. Meetings.

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

3. Purpose/Goals/Responsibilities

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

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

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

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

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

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

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

3.2.3.3. The applicant has received involuntary limitation, reduction, denial, or loss
of clinical privileges.
3.2.3.4. There has been a final judgment adverse to the applicant in a professional liability action which in the opinion of the MEC represents a significant clinical departure from accepted standards of practice.
3.2.3.5. QPSC is not recommending that privileges be granted to the applicant.

3.3. Delegated Authority – Policies and Procedures. The Board of Trustees has delegated authority to QPSC to act on behalf of the full Board of Trustees on matters related to approving policies and procedures that have been approved and recommended by the appropriate medical staff.
3.3.1. All actions of QPSC taken pursuant to this delegation by the Board of Trustees shall be forwarded to the Board of Trustees for ratification on a regular basis.

3.4. Other Responsibilities. QPSC shall receive reports and make recommendations to the Board on matters related to any of the following in conjunction with the Board’s safety and quality of patient care responsibilities:
3.4.1. organizational quality assurance report and quality related reports related to Medical Staff and AHS organizational performance including departmental quality assurance reports, mortality and morbidity rates, significant adverse drug reactions, medication errors, transfusion reactions, and infection rates;
3.4.2. patient satisfaction;
3.4.3. Medical Staff monitoring and special committee reports, and results of performance improvement team activities;
3.4.4. other reports related to patient care and safety including safety committee reports, assessments of the buildings and grounds (at least annually);
3.4.5. reports related to the adequacy of access to all services;
3.4.6. risk management reports of all unusual occurrences and significant potential and actual liabilities;
3.4.7. staff competency reports of all unusual occurrences and significant potential and actual liabilities;
3.4.8. AHS performance improvement plan (at least annually);
3.4.9. survey and regulatory reports, including Department of Health Services;
3.4.10. licensure and certification reports;
3.4.11. sentinel events or near-miss sentinel events and analysis thereof;
3.4.12. corrective action plans in response to survey or regulatory reports, complaints and sentinel events, including review of all plans of correction to regulatory reports;
3.4.13. Medical Staff peer review and performance improvement activities;
3.4.14. reports related to adequacy of house staff supervision;
3.4.15. additions or modifications to Medical Staff Bylaws and Rules and Regulations; and
3.4.16. additions or modification to the medical staff and organizational clinical policies and procedures.

4. Reporting to Full Board

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