El Camino Health

AGENDA
QUALITY, PATIENT CARE, AND PATIENT EXPERIENCE COMMITTEE OF THE EL CAMINO HEALTH BOARD OF DIRECTORS

Monday, June 2, 2025 – 5:30 pm

El Camino Health | 2500 Grant Road, Mountain View, CA 94040 | Sobrato Boardroom 1

Krutica Sharma will be participating via teleconference from 4650 Broadway, Apt 2006, New York, NY 10040

THE PUBLIC IS INVITED TO JOIN THE OPEN SESSION PORTION OF THE MEETING LIVE AT THE ADDRESS ABOVE OR VIA TELECONFERENCE AT: **1-669-900-9128, MEETING CODE: 927 5520 4656 # No participant code. Just press #.**

To watch the meeting, please visit: Quality Committee Meeting Link

Please note that the live stream is for meeting viewing only, and there is a slight delay; to provide public comment, please use the phone number listed above.

NOTE: In the event that there are technical problems or disruptions that prevent remote public participation, the Chair has the discretion to continue the meeting without remote public participation options, provided that no Board member is participating in the meeting via teleconference.

A copy of the agenda for the Meeting will be posted and distributed at least seventy-two (72) hours prior to the meeting. In observance of the Americans with Disabilities Act, please notify us at **(650) 988-3218** prior to the meeting so that we may provide the agenda in alternative formats or make disability-related modifications and accommodations.

	AGENDA ITEM	PRESENTED BY	ACTION	ESTIMATED TIMES
1.	**CALL TO ORDER/ROLL CALL**	Carol Somersille, MD Quality Committee Chair		**5:30 pm**
2.	**CONSIDER APPROVAL FOR AB 2449 REQUESTS**	Carol Somersille, MD Quality Committee Chair	Possible Motion	**5:30 pm**
3.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Carol Somersille, MD Quality Committee Chair	Information	**5:30 pm**
4.	**PUBLIC COMMUNICATION** a. Oral Comments *This opportunity is provided for persons to address the Board on any matter within the subject matter jurisdiction of the Board that is not on this agenda. Speakers are limited to three (3) minutes each.* b. Written Public Comments *Comments may be submitted by mail to the El Camino Hospital Board Quality Committee at 2500 Grant Avenue, Mountain View, CA 94040. Written comments will be distributed to the Board as quickly as possible. Please note it may take up to 24 hours for documents to be posted on the agenda.*	Carol Somersille, MD Quality Committee Chair	Information	**5:30 pm**
5.	**RECOGNITION OF QUALITY COMMITTEE MEMBER MELORA SIMON**	Carol Somersille, MD Quality Committee Chair	Information	**5:30 – 5:35**

	AGENDA ITEM	PRESENTED BY	ACTION	ESTIMATED TIMES
6.	**CONSENT CALENDAR ITEMS** a. Approve Minutes of the Open Session of the Quality Committee Meeting (05/05/2025) b. FY2025 Pacing Plan c. Progress against FY2025 Goals d. Progress against Committee Survey Results e. Leapfrog	Carol Somersille, MD Quality Committee Chair	**Motion Required**	**5:35 – 5:45**
7.	**INTERVIEW NOMINEES FOR QUALITY, PATIENT CARE, AND PATIENT EXPERIENCE COMMITTEE** a. Erica Jiang b. Barbara Pelletreau c. Diane Schweitzer d. Sharon Richmond	Krutica Sharma, MD Ad Hoc Committee Chair	Discussion	**5:45 – 6:05**
8.	**SELECT NOMINEES FOR QUALITY, PATIENT CARE, AND PATIENT EXPERIENCE COMMITTEE FOR RECOMMENDATION TO THE HOSPITAL BOARD** a. Erica Jiang b. Barbara Pelletreau c. Diane Schweitzer d. Sharon Richmond	Carol Somersille, MD Quality Committee Chair	**Motion Required**	**6:05 – 6:15**
9.	**PATIENT STORY**	Cheryl Reinking, DNP, RN NEA-BC, Chief Nursing Officer	Information	**6:15 – 6:25**
10.	**HEALTH CARE EQUITY**	Shreyas Mallur, MD, Chief Quality Officer	Discussion	**6:25 – 6:45**
11.	**REFRESH STEEEP DASHBOARD MEASURES FOR FY2026**	Shreyas Mallur, MD, Chief Quality Officer	Discussion	**6:45 – 7:00**
12.	**FY2025 ENTERPRISE QUALITY DASHBOARD**	Shreyas Mallur, MD, Chief Quality Officer	Discussion	**7:00 – 7:10**
13.	**RECESS TO CLOSED SESSION**	Carol Somersille, MD Quality Committee Chair	**Motion Required**	**7:10 – 7:11**
14.	**QUALITY COUNCIL MINUTES** a. Quality Council Minutes (05/07/2025) *Health and Safety Code section 32155 – Deliberations concerning reports on Medical Staff Quality Assurance committee*	Carol Somersille, MD Quality Committee Chair	Information	**7:11– 7:16**
15.	**APPROVE MINUTES OF THE CLOSED SESSION OF THE EL CAMINO HOSPITAL QUALITY COMMITTEE (05/05/2025)** *Report involving Gov't Code Section 54957.2 for closed session minutes.*	Carol Somersille, MD Quality Committee Chair	**Motion Required**	**7:16 – 7:21**
16.	**RECOMMEND FOR APPROVAL CREDENTIALING AND PRIVILEGES REPORT** *Health and Safety Code Section 32155 and Gov't Code Section 54957 – Deliberations concerning reports on Medical Staff quality assurance committee and report regarding personnel performance of the Medical Staff*	Mark Adams, MD, Chief Medical Officer	**Motion Required**	**7:21 – 7:31**

	AGENDA ITEM	PRESENTED BY	ACTION	ESTIMATED TIMES
17.	**VERBAL SERIOUS SAFETY EVENT REPORT** *Health and Safety Code section 32155 – Deliberations concerning reports on Medical Staff Quality Assurance committee*	Shreyas Mallur, MD, Chief Quality Officer	Discussion	**7:31 – 7:36**
18.	**RECONVENE TO OPEN SESSION**	Carol Somersille, MD Quality Committee Chair	**Motion Required**	**7:36 – 7:36**
19.	**CLOSED SESSION REPORT OUT** To report any required disclosures regarding permissible actions taken during Closed Session.	Carol Somersille, MD Quality Committee Chair	Information	**7:36 – 7:37**
20.	**COMMITTEE ANNOUNCEMENTS**	Carol Somersille, MD Quality Committee Chair	Information	**7:37 – 7:40**
21.	**ADJOURNMENT**	Carol Somersille, MD Quality Committee Chair	**Motion Required**	**7:40 – 7:40**

Next Meetings: September 8, 2025; November 3, 2025; December 1, 2025; February 2, 2025; March 2, 2025; May 4, 2025; June 1, 2025

Minutes of the Open Session of the
Quality, Patient Care, and Patient Experience Committee
of the El Camino Health Board of Directors
Monday, May 5, 2025
El Camino Hospital | 2500 Grant Road, Mountain View, CA 94040

Members Present	Members Absent	Staff Present
Carol Somersille, MD, Chair	**Shahram Gholami, MD**	**Dan Woods,** CEO
Melora Simon, Vice Chair *(joined at 5:35 p.m.)*		**Shreyas Mallur, MD,** CQO
Pancho Chang		**Cheryl Reinking**, DPN, RN CNO
Jack Po, MD		**Tracey Lewis Taylor,** COO
Krutica Sharma, MD *(joined at 5:33 p.m.)*		**Christine Cunningham,** Chief Experience and Performance Improvement Officer
Steven Xanthopoulos, MD		**AJ Reall,** VP, Strategy
John Zoglin		**Lyn Garrett,** Senior Director, Quality
		Peter Goll, CAO, ECHMN
	**via teleconference	**Jaideep Iyengar, MD,** ECHMN
		Kirstan Smith, BSN, Director of Clinical Quality, ECHMN
		Anne J. Yang, Executive Director, Governance Services
		Gabriel Fernandez, Coordinator, Governance Services

Agenda Item	Comments/Discussion	Approvals/ Action
1. CALL TO ORDER/ ROLL CALL	The open session meeting of the Quality, Patient Care, and Patient Experience Committee of El Camino Health (the "Committee") was called to order at **5:31 p.m.** by Chair Carol Somersille. A verbal roll call was taken. A quorum was present. Dr. Gholami, Dr. Sharma, and Ms. Simon were absent at the roll call.	Call to order at **5:31 p.m.**
2. CONSIDER APPROVAL FOR AB 2449 REQUESTS	No members of the Quality Committee requested Emergency AB-2449 approval.	
3. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	Chair Somersille asked if any Committee members had a conflict of interest with any of the items on the agenda. No conflicts were reported.	
4. PUBLIC COMMUNICATION	There were no comments from the members of the public.	
5. CONSENT CALENDAR	Chair Somersille asked if any Committee member would like to pull an item from the consent calendar. Chair Somersille commented on item (c) Core Measures, specifically highlighting measure number five: "Median Time from ED Arrival to ED Departure for Discharged ED Patients." She acknowledged that while this metric had previously been a challenge, it has since been	***Consent Calendar Approved***

	successfully addressed and continues to show sustained improvement. **Motion**: To approve consent calendar (a) Minutes of the Open Session of the Quality Committee Meeting (03/03/2025). **Received**: (b) FY25 Pacing Plan, (c) Core Measures **Movant**: Po **Second**: Zoglin **Ayes**: Somersille, Simon, Chang, Po, Sharma, Xanthopoulos, Zoglin **Noes**: None **Abstain**: None **Absent:** Gholami **Recused**: None	
6. AD HOC COMMITTEE VERBAL UPDATE	Dr. Sharma provided an update on the Ad Hoc Committee's recruitment efforts. The committee finalized and posted the role descriptions, receiving 19 applications. Following a review for relevance and qualifications, seven candidates were selected for interviews. A final recommendation will be presented to the Quality Committee for approval. In response to a question from Director Zoglin, Dr. Somersille confirmed that the Ad Hoc Committee will bring forward its final selections for committee consideration.	
7. PATIENT STORY	Ms. Reinking shared a letter from a patient, who is a physician with 30 years of experience and received care at the Los Gatos campus. The patient praised the personalized and compassionate care he experienced throughout his visit, from registration through post-operative recovery. Ms. Reinking highlighted that this feedback reflects ongoing efforts at Los Gatos to enhance patient experience, including improved communication strategies.	

8. EL CAMINO HEALTH MEDICAL NETWORK REPORT	Ms. Smith presented the 2025 Quality Program for the El Camino Health Medical Network, encompassing urgent care and primary care providers. The discussion centered on the complexity of managing diverse quality metrics across varied patient populations, particularly in the context of MIPS (Merit-based Incentive Payment System) and the transition to MVPs (MIPS Value Pathways). Committee members emphasized the importance of aligning quality metrics with the network's strategic goals and recommended presenting the program to the ECHMN Board prior to submission to the ECHB. Key challenges discussed included: • Transitioning from provider attribution to MIPS • Variability in metrics across health plans • Limited integration of quality data into Epic due to resource constraints Ms. Smith acknowledged the difficulty of maintaining consistent quality performance as the network grows. Committee members stressed the need for a comprehensive strategy that aligns quality measures with organizational growth. The potential role of a CQM vendor in supporting metric tracking, particularly for IPAs, was also discussed.	***Actions:*** *Ensure strategic alignment, starting with ECHMN, then proceeding to the ECHB. Confirm if Strategy's analysis includes the costs and needs of ECHMN.* *Develop roadmaps of quality measures being tracked within each strategic pathway of the hybrid model.* *For future reporting, include IPA metrics, pending onboarding of a CQM vendor to ensure realistic data, with a target for data availability in 2026.*

9. PATIENT EXPERIENCE FOR EL CAMINO HEALTH MEDICAL NETWORK	Ms. Cunningham presented the Patient Experience report, highlighting ongoing challenges in meeting patient expectations in clinic settings, particularly related to staffing, wait times, and service consistency. She outlined strategies to address these issues, including targeted coaching, leadership site visits, and the implementation of a regional director model to enhance support. Ms. Cunningham reported that Likelihood to Recommend (LTR) metrics continue to improve year over year by specialty area, with notable growth in services, providers, and staff. These gains have been sustained despite variability and leadership transitions. Ongoing efforts include direct engagement with clinic teams, standardized training, and targeted improvements at underperforming sites. Committee members requested information on the confidence interval of top box scores in order to determine if the difference between top box scores and scores just below is statistically significant. The Committee discussed the balance between pursuing top satisfaction scores and addressing foundational service gaps, such as access. The Committee emphasized the need to balance experience enhancements with operational capacity and ensure alignment with overall network growth goals.	***Actions:*** *Assess the statistical significance of changes in patient experience scores to determine whether observed variations are meaningful.* *Identify and focus on the primary drivers of patient experience changes, concentrating on high-impact factors.* *Develop a clear strategy to align patient experience efforts with organizational capacity and growth goals.*
10. Q3 FY2025 STEEEP DASHBOARD REVIEW / FY2025 ENTERPRISE QUALITY DASHBOARD	Dr. Mallur presented the Q3 FY2025 STEEEP Dashboard and FY 2025 Enterprise Quality Dashboard, highlighting performance across key quality areas, including hospital-acquired conditions (HACs) such as C. diff, CAUTI, and CLABSI. While some indicators remain red, underlying trends are improving due to evidence-based interventions. He noted progress in reducing infection rates through enhanced cleaning protocols, antibiotic stewardship, and staff training. C. diff and CLABSI targets are on track for year-end, though CAUTI remains a focus. The discussion acknowledged the complexity of maintaining consistent outcomes across both campuses, with Los Gatos facing unique challenges. Dr. Mallur emphasized the impact of staffing stability on quality outcomes and the importance of realistic targets	***Actions:*** *Evaluate the impact of staff retention and unit leadership on quality outcomes, with a focus on maintaining stable teams.* *Further explore the influence of palliative care practices on CAUTI rates and consider refining protocols.*

	that reflect each campus's context. The use of standardized infection ratios (SIRs) for benchmarking was also discussed, along with efforts to address CAUTI rates in palliative care settings.	*Assess the statistical significance of quality metric changes to ensure meaningful improvements are identified and addressed.*
11. RECOMMEND FY2026 COMMITTEE PLANNING ITEMS FOR APPROVAL	The Committee reviewed FY2026 planning items, including meeting dates, goals, pacing plan, and the committee charter. Committee Members emphasized the importance of setting clear, measurable goals and agreed on a 50% attendance target for educational sessions. Following discussion, the Committee established a minimum of five in-person meetings per year to support active in-person participation. The charter was updated to align with other Board committees, reinforcing consistency in goal-setting responsibilities and organizational performance oversight. **Motion**: To approve the FY2026 Committee planning items as discussed. **Movant**: Zoglin **Second**: Po **Ayes**: Somersille, Chang, Po, Sharma, Xanthopoulos, Zoglin **Noes**: None **Abstain**: Simon **Absent:** Gholami **Recused**: None	***FY2026 Committee Planning Items were approved.*** *Update committee goal for educational attendance to 50%.* *Set attendance expectation at a minimum of five in-person meetings per year.*
12. RECESS TO CLOSED SESSION	**Motion**: To recess to closed session at 7:15 p.m. **Movant**: Chang **Second**: Simon **Ayes**: Somersille, Simon, Chang, Po, Sharma, Xanthopoulos, Zoglin **Noes**: None **Abstain**: None **Absent:** Gholami **Recused**: None	***Recessed to Closed Session at 7:15 p.m.***

13. AGENDA ITEM 20: CLOSED SESSION REPORT OUT	During the closed session, the Quality Committee approved the recommendation of the Credentialing and Privileges Report for approval by the El Camino Hospital Board of Directors and the Closed Session Minutes of the March 3rd, 2025 meeting.	***Reconvened Open Session at 7:50 p.m.***
14. AGENDA ITEM 21: RECOMMEND FOR APPROVAL FY2026 ENTERPRISE QUALITY AND PATIENT EXPERIENCE - RELATED ANNUAL ORGANIZATIONAL PERFORMANCE INCENTIVE METRICS AND GOAL-SETTING METHODOLOGIES	**Motion**: To recommend for board approval the fiscal year 2026 Enterprise Quality and Patient experience related annual organizational performance, incentive methods and goal setting methodologies with the two edits. **Movant**: Sharma **Second**: Zoglin **Ayes**: Somersille, Simon, Chang, Po, Sharma, Xanthopoulos, Zoglin **Noes**: None **Abstain**: None **Absent:** Gholami **Recused**: None	
15. AGENDA ITEM 22: COMMITTEE ANNOUNCEMENTS	Ms. Simon announced that she will be stepping down from the Committee at the end of the fiscal year.	
16. AGENDA ITEM 23: ADJOURNMENT	**Motion**: To adjourn at 7:52 p.m. **Movant**: Po **Second**: Sharma **Ayes**: Somersille, Simon, Chang, Po, Sharma, Xanthopoulos, Zoglin **Noes**: None **Abstain**: None **Absent:** Gholami **Recused**: None	***Meeting adjourned at 7:52 p.m.***

Attest as to the approval of the preceding minutes by the Quality, Patient Care, and Patient Experience Committee of El Camino Hospital:

_____
Gabriel Fernandez, Coordinator, Governance Services

Prepared by: Gabriel Fernandez, Coordinator, Governance Services
Reviewed by: Carol Somersille, MD, Quality Committee Chair; Anne Yang, Executive Director, Governance Services

APPROVED BY QC
05/06/2024

Quality, Patient Care, and Patient Experience Committee
FY25 Pacing Plan

AGENDA ITEM	Q1			Q2			Q3			Q4		
	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
STANDING AGENDA ITEMS												
Consent Calendar[1]		✓	✓		✓	✓		✓	✓		✓	✓
Verbal Committee Member Expertise Sharing or Chair's Report		✓	✓		✓	✓		✓	✓		✓	✓
Patient Experience Story		✓	✓		✓	✓		✓	✓		✓	✓
Serious Safety Event (as needed)		✓	✓		✓	✓		✓	✓		✓	✓
Recommend Credentialing and Privileges Report		✓	✓		✓	✓		✓	✓		✓	✓
Quality Council Minutes		✓	✓		✓	✓		✓	✓		✓	✓
SPECIAL AGENDA ITEMS – OTHER REPORTS												
Quality & Safety Review of reportable events		✓			✓			✓			✓	
Quarterly Board Level Enterprise/ STEEEP Dashboard Review		✓			✓			✓			✓	
El Camino Health Medical Network Report		✓			✓			✓			✓	
Committee Self-Assessment Results Review												✓
Annual Patient Safety Report			✓									
Annual Culture of Safety Survey Report			✓									
Patient Experience Report			✓						✓			
Health Equity Report						✓						✓
Recommend Safety Report for the Environment of Care					✓							
PSI Report						✓						
Value-Based Purchasing Report									✓			
Recommend Quality Improvement & Patient Safety Plan (QIPS)								✓				
Refresh Quality/Experience Dashboard measures for FY26												✓
Artificial Intelligence Report						✓						
COMMITTEE/ORGANIZATIONAL GOALS/CALENDAR												
Propose Committee Goals									✓			
Recommend Committee Goals											✓	
Propose FY Committee Meeting dates									✓			
Recommend FY Committee Meeting dates											✓	
Propose Organization Goals									✓			
Recommend Organization Goals											✓	
Propose Pacing Plan									✓			
Recommend Pacing Plan											✓	
Review & Revise Charter									✓			
Recommend Charter											✓	

1: Includes Approval of Minutes (Open & Closed), Progress Against FY Committee Goals (Quarterly), Current FY Pacing Plan (Quarterly), CDI Dashboard (November), Core Measures (Semi-Annual), Leapfrog (June)

El Camino Health

FY25 COMMITTEE GOALS

Quality, Patient Care, and Patient Experience Committee

PURPOSE

The purpose of the Quality, Patient Care, and Patient Experience Committee ("Quality Committee" or the "Committee") is to advise and assist the El Camino Hospital Board of Directors ("Board") to monitor and support the quality and safety of care provided at El Camino Health ("ECH"). The Committee will utilize the Institute of Medicine's framework for measuring and improving quality care in these five domains: **s**afe, **t**imely, **e**ffective, **e**fficient, **e**quitable, and **p**erson-centered (STEEEP).

STAFF: Chief Quality Officer (Executive Sponsor)

The CQO and Senior Director of Quality shall serve as the primary staff to support the Committee and are responsible for drafting the Committee meeting agenda for the Committee Chair's consideration. Additional clinical representatives and members of the Executive Team may participate in the meetings upon the recommendation of the Executive Sponsor and at the discretion of the Committee Chair. These may include: Chiefs/Vice Chiefs of the Medical Staff, physicians, nurses, and members from the community advisory councils, or the community at-large.

GOALS	TIMELINE	METRICS
1. Ensure the metrics included on the Quality Committee dashboards are in alignment with the El Camino Hospital Board strategic plan.	Q4FY24 review and update which measures to include on the FY25 Quality Dashboards.	Quality and experience performance measures aligned with the STEEEP domains of; safe, timely, effective, efficient, equitable, and person-centered.
2. Monitor Quality, Patient Care, and Patient Experience performance in accordance with the pacing plan to track progress towards achieving targets.	Q4FY24 review FY25 Incentive Goal recommendations for Quality, Safety, and Patient Experience pillars.	Performance measures on the Quality Dashboards. ▪ Monthly Quality Dashboard ▪ Quarterly Board Level Quality Dashboard
3. Identify and reduce health care disparities for ECH patients.	Biannual report to Quality Committee FY25.	Monitor the effectiveness of ECH activities to reduce healthcare disparities through review of the biannual "health equity report".
4. Foster a culture of collaboration, transparency, and continuous improvement within the Quality Committee.	Fiscal Year 2025	• Attend a minimum of 6 meetings in person. • Actively participate in discussions at each meeting. • Review of annual committee self-assessment results
5. Committee members participate in ongoing training and development to deepen their knowledge of quality, patient care, and patient experience topics.	Fiscal Year 2025	Attend a conference and/or session with a subject matter expert. • Verbal/Written report of key learnings to the Quality Committee.

Chair: Carol Somersille, MD
Executive Sponsor: Shreyas Mallur, MD, Chief Quality Officer

SpencerStuart

El Camino Health

Quality, Patient Care and Patient Experience Committee Survey Results

September 2024

Prepared for El Camino Health

Committee Review Process

- Spencer Stuart was engaged by the Board and Chief Executive Officer of El Camino Health to assist with a survey-based review of the El Camino Health Board Committees.

- The online survey was open from August 12 – 23, 2024. All Committee Members completed the survey. The survey results and open response comments are presented on an unattributed basis in this report.
  - Individual Committee questions were only answered by Committee Members on those Committees:
    - Quality, Patient Care and Patient Experience, "n" = 6
  - In some cases, the total number of responses does not add up to the above "n." In those cases, not every Committee Member answered the question.

- Participants were asked to answer a series of questions on a 4-point Likert scale, where a rating of "1" indicates strong disagreement and a rating of "4" indicates strong agreement. Participants were also given the option to respond "N/A", indicating "no opportunity to observe."

- Comments in the Open Response sections may have been edited for clarity or to protect the identity of the authors. Certain comments have been redacted or modified if they referenced individuals in a directly identifiable way.

- This report will be reviewed by the Governance Committee at its September 17, 2024 meeting.

Summary: Highest and Lowest Rated Areas

The highest and lowest rated items by the Committee about the Committee as a collective. Scores were given on a 1-4 scale, from "Strongly Disagree" to "Strongly Agree." A 4.0 rating is the average highest score possible. A 1.0 rating is the lowest.

Highest Rated	Avg. Score	Lowest Rated	Avg. Score
Meetings: The Committee Chair effectively manages Committee dialogue, e.g., ensures that all voices are heard, guides discussion towards closure and decision, manages time and the meeting agenda effectively.	4.0	**Committee Effectiveness:** The Committee has the proper number of community members representing specific issues of specialized expertise.	2.2
Committee Role: The time commitment Committee Members are asked to make is reasonable and appropriate for fulfilling our duties.	3.8	**Skills, Experiences, and Attributes:** The Committee actively cultivates new candidates to form a pipeline of potential candidates who are qualified based on a defined, competency-based criteria.	2.4
Committee Effectiveness: The Committee has strong leadership.	3.8	**Skills, Experiences, and Attributes:** The Committee is composed of members with optimal subject matter expertise and appropriate competencies.	2.6
Meetings: The Committee accomplishes our duties with adequate time for thoughtful inquiry and oversight, achieving the appropriate balance between presentation and engagement/discussion.	3.7	**Skills, Experiences, and Attributes:** Committee membership comprises diversity of thought, experience, gender, race and ethnic representation, and perspective in order to add greater value to the Committee's deliberations.	2.8
Meetings: Committee Members receive meeting notices, written agendas, minutes and other appropriate materials well in advance of meetings with appropriate time to review and prepare for meetings.	3.7	**Execution of Oversight Responsibilities:** The organization's strategic planning processes are effective, and the Committee provides appropriate input into the strategic planning process, taking into account all key stakeholders.	2.8
Committee Effectiveness: During the course of the year, the Committee effectively monitors performance against its goals and provides feedback regarding any needed course correction, including through regular reports of the appropriate committees tasked with specific oversight responsibilities.	3.7	**Execution of Oversight Responsibilities:** On an annual basis, the Committee effectively deliberates on and approves appropriate performance goals.	3.0
		Relationship with Management: The Committee and management exhibit mutual trust and respect and foster transparency in the working relationship.	3.0
		Culture and Dynamics: Committee Members honor the professional boundaries between governance and management.	3.0

Note: Reported scores here are for the Committee as a collective and do not include the "Self-Reflection" questions.

Committee Meetings

Question	Distribution of Scores					
	N/A / Unknown	Strong Disagree "1"	Disagree "2"	Agree "3"	Strongly Agree "4"	Average Score
The Committee Chair effectively manages Committee dialogue, e.g., ensures that all voices are heard, guides discussion towards closure and decision, manages time and the meeting agenda effectively.					6	4.0
The Committee accomplishes our duties with adequate time for thoughtful inquiry and oversight, achieving the appropriate balance between presentation and engagement/discussion.				2	4	3.7
Committee Members receive meeting notices, written agendas, minutes and other appropriate materials well in advance of meetings with appropriate time to review and prepare for meetings.				2	4	3.7
Committee meetings focus on appropriate topics, such as areas of oversight and related education.				3	3	3.5

Committee Meetings

Prompt	Open Response
What topics would you like to see covered in future Committee meetings?	• Enhancing current Press Ganey patient experience ratings with other, culturally competent processes and measures like regular community focus groups, charrettes and surveys, particularly for the first generation South Asian and East Asian patients who use El Camino. • Value Based Care arrangements and ECH approach and performance against the same. • Organizational strategy to better evaluate potential impacts on Quality and Patient Experience. • Use of transformative AI in healthcare. • Analytics - timelines/cadence of teams' ability to identify meaningful changes in performance. • We have a good pacing plan.

Committee Meetings

Prompt	Open Response
Additional comments on Committee meetings?	• As the Quality Committee refines its clinical measures, it might consider ways to demonstrate how El Camino's care improves the overall health of the health district it serves. • Punctual and well managed; tenor and discussion has been more productive since the last few meetings. • There has been significant tension between the Committee and management. With Dr. Mallur leading, I hope that will be resolved as it makes it difficult to do governance when the management reaction is one of defensiveness and obfuscation. • Engaging, respectful, and well run. • Some physicians still dig a bit too far into specifics of care vs. KPIs/goals/directions.

Committee Role

Question	Distribution of Scores					
	N/A / Unknown	Strong Disagree "1"	Disagree "2"	Agree "3"	Strongly Agree "4"	**Average Score**
The time commitment Committee Members are asked to make is reasonable and appropriate for fulfilling our duties.				1	5	3.8
The expectations for Committee service are clearly articulated and well understood by Committee members.				3	3	3.5
Committee Members engage in productive and meaningful discussion.				3	3	3.5

Committee Role

Prompt	Open Response
Additional comments on the Committee role?	• Consider incorporating training and patient safety education activities into Committee meetings. • It could be clearer - the role of the Committee vs. the Board. On the Committee, we don't always hear what the Board needs/wants from us. Similarly, the different roles of the different Committees related to setting the goals that feed into executive compensation are not clear. • Some issues with the staff/executive team's understanding of the Committee's role and their role in supporting the Committee's direction and guidance.

Committee Culture and Dynamics

Question	Distribution of Scores					
	N/A / Unknown	Strong Disagree "1"	Disagree "2"	Agree "3"	Strongly Agree "4"	**Average Score**
The Committee operates with a spirit of collegiality and there is a culture of mutual respect among Committee members.			1	1	4	3.5
Committee Members possess strong communication skills, knowing when to listen and when to speak up.				4	2	3.3
Committee Members are comfortable expressing their views openly and productively both in Committee meetings and with Committee leadership and management, as needed.				4	2	3.3
Committee Members honor the professional boundaries between governance and management.			1	4	1	3.0

Committee Culture and Dynamics

Prompt	Open Response
Additional comments on Committee culture and dynamics?	• The Chair works effectively and collaboratively with El Camino management. • This is a work in progress. Historically, management has been very defensive, and some Committee Members have been deep in the weeds, creating a difficult dynamic. Dr. Mallur is more open and forthright, and his answers make sense, making it easier to stay at a governance level. • The change in executive leadership has created a spirit of enhanced collaboration. There is less of a defensive response and more discussion on how to achieve shared goals. • Doing better lately. Impossible to consistently "toe the line" between management and governance but any time a Committee Member seems to start going into management level discussion, other Members and often the Members themselves are effectively able to zoom back out to the governance role. • Occasionally, "dig too deep" into how the management team should execute against KPIs - which then forces the management team to spend too much time on specifics of execution.

Committee Skills, Experiences, and Attributes

Question	Distribution of Scores					
	N/A / Unknown	Strong Disagree "1"	Disagree "2"	Agree "3"	Strongly Agree "4"	**Average Score**
The Committee membership comprises diversity of thought, experience, gender, race and ethnic representation, and perspective in order to add greater value to the Committee's deliberations.	1		2	1	1	2.8
The Committee is composed of members with optimal subject matter expertise and appropriate competencies.			2	3		2.6
The Committee actively cultivates new candidates to form a pipeline of potential candidates who are qualified based on a defined, competency-based criteria.			3	2		2.4

Committee Skills, Experiences, and Attributes

Prompt	Open Response
Additional comments on committee skills, experiences, and attributes?	• Missing patient perspective. This is a significant gap for a Committee with responsibility of governing oversight over patient experience. • Talent spotting and pipeline development do not appear to take place regularly or routinely. Data science and community-based participatory research skills do not appear to be represented on the Committee. • Our Committee lacks anyone with Latino/a ethnicity, despite the fact that ECH sees many patients with that ethnicity. We also don't have anyone who brings deep expertise on patient experience, and we have less experience in quality than we have had in the past. There is no pipeline, and we have fewer Members than we need. • The Committee charter is potentially too broad - quality and customer experience. Not much depth of experience in latter responsibility.

Relationship with Management

Question	Distribution of Scores					
	N/A / Unknown	Strong Disagree "1"	Disagree "2"	Agree "3"	Strongly Agree "4"	**Average Score**
Management provides high quality Committee materials, with the appropriate level of detail, to enable the Committee to effectively carry out its oversight responsibilities.				4	2	3.3
The Committee has an effective working relationship with the executive sponsor and hospital staff.				4	2	3.3
The Committee and management exhibit mutual trust and respect and foster transparency in the working relationship.			2	2	2	3.0

Relationship with Management

Prompt	Open Response
Additional comments on the Committee's relationship with management?	• Responded "Agree" to all three questions since the relationship and dynamic is rapidly evolving to a healthy ideal state. It hasn't always been the case, so I cannot give a "Strongly Agree." • The new CQO is the bomb. • Excellent choice of CQO. • Current executive sponsor is wonderful.

Execution of Committee's Oversight Responsibilities

Question	Distribution of Scores					
	N/A / Unknown	Strong Disagree "1"	Disagree "2"	Agree "3"	Strongly Agree "4"	**Average Score**
The Committee understands the mission and vision and reflects these understandings on key issues throughout the year.				4	2	3.3
The Committee has established procedures to effectively oversee quality.				4	2	3.3
The Committee has an effective mechanism in place for resolving potential conflicts of interest.			1	3	2	3.2
On an annual basis, the Committee effectively deliberates on and approves appropriate performance goals.			2	2	2	3.0
The organization's strategic planning processes are effective, and the Committee provides appropriate input into the strategic planning process, taking into account all key stakeholders.			3	1	2	2.8

Execution of Committee's Oversight Responsibilities

Prompt	Open Response
Additional comments on oversight of setting strategy, performance goals and other key areas of responsibility?	• It is not clear how the Committee seeks and includes local policy and payer stakeholders. • Strategic direction and performance goals are often brought to the Committee for "review and approval" and have almost always been a point of contention. Would be helpful if the Committee was engaged sooner and a greater number of times in the process. • The Committee has played no role in strategy setting in the time I have served on it. • #73 points to whole point - this is not just the Quality Committee - where is the question about overseeing patient experience?

Committee Effectiveness

Question	Distribution of Scores					
	N/A / Unknown	Strong Disagree "1"	Disagree "2"	Agree "3"	Strongly Agree "4"	**Average Score**
The Committee has strong leadership.				1	5	3.8
During the course of the year, the Committee effectively monitors performance against its goals and provides feedback regarding any needed course correction, including through regular reports of the appropriate committees tasked with specific oversight responsibilities.				2	4	3.7
The current committee structure and operating procedures are effective.				3	3	3.5
Committee Members have the experience to serve effectively.				3	3	3.5
Committee agendas are prepared and circulated timely and contain all pertinent information, minutes are taken accurately, and informational and logistical support are provided by management and outside advisors.			1	2	3	3.3
The Committee has the proper number of community members representing specific issues of specialized expertise.		1	4		1	2.2

Committee Effectiveness

Prompt	Open Response
Additional comments on Committee effectiveness?	• The Committee would benefit from adding one to two community members with relevant expertise. Current make up - three Board Members, two Chiefs of Staff, three community members - seems a bit skewed. • We need more community members that bring specific expertise and experience. • We need more community members on the Committee. • Staff support has improved but response times appear to be lengthened by extensive chain of command protocols and constant compliance referrals. • Dr. Somersille has come a long way in her leadership of the Committee, and now it's a well-oiled machine with her own personality on it (like the teaching rounds). • More experience on patient experience. Still floundering a bit on how to engage/oversee quality and patient experience of the now 200 affiliated physicians. The Committee is not responsible for El Camino Hospital but El Camino Health.

Self-reflection on Your Contributions to the Committee

Question	Distribution of Scores					
	N/A / Unknown	Strong Disagree "1"	Disagree "2"	Agree "3"	Strongly Agree "4"	**Average Score**
I understand what the Committee expects of me in my role as member and the function, role, and responsibilities of being a Committee Member.				1	4	3.8
I have a positive working relationship with other Committee Members.				1	4	3.8
I prepare for and actively participate in Committee meetings as well as other activities expected of me as a Committee Member.				2	3	3.6
I find serving on the Committee to be a satisfying and rewarding experience.				3	3	3.5
As a Committee Member, my expertise and experience are being fully leveraged.			1	2	2	3.2

Additional Reflection on the Performance of the Committee

Prompt	Open Response
1. Please provide any additional comments on the effectiveness of the Committee over the last year. 2. Looking to the future, what should be the goals of the Committee over the next two years; what do we want to accomplish as a Committee separate from the goals of the organization? (E.g., expanded Committee education programs; changes; enhanced communication; better use of Committee meeting time; other potential areas of responsibility and oversight?). 3. Do you have other input about the Committee that has not been addressed in this survey?	• In addition to quality/safety/experience content being considered for Committee education, it will benefit the Committee to understand the charter/structure/function of other ECH Board Committees to get a better understanding of the interconnectedness of these various forums and how it all culminates into supporting the Hospital Board in their governance responsibilities. • Reorienting/resetting the tenor and relationship between management and committee; having a role in setting/reacting to strategy; clearer roles and responsibilities between Committee Members. • We could probably use one or even two fewer Committee Meetings a year. • Excellent Chair. Excellent discussion. Forward thinking group. • Resolve how we manage ECHMN and affiliated organizations' quality and patient experience.

SpencerStuart

El Camino Health

EL CAMINO HEALTH
COMMITTEE MEETING COVER MEMO

To: Quality, Patient Care and Patient Experience Committee
From: Lyn Garrett, MHA, MS, CPHQ, and Senior Quality Director
Date: June 2, 2025
Subject: Leapfrog Hospital Safety Grade Spring 2025

Purpose:

To update the Quality, Patient Care and Patient Experience Committee on the Leapfrog Hospital Safety Grade (Spring 2025) for both Mountain View (MV) & Los Gatos (LG) Campuses.

Background:

Leapfrog started with a focus on employers looking at the safety of hospital care. In 2012 they decided to expand this work to reach out to consumers directly with a Hospital Safety Grade. This grade is meant to help patients determine how safe hospitals are for patients. The safety grade aims to provide patients with a letter grade rating that summarizes how likely they are to experience accidents, injuries, errors or harm while in the hospital. The two domains of the Leapfrog Hospital Safety Grade are:

1. Process/Structural Measures [12 measures] from the Leapfrog Hospital Survey and
2. Outcome Measures from CMS [10 measures]. Focusing on patient safety through participation in Leapfrog is supportive of our High Reliability aim of achieving zero patient harm.

Assessment:

Leapfrog Survey raises the bar for safer health care by building a movement for transparency. Over 2,200 hospitals voluntarily participate in the Leapfrog Program each year. The support and engagement of our leadership to participate in this survey shows our utmost pursuit for excellent and safe care. Leapfrog evaluates both campuses individually; however, for CMS specific metrics (HCAHPS and PSI-90), MV and LG share scores.

A. Both Los Gatos and Mountain View Campus earned a letter grade A for the Spring 2025 reporting period.
B. MV has achieved “Straight A” status for the last 10 consecutive reporting periods.
C. LG has achieved “Strait A” status for the last 6 consecutive reporting periods.
D. Both the Mountain View and Los Gatos campuses achieved the standards for Computerized Physician Order Entry (CPOE) and Bar Code Medication Administration (BCMA). Both campuses reported zero air embolisms during the Leapfrog measurement period. Additionally, having handwashing policy and evaluating how healthcare workers follow that policy earned us 100 points or achieved the standards. As a result of these exceptional clinical outcomes and process measures, both the Los Gatos and Mountain View campuses were awarded Hospital Safety Grade of A.

Enterprise Opportunities

A. All the HCAHPS scores for the Leapfrog Spring of 2025 are above the Average Performing Hospitals but below Best Performing Hospitals for the timeframe CY2023.
B. Both campuses scored below Average Performing Hospitals in Retained Foreign Object.

MV Opportunities

A. CAUTI- for reporting period 07/01/2023 - 06/30/2024 MV's CAUTI is higher than the average Performing Hospitals. CAUTI reduction efforts continue with a focus on Foley insertion, maintenance, and duration.

LG Opportunities

A. Hospitals can earn up to 100 points for staffing their ICUs with 24/7 intensivists. Thus, LG only achieved considerable achievement. Although, LG's score went up from 5 points to 50 points because an on-site clinical pharmacist makes daily rounds on all critical care patients in the adult ICU at least five days/week, and on the other two days/week, a clinical pharmacist returns more than 95% of calls/pages/texts from the unit within five minutes.

List of Attachments:

1. Attachment 1: MV Leapfrog Survey Spring 2025 letter grade calculator
2. Attachment 2: LG Leapfrog Survey Spring 2025 letter grade calculator

© The Leapfrog Hospital Safety Grade Calculator -- April 2025

The Safety Grade Calculator is provided as a courtesy to help hospitals review their performance on each of the measures used in the Hospital Safety Grade as of the Data Snapshot Date (January 31, 2025).
Please enter your hospital's data and review this information to ensure that Leapfrog recorded the correct measure score from each publicly available data source.
More information about the Leapfrog Hospital Safety Grade and its methodology can be found at:
https://www.hospitalsafetygrade.org/for-hospitals/data-review/review-login

Means, standard deviations, and measure weights have been finalized following the Safety Grade Review Period as a result of changes that occurred during the review process (February 24, 2025 - March 14

Instructions for the Hospital Safety Grade Calculator
1. Enter your hospital's source data in Column E (Your Hospital's Score)
2. If you have a score of zero (0), enter 0, not N/A, into the calculator
3. If you have a score that has been imputed or trimmed, enter only the numerical score into the calculator (do not include asterisks)
4. If you have a score of Not Available or Declined to Report for a measure, enter N/A into the calculator

Additional Information	
Final Safety Grade	The final calculated letter grade is found on the last row of the Hospital Safety Grade Calculator (row 33).
Reporting Periods	Please see the the third sheet in this file labeled "Reporting Periods" to view the reporting periods of each Safety Grade Measure.
Standard Weights	The standard weights will be applied unless you are scored as Not Available or Declined to Report for a measure. Please refer to column S to determine the final weight that was applied to each measure.
Negative z-scores	To ensure that a single measure does not dominate a hospital's overall score in an unintended way, Leapfrog truncated negative z-scores at -5.00. Hospitals that have a calculated z-score below -5.00 on a measure will receive a modified z-score of -5.00 on that measure.

April 2025

Measure Domain	Measure	Enter Your Hospital's Score Here (Do NOT Leave Blanks)	Mean	Standard Deviation	Z-Score[1]		Inputs to Weighting Individual Measures[2]				Weight[3]		Weighted Measure Score (Modified Z-Score x Final Weight)
					Original Z-Score	Modified Z-Score	Evidence	Opportunity	Impact	Number of Component Measures[4]	Standard Weight	Final Weight (N/A redistributes)	
Process/Structural Measures	Computerized Physician Order Entry (CPOE)	100	80.23	34.14	0.5790	0.5790	2	1.43	3	1	6.157%	6.2%	0.0356
	Bar Code Medication Administration (BCMA)	100	81.87	30.45	0.5955	0.5955	2	1.37	3	1	6.000%	6.0%	0.0357
	ICU Physician Staffing (IPS)	100	65.15	43.73	0.7968	0.7968	2	1.67	3	1	6.881%	6.9%	0.0548
	Safe Practice 1: Culture of Leadership Structures and Systems	120.00	117.49	6.79	0.3702	0.3702	1	1.06	2	1	3.056%	3.1%	0.0113
	Safe Practice 2: Culture Measurement, Feedback, & Intervention	120.00	116.85	13.98	0.2251	0.2251	1	1.12	2	1	3.178%	3.2%	0.0072
	Total Nursing Care Hours per Patient Day	100	77.07	31.61	0.7255	0.7255	2	1.41	2	1	4.729%	4.7%	0.0343
	Hand Hygiene	100	74.40	36.14	0.7084	0.7084	2	1.49	2	1	4.877%	4.9%	0.0345
	H-COMP-1: Nurse Communication	91	90.19	2.51	0.3221	0.3221	1	1.03	2	1	2.998%	3.0%	0.0097
	H-COMP-2: Doctor Communication	91	89.91	2.48	0.4392	0.4392	1	1.03	2	1	2.997%	3.0%	0.0132
	H-COMP-3: Staff Responsiveness	82	81.63	4.36	0.0859	0.0859	1	1.05	2	1	3.048%	3.0%	0.0026
	H-COMP-5: Communication about Medicines	75	74.42	4.13	0.1397	0.1397	1	1.06	2	1	3.052%	3.1%	0.0043
	H-COMP-6: Discharge Information	87	85.25	3.70	0.4719	0.4719	1	1.04	2	1	3.028%	3.0%	0.0143
Outcome Measures	Foreign Object Retained	0.085	0.014	0.05	-1.4213	-1.4213	1	3.00	2	1	4.208%	4.2%	-0.0598
	Air Embolism	0.000	0.002	0.06	0.0348	0.0348	1	3.00	1	1	2.405%	2.4%	0.0008
	Falls and Trauma	0.170	0.384	0.40	0.5326	0.5326	2	2.05	3	1	4.894%	4.9%	0.0261
	CLABSI	0.272	0.651	0.55	0.6858	0.6858	2	1.85	3	1	4.536%	4.5%	0.0311
	CAUTI	0.999	0.540	0.49	-0.9295	-0.9295	2	1.91	3	1	4.654%	4.7%	-0.0433
	SSI: Colon	0.429	0.831	0.69	0.5843	0.5843	2	1.83	2	1	3.400%	3.4%	0.0199
	MRSA	0.257	0.719	0.59	0.7815	0.7815	2	1.82	3	1	4.489%	4.5%	0.0351
	C. Diff.	0.409	0.401	0.33	-0.0260	-0.0260	2	1.81	3	1	4.474%	4.5%	-0.0012
	PSI 4: Death rate among surgical inpatients with serious treatable conditions	166.97	177.45	24.02	0.4364	0.4364	1	1.14	2	1	1.966%	2.0%	0.0086
	CMS Medicare PSI 90: Patient safety and adverse events composite	0.87	1.00	0.20	0.6751	0.6751	1	1.20	2	10	14.974%	15.0%	0.1011
Process Measure Domain Score:		0.2575											
Outcome Measure Domain Score:		0.1184											
Process/Outcome Domains - Combined Score:		0.3759											
Normalized Numerical Score:		3.3759											
Hospital Safety Grade (Letter Grade):		A											

Additional Resources:

[1]Please refer to the 'Calculating Z-scores' section of the methodology document for more details.

[2]Please refer to the 'Weighting Individual Measures' section of the methodology document for more details.

[3]Please refer to the 'Dealing with Missing Data' section of the methodology document for more details.

[4]Please refer to the 'Number of Component Measures' section of the methodology document for more details.

Spring 2025

Measure Domain	Measure	Primary Data Source	Reporting Period	Secondary Data Source	Reporting Period
Process/Structural Measures	Computerized Physician Order Entry (CPOE)	2024 Leapfrog Hospital Survey	2024	Imputation Model Applied[i]	N/A
	Bar Code Medication Administration (BCMA)	2024 Leapfrog Hospital Survey	2024	Imputation Model Applied[i]	N/A
	ICU Physician Staffing (IPS)	2024 Leapfrog Hospital Survey	2024	Imputation Model Applied[i]	N/A
	Safe Practice 1: Culture of Leadership Structures and Systems	2024 Leapfrog Hospital Survey	2024	N/A	N/A
	Safe Practice 2: Culture Measurement, Feedback, & Intervention	2024 Leapfrog Hospital Survey	2024	N/A	N/A
	Total Nursing Care Hours per Patient Day	2024 Leapfrog Hospital Survey	01/01/2023 - 12/31/2023 or 07/01/2023 - 06/30/2024	N/A	N/A
	Hand Hygiene	2024 Leapfrog Hospital Survey	2024	Imputation Model Applied[i]	N/A
	H-COMP-1: Nurse Communication	CMS	01/01/2023 - 12/31/2023	N/A	N/A
	H-COMP-2: Doctor Communication	CMS	01/01/2023 - 12/31/2023	N/A	N/A
	H-COMP-3: Staff Responsiveness	CMS	01/01/2023 - 12/31/2023	N/A	N/A
	H-COMP-5: Communication about Medicines	CMS	01/01/2023 - 12/31/2023	N/A	N/A
	H-COMP-6: Discharge Information	CMS	01/01/2023 - 12/31/2023	N/A	N/A
Outcome Measures	Foreign Object Retained	CMS	07/01/2021 - 06/30/2023	N/A	N/A
	Air Embolism	CMS	07/01/2021 - 06/30/2023	N/A	N/A
	Falls and Trauma	CMS	07/01/2021 - 06/30/2023	N/A	N/A
	CLABSI	2024 Leapfrog Hospital Survey	07/01/2023 - 06/30/2024	CMS	01/01/2023 - 12/31/2023
	CAUTI	2024 Leapfrog Hospital Survey	07/01/2023 - 06/30/2024	CMS	01/01/2023 - 12/31/2023
	SSI: Colon	2024 Leapfrog Hospital Survey	07/01/2023 - 06/30/2024	CMS	01/01/2023 - 12/31/2023
	MRSA	2024 Leapfrog Hospital Survey	07/01/2023 - 06/30/2024	CMS	01/01/2023 - 12/31/2023
	C. Diff.	2024 Leapfrog Hospital Survey	07/01/2023 - 06/30/2024	CMS	01/01/2023 - 12/31/2023
	PSI 4: Death Rate among Surgical Inpatients with Serious Treatable Conditions	CMS	07/01/2021 - 06/30/2023	N/A	N/A
	CMS Medicare PSI 90: Patient safety and adverse events composite	CMS	07/01/2021 - 06/30/2023	N/A	N/A

[i]See the Instructions and Methodology document for more information about the Imputation Model used for missing CPOE, BCMA, Hand Hygiene, and IPS data.

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April 2025

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	CMS Medicare PSI 90: Patient safety and adverse events composite	0.87	1.00	0.20	0.6751	0.6751	1	1.20	2	10	14.974%	16.5%	0.1111
Process Measure Domain Score:		0.1788											
Outcome Measure Domain Score:		0.1617											
Process/Outcome Domains - Combined Score:		0.3406											
Normalized Numerical Score:		3.3406											
Hospital Safety Grade (Letter Grade):		A											

Additional Resources:

[1]Please refer to the 'Calculating Z-scores' section of the methodology document for more details.

[2]Please refer to the 'Weighting Individual Measures' section of the methodology document for more details.

[3]Please refer to the 'Dealing with Missing Data' section of the methodology document for more details.

[4]Please refer to the 'Number of Component Measures' section of the methodology document for more details.

Spring 2025

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	H-COMP-2: Doctor Communication	CMS	01/01/2023 - 12/31/2023	N/A	N/A
	H-COMP-3: Staff Responsiveness	CMS	01/01/2023 - 12/31/2023	N/A	N/A
	H-COMP-5: Communication about Medicines	CMS	01/01/2023 - 12/31/2023	N/A	N/A
	H-COMP-6: Discharge Information	CMS	01/01/2023 - 12/31/2023	N/A	N/A
Outcome Measures	Foreign Object Retained	CMS	07/01/2021 - 06/30/2023	N/A	N/A
	Air Embolism	CMS	07/01/2021 - 06/30/2023	N/A	N/A
	Falls and Trauma	CMS	07/01/2021 - 06/30/2023	N/A	N/A
	CLABSI	2024 Leapfrog Hospital Survey	07/01/2023 - 06/30/2024	CMS	01/01/2023 - 12/31/2023
	CAUTI	2024 Leapfrog Hospital Survey	07/01/2023 - 06/30/2024	CMS	01/01/2023 - 12/31/2023
	SSI: Colon	2024 Leapfrog Hospital Survey	07/01/2023 - 06/30/2024	CMS	01/01/2023 - 12/31/2023
	MRSA	2024 Leapfrog Hospital Survey	07/01/2023 - 06/30/2024	CMS	01/01/2023 - 12/31/2023
	C. Diff.	2024 Leapfrog Hospital Survey	07/01/2023 - 06/30/2024	CMS	01/01/2023 - 12/31/2023
	PSI 4: Death Rate among Surgical Inpatients with Serious Treatable Conditions	CMS	07/01/2021 - 06/30/2023	N/A	N/A
	CMS Medicare PSI 90: Patient safety and adverse events composite	CMS	07/01/2021 - 06/30/2023	N/A	N/A

[i]See the Instructions and Methodology document for more information about the Imputation Model used for missing CPOE, BCMA, Hand Hygiene, and IPS data.

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
QUALITY COMMITTEE MEETING MEMO

To: El Camino Hospital Quality Committee
From: Krutica Sharma, MD, Ad Hoc Committee Chair
Date: June 2, 2025
Subject: Nominees for Quality, Patient Care, and Patient Experience Committee

Recommendation: Recommend the four (4) nominees selected by the Ad Hoc Committee for appointment to the Quality, Patient Care, and Patient Experience Committee to the Hospital Board for approval.

Summary:

1. Situation: Per the Hospital Board's Charter, the Quality Committee shall include two (2) or more Hospital Board members. The Committee may also include up to nine (9) community members with expertise in areas such as quality indicators, patient safety, care integration, payor industry issues, customer service, population health management, goal alignment, or executive leadership in healthcare institutions.

2. Authority: The Quality Committee appointed Krutica Sharma, MD (Chair), Melora Simon, and Carol Somersille, MD, to an Ad Hoc Committee to identify qualified community candidates with expertise in three specific areas: health equity, customer and patient experience, and outpatient quality.

3. Background: The Ad Hoc Committee developed and executed a recruitment plan that attracted a strong pool of community applicants. Seven candidates with extensive experience and qualifications were selected for interviews. Following the interviews, the Ad Hoc Committee identified four candidates to recommend for consideration by the Quality Committee and subsequent approval by the Hospital Board.

Each candidate will be allotted five (5) minutes to engage with the Committee. The interview format will be structured as follows:

- 1 minute: Self-introduction and background
- 3 minutes: Response to any Committee questions
- 1 minute: Closing remarks and/or questions for the Committee

Following the interviews, the Committee will deliberate and vote on the Ad Hoc Committee's recommendation.

4. **List of Attachments:**

The Candidates' resumes and responses to the Candidate Questionnaire have been included for review.

a. Erica Jiang
b. Barbara Pelletreau
c. Diane Schweitzer
d. Sharon Richmond

Erica Jiang

[redacted] ▪ [redacted] ▪ San Francisco Bay Area

SUMMARY

Full-stack business leader with technical depth; **drove $3B incremental impact and owned $1B P&L to date**

- **Cross-lifecycle experience:** from pre-seed to exited startups, SMBs, Tech and FinTech giants
- **P&L ownership:** 10 years of full P&L ownership worth $1B to date, e.g. a zero-to-one SaaS product line, a Series A startup, Series C+ and Tech giant's global portfolios
- **Venture Capital expertise:** as Venture Partner driving and accelerating growth for venture capital fund and portfolio companies across sectors e.g. Tech, FinTech, AI, Web3, Health, Education, Hospitality, Consumer, and Enterprise
- **Organizational leadership:** 10 years in building, developing, transforming, scaling, and leading teams, including global and remote teams; experienced in overseeing business and technical functions e.g. product, customer, sales, marketing, strategy, operations, data science and engineering; adept at cross-level management and influence from executive leadership to frontline; proven track record of driving cross-functional collaboration and alignment, skilled in fostering synergies between departments to optimize performance, innovation, and growth
- **Technical depth:** 8 years in AI (products, applications, go-to-market, building co-pilot), 10 years in Data Science
- **Global expertise:** proven track record of driving bottom-line growth across Americas, EMEA, and APAC

EXPERIENCE

Loyal VC | Venture Partner San Francisco, CA | 2024 – Present

- Shaped industry-leading portfolio companies across Americas, EMEA, and APAC by providing strategic guidance, mentoring startup founders, and facilitating business-critical decisions and innovations
- Helped >90% of portfolio companies achieve significant milestones e.g. fundraising, product-market fit, go-to-market, scalability and growth, profitability, competitive differentiation and moat, global expansion, operational excellence, and organizational development
- Drove fund growth by spearheading global mass fundraising, building and managing valuable networks, identifying transformative investments, ensuring sound investment decisions, and advising General Partners on deal structuring, term negotiation, portfolio exits, strategic partnerships, market and competitive intelligence, and fundraising strategies
- Elevated fund operations by spearheading its AI strategies, co-building its AI co-pilot, and improving global marketing

Meta | Head, Launch Management Menlo Park, CA | 2021 – 2023

- Led teams of people managers and individual contributors across 3 functions:
  - Emerging Products: led the global strategy and go-to-market for 200+ Meta products and features, e.g. AI, Crypto
  - Strategic Initiatives: advanced product operations, e.g. its maturity, scalability, and AI applications
  - Chief-of-Staff: supported executive leaders across functions on company-wide priorities
- Built, developed, and scaled the team and its operations
  - Realized +35% productivity while +40% cost savings
  - Scaled team size and scope by 2.5x, including building the Strategic Initiatives function and its Data Science arm from zero to hero
- Built and led the Data Science arm to develop true-north metrics and goals, automated data pipelines and dashboards, scalable measurements and models, and innovative data solutions, improving go-to-market success by 50%
- Spearheaded 10+ innovations and scaled their implementation to 15 functions, improving operational efficiency and organizational effectiveness at scale
- Led and influenced at scale, by driving 3 and influencing 9 strategic goals at executive leadership level, and advancing team and talent management practices for 300+ FTEs

Google | Lead, Global Business Strategy and Operations Mountain View, CA | 2016 – 2021

- Led teams of people managers and individual contributors to develop and operationalize 2 C-level strategies and programs that impacted the entirety of Google's Ads business globally
  - Drove better products, stronger go-to-market (sales, marketing, partnership, customer success), and significant growth across global markets and customer types, including ~$700M incremental increase in annual revenue and 10% of Google's annual growth in customer acquisition and retention
  - Identified business-critical growth opportunities; spearheaded unified strategies and operations across functions, levels, and global markets to land and maximize impact; developed company-wide true-north metrics and goals; consistently met and exceeded goals
  - Spearheaded data science and engineering on Google's big data from end to end, employing various AI and ML methodologies and solutions; created and automated 2 company-wide true-north dashboards, a CRM data pipeline, and a seller management database that together underpin the entirety of Google's Ads business
- Co-led the structuring of a $300M flagship incentive program for Google Ads partners worldwide
- Advised Google AI teams on consumer and enterprise AI products and their go-to-market

Mastercard | Senior Consultant San Francisco, CA | 2014 – 2016

- Led team to drive $2B incremental impact globally for clients in Tech, Retail, and Hospitality sectors by providing management consulting, big data science and engineering, and SaaS products, e.g.:
  - Optimized $700M marketing spend for a Fortune 50 Tech giant
  - Optimized $100M go-to-market across eCommerce and brick-and-mortar channels for a Fortune 200 retailer
  - Spearheaded 2 innovations on A/B testing methodology that unlocked its application to 2 new use cases (CRM, Philanthropy) and expanded the firm's clientele to 2 new industries (Tech, Nonprofit)
  - Drove critical improvements across the product development cycle for the firm's SaaS products
- Managed $12M client relationships, cross-selling 5 contracts, renewing 3 deals, and rolling out 1 pilot

Filey | Product Manager San Mateo, CA | 2013 – 2013

Filey is a SaaS startup providing cloud solutions to automate and simplify the management of email attachments

- Pivoted product, led go-to-market, and drove adoption and growth across B2C and B2B, increasing seed funding by 5.4x
- Improved the governance of engineering operations by establishing quality control and center of excellence

Nanjing ProStrategy Technology | Solution Consultant Nanjing, China | 2011 – 2012

ProStrategy is a SaaS startup providing cloud and on-premises business intelligence solutions for enterprises

- Led field research, financial modeling, and interface design to develop an enterprise performance management platform, accelerating executive decision cycle by 100% for a $14B industrial conglomerate
- Enabled structural change in how a $100B telecommunications enterprise manages customer incentives, by leading analytics and developing strategies to reduce cost by 60% and improve internal audit effectiveness by 150%

Bank of China | Assistant Manager, Client Development Nanjing, China | 2010 – 2011

- Drove 50% sales growth via cross-selling, up-selling, and high-value customer acquisition
- Awarded "New Employee of the Year"

Beijing Qiancheng Shuyuan Culture Development | Editor-in-Chief Beijing, China | 2008 – 2010

Qiancheng Shuyuan provides market-ready bilingual books for leading publishers in China

- Led teams of people managers and individual contributors to publish 57 books with 8 publishers
- Established partnership with world's 6th largest publisher; awarded Best Seller by leading bookstore in China

EDUCATION

Stanford University, M.S. in Management Science & Engineering
Beijing Foreign Studies University, B.A. in Economics

Submitted on Thu, 03/20/2025 - 03:20 PM

Submitted by: Anonymous

Submitted values are:

Full Name
Erica Jiang

[redacted]

[redacted]

[redacted]

a) Customer or Patient Experience. Experience driving improvement and service recovery, including experience utilizing the net promotor score or other loyalty-based measurements as a key performance indicator.
16 years of experience in customer experience, including but not limited to: CSAT score, NPS score, loyalty strategies and programs, incentive programs, customer retainment and sustainability, client relationship building and management, across customer types, sizes, and lifecycle stages. As a result, spearheaded $3B incremental impact and $1B P&L ownership to date

b) Health Equity. Health system experience in defining, evaluating, and mitigating the social determinants that stand in the way of health and well-being.
Supported and guided disadvantaged markets and minorities on their health equity and empowerment, including but not limited to women, Africa, eCommerce, FinTech, non-profit

c) High Reliability Organization. Experience in maintaining a high-reliability organization with a culture of safety.
10 years of organizational leadership, oriented around psychological safety and accountability / reliability

3. Below are critical characteristics and behaviors essential to being a successful Committee Member. Please provide an example that illustrates how you demonstrate at least one of the following characteristics:

Impeccable Reputation, Collaborative nature, Solid communication and interpersonal skills, with the ability to be effective with other Board and Committee members and executive management, High energy and sense of urgency, Innovative, creative, and imaginative, Mission-driven, Comfortable with change, Led teams of people managers and individual contributors to develop and operationalize 2 C-level strategies and programs that impacted the entirety of Google's Ads business globally - Trusted to spearhead such cross-level cross-market cross-customer-segment efforts, twice, because of all these factors - Able to successfully bring such efforts to success from zero to hero globally, twice, because of all these factors

4. Are there any other aspects of the position description that you have experience with that are not specifically listed above? If so, please describe that experience.

Board experience

Health experience, including but not limited to: healthcare, biotech, non-therapeutic, mental health, health equity

Non-profit experience, including but not limited to: San Francisco Mayor's Office, health equity programs (e.g. women, Africa)

a) Do you have any other skills, qualifications, or subject matter expertise that you believe would be an asset to the Committee? If so, please describe.
Expertise in FinTech, Tech, AI, big data / data science and engineering, global markets, Venture Partner

5. Are there any civil, employment-related, or criminal incidents in your background that we may uncover in a reference or background check? Have you ever been involved in a government investigating for business related issues (e.g. SEC)? (Note: Disclosure of a civil, employment-related, criminal incident (s) or government investigation will not necessarily disqualify you from appointment. The nature and timeframe with be taken into consideration.)

No

6. Are you able to make the necessary time commitment as laid out in the position description?

Yes

7. Would this position create a conflict of interest with any of your other commitments?

No

8. The El Camino Health Quality, Patient Care, and Patient Experience Committee Member position is non-compensated (i.e. volunteer) and has a three-year renewable term. Is this acceptable?

Yes

9. Please specify how you found out about this position.

Stanfod Women on Board

10. Why are you interested in being considered for the Quality, Patient Care, and Patient Experience Committee Member position with El Camino Health?

Passionate about health equity
Find strong fit with my skills and experiences to date
Believe I can contribute in meaningful ways, and pay it forward socially

[redacted]

Barbara A. Pelletreau RN MPH

Lafayette, CA 94549
[redacted]

SUMMARY OF QUALIFICATIONS

Previous Senior Vice President of Patient Safety, with expertise in transforming large organizations and driving safer care by building and administering patient safety best practices, worker's compensation practices, clinical risk management principles, and risk mitigation programs. An early adopter and visionary who is instrumental in creating and implementing new evidence-based practices, methodologies, best practices, benchmarks, metrics, and digital solutions. Build and lead high-performing teams and transform organizational culture based on values-based leadership principles. Recognized as an industry leader and one of the top 50 Experts in 2016 and 2017 leading the field of Patient Safety. Key contributor to numerous published articles in national and international medical journals and featured speaker at conferences. Her professional passions include safer care, deliverable results, and highly engaged teams.

PROFESSIONAL EXPERIENCE

CommonSpirit Health (formerly Dignity Health, Catholic Healthcare West)

Senior Vice President, Patient Safety (2011 -

- Direct the Patient Safety Department to execute strategic programs for patient safety, emergency and perinatal service lines, regulatory readiness, medication safety, infection prevention, voluntary and claims reporting systems, and federal contracts to reduce harm across a 140-hospital health system resulting in large-scale transformational change, improvement of healthcare quality and achievement of measurable outcomes. Achieve compliance with The Joint Commission and Center for Medicare and Medicaid Services regulations.
- Manage a $6M budget and direct a team of 30 while building and cultivating a values-based leadership culture. Employee engagement leadership scores are exceptional.
- Provide overall leadership and direction for large-scale implementation of evidence-based practices in high-risk clinical areas (i.e. Emergency Departments, Perinatal Units, and Operating Rooms).
- Responsible for the application, results, and project oversight of large-scale quality improvement projects including:

  1) Partnership for Patients Hospital Engagement Network (HEN 1.0, HEN 2.0) and Partnership for Patients Hospital Improvement & Innovation Networks (HIIN) resulting in preventing harm to more than xx patients, achieving an estimated savings of more than $137 million (based on estimates from research and as reported to CMS) and reducing patient harm by 20% - 40% through the reduction of Hospital Acquired Conditions.

  2) Promoting Excellence in Maternal Child Health Service Line (more than 750 physicians and midwives and 1,600 nurses) in its network. Deliverable results include 100% adoption of AirStrip OB (remote fetal monitoring), claims reduction from $110M to $28M, and 100% adoption of electronic triggers to identify (and reduce) patient harm.

  3) Co-created with Agency for Healthcare Research (AHRQ) a now nationally available AHRQ CANDOR (Communication and Optimal Resolution) Toolkit for hospitals and physicians to use when managing an adverse event and supporting clinicians involved with the event.

  4) Developed and introduced safe practices in the Emergency Services including timely review of lab values, opioid management, standardized policies (e.g. EMTALA, use of scribes, management of the pregnant patient), measurement of triage competencies, and improved bar code scanning (from 72% to 90%).

  5) Implemented a system-wide controlled substances management program for early detection of diversions and adoption of strict controls. Complied with the penalty resolution from the DEA after designing a corporate integrity agreement (template now used nationally) and negotiating the reduction of the initial $13M penalty to $1.25M.

  6) Co-developed (with a national expert) a system-wide policy on the prevention of retained surgical items for system-wide adoption.

7) Established multiple system-wide tactics to reduce hospital infections such as CAUTI, CLABSI, and CDIFF (greater than 20% reduction).

- Adopt and spread system-wide innovative technology using electronic triggers from the health record to identify harm. Partnered with Yale University Center for Outcomes Research and Evaluation and CMS to create new national definitions of patient harm.
- Responsible for the submission of six proposals and deliverable results to adopt innovative approaches and reduce patient harm/improve efficiencies. Results include a greater than 20% reduction of hospital-acquired conditions in a majority of categories and secured $18M in funding,
- Executive sponsor for clinical summits each year that gather physicians, nurses, and other key stakeholders to adopt evidence-based practices and improve care processes across perinatal and emergency service areas. Clinical summits consistently received extremely high satisfaction ratings.

Vice President, Patient Safety & Clinical Risk Management (2007 - 2011)

- Identified and implemented system-wide initiatives based on findings/learnings from claims, events, and root cause analysis.
- Assured the safest clinical practices were adopted, especially in high-risk areas such as Perinatal, Surgery, Radiology, and Medication Safety, and ensured that all hospitals were fully compliant with The Joint Commission (TJC) and Center for Medicare and Medicaid Services (CMS) regulations.
- Managed a $11M budget and built and directed a team of eight healthcare professionals and third-party worker's compensation administrator.
- Provided hospitals with easy-to-use software applications to maximize their resources and allow them to effectively implement programs and processes (based on research) to improve patient outcomes. Software included tracking and monitoring Executive WalkRounds, National Patient Safety Goals, Safety Attitude Questionnaires, and regulatory activity.

Senior Director, Risk Services and Systems (2004 - 2007)

- Established the first system-wide Patient Safety Program and project oversight of workers' compensation, risk financing, risk information management systems, and event reporting initiative. Developed strategies to reduce worker's compensation costs resulting in a $70M system-wide savings.
- Directed a staff of five system administrators, analysts, and actuaries and the Third Party Administrator (TPA) team of 75. Managed a $3M operating and project budget.
- Managed the actuarial process to determine program funding, including the contract, timeline, presentation of summary), and results for senior leadership (developed a quarterly scorecard by the hospital on claim trends).
- Responsible for designing, implementing, and testing a system-wide (ERS) Event Reporting System resulting in a 52% increase in voluntary reported safety opportunities.
- Managed all risk services information systems, including Worker's Compensation, professional liability, general liability, and ERS.
- Selected as Project Manager for special CEO/Chief Medical Officers project to reduce catastrophic risk, based on learning from Hurricane Katrina, and as a result developed and coordinated a holistic enterprise-wide approach to address possible interruptions at regional business facilities by managing and implementing (BCP) Business Continuity Planning and (PERA) Post Event Recovery Assessments (PERA).
- Identified an opportunity to reduce costs at a corporate and facility level by centralizing (TJC) the Joint Commission Assessment Software on a single server.

Director, Workers' Compensation (2002 - 2004)

- Reengineered and administered the system-wide Workers' Compensation Program and was accountable for the performance, service quality, development of standards, policies and procedures, budgeting, contract negotiation, and overall management of claims through coordination with the Third Party Administrator (TPA), medical providers, nurses, consultants, and attorneys.
- Reversed negative trends and improved results by training hospital leadership, and developing and introducing benchmarks and outcomes focused on hospitals and TPA resulting in the reduction of annual program funding from $85M to $50M in three years with continued improvement each year.
- Ensured compliance with all federal, state, and local laws, regulations, rules, and codes. Met annual reporting requirements, and responded to inquiries from the Department of Health, the Joint Commission, and other regulatory bodies.

- Developed programs including loss prevention strategies, return to work opportunities, medical management, and ongoing education/training which significantly reduced harm and costs.
- Served as part of the Employers' Advisory Group on behalf of the California State Governor's office for the development of reform legislation.
- Completed special projects including the analysis and development of benchmarks, establishment of policies (First Aid and Workers' Comp HIPAA policy), and claims auditing project.
- Designed three core metrics (frequency of injuries, loss days, and medical costs) to focus hospitals on reducing injuries and costs. This approach resulted in a 20% injury rate reduction and a 53% reduction in loss days.
- She received the National Recognition Award for continual improvements in Workers' Compensation and identifying best practices for the Healthcare industry (Theodore Roosevelt Award 2005).

University of California, Office of the President, Oakland, CA **1998 - 2002**
Manager, Workers' Compensation

- Administered the Workers' Compensation Program including managing the contract with Third third-party administrator (TPA), establishing policies for funding individual locations, implementing key cost containment strategies, and evaluating and providing supportive consultative services to five medical centers, two laboratories, and nine campuses (200,000 employees).
- Established benchmarks for UC locations to evaluate their program trends, outcomes, and financial impact of new programs.
- Designed and implemented a Risk Management Information System, (RMIS) and received high ratings for orchestration, change management, and adoption from UC locations and the TPA.
- Consolidated nine TPA offices into six and strengthened claims supervision without increasing administrative costs.

Health Net, Walnut Creek, CA **1993 - 1998**
Division Manager, Pacific Bell

- Managed the overall operation of the Pacific Bell Workers' Compensation Program, including creating cost containment programs, and developing and implementing new policies and procedures. These efforts resulted in the initial investigation of 99% of cases within five days, a greater than 117% closing ratio over a million dollars in savings from medical management, and a decrease of claims costs by 5% for three consecutive years.
- Developed performance standards and improved operational efficiency resulting in increased client satisfaction and a budget reduction of $200k in operating costs.
- Selected a monthly legal review committee to expedite case settlement and reduce claims costs.

Division Manager, Health Care

- Responsible for producing services and managing operations for 15 self-insured Healthcare clients. Accomplishments included achieving a high closing ratio, improving customer satisfaction, and optimizing workflow with clients.
- Developed and implemented an Injury Management Program that decreased costs of Workers' Compensation Programs for participating clients and reduced injury rates by 10 to 20%.
- Coordinated quarterly education programs and annual seminars on pertinent Workers' Compensation topics for clients.
- Designed an annual healthcare client comparison report.

John Muir Medical Center, Walnut Creek, CA **1981 - 1993**
Director, Health Management Services

- Developed and implemented Corporate Health Services Programs representing 22 external clients with over 384,000 participating in the programs over an eight-year period which generated additional hospital revenue.
- Managed programs including Employee Health and Wellness, Occupational Health Services, and Workers' Compensation. Specific programs developed to decrease costs and improve employee experience included a modified Return to Work Program, the use of an on-site physician for post-injury medical management, and a departmental Injury Management Program, resulting in a significant decrease in lost days, medical expenses, and injury rates.
- Directed a staff of 23 and managed a budget of $5M.
- Launched Employee required Immunization Program (achieving more than 95% compliance) and several wellness programs/services with 65% participation each year (2200 employees).
- Managed the opening and operation of a community-centered health promotion center offering preventative screenings each month to over 500 customers in partnership with 60 physicians.
- Held positions including Registered Nurse (medical surgery, cardiac rehab) and Assistant Director of Wellness Services.

ADDITIONAL PROFESSIONAL EXPERIENCE

Carol Emmott Fellowship - National Advisory Board Member and Mentor for Fellows
University of Washington – Collaborative for Accountability and Improvement, CoChair Policy Committee and Coach for healthcare organizations adopting and implementing CANDOR Advisory
University of Washington - Collaborative for Accountability and Improvement, Best Practices Committee
Diablo Valley College, Concord, CA, and San Jose State University, San Jose, CA – Instructor for undergraduates and graduates in Health Science Departments
Advisor to several companies - Pascal Metrics, Care.ai, and Channel Portal, Inc.

ADDITIONAL PROFESSIONAL EXPERIENCE

- Agency for Healthcare Quality and Research – Technical Experts Partners work group for improving website and public resources
- Advisor to Technology Companies - Care.ai, Pascal Metrics, Channel Portal Inc.
- American Heart Association Board Member, Contra Costa County, CA
- California Hospital Association, Hospital Quality Improvement – Board Member
- Carol Emmott Fellowship – Mentor and Coach for Healthcare Executive Fellows
- Carol Emmott Fellowship - National Leadership Committee
- Diablo Valley College, Concord, CA - Instructor for Women's Health class
- Patient Safety Authority Journal – Editorial Board
- Patient Safety Internship – Created a Change Management Program for undergraduates in partnership with human resources on the culture of safety at CommonSpirit Health
- Perinatal Safety Annual Summits – Executive Sponsor for Dignity Health
- Risk Management Presentations to Hospital Professional Liability Underwriters in London and New York annually
- San Jose State University, San Jose, CA – Instructor for undergraduate and graduate students in the Health Science Department
- University of Washington – CANDOR Advisory Committee, co-chair CRP (Communication and Resolution Program) Policy Committee, and member of CRP Best Practices Committee
- Virtual Nursing Podcast with Care.ai - Smart Care Team Spotlight Series on quality and safety with artificial intelligence

AWARDS AND RECOGNITION

- Acts of Humankindness Award Nominee 2016, 2017
- ECRI Institute Alert Tracker Achieve Award Winner 2018, 2019
- Modern Healthcare Top 50 Patient Safety Officers 2018, 2019
- Modern Healthcare Top 25 Innovators 2019

- Patient Safety Movement 5 Star Hospital Recipient 2019
- Patient Safety Movement Foundation – Recipient of Steve Moreau Humanitarian Award 2021
- Values in Action Awards CommonSpirit Health

EDUCATION
Patient Safety Fellowship through the American Hospital Association
Masters of Public Health, San Jose State University, San Jose, CA
Bachelor of Science in Nursing, Fresno State University, Fresno, CA
Bachelor of Science in Health Science, Fresno State University, Fresno, CA

VOLUNTEER EXPERIENCE
Chair of Road Maintenance Committee, Hidden Oaks Homes, Lafayette
Chair Serene Lakes Property Owners Association Safety Committee

PASSIONS BEYOND PROFESSIONAL EFFORTS
Hiking, mountain biking, yoga, paddle boarding, travel/outdoor adventures, entertaining friends and family, and any activity with the family

PUBLICATIONS
A Standardized Approach for Category II Fetal Heart Rate with Significant Decelerations: Maternal and Neonatal Outcomes.
Shields LE, Wiesner S, Klein C, Pelletreau B, Hedriana HL.
Am J Perinatol. 2018 Dec;35(14):1405-1410
PMID: 29895077

A Comparison of the Nulliparous-Term-Singleton-Vertex and Society of Maternal-Fetal Medicine Cesarean Birth Metrics Based on Hospital Size.
Shields LE, Walker S, Hedriana HL, Wiesner S, Pelletreau B, Hitt J, Benedetti TJ. Am J Perinatol. 2018 Mar;35(4):390-396
PMID: 29100260

Early standardized treatment of critical blood pressure elevations is associated with a reduction in eclampsia and severe maternal morbidity.
Shields LE, Weisner S, Klein C, Pelletreau B, Hedriana HL.
Am J Obstet Gynecol. 2017 Apr;216(4):415.e1-415.e5
PMID: 28153655

Decreased rates of shoulder dystocia and brachial plexus injury via an evidence-based practice bundle. Sienas LE, Hedriana HL, Wiesner S, Pelletreau B, Wilson MD, Shields LE.
Int J Gynaecol Obstet. 2017 Feb;136(2):162-167
PMID: 28099737

Use of Maternal Early Warning Trigger tool reduces maternal morbidity.
Shields, LE, Wiesner S, Klein C, Pelletreau B, Hedriana HL.
Am J Obstet Gynecology. 2016 April; 214(4):527.e1-527.e6
PMID: 26924745

Baseline assessment of a hospital-specific early warning trigger system for reducing maternal morbidity. Hedriana HL, Wiesner S, Downs BG, Pelletreau B, Shields LE.
Int J Gynaecol Obstet. 2016 Mar;132(3):337-41
PMID: 26797195

Comprehensive maternal hemorrhage protocols reduce the use of blood products and improve patient safety.
Shields LE, Wiesner S, Fulton J, Pelletreau B.
Am J Obstet Gynecol. 2015 Mar;212(3):272-80

PMID: 25025944 Clinical Trial

A system-wide initiative to prevent retained vaginal sponges.
Chagolla BA, Gibbs VC, Keats JP, Pelletreau B.
MCN Am J. Matern Child Nurs. 2011 Sep-Oct;36(5):312-7
PMID: 21857202

Improving patient safety in perinatal services.
Pelletreau B, Trippe H, Ziemba E.
Health Prog. 2007 Jan-Feb;88(1):58-9
PMID: 17274581

Technology helps manage workers' compensation risks in the healthcare setting.
Vaughn R, Pelletreau B.
J Healthcare Risk Manag. 2004; 24(1):13-17
PMID: 16383260

Barbara Pelletreau

[redacted]

Lafayette, CA 94549

[redacted]

[redacted]

1. Below are critical characteristics and behaviors essential to being a successful Committee Member. Please provide an example that illustrates how you demonstrate at least one of the following characteristics:

- **An impeccable reputation for honesty and integrity**

Integrity is extremely important to me. Sometimes it is not easy to do the right thing, but throughout my career, especially in the past 25 years, my motto has been - it is not who is right, but what is right. In order to make significant achievements, it is vital that you are a person of integrity, and truth seeking especially when navigating change through tumultuous waters. And, never forget, that all deliveries must be with diplomacy. Please refer to the internal announcement from Robert Wiebe MD, Chief Medical Officer at CommonSpirit Health from when I transitioned from SVP Patient Safety to “preferment” (some call it retirement!).

- **Collaborative nature**

In addition to having a reputation of being extremely collaborative across all service lines, departments, and regions, I am collaborative by nature. My favorite word is synergy - I am passionate about coming together to make something happen because the whole is greater than the individual parts. In our private community, I lead the efforts to resurface our roads, maintain our entrance, and Firewise Safety Programs. I was also nominated by my pickleball peers to be the Captain of our 30 person Pickleball Interclub League. At our Tahoe home, I chaired the FireWise Defensible Safety efforts for our community of 1,300 homes/lots. Our FireWise Committee raised $130,000 in one year to place a rotating camera with artificial intelligence on one of our mountains for early fire detection and fire management. Working with ours brings results and personal joy.

- **Solid communication and interpersonal skills, with the ability to be effective with other Board and Committee members and executive management**

For the past 20 plus years at CommonSpirit Health/Dignity Healthy, I reported to the Chief Medical Officer who was executive lead for the Quality and Safety Committee of the Board. I was responsible for patient safety reports (5x per year) as well as reporting out on Patient Safety measures, projects/results, and other pertinent efforts at the Quality and Safety Committee.

- **High energy and sense of urgency**
- **Innovative, creative, and imaginative**
- **Mission-driven**
- **Comfortable with change**

Ha ha ha! I create change - especially, if it isn't currently working! I often said that my true skill set facilitates large scale change. And I love a good outdoor national or international adventure - the unexpected and changes are often by the minute.

2. Are there any other aspects of the position description that you have experience with that are not specifically listed above? If so, please describe that experience.

a. Do you have any other skills, qualifications, or subject matter expertise that you believe would be an asset to the Committee? If so, please describe.

This question is difficult to answer since I am not sure what the current skills/expertise are on the current committee. I might be able to add a "national" perspective from my current patient safety efforts. I am currently President Elect for the Collaborative for Accountability and Improvement (out of the University of Washington). I am passionate about this work - the national adoption of CANDOR (Communication and Optimal Resolution - also called CRP). I am currently Adjunct Professor at Georgetown University teaching in the Executive Masters in Clinical Quality, Safety, and Leadership. My students are generally Chief Medical Officers, physician leaders, chief quality officers, chief patient safety officers, and other healthcare leaders. Please see my attached resume for additional information on contributions, accomplishments, and expertise.

3. Are there any civil, employment-related, or criminal incidents in your background that we may uncover in a reference or background check? Have you ever been involved in a government investigating for business related issues (e.g. SEC)? (Note: Disclosure of a civil, employment-related, criminal incident (s)

or government investigation will not necessarily disqualify you from appointment. The nature and timeframe with be taken into consideration.)

Absolutely not!

4. Are you able to make the necessary time commitment as laid out in the position description?

I believe so. I am not clear on exactly how often the committee meets. I think the first meeting in September 2025, I will be cycling in Europe.

5. Would this position create a conflict of interest with any of your other commitments?

It would not.

6. The El Camino Health Quality, Patient Care, and Patient Experience Committee Member position is non-compensated (i.e. volunteer) and has a three-year renewable term. Is this acceptable?

Yes.

7. Please specify how you found out about this position.

I was contacted by Anna Fang, CFA.

8. Why are you interested in being considered for the Quality, Patient Care, and Patient Experience Committee Member position with El Camino Health?

When I “retired” two years ago, I adopted two guiding themes. “Pay it forward” which guides me to invest in the next generation of leaders. I mentor women in health care through the Carol Emmott Foundation. My other theme is “Keep making a difference”! I am an advisor to two start up companies. I also serve on two other nonprofit healthcare organizations. I have always held El Camino Health in high esteem - going back to my young professional days at John Muir Medical Center where I met Charlene Glinecki. Charlene was the employee health nurse (among other responsibilities). She always had wonderful things to say about El Camino Health. And now, a good friend of mine, Mark Klein, is on the executive team and he speaks highly of El Camino. While it is a bit of a drive, I would be honored to assist how best I can to keep El Camino in high standings and support the local team.

DIANE L. SCHWEITZER

[redacted] Mountain View, CA 94041

PHILANTHROPY EXECUTIVE

ORGANIZATIONAL TRANSFORMATIONS. STRATEGIC PLANNING. OPERATIONAL EFFECTIVENESS.

Impact-oriented philanthropy executive with expertise driving programs to improve outcomes in health care, education, and social services. Successful track record directing effective grant allocations up to $40M annually. Extensive experience in: building and leading teams; setting and aligning organizational strategy to program operations; grant making; program evaluation; capacity-building; and board development. Recognized for collaborative leadership style with the ability to manage up and down the organization while navigating ambiguity and partnering with diverse stakeholders up to the trustee level. Deep functional knowledge in health care delivery (including hospitals; women's health; nursing), and consulting expertise drawn from top-tier professional services experience and as a trusted advisor to 100+ nonprofits.

STRATEGIC LEADERSHIP Skilled at developing the vision, plan, and operations for key outcomes, and inspiring teams to achieve meaningful and measurable results (2018 recipients of President's Citation by AAHPM).

PHILANTHROPIC IMPACT Dedicated to creating philanthropic excellence, with expertise gained as a leader at two top U.S. foundations (the Robin Hood Foundation & the Gordon and Betty Moore Foundation). Engaged as a consultant to multiple leading foundations to design programs for impact and evaluate results.

HEALTH CARE EXPERTISE Deep knowledge of health care delivery issues and quality improvement; frequent presenter at conferences and panels (e.g., *Health Affairs* special issue launches & Grantmakers in Health events).

OPERATIONAL EXCELLENCE Recognized as a leading exemplar on the best grant making approach to ensure both grantees and the foundation achieve desired outcomes. Dedicated to ongoing development of people and teams to foster a learning organization while driving continual operational improvement.

PROFESSIONAL EXPERIENCE

DIANE SCHWEITZER CONSULTING, San Francisco Bay Area, CA 2020 – present

Principal

Strategy consulting to foundations and individual nonprofits, focused on organizational transformation of philanthropic organizations and nonprofit agencies. Consulting engagements include a project for the Robert Wood Johnson Foundation focused on strengthening the healthcare workforce and an exploration of digital health options for adolescent mental health.

GORDON AND BETTY MOORE FOUNDATION, Palo Alto, CA 2007 – 2019

Interim Chief Program Officer, Patient Care

(Previously Program Director, Patient Care; and Consultant for the Betty Irene Moore Nursing Initiative)

Leadership of the Moore Foundation's efforts to improve the experience and outcomes of patient care, and member of Senior Management Team and Executive Team. Strategic oversight of investments in diagnostic excellence and medication safety in the community, plus management of the award-winning team exploring high-quality, community-based care for high-need patients.

- Responsible for $40M annual grant making allocation and $3M program operating budget.
- Key architect of the High-Need Patients Investigation, approved by board of trustees at $40M over three years (2016). Foundation subsequently received the 2018 American Association for Hospice and Palliative Medicine President's Citation.
- Managed the $100M commitment to the Betty Irene Moore School of Nursing at UC Davis.
- Oversaw development of the Diagnostic Excellence Initiative, approved by board of trustees at $85M for eight years (2018).
- Assumed leadership of the Betty Irene Moore Nursing Initiative workforce strategy and of the SF Bay Area quality improvement portfolio. In 2014 and 2015, focused on the nursing initiative exit and dissemination efforts.
- Responsible for recruiting, hiring, and managing team of 10, including supporting professional development activities.
- Selected to speak at conferences and meetings, including presentations, webinars, and panel discussions across the U.S.
- Managed key external relationships with other funders, government agencies, health care organizations, and grantees.

- Presented to the full board of trustees quarterly and to the four-member Trustee Advisory Group semi-annually.

DIANE SCHWEITZER CONSULTING, San Francisco Bay Area, CA 2002 – 2016

Principal

Strategy consulting to foundations and individual nonprofits, focused on organizational transformation of philanthropic organizations and nonprofit agencies. Consulting engagements include: Blue Shield of California Foundation, The James Irvine Foundation, the California HealthCare Foundation, The California Endowment, and the Women's Community Clinic.

- Developed the strategic plan to guide the direction of a women's nonprofit health care services provider, providing business modeling, operations, and staffing plan, culture, facilities management, and types of clients served.
- Mentored two staff members at The Tides Foundation into positions of greater responsibility and authority, and developed recommendations for improving the operations of the foundation.
- Authored an issue brief for the California HealthCare Foundation that explored potential impacts of proposed changes to MediCal (published by CHCF).
- Engaged to design and implement an evaluation strategy for three program areas of a large regional health care foundation.
- Over eight years, delivered external feedback on 50 projects yearly for global consulting firm (FSG), including clients in: philanthropy, global health, corporate social responsibility, education, and collective impact. Conducted feedback sessions, collected and analyzed results, created persuasive annual presentations with identified themes and recommendations for leadership.
- Developed strategic plan for social enterprise nonprofit with $15M annual budget to strengthen impact and guide growth.
- Retained by board of directors for nonprofit Internet organization to create new organizational strategy; consulting deliverables included market segmentation, competitive analysis, and interviews with national thought leaders.
- Served as a member of senior management team for a new national nonprofit; developed and managed market research guided product development strategy and implementation.
- Explored replication in Northern & Central California of NY-based after-school program with proven results to improve high-school graduation rates, decrease teen pregnancies, and increase employment opportunities.

501CLICK CORPORATION, Oakland, CA 2000 – 2001

President and Co-Founder

Established and launched a one-stop, nonprofit business-intelligence service, offering nonprofit organizations easy access to the best online resources, services and products at cost-effective rates.

- Raised $1.6M in two rounds of funding to grow, train, and develop the team from 0-12 FTE in less than four months.
- Developed vision, goals and functional strategies, and quarterly finance projections. Provided operations oversight: product development, marketing, site development, customer support, QA, ordering and fulfillment.
- Represented company at industry conferences, panel discussions, and investor meetings.

THE ROBIN HOOD FOUNDATION, New York, NY 1994 –2000

Director of Management Assistance

Managed Foundation's management assistance program (1999 total value of services: $2 M); developed program strategies and budgets; recruited, trained, and managed staff of four, and provided management and technical assistance.

- Provided direct consulting in strategic planning, business planning, board recruitment and development, operational effectiveness program evaluation, accounting, legal, technology and real estate assistance to 100+ not-for-profits.
- Solicited and managed relationships with corporate partners such as Deloitte & Touche, LLP, Monitor Company, and Bankers Trust, which provided *pro bono* and volunteer technical and management assistance; served as project manager and liaison (including legal, technology, accounting, fund raising, HR, marketing, and real estate projects).
- Presented strategies for engaged grantmaking and venture philanthropy initiatives to other private funders and graduate schools; represented Foundation as speaker at various conferences.
- Served as Acting Program Officer for selected Early Childhood, Education, and Youth programs; responsibilities include reviewing grant proposals, establishing relationships with potential and current grant recipients, monitoring current grants, recommending funding to the Board of Directors, setting contract goals, and overseeing program evaluation efforts.

BOOZ•ALLEN & HAMILTON, INC., New York, NY 1991 – 1994

Associate

Specializing in strategy for marketing intensive companies. Sample projects:

- Assisted $1B Canadian consumer products company in developing long-range marketing plan.
- Conducted strategy due diligence for $1.1B specialty food company acquisition.
- Evaluated profit opportunities for $350M division of major consumer packaged goods company; analyses included evaluation of marketing, distribution, revenue collection, cost-to-serve customers, and channel dynamics and trends.
- Created product strategy, with emphasis on consumer marketing opportunities, for $5.6B packaged goods company.

PLANNED PARENTHOOD FEDERATION OF AMERICA, INC., New York, NY Summer 1990

Assistant to Executive Vice President

- Developed protocol for PPFA's first long-range financial plan.
- Investigated information flow to Executive Staff and recommended new management tools and mechanisms for improved communication throughout the organization.

MORGAN STANLEY & CO., INC., New York, NY 1985 – 1989

Associate, Information Services

(Promoted from: Manager, IS Recruiting; and previously from Analyst, Database Administration)

- Managed staff of three to support external and internal client usage of global, multi-currency portfolio reporting system.
- Coordinated conversion of core data processing systems in preparation for opening firm's Zurich and Hong Kong offices.
- Managed recruitment of over 250 professionals, contract programmers, and college graduates for department of 800+.

THE WORLD BANK, Washington, D.C. Summer 1983

Research Associate

- Co-authored and published technical training and education manuscript, *Science and Technology Capacity of Nigeria.*

NATIONAL ACADEMY OF SCIENCES, Washington, D.C. Summer 1982

Research Assistant, Board on Science and Technology for International Development

- Identified science and technology research areas for grants program in developing countries.

EDUCATION

YALE SCHOOL OF MANAGEMENT, New Haven, CT

Master's degree in Public and Private Management (MPPM)

Teaching Assistant for graduate level economics and finance courses.

STANFORD UNIVERSITY, Stanford, CA and STANFORD-IN-FRANCE, Tours, France

A.B., Human Biology and French Studies (Previously fluent in French)

ACHIEVEMENTS

- Advisor to senior international development professional in Africa (2023-present).
- Advisor to President of international research organization advancing sexual and reproductive autonomy, choices, and health worldwide, through How Women Lead Global Advisor program (2022-present).
- Judge, Evaluation Panel for the Robin Hood AI Poverty Challenge. Evaluated ten applications for the Robin Hood AI Poverty Challenge, which aims to advance innovative uses of AI that will expand opportunity and enable more people to achieve greater economic security (summer 2024).
- Member, Stanford Women on Boards Healthcare Experience Group Steering Committee, 2023-present.
- Co-Author, “Advancing Health Worker Well-Being: Trends and Opportunities”, Healthforce Center at UCSF, 2021.
- Member of National Advisory Council, Betty Irene Moore School of Nursing at UC Davis (2017-2019).
- Mentor for Summer Fellow in New Sector Alliance’s Residency in Social Enterprise – RISE (2011).
- Author, “Streamlining Children’s Eligibility Processing for Medi-Cal,” California HealthCare Foundation Issue Brief, 2005.
- Judge for National Business Plan Competition for Nonprofit Organizations (Yale School of Management – The Goldman Sachs Foundation Partnership on Nonprofit Ventures (2003, 2004)).
- Elected Steering Committee member of the Philanthropy Consultants Network (2003-2009).
- Elected member of Yale School of Management Alumni Board of Directors (1995-1998).
- Former Girl Scout leader for troop in New York City welfare hotel.
- Author, "International Policy Aspects of Biotechnology: The Case of Monoclonal Antibodies for Disease Diagnosis," Bureau of Intelligence and Research, US Department of State, 1984.
- Co-author, *Science and Technology Capacity of Nigeria,* World Bank, 1983.
- Recipient of US Foreign Service appointment (declined).

Submitted on Mon, 03/31/2025 - 08:23 AM

Submitted by: Anonymous

Submitted values are:

Full Name
Diane Schweitzer

Residence Address
[redacted] Mountain View CA 94041

[redacted]

[redacted]

c) High Reliability Organization. Experience in maintaining a high-reliability organization with a culture of safety.
Extensive experience with improving experiences and outcomes of patient care in U.S. healthcare delivery system, as both a consultant to private foundations and nonprofits and as a senior leader at the Gordon and Betty Moore Foundation. Areas of focus: improving nursing in Bay Area adult acute care hospitals and strengthening nursing education (through the Moore Foundation's Nursing Initiative); strategic oversight of investments in diagnostic excellence and medication safety in the community; and management of the award-winning Moore Foundation team exploring high-quality, community-based care for high-need patients.

Broad perspective on Bay Area and national healthcare: I worked with all of the adult acute care hospitals in the five Bay Area counties, giving me an understanding of the local context and competition. Through my work to improve healthcare delivery on a national level, I bring knowledge of government

regulations; national quality improvement efforts; payment models and policies (including measure development and implementation); accreditation; and the national landscape regarding healthcare trends, key players, and emerging issues.

3. Below are critical characteristics and behaviors essential to being a successful Committee Member. Please provide an example that illustrates how you demonstrate at least one of the following characteristics:

Collaborative nature, So many of my projects as an independent consultant required collaboration among multiple stakeholders to develop and embrace a new strategic direction. For one organization that provides social services and job training, I structured the strategic planning project with two workgroups to provide guidance and to review findings: a board committee and a middle/senior manager committee. As I wanted to reach out to virtually everyone in the organization (a few hundred) to solicit input, the second group was especially helpful in determining the process to do so and the content of a survey plus focus groups questions. I looked to the board committee to provide the big picture and to help me navigate through the inevitable thorny issues related to history and culture. I also conducted interviews with various external stakeholders, including funders and clients As both a consultant and as a senior executive trying to move a board toward decision making, I have found it helpful to work closely with board committees to vet findings and recommendations and to bring those board members along as advocates for any proposal. The board chair is also instrumental in identifying potential hurdles ahead of time and strategizing approaches. As an advisory board member, my approach is to try to understand a bit about my fellow board members: their backgrounds and experiences, their specific interests in being on that board, and maybe a bit about the personal dynamics. I believe most if not all people serve on boards because they believe in the mission of the organization, and I try to look for the best intentions in all. Respectfully looking for areas where we all agree and trying to hone in on exactly what the points of difference might be can help focus efforts on moving forward collegially.

4. Are there any other aspects of the position description that you have experience with that are not specifically listed above? If so, please describe that experience.

Specific experience working with El Camino Health: In reflecting back on my engagement with El Camino Hospital during my tenure with the Gordon and Betty Moore Foundation Nursing Initiative, our work to support the Magnet journey comes first to mind (of course, we also supported projects around reducing readmissions and other quality and safety goals). El Camino stood out, not just because of their hard work to improve patient quality and safety plus nurse satisfaction within the hospital but also as a leader among the other Bay Area hospitals also on the Magnet Journey.

a) Do you have any other skills, qualifications, or subject matter expertise that you believe would be an asset to the Committee? If so, please describe.
I bring extensive governance experience. Over the years, I have worked in and with boardrooms of all kinds—from multi-billion-dollar global corporations to large foundations and small- to medium-sized nonprofits. At the Robin Hood Foundation and the Gordon and Betty Moore Foundation, I led board committees and presented regularly to the full boards. I have also consulted with boards on effective

governance, trained prospective board members, and matched them with nonprofits. This breadth of experience has given me a unique perspective on how boards, both governance and advisory, can lead with impact and effectiveness.

5. Are there any civil, employment-related, or criminal incidents in your background that we may uncover in a reference or background check? Have you ever been involved in a government investigating for business related issues (e.g. SEC)? (Note: Disclosure of a civil, employment-related, criminal incident (s) or government investigation will not necessarily disqualify you from appointment. The nature and timeframe with be taken into consideration.)

No

6. Are you able to make the necessary time commitment as laid out in the position description?

Yes

7. Would this position create a conflict of interest with any of your other commitments?

No

8. The El Camino Health Quality, Patient Care, and Patient Experience Committee Member position is non-compensated (i.e. volunteer) and has a three-year renewable term. Is this acceptable?

No

9. Please specify how you found out about this position.

Stanford Women on Boards (I am on the SWB Healthcare Experience Team that organizes events for that interest group)

10. Why are you interested in being considered for the Quality, Patient Care, and Patient Experience Committee Member position with El Camino Health?

I am committed to using my skills and experience in service of doing good. This position would tap into my deep knowledge of health care delivery issues and quality improvement. As I am a long-time Mountain View resident and have been an ECH patient over the years, as have members of my family, I would be making a meaningful contribution to my immediate community.

[redacted]

- [redacted]

Sharon Lebovitz Richmond
Executive Coach - Advisor – Strategic Facilitator

Managing Director, Leading Large / Richmond Associates Consulting
[redacted]

Sharon helps executives envision and build successful, healthy companies fueled by cultures of accountability and mutual respect. Companies from Silicon Valley to Saudi Arabia have benefited from her help clarifying intentions and priorities, energizing teams and organizations, and ensuring effective, achievable action plans. Leveraging decades of experience with leadership teams in technology, healthcare, education, retail, and biopharma, Sharon coaches C-levels and their teams to face important opportunities and challenges together, lead with care and intention, and have the conversations needed to ensure their shared success.

Sharon's clients include AMD, Apple, Cisco, Google, VMware, Wells Fargo, Woven-Toyota and Yahoo! Fast-growth tech clients include Aikon, CloudLinux, Clover, Foodics, Hover, IMVU, and Jupiter Intel. Healthcare/biopharma clients include Blue Shield, East Bay Medical Group, Epocrates, Intuitive Surgical, Oregon Health Sciences University, Roche/Genentech, and Stanford Healthcare. Education clients include Emeritus, FlexSchool, Masterclass, Stanford Graduate School of Business, Stanford School of Medicine, and USF.

Sharon coaches individual executives and their teams, facilitates culture building; leads Mission, Vision, and Values development; and guides strategic planning processes. She boosts EQ on executive teams, coaches large-scale transformations, and advises executives on scaling growth. Sharon's clients describe her as a warm, direct, wise, and practical thought partner. She is committed to curious inquiry, truth-telling, and long-life learning, and promotes inclusive approaches to organizational changes, which results in clear goals, well-aligned stakeholders, and realistic implementation plans.

Clients appreciate Sharon's ability to confidentially challenge and support them as needed, as well as the new perspectives she offers on nagging issues and situations. Sharon brings simple, practical frameworks forward to help clients surface what they, their teams, and their organizations must do to win – to have better conversations, made better decisions, and get better results.

Sharon hosts the podcast *To Lead Is Human*, a top 10% podcast launched in 2022. She authored *Introduction to Myers-Briggs Type and Leadership* (2008, 2016) and is a popular presenter and keynoter at global conferences including Association for Change Management Professionals, MBTI® Users Conference, and Association of Psychological Type International (2004 – 2015), on topics such as *We Get the Leaders We Deserve*. She has been an MBTI® Master Practitioner for more than 20 years.

Sharon earned her MBA at Stanford Graduate School of Business, where she taught leadership, designed courses, and facilitated Interpersonal Dynamics, the course regularly cited by alums as most valuable for their careers, for more than 20 years. She collaborated with Dr. Jeffrey Pfeffer to bring experiential learning into his famous Paths to Power course and Dr Charles O'Reilly in several leadership programs.

Sharon serves as an Alumni co-chair for the Modern Elder Academy, and has previously served on the boards of Stanford Women on Boards, GSB Alumni Consulting Teams, and is past chair of the APT International Board of Directors, where she served an international community for 8 years. Her undergraduate studies at Duke University were in Developmental Psychology.

Submitted on Wed, 03/19/2025 - 01:57 PM

Submitted by: Anonymous

Submitted values are:

Full Name
Sharon Lebovitz Richmond

Residence Address
[redacted] Palo Alto 94303

[redacted]

[redacted]

a) Customer or Patient Experience. Experience driving improvement and service recovery, including experience utilizing the net promotor score or other loyalty-based measurements as a key performance indicator.
As a long time consultant and executive coach, I've worked both within and for large, safety oriented organizations (e.g. PG&E), healthcare providers (Stanford HealthCare and affiliates, Lucile Packard Children's Hospital (now part of SHC), community hospitals (Bend OR and Yakima WA), and many technology firms, from large (Cisco, where I founded and led their global Center of Excellence on Leading Change) to small (venture-backed companies in tech, climate, healthcare, pharmaceuticals, mental health, etc.)

In specific, I helped SHC evaluate patient feedback and use the inputs in a large call center redesign project, as well as process improvements in gathering customer feedback. I helped Oregon Health Sciences University's medical center evaluate and improve processes in their operating suites and their

radiology and transport departments. All these organizations use NPS or something similar to evaluate satisfaction (along wiht Press-Ganey).

In addition I coach exec leaders and teams in organizations of many sizes, and with substantial coaching and consulting experience, I am very comfortable with ways to evaluate satisfaction / quality, etc.

b) Health Equity. Health system experience in defining, evaluating, and mitigating the social determinants that stand in the way of health and well-being.
Among the many groups I've worked with at SHC, I've helped reset strategic priorities, and reviewed progress, with several community health group(s). My familiarity with how healthcare systems run, some of the operational challenges, and the large scale change efforts needed in today's healthcare organizations gives me a fair amount of background knowledge which I think would be helpful on this committee. And as a long time Palo Alto resident, I am passionate about ensuring health equity in our community.

c) High Reliability Organization. Experience in maintaining a high-reliability organization with a culture of safety.
All healthcare and pharma organizations that I've worked in or with prioritize both safety and reliability. I also worked closely with the former director of Quality at Cisco, as they improved both their quality and safety culture over two-three years.

3. Below are critical characteristics and behaviors essential to being a successful Committee Member. Please provide an example that illustrates how you demonstrate at least one of the following characteristics:

Impeccable Reputation, Collaborative nature, Solid communication and interpersonal skills, with the ability to be effective with other Board and Committee members and executive management, High energy and sense of urgency, Innovative, creative, and imaginative, Mission-driven, Comfortable with change, WIthout sounding too braggy, I offer up my nearly 40 year track record advising and coaching executives across a wide range of organizations as a solid demonstration of the maturity and collaboration needed to be an effective team member. I've run my own business, worked inside large organizations, taught and presented at global conferences. I often collaborate with others on larger projects, and the top focus of many of my projects is collaboration including all voices, at all levels, and balancing the needs of the many different constituents, whether in healthcare, education, or tech companies. In addition, I coach/teach frequently in Stanford GSB's Interpersonal Dynamics program (EQ, interpersonal skills, learning, building relationships). I've presided over an international professional organization and served on its board for 8 years. I've also served on the advisory board of Stanford Women on Boards, where I helped guide the organization's growth over about a 10 year period.

4. Are there any other aspects of the position description that you have experience with that are not specifically listed above? If so, please describe that experience.

I think I've pretty well covered my background knowledge, skills, and capabilities.
I will add that I care deeply about ensuring health equity, especially in this area, and at this time, when government funding is decreasing, reimbursements are decreasing, and care needs are rising in our

communities.

a) Do you have any other skills, qualifications, or subject matter expertise that you believe would be an asset to the Committee? If so, please describe.
I am an excellent team builder, coach, and consultant. I focus on not just the results needed, but HOW the people want to work together to create their shared future. I would be honored to be able to participate, if you think my skills and experience would enhance the committee's efforts.

5. Are there any civil, employment-related, or criminal incidents in your background that we may uncover in a reference or background check? Have you ever been involved in a government investigating for business related issues (e.g. SEC)? (Note: Disclosure of a civil, employment-related, criminal incident (s) or government investigation will not necessarily disqualify you from appointment. The nature and timeframe with be taken into consideration.)

No

6. Are you able to make the necessary time commitment as laid out in the position description?

Yes

7. Would this position create a conflict of interest with any of your other commitments?

No

8. The El Camino Health Quality, Patient Care, and Patient Experience Committee Member position is non-compensated (i.e. volunteer) and has a three-year renewable term. Is this acceptable?

Yes

9. Please specify how you found out about this position.

Stanford Women on Boards listing.

10. Why are you interested in being considered for the Quality, Patient Care, and Patient Experience Committee Member position with El Camino Health?

I would be honored to help ensure that ECH continues as the strong community hospital that it has always been known to be. My mother was treated there during a visit here (years ago) and she was

treated with respect and care as I would have wanted her to be. There aren't a lot of civic issues I care about more than the health of our community, and the security of knowing that everyone can be treated when needed.

[redacted]

- [redacted]

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
COMMITTEE MEETING MEMO

To: Quality Committee of the Board of Directors, El Camino Health
From: Cheryl Reinking, DNP, RN, NEA-BC, DipACLM
Date: June 2, 2025
Subject: Patient Experience Letter received from Los Gatos Rehab Patient

Purpose: To provide the Committee with written feedback received from a grateful patient via an individualized letter.

Summary:

1. Situation: This unsolicited letter is from a patient who received care in our rehabilitation clinics at El Camino Health Los Gatos from March 11 – April 18, 2025

2. Authority: To provide insight into one patient's experience of this critical service at our Los Gatos Campus.

3. Background: This patient states that they are very familiar with the 'service industry' and had a very favorable experience

4. Assessment: The patient commented about 'a team united in purpose' which is a key driver for patient experience. The patient saw our staff 'working in harmony and creating an atmosphere filled with warmth and positivity, and genuine care shows in every interaction". This journey for the patient spanned over a month and consistency and compassion were highlighted.

5. Outcomes: El Camino Health Los Gatos provided an exceptional care experience for this patient due to teamwork and staff working in harmony. The staff at this location are engaged in patient experience best practices (WeCare) and our patients can see the difference in the care they receive.

6. List of Attachments: See patient comments.

Suggested Committee Discussion Questions:

1. How do we recognize the team for exceptional patient experience scores and comments?

2. How can we leverage this team and learn how they foster teamwork?

May 12th, 2025

In my profession, I encounter many “service” operations that struggle with discontent and a lack of shared purpose. That’s why what I experienced at El Camino Health — and specifically at your Acute Rehabilitation Center (Los Gatos) — stands out so clearly. From the moment I arrived, I witnessed something rare: a team united in purpose, working in harmony, and creating an atmosphere filled with warmth and positivity. It was more than comforting — it was healing.

Your team is a reflection of strong leadership. A crew takes its cue from the captain, and it is clear that under your guidance, excellence is not just encouraged — it’s lived every day. Your commitment to fostering a culture of enthusiasm, passion, and genuine care shows in every interaction. You have not just built an inpatient rehabilitation service — you’ve built a sanctuary of healing.

As we celebrate the last day of Nurse's Week today, Monday, May 12th, 2025, I want to take this moment to express my heartfelt appreciation for all of you. Nursing is more than a profession — it’s a calling. Your compassion, resilience, and dedication, especially in the face of the most challenging moments, speak volumes about who you are as individuals and as a team. The empathy, patience, and humanity you bring to your roles are lifechanging. I am writing this letter as a grateful patient who was fortunate to experience your extraordinary care during my recovery from Guillain-Barré Syndrome. The journey was uncertain and often overwhelming, but your steady presence and encouragement became my anchor. Your skill, your attention to every need — physical and emotional — and your unwavering belief in my potential reminded me every day that healing was possible.
You didn’t just help me walk again. You helped me rediscover my independence, my hope, and my sense of self. From the smallest gestures of kindness to your highest standards of professional care, you gave me so much more than treatment — you gave me back my life. Thank you for being more than caregivers. Thank you for being healers, motivators, and true partners in my journey. You are the heart of healthcare, and I will always carry deep gratitude for each of you.

With sincere thanks and admiration,

Admission Date: March 11th, 2025
Discharge Date: April 18th, 2025

El Camino Health

El Camino Health Board of Directors
Quality, Patient Care, and Patient Experience Committee Memo

To: Quality, Patient Care and Patient Experience Committee
From: Shreyas Mallur, MD, Chief Quality Officer
Date: June 2, 2025
Subject: Health Equity Update: SDOH-1 and SDOH-2 CMS Mandates

Recommendation: Review and reflect on El Camino Health SDOH-1 and SDOH-2 submitted report and action plan attached to this memo.

Background: The SDOH-1 (Social Determinants of Health Screening) CMS requirement mandates that healthcare providers systematically screen patients for social determinants affecting health, such as housing instability, food insecurity, transportation barriers, financial instability and interpersonal safety. The SDOH-2 (Social Needs Action Plan) requirement compels providers to develop and implement action plans to address identified social needs, integrating these into patient care plans. Both requirements aim to improve health outcomes by addressing non-medical factors impacting patient health. Compliance involves regular data collection, documentation, and reporting to CMS to demonstrate efforts and outcomes in mitigating social health determinants.

Assessment: El Camino Health successfully attested on all measures for the mandatory reporting period 01/01/2024 – 12/31/2024. The required elements of performance for SDOH-1 and SDOH-2 are:

1. Engagement of the hospital or health system to participate in a Statewide and/or National Perinatal Improvement Collaboration Program aimed at improving maternal outcomes during inpatient labor, delivery and postpartum care, and has implemented patient safety practices or bundles related to maternal morbidity to address complications, including, but not limited to, hemorrhage, severe hypertension/preeclampsia or sepsis.

2. Hospital Commitment to Health Equity (HCHE). It measures if the hospital has a strategic plan for advancing health equity, including identifying priority population who currently experiencing health disparities. Identifying health equity goals and discrete action steps to achieve these goals. Outlines specific resources which have been dedicated to achieving our equity goals. Describes the approach for engaging key stakeholders, such as community-based organizations.

3. Collects demographic information (such as self-reported race, national origin, primary language, and ethnicity data) and/or social determinant of health information on most of our patients.

4. Report on five categories of SDOH:

    - House Instability Screening
    - Food Insecurity Screening
    - Transportation Needs
    - Utility Difficulties
    - Interpersonal Safety

Attachment(s):

1. SDOH-1 and SDOH-2 mandates
2. El Camino Health SDOH-1 and SDOH-2 Action Plan

El Camino Health Board of Directors
Quality Committee Memo

To: Quality, Patient Care and Patient Experience Committee
From: Shreyas Mallur, MD, Chief Quality Officer
Date: June 2, 2025
Subject: SDOH-1 and SDOH-2 submission report and action plan for CY 2025

The following rates have been reported for period 01/01/2024 – 12/31/2024:

1. **SDOH Screening Rate**: The number of patients admitted for an inpatient hospital stay who are 18 years or older or the date of admission and are screened for all of the following five HRSNs (health related social needs) – (food insecurity, housing instability, transportation needs, utility difficulties and interpersonal safety) during their hospital inpatient stay.

   1568 / 24876 (6% of the adult medical and surgical patients)

2. **Food Insecurity**: The number of patients admitted for an inpatient hospital stay who are 18 years or older on the date of admission, who were screened for all five HRSN, and who screen positive for food insecurity.

   30 / 1568 (1.9% of screened patients)

3. **Housing Instability:** The number of patients admitted for an inpatient hospital stay who are 18 years or older on the date of admission, who were screened for all five HRSN, and who screen positive for housing instability.

   32 / 1568 (2% of screened patients)

4. **Transportation needs:** The number of patients admitted for an inpatient hospital stay who are 18 years or older on the date of admission, who were screened for all five HRSN, and who screen positive for transportation needs.

   38 / 1568 (2.4% of screened patients)

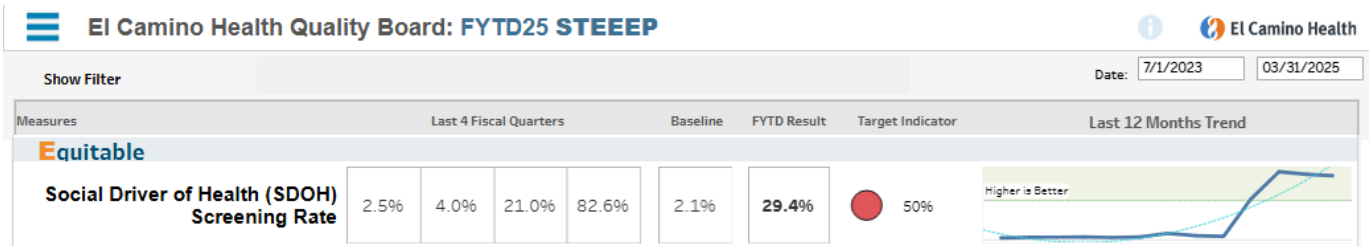
5. **Utilities difficulties:** The number of patients admitted for an inpatient hospital stay who are 18 years or older on the date of admission, who were screened for all five HRSN, and who screen positive for utility difficulties.

   28 / 1568 (1.7% of screened patients)

6. **Interpersonal Safety:** The number of patients admitted for an inpatient hospital stay who are 18 years or older on the date of admission, who were screened for all five HRSN, and who screen positive for interpersonal safety.

   2 / 1568 (0.1% of screened patients)

STEEP Dashboard FY 2024-2025



Action plan for CY 2025

1. Create an integrated data governance structure: An integrated approach to SDOH data collection is imperative to avoid duplicative efforts, ensure data validity but most importantly accommodate patient preferences.

2. Train users to collect SDOH data: First, establish the WHY? It`s important to document SDOHs with real life clinical examples so that clinicians can buy in to the change. Establish scripts and workflows that can be easily replicated and scalable. Finally, hold workshops to give staff the chance to train and practice.

3. Set quantifiable goals: Develop process metrics, like screening rates and resource recommendations rates. Also, quality indicators that are reflected through the SDOH framework (readmission and house instability, mortality and food insecurity etc.)

4. A follow through mechanism on addressing social needs: Collaborate with care coordination, community benefit, district population health departments to address identified disparities, ranging from adding resources to the navigation programs, coordination efforts with community-based organizations, other renovative ideas to coordinate the continuum of care for socially vulnerable patients.

5. Determine a data governance and exchange structure: review regulations and contracts to determine how to exchange data with our partners.

Update: The SDOH (Social Determinants of Health) Assessment Tool has been implemented on December 9th, 2024. However small adjustments in the screening and assessment process had to be done through an initial PDSA cycle, with the first batch of consistent and accurate data being reflected beginning January 20th, 2025. The new tool requires all ED, inpatient, and OB nurses to screen patients for Social Drivers of Health. Patients who screen positive will be referred to Care Coordinators or Social Workers for further follow-up and to ensure they receive the necessary resources.

El Camino Health

El Camino Health Board of Directors
Quality, Patient Care, and Patient Experience Committee Memo

To: Quality, Patient Care, and Patient Experience Committee
From: Shreyas Mallur, MD, Chief Quality Officer
Date: June 2, 2025
Subject: El Camino Health, Update on Health Equity

Purpose:

During the June 2024 meeting of the Quality, Patient Care, and Patient Experience Committee, a focused review of Health Equity's initial priorities and initiatives for El Camino Health was discussed. The initial Health Equity Plan was also shared with the El Camino Health Board of Directors in August 2024. Both governing bodies endorsed the direction of the work. An update on the status of our Health Equity initiatives will be reviewed during the regular Quality, Patient Care, and Patient Experience Committee meetings.

Summary:

El Camino Health, Health Equity Initial priorities as discussed in the June 2024 Quality Committee Meeting are:

1. Identify who, when & how our team will collect Race Ethnicity Language-Disability (REaL-D), Sexual Orientation and Gender Identity (SOGI), Social Drivers of Health (SDOH) data. The gold standard for collecting accurate information in these domains is that it is patient self-reported with the help of patient centered technology tools.
2. Optimize technology and tools for data collection and analysis.
3. Four initial initiatives identified.
    1. Quality Council Reporting and Analysis with an equity lens for all reporting departments.
    2. Communicate with patients in their preferred language.
    3. Do we recognize and support homeless patients per our policies.
    4. Collect Social Drivers of Health per CMS and TJC mandates.

Progress on Priorities:

1. Patient data collection and technology optimization.
    a. The electronic medical record, EPIC, has a module to facilitate the collection, capture, and analysis of patient reported information on REAL, SOGI and SDOH. This module has just been implemented, and our team is focused, in partnership with Information Technology, Care Coordination, Social Work and the Health Equity teams to optimize the build and tools in EPIC.

2. Four Initiatives
    a. Quality Council Reporting. We have refined the template departments utilize to report their process improvement initiatives and outcomes. Additionally, the Quality and Health Equity teams provide support, analytics and thought partnering to enable each department to report on at least one measure through an equity lens.

b. Communicating with patients in their preferred language. This initiative is driving improvement with two parallel paths. First, increasing the availability of language translation iPad in the pilot units 2C, 3C, and 2B. Second, optimizing the training and tools provided to our registration team to determine more accurately which of our patients would benefit from translation services.

c. Homeless Committee reinstated in July 2024. The stakeholders are Patient Safety, Patient Access Services, Licensing and Reporting Department, Care Coordination and Social Work, Patient Experience, Clinical Leadership, IT, Health Equity, HIM and Process Improvement departments. The process of screening, assessment, data collection as well as resource allocation is being momentarily revamped.

d. Social Driver of Health screening and assessment project is in the final implementation phase. Please see attached CMS reported Measures and STEEP Dashboard recent numbers.

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
MEMO TO THE EXECUTIVE COMPENSATION COMMITTEE

To: El Camino Hospital Board of Directors
From: Shreyas Mallur, M.D
Date: June 3, 2025
Subject: Refresh STEEEP Dashboard for FY 2026

Purpose:

The STEEEP dashboard is intended to be a Governance Level report, which is shared with the El Camino Hospital Board of Directors on behalf of the Quality Committee once a quarter. There are 20 measures which are tracked on the STEEEP dashboard and most of these measures are also tracked in the Enterprise Quality Dashboard. We propose changing two of the measures on the STEEEP dashboard, one being a health equity measure and the other being the patient experience measure.

Summary:

Change in the Health Equity measure : There are two health equity measures which are tracked on the STEEEP dashboard for FY 25, one being screening for Social Determinants of Health Screening rate and the second being Voyce (translation) interpretation minutes used by caregivers in the hospital. The reason for choosing these in FY 25 was CMS mandates to measure SDOH screening rates and the fact that language barriers were among the factors identified in providing equitable care to our patients.

For FY 26, we propose continuing to track the SDOH screening rate. We propose changing the measure for translation minutes to Homeless Patient Discharge Compliance. Patients experiencing homelessness face complex medical and social challenges that place them at disproportionate risk for adverse outcomes during and after hospitalization. These include:

- Higher rates of readmissions
- Poor medication adherence
- Difficulty following discharge plans
- Lack of transportation or follow-up care access

Tracking discharge compliance for homeless patients allows us to assess and close gaps in how well we support one of our most vulnerable populations at a critical transition point.

Change in the Patient Experience Likelihood to Recommend (LTR) measure: We also propose using a composite score for the FY26 Likelihood to Recommend metric versus reporting only the LTR for the hospital inpatient units (which accounts for a small proportion of our total volume). The composite score for patient experience aggregates data received from patient surveys across all areas of the hospital areas such as inpatient care, mother / baby, emergency department (ED), outpatient surgery, outpatient services (imaging, rehab, lab, etc), and other hospital-based service lines and weights the overall LTR score in alignment with ECH's strategic priorities.

By focusing on patient experience across multiple domains and areas of the hospital setting, we believe that it will not only improve patient satisfaction, but it will allow us to more effectively engage

all members of our team, improve operational efficiency and enhance our reputation across service lines.

The benefits of using a composite score across that includes all Hospital service lines include:

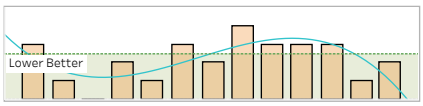
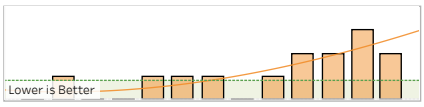
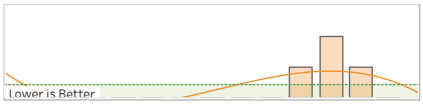
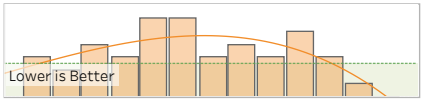
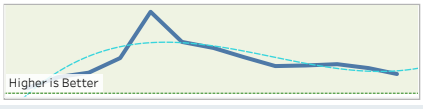
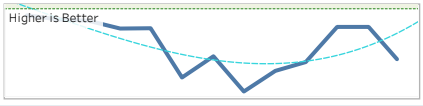
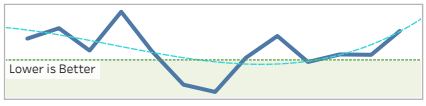
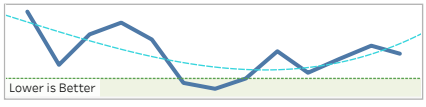
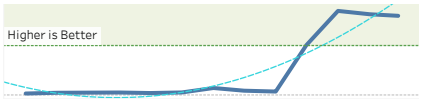
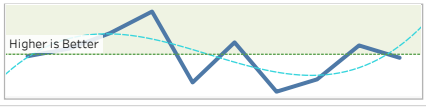
- Alignment with the ECH strategic framework of growth and revenue (oncology, procedural areas, etc.)
- Engagement of all hospital departments in improvement efforts with visibility for improvement work at the department / campus level.
- Capture patient experience feedback across all areas of the organization
- This hospital composite does not preclude independent measurement of ECHMN.

El Camino Health Quality Board: FY2026 STEEEP [MOCK Dashboard for FY2026]

El Camino Health

Show Filter

Date: 5/1/2024 03/31/2025

Measures	Last 4 Fiscal Quarters				Baseline	FYTD Result	Target Indicator		Last 12 Months Trend
Safe Care									
	FY 24Q4	FY 25Q1	FY 25Q2	FY 25Q3	FY25	FYTD26			Trend Chart Period: 5/1/2024 to 03/31/2025
C-Diff Clostridioides Difficile Infection	3	6	10	6	28	**22**		<= 27 cases	
CAUTI (Catheter-Associated Urinary Tract Infection)	1	3	3	7	11	**13**		<=10 cases	
CLABSI (Central Line-Associated Bloodstream Infection)	0	0	1	3	3	**4**		<=5 cases	
SSI (Surgical Site Infection)	9	15	12	4	38	**31**		<=30 cases	
Hand Hygiene Audit Compliance (Leapfrog measure)	87.3%	85.3%	81.5%	80.9%	84.1%	**82.3%**		>=85%	
Timely									
Imaging TAT in ED Including Xray (target = % completed ≤ 45 min)	81.0%	74.0%	69.4%	77.7%	77.7%	**73.7%**		>=84.0%	
Effective									
30-Day Readmission Rate (Based on Vizient Risk Model)	10.0%	9.1%	9.7%	8.6%	9.8%	**9.2%**		<=9.8%	
Hospital Mortality O/E Index (Vizient Risk-Adjusted Mortality Model)	1.25	0.87	1.06	1.11	1.16	**1.02**		<= 1.0	
Sepsis Mortality O/E Index (Vizient Risk-Adjusted Mortality Model)	1.36	1.06	1.10	1.23	1.35	**1.13**		<=1.0	
NTSV Cesarean Section (CMS PC-02 Measure)	26.7%	24.2%	27.5%	26.0%	24.7%	**25.9%**		<=23.9%	
Efficient									
Length of Stay (LOS) O/E Index (Inpatient Discharges, Exclude Mental Health, Acute Rehab, and OB Service)	1.04	1.00	1.03	1.03	1.03	**1.02**		1.02	
ED Arrival to Departure Time (For patients discharged from ED to home, Median time in minutes)	155	151	152	154	155.8	**152.1**		<=160	
Equitable									
Social Driver of Health (SDOH) Screening Rate	2.5%	4.0%	21.0%	82.6%	2.1%	**29.4%**		50%	
Homeless Patients Discharge Planning Compliance			(Mock Data)					TBD	
Patient-Centered									
Hospital LTR Composite Likelihood To Recommend (LTR) based on Press Ganey Survey	83.4	80.7	81.5	82.0 (Mock Data)	81.9	**81.9**		81.9	

El Camino Health

El Camino Health Board of Directors
Quality, Patient Care, and Patient Experience Committee Memo

To: Quality, Patient Care, and Patient Experience Committee
From: Shreyas Mallur, M.D, Chief Quality Officer and Lyn Garrett, MHA, MS, CPHQ
Date: June 2, 2025
Subject: Enterprise Quality, Safety and Experience Dashboard FY25 through March 2025.

Purpose: To update the Quality, Patient Care and Patient Experience Committee on quality, safety, and experience measure performance through **April 2025** (unless otherwise noted).

Summary: The FY 25 Enterprise Quality, Safety, and Experience Dashboard is updated monthly and tracks eighteen quality measures including hospital acquired conditions (HAC).

1. **C. Difficile Infection:** There have been 23 cases (Goal: </= 27 infections FY 2025) Hospital Acquired C=Diff infections YTD FY2025. Areas of focus to decrease C. Diff are three-fold. First, hospital wide education on C. Diff screening, testing and prevention. Second, deployment of an enterprise-wide hand hygiene program has been implemented. Third, a robust antibiotic stewardship program is in place. (Timeline for improvement: We are on track to meet this goal)

2. **Catheter Associated Urinary Tract Infection (CAUTI):** There have been 13 CAUTI YTD FY2025 with a goal to have less than ten for the fiscal year. There were zero CAUTI's in the month of April. Process improvement foci to reduce CAUTI are 1. Remove catheters as soon as possible when clinically appropriate, and 2. Ensure insertion and maintenance best practices are followed. To achieve shorter catheter duration, our infection prevention team reviews every single patient with a catheter in for greater than three days and collaborates with the nurse and physician to review indications for the catheter and direct attention to the importance of removing the catheter as soon as clinically appropriate. (Timeline for improvement: We did not meet the target for FY 25. However, the processes put in place over the last few months should have us improving and show sustained improvement from Q1 FY2026)

3. **Central Line Associated Blood Stream Infection (CLABSI)**. We have had 4 CLABSI YTD FY 2025 to a target of 5. We had zero CLABI in the month of April. Our focus, to sustain our favorable CLABSI performance, is on optimizing care and management of hemodyalsis catheters. (Timeline for improvement: We are on track to meet target)

4. **Surgical Site Infection**. The number of cases/month of surgical site infections for YTD FY2025 (3.30 cases/month) is unfavorable to target (2.5). A taskforce including SPD, OR staff, physicians has been instituted to reinforce best practices, enforce normothermia, timing of preoperative antibiotics and clean closure tray utilization in the OR and perioperative areas. (Timeline for improvement: We anticipate that our SSI rate will go down by Q4 of FY 2025/ Q1 of FY 2026. This is a major focus for the organization, and we have devoted significant resources to understand and implement any changes needed)

5. **Hand Hygiene Combined Compliance rate:** Performance for Q2 FY2025 is unfavorable (82.6%) to target of 85%. (Timeline for improvement: We are reemphasizing with staff on the importance of hand hygiene compliance to prevent HAIs)

6. **Hand Hygiene % of Departments Meeting Audit Compliance target:** Performance for Q2 FY2025 is favorable (100%) to target of 80% of units.

7. **Serious Safety Event Rate:** Performance YTD FY2025 (Through September 2024) is favorable (1.68) compared to baseline of 1.93 FY2024.

8. **30 Day Readmission Observed Rate:** Performance through Q2 FY2025 (9.3%) is favorable to target (</=9.8%). El Camino Health remains committed to ensuring timely follow-up care for patients under primary care providers, after they are discharged from the hospital. We are also partnering with our colleagues at the County as well as Palo Alto Medical Foundation to get timely appointments for patients who are discharged from the hospital. In addition, our Post-Acute Network Integrated Care team has also implemented a process to identify high-risk patients and coordinate their care with our Preferred Aligned Network (PAN) providers, including home health care services and skilled nursing facilities. The goal is to ensure timely follow-up appointments with patients' primary care providers after they are discharged from a PAN provider, thereby reducing the risk of readmissions back to the hospital. (Timeline for improvement: We are on track to achieve target for FY 2025)

9. **Complications- Inpatient Hip & Knee Observed rate:** Performance through Q3 FY 2025 is unfavorable (4.9%) to target of <= 3.5%. However, we have made significant improvements to baseline of 5.9% noted in FY 25. We are tracking this measure since this is a CMS metric used for VBP, Star rating and benchmarking of health systems. The major reason for the increased rate is due to most Hip and Knee procedures are now outpatient and only the high acuity remain as inpatient. (Timeline for improvement: Q1 FY2026. We will continue to focus on reducing hip/knee SSIs in addition to engaging with surgeons to understand causes of complications)

10. **Risk Adjusted Mortality Index.** Performance YTD FY 2025 (0.99) is favorable to target (1.00). Mortality index tracks, and for this time frame, is driven by sepsis mortality. Though we are on track for this metric, we will be closely monitoring this since the system changes introduced in documentation integrity, reduction in clinical variation and institution of earlier hospice and GIP are just in the initial phases of implementation. (Timeline for improvement: We are on track to achieve this target for FY 2025, based on recently received data. We expect significant improvement in FY 2026)

11. **Sepsis Mortality Index.** Performance for YTD FY2025 (1.06) is unfavorable to target (1.00). We have seen a significant improvement in this metric compared to FY 25. Patients often arrive in the ED in Septic Shock. We are working to increase Social Work and/or Palliative Care support in the ED for goals of care discussions. Pursue hospice when appropriate for patients in the ED to go home, or if admitted then to a robust GIP program. A recent process change internally was that the sepsis coordinators provide concurrent sepsis bundle compliance to ED physicians and staff in the real time. We are doing an excellent job of caring for patients with sepsis. We have an opportunity to improve the support we provide to patients and their families at the end of life through a robust GIP program. (Timeline for improvement: The GIP program is planned for go-Live in Q1 of FY 2026. With a robust program, there will be a trickle-down impact on driving earlier referral for Palliative Care consultation.)

12. **Median Time from ED Arrival to ED Departure (Enterprise).** The current FY25 performance (154 minutes) is favorable to the target of 160 minutes (lower is better). This performance is years in the making with an overhaul of the patient triage process, creation of additional chairs for less acute patients, and, most recently the creation of an ED express area

on the Mountain View Campus. The ED express has capacity for 6 patients of lower acuity and will allow our teams to provide more efficient care for patients of lower acuity (treat to street). (Timeline for improvement: We are on track to achieve this target for FY 2025).

13. **PC-02 Nulliparous Term Singleton Vertex C-Section (NTSV)**. **(Data through January 2025)** FY 2025 performance through Jan of 2025 (25.9% is unfavorable) to target of 23.9%. We have seen a decrease year over year in the metric, though not at target. This is a big reduction year over year and is attributed to our MCH team's focus and efforts. The MCH team shares data quarterly with the medical staff regarding individual physician NTSV rates. The introduction of a NTSV check list had a positive impact on decreasing c/s rate initially after roll out in Q2 of 2024. What has been most impactful is the bi-weekly review by a multidisciplinary team of nurses, midwives, and physicians to review the indication for every single NTSV. When an opportunity for improvement is identified, MCH leaders reach out to the provider with feedback. (Timeline for improvement: This metric has proved challenging to achieve. We will continue to evaluate methods of decreasing the rate of NTSV C Sections)

14. **PC-05: Exclusive Breast Milk Feeding:** Performance for FY 2025 YTD for Enterprise is favorable (76.8%) to target of 65.1%. Performance for FY 2025 for LG is favorable (84.9%) to target of 70%. There has been an intense effort by the MCH department to improve this measure over the last year. (Timeline for improvement: We are on track to achieve this goal for FY 2025)

15. **Inpatient HCAHPS Likelihood to Recommend Percentile.** Performance for FY2025 is favorable and above target for April and for FY25 with a percentile rank of 83. Our Inpatient units achieved target for both April and fiscal year to date. Our Los Gatos campus made incredible strides during April. Training and standard work continue with bedside shift reports, purposeful rounding, and key drivers.

16. **Inpatient Maternal Child Health-HCAHPS Likelihood to Recommend Top Box Rating of "Yes, Definitely Likely to Recommend".** Performance for YTD FY2025 is unfavorable (80.3 %) compared to target of (82.0). Our Mother / Baby did not achieve target for the month of April but remained at 82%ile nationwide. We moved into our new L&D units and the construction continued to be a temporary patient dissatisfier. Our Los Gatos campus exceeded target for April.

17. **ED Likelihood to Recommend Top Box Rating of "Yes, Definitely Likely to Recommend".** Performance for YTD FY2025 is favorable (77.4) to target of (77.2). Our Emergency Department as an enterprise did achieve its target for the month of April. Our Mountain View campus was slightly below target (Los Gatos campus exceeded target). We are on target to exceed this goal for our current fiscal year.

18. **El Camino Health Medical Network: Likelihood to Recommend Clinic Top Box Rating of "Yes, Definitely likely to Recommend".** Performance for YTD FY2025 is unfavorable (81.9) to target of (83.4). ECHMN did not achieve their target for April with primary care taking a dip and our specialty care area improving. We had a few primary care physicians out of the office in April impacting access. USNC, our large Urology group, saw an increase in their low performing areas resulting in an increase in our specialty scores. We have started an enterprise clinic competition to focus on improving our scores.

Attachment(s): Enterprise Quality Dashboard FY 25 through April 2025.

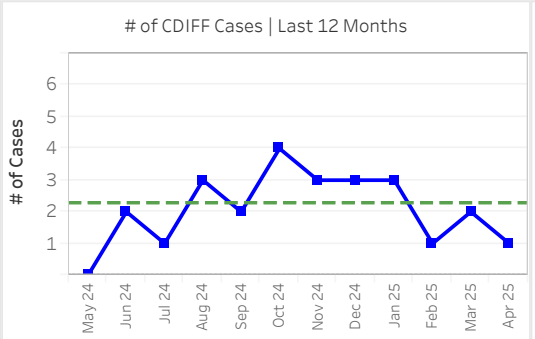
El Camino Health

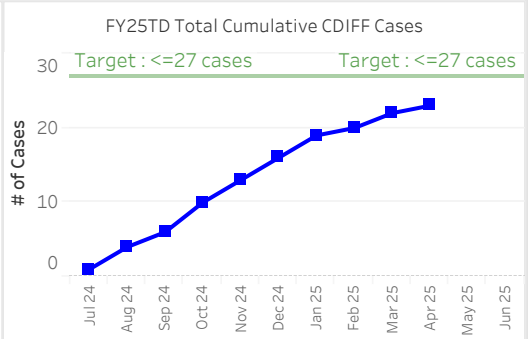
FY25 Enterprise Quality, Safety and Experience Dashboard

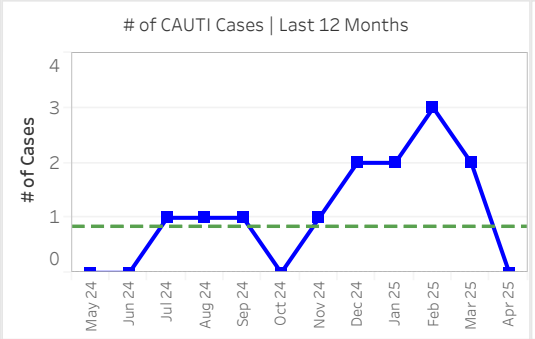
April 2025 (unless other specified)

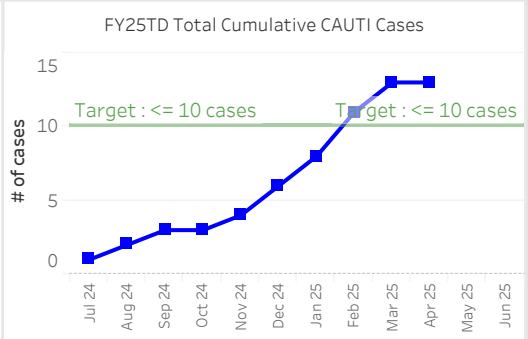
Month to Board Quality Committee : June 2025

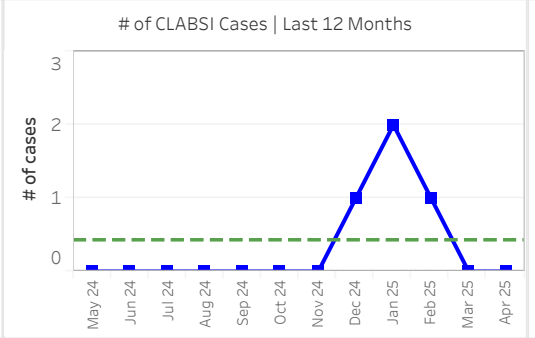
Measure	FY25 Performance		Baseline FY24 Actual	FY 25 Target	Trend	FYTD or Rolling 12 Month Average
	Latest Month	FYTD				
*Organizational Goal Clostridium Difficile Infections (C-Diff) cases Latest Month : April 2025	1 cases	2.30 cases/mo	2.33 cases/mo	2.25 cases/mo	BETTER	BETTER
*Organizational Goal Catheter Associated Urinary Tract Infection (CAUTI) cases Latest Month : April 2025	0 cases	1.30 cases/mo	0.92 cases/mo	0.83 cases/mo	BETTER	BETTER
Central Line Associated Blood Stream Infection (CLABSI) cases Latest Month : April 2025	0 cases	0.40 cases/mo	0.25 cases/mo	0.42 cases/mo	BETTER	BETTER

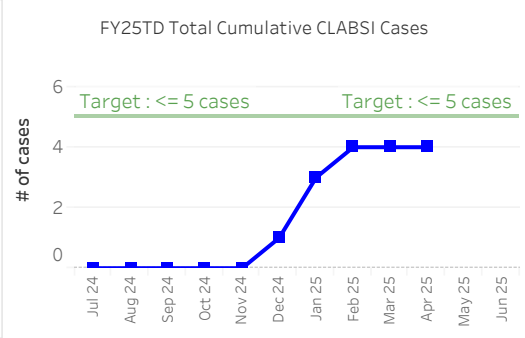












Quality Department | Note : updated as of May 19, 2025

Measure	Definition Owner	Metric Definition	Data Source
*Organizational Goal Clostridium Difficile Infections (C-Diff) cases	C. Nalesnik	1) Based on NHSN defined criteria 2) Exclusions : ED & OP	**Numerator:** Infection control Dept. **Denominator**: EPIC Report
*Organizational Goal Catheter Associated Urinary Tract Infection (CAUTI) cases	C. Nalesnik	1) Based on NHSN defined criteria 2) Exclusions : ED & OP	**Numerator:** Infection control Dept. **Denominator**: EPIC Report
Central Line Associated Blood Stream Infection (CLABSI) cases	C. Nalesnik	1) Based on NHSN defined criteria 2) Exclusions : ED & OP	**Numerator**: Infection control Dept. **Denominator**: EPIC Report

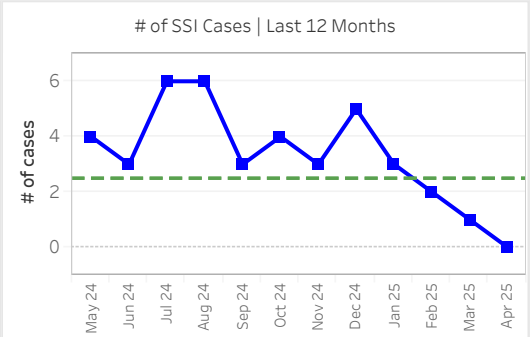
El Camino Health

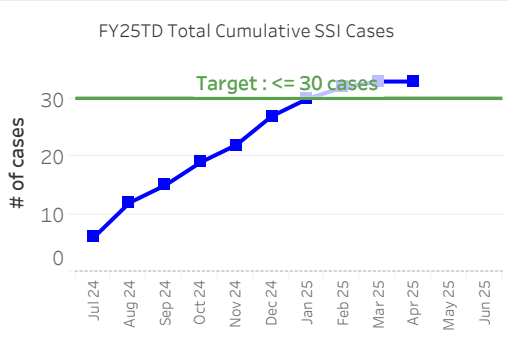
FY25 Enterprise Quality, Safety and Experience Dashboard

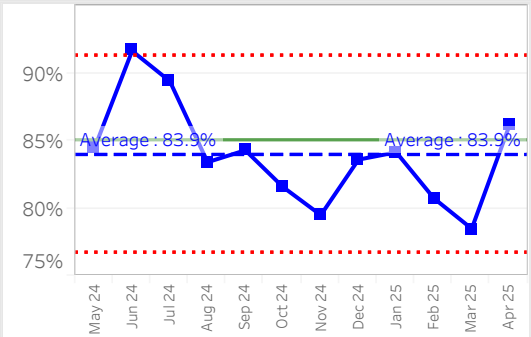
April 2025 (unless other specified)

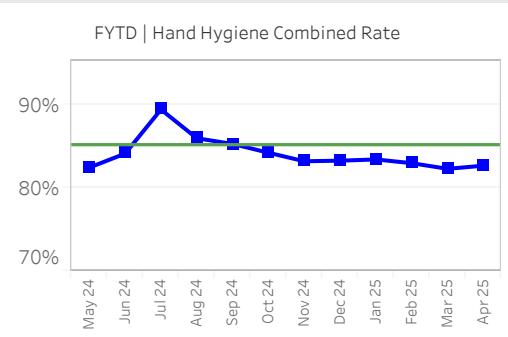
Month to Board Quality Committee : June 2025

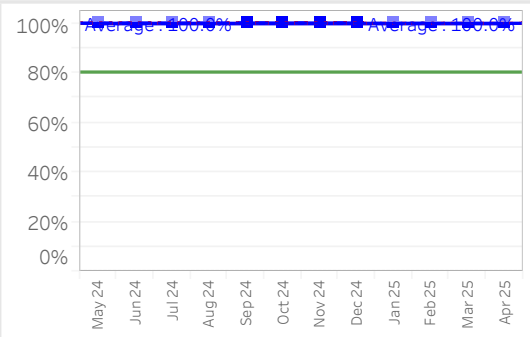
Measure	FY25 Performance		Baseline FY24 Actual	FY 25 Target	Trend	FYTD or Rolling 12 Month Average
	Latest Month	FYTD				
Surgical Site Infections (SSI) cases Latest Month : April 2025	0 cases	3.30 cases/mo	3.17 cases/mo	2.50 cases/mo	BETTER	BETTER
Hand Hygiene Combined Compliance Rate Latest Month : April 2025	86.1% (14938 / 17345)	82.6% (146522 / 177297)	84.1% (64956 / 77245)	85%	BETTER	BETTER
Hand Hygiene % of Departments Meeting Target Latest Month : April 2025	100.0% (25 / 25)	100.0% (250 / 250)	54.7% (164 / 300)	80% of units	BETTER	BETTER

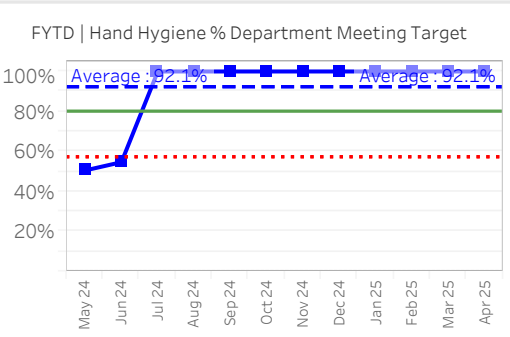












Quality Department | Note : updated as of May 19, 2025

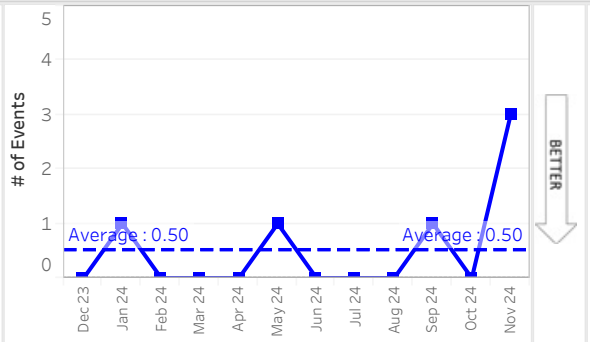
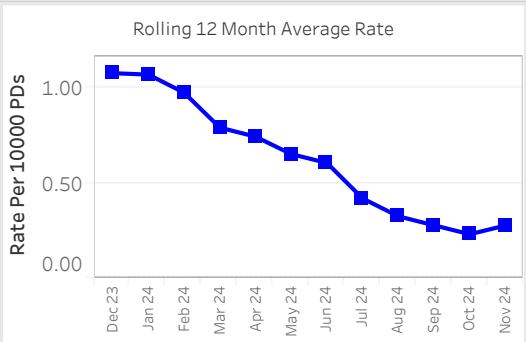
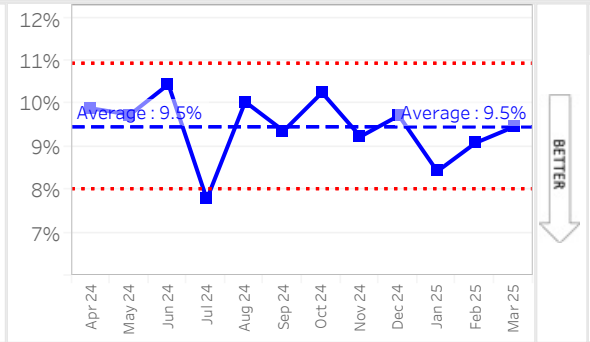
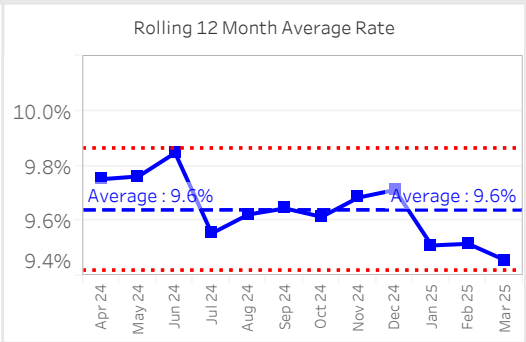
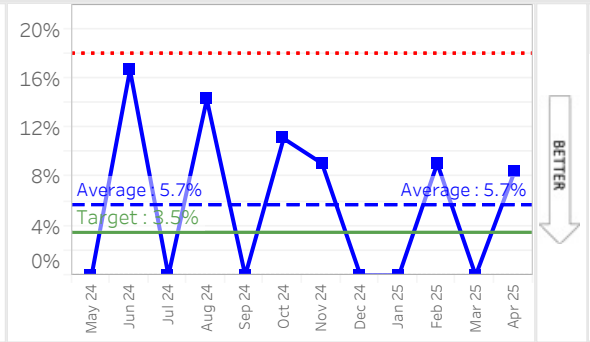
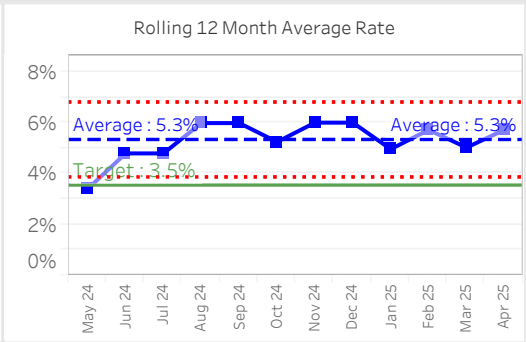
Measure	Definition Owner	Metric Definition	Data Source
Surgical Site Infections (SSI) cases	C. Nalesnik	1) Based on NHSN defined criteria 2) Inclusions: Surgical cases categorized with either a "clean wound class" or "clean-contaminated wound class" 3) Exclusions: surgical cases with a wound class of "contaminated" or "dirty". 4) SSIs that are classified: "deep –incisional" and "organ-space" are reportable. 5) Latency: SSIs may be identified up to 90 days following surgery, thus previously reported results may change.	**Numerator:** Infection control Dept. **Denominator**: EPIC Report
Hand Hygiene Combined Compliance Rate	S. Mallur, MD / Lyn Garrett	% of yes Cleaning Before Entering or Exit	Hand Hygiene Audit from Laudio Audit Tool Hand Hygiene Leapfrog Tableau Dashboard maintained by: **Hsiao-Lan Shih**
Hand Hygiene % of Departments Meeting Target	S. Mallur, MD / Lyn Garrett	Number of Unit done Audit according to their Target (Only Leapfrog units)	Hand Hygiene Audit from Laudio Audit Tool Hand Hygiene Leapfrog Tableau Dashboard maintained by: **Hsiao-Lan Shih**

El Camino Health

FY25 Enterprise Quality, Safety and Experience Dashboard

April 2025 (unless other specified)

Month to Board Quality Committee : June 2025

Measure	FY25 Performance		Baseline FY24 Actual	FY 25 Target	Trend	FYTD or Rolling 12 Month Average
	Latest Month	FYTD				
Serious Safety Event Rate (SSER) Latest Month : November 2024	3 events	1.68 (3 / 17885)	1.93 (41 / 212460)	n/a		
30-Day Readmission Observed Rate Vizient Risk Model Latest Month : March 2025	9.5% (129 / 1363)	9.3% (1133 / 12216)	9.8% (1519 / 15552)	<= 9.8%		
Complications - Inpatient Hip & Knee Observed Rate (within 90 days of procedure) Latest Month : April 2025	8.3% (1 / 12)	4.9% (5 / 102)	5.9% (5 / 85)	<= 3.5%		

Quality Department | Note : updated as of May 19, 2025

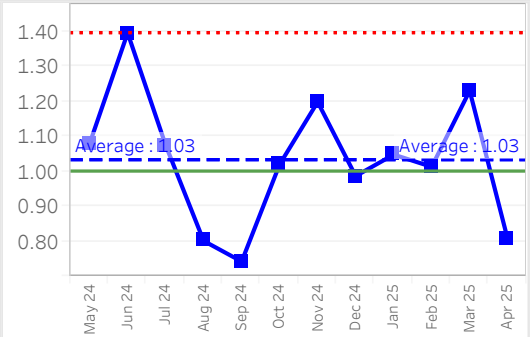
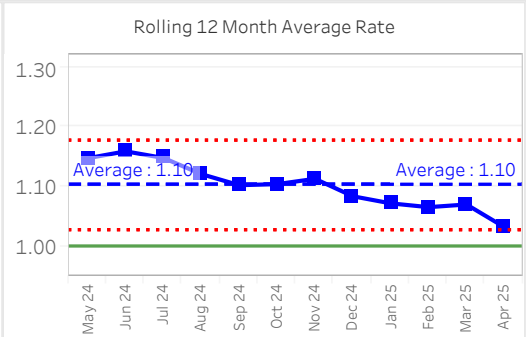
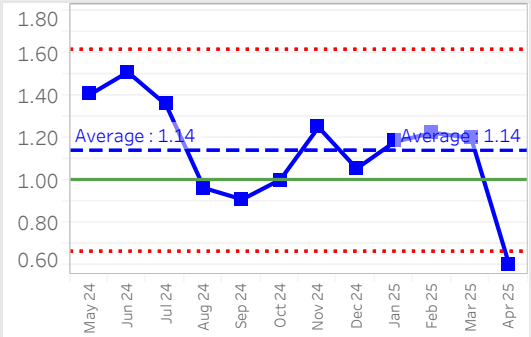
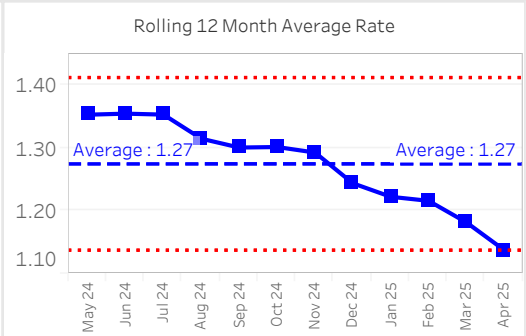
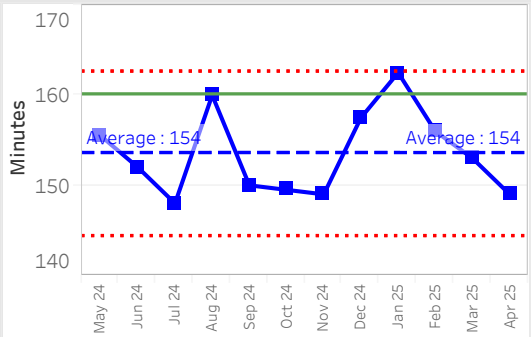
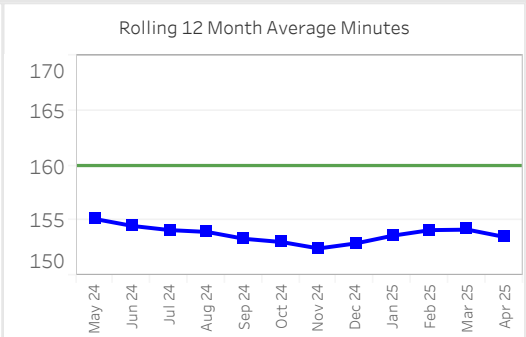
Measure	Definition Owner	Metric Definition	Data Source
Serious Safety Event Rate (SSER)	S. Shah	1) An event where there was a deviation from generally accepted performance standard that resulted in moderate to severe harm or death to a patient. 2) Inclusions: events determined to be serious safety events per Safety Event Classification team 3) NOTE: the count of SSE HAPIs MAY differ from internally-tracked HAPIs 4) Denominator: EPSI Acute Adjusted Patient Days For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value </= zero. New classification rules in effect as of 7/1/22	HPI Systems Safety Event Tableau Dashboard maintained by: **Michael Moa**
30-Day Readmission Observed Rate Vizient Risk Model	S. Mallur, MD	1) An inpatient admission of the same patient to the same facility within 30D of a prior admission, regardless of cause (All Cause). 2) Based upon Vizient Risk Model 2023 Community + CMS' All-Cause 30D readmission methodology (excludes cases CMS deems 'planned'). 3) Numerator inclusions: Patient Type = Inpatient (excluding Hospice, Rehab, Behavioral Health (defined Vizient Service Line = Behavioral Health), Nonviable Neonate & Normal Newborn	Vizient Clinical Database Readmission Tableau Dashboard maintained by: **Steven Sun**
Complications - Hip & Knee Observed Rate Vizient Risk Model	S. Mallur, MD	Based on the Center for Medicare and Medicaid Services (CMS) Metric criteria, complications following an elective primary total hip arthoplasty (THA), total knee arthoplasty (TKA) procedure. Numerator : Distinct count of patients having complications / Total Cases. Patients with complications are counted in the numerator only once, regardless of the number or type of complication. Denominator : Eligible index admissions who have undergone a qualifying elective primary THA or TKA procedure. 2.) Based upon Vizient Risk Model 2023 Community + AHRQ Version 2023 3) Numerator inclusions: Patient Type = Inpatient (excluding Hospice, Rehab, Nonviable Neonate & Normal Newborn)	Vizient Clinical Database

El Camino Health

FY25 Enterprise Quality, Safety and Experience Dashboard

April 2025 (unless other specified)

Month to Board Quality Committee : June 2025

Measure	FY25 Performance		Baseline FY24 Actual	FY 25 Target	Trend	FYTD or Rolling 12 Month Average
	Latest Month	FYTD				
Mortality Index Observed / Expected Vizient Risk Model Latest Month : April 2025	0.81 (2.05% / 2.54%)	0.99 (2.24% / 2.26%)	1.16 (2.55% / 2.20%)	1.00		
Sepsis Mortality Index Observed / Expected Vizient Risk Model Latest Month : April 2025	0.60 (6.28% / 10.53%)	1.06 (10.37% / 9.78%)	1.35 (13.37% / 9.91%)	1.00		
Median Time from ED Arrival to ED Departure [TAT-D] (Enterprise) Latest Month : April 2025	MV : 164 mins LG : 134 mins ENT : 149 mins	MV : 169 mins LG : 138 mins ENT : 154 mins	MV : 174 mins LG : 135 mins ENT : 155 mins	MV ED = 180 min LG ED = 140 min ENT = 160 min		

Quality Department | Note : updated as of May 19, 2025

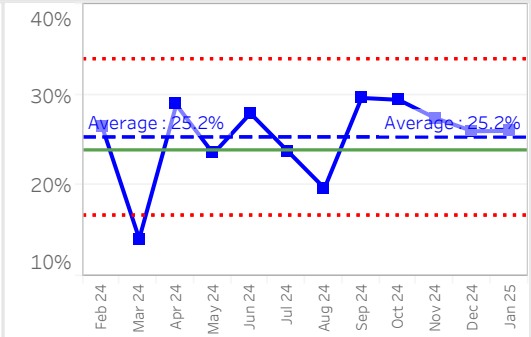
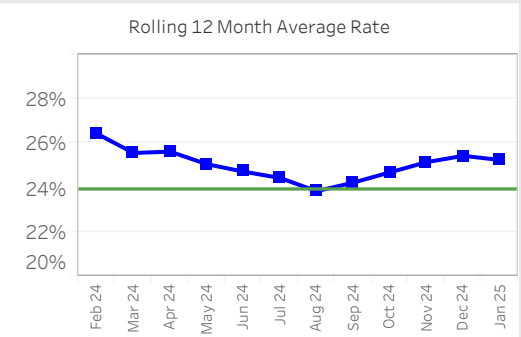
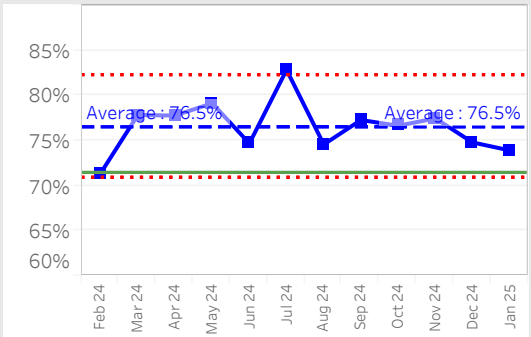
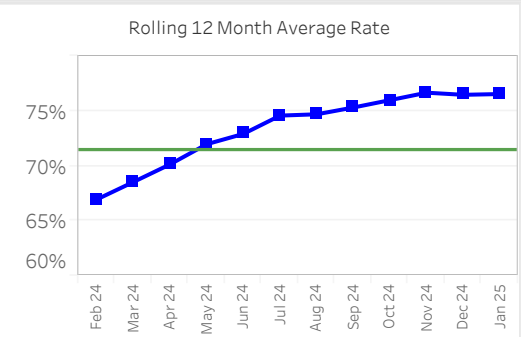
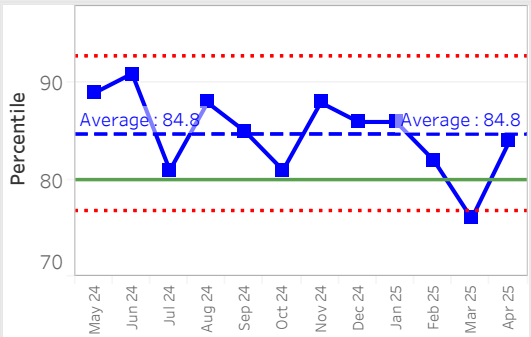
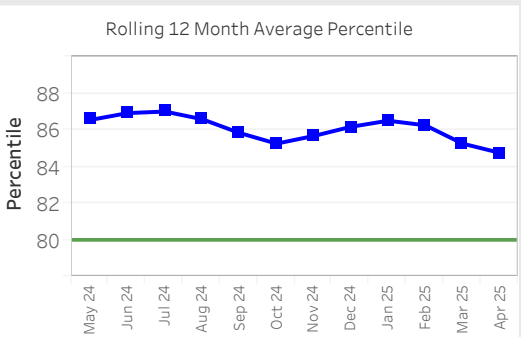
Measure	Definition Owner	Metric Definition	Data Source
Mortality Index Observed / Expected Vizient Risk Model	S. Mallur, MD	1) Based upon Vizient Risk Model 2023 Community for expected risk used by O/E ratio. 2) Criteria: inclusion: Patient Type = Inpatient (excluding Hospice, Rehab, Behavioral Health (defined Vizient Service Line = Behavioral Health), Nonviable Neonate & Normal Newborn For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value </= to zero.	Vizient Clinical Database
Sepsis Mortality Index Observed / Expected Vizient Risk Model	S. Mallur, MD Maria Consunji	1) Numerator inclusions: Patient Type = Inpatient (exclude Rehab, Hospice, Nonviable Neonate & Normal Newborn + Behavioral Health (based on Vizient Service Line = Behavioral Health), Prin or 2nd diagnosis of sepsis (SEP-1 list of codes) & age 18+ yrs 2) Numerator exclusions: LOS > 120 days, patients transferred to ECH from another hospital, MDC = 14 (OB) For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value </= zero.	Vizient Clinical Database
Median Time from ED Arrival to ED Departure [TAT-D] (Enterprise)	J. Baluom	ED Arrival to ED Departure (TAT-D - Direct Discharge): This metric is the median arrival to patient discharged time from ED. This metric excludes Inpatients, Outpatients, Observation Patients, and Hospital Outpatient Surgery Patients who arrive via the ED. Time stamp is used for this calculation: ED Arrival - Patient Arrived in ED (50) (ADT_ARRIVAL_DTTM in Clarity "F_ED_ENCOUNTERS" table) ED Departure Time - "ED_Departure_DTTM" in Clarity "F_ED_ENCOUNTERS" table	EDSBAR Tableau Dashboard; EDOC Monthly Meeting Dashboard ED Tableau Dashboard maintained by: **Hsiao-Lan Shih**

El Camino Health

FY25 Enterprise Quality, Safety and Experience Dashboard

April 2025 (unless other specified)

Month to Board Quality Committee : June 2025

Measure	FY25 Performance		Baseline FY24 Actual	FY 25 Target	Trend	FYTD or Rolling 12 Month Average
	Latest Month	FYTD				
PC-02 : Cesarean Birth	MV : 26.5% (39 / 147)	MV : 26.8% (296 / 1105)	MV : 27.6% (516 / 1870)	23.9% (FY24 ENT Target)		
	LG : 23.1% (6 / 26)	LG : 21.2% (43 / 203)	LG : 19.4% (62 / 320)			
Latest Month : January 2025	ENT : 26.0% (45 / 173)	ENT : 25.9% (339 / 1308)	ENT : 26.4% (578 / 2190)			
PC-05 : Exclusive Breast Milk Feeding	MV : 72.6% (199 / 274)	MV : 75.2% (1528 / 2031)	MV : 58.1% (1998 / 3437)	65.1% (FY24 ENT & MV Target)		
	LG : 81.3% (39 / 48)	LG : 84.9% (331 / 390)	LG : 68.4% (428 / 626)	70.0% (FY24 LG Target)		
Latest Month : January 2025	ENT : 73.9% (238 / 322)	ENT : 76.8% (1859 / 2421)	ENT : 59.7% (2426 / 4063)			
*Organizational Goal IP Units - HCAHPS LTR Top Box Rating of 'Yes, Definately Likely to Recommend' %, Adjusted	84	83	86	80%ile		
Latest Month : April 2025						

Quality Department | Note : updated as of May 19, 2025

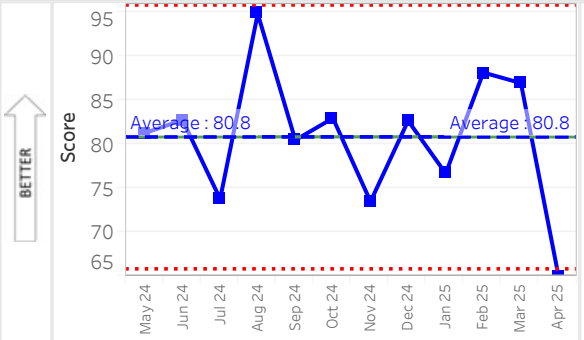
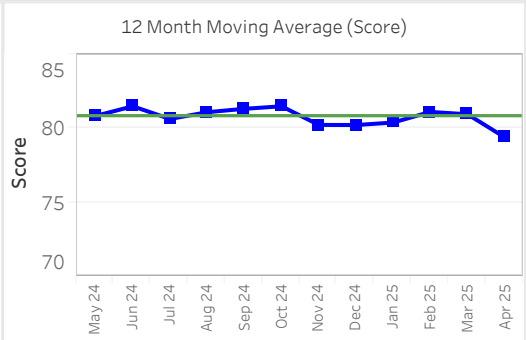
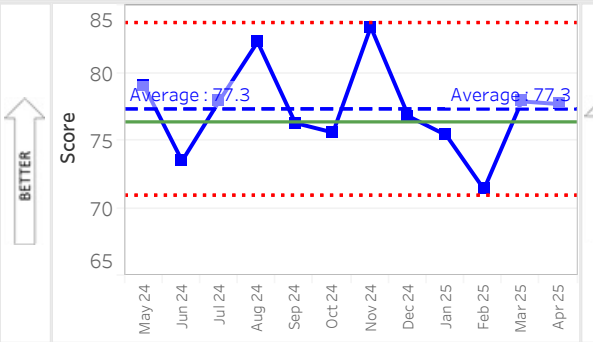
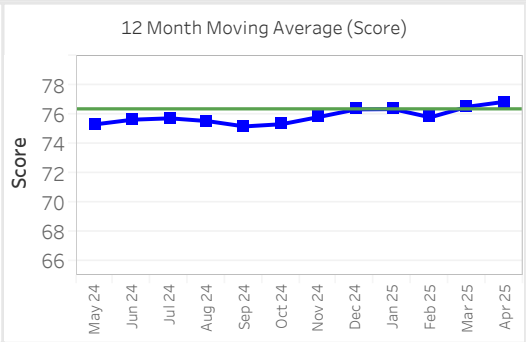
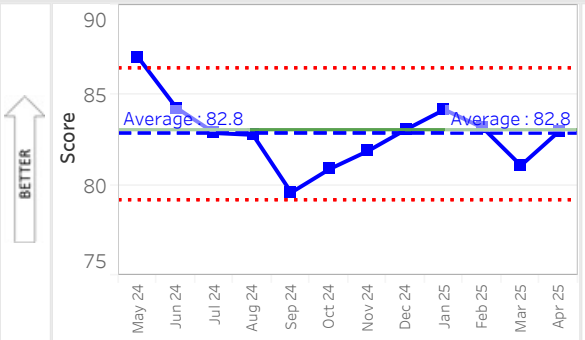
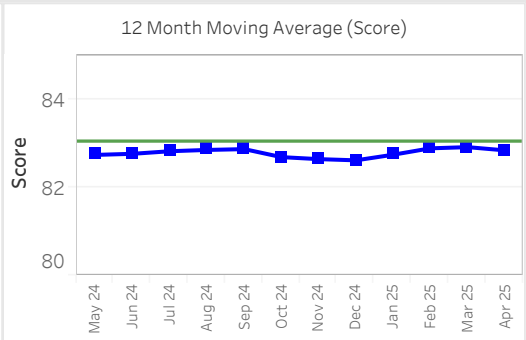
Measure	Definition Owner	Metric Definition	Data Source
PC-02 : Cesarean Birth	H. Freeman	1) **Numerator**: Patients with cesarean births 2) **Denominator**: Nulliparous patients delivered of a live term singleton newborn in vertex presentation	CMQCC
PC-05 : Exclusive Breast Milk Feeding	H. Freeman	1) **Numerator**: Newborns that were fed breast milk only since birth 2) **Denominator**: Single term newborns discharged alive from the hospital	CMQCC
*Organizational Goal IP Units - HCAHPS LTR Top Box Rating of 'Yes, Definately Likely to Recommend' %, Adjusted	C. Cunningham	1) Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey. 2) Inclusions: Inpatient nursing units; excludes: MBU. 3) Data run criteria, 'Top Box, Received Date, and Adjusted' For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value </= zero.	HCAHPS

El Camino Health

FY25 Enterprise Quality, Safety and Experience Dashboard

April 2025 (unless other specified)

Month to Board Quality Committee : May 2025

Measure	FY25 Performance		Baseline FY24 Actual	FY 25 Target	Trend	FYTD or Rolling 12 Month Average
	Latest Month	FYTD				
IP MCH - HCAHPS LTR Top Box Rating of 'Yes, Definately Likely to Recommend' %, Adjusted Latest Month : April 2025	65.0	80.3	82.0	82.0		
ED Likelihood to Recommend Top Box Rating of 'Yes, Definately Likely to Recommend' %, Adjusted Latest Month : April 2025	77.7	77.4	75.5	77.2		
ECHMN Likelihood to Recommend Top Box Rating of 'Yes, Definately Likely to Recommend' %, Adjusted Latest Month : April 2025	83.0	81.9	82.1	83.4		

Quality Department | Note : updated as of May 19, 2025

Measure	Definition Owner	Metric Definition	Data Source
IP MCH - HCAHPS LTR Top Box Rating of 'Yes, Definately Likely to Recommend' %, Adjusted	C. Cunningham	Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey. Mother Baby Units only. Data run criteria, 'Top Box, Received Date, and Adjusted' For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value </= zero.	HCAHPS
ED Likelihood to Recommend Top Box Rating of 'Yes, Definately Likely to Recommend' %, Adjusted	C. Cunningham	ED Likelihood to Recommend - PressGaney data (not part of HCAHPS) Data run criteria, 'Top Box, Received Date, and Adjusted' For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value </= zero.	Press Ganey
ECHMN Likelihood to Recommend Top Box Rating of 'Yes, Definately Likely to Recommend' %, Adjusted	C. Cunningham	Switched Vendor NRC to PressGaney in January 2022. Started reporting in FY 23 dashboards 'Top Box, Received Date, and Unadjusted' For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value </= zero.	Press Ganey