El Camino Health

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

Monday, December 1, 2025 – 5:30 pm
El Camino Health | 2500 Grant Road, Mountain View, CA 94040 | Sobrato Boardroom 1

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: 930 2308 1082 # 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.

TIME ESTIMATES: Except where noted as TIME CERTAIN, listed times are estimates only and are subject to change at any time, including while the meeting is in progress. The Committee reserves the right to use more or less time on any item, to change the order of items, and/or to continue items to another meeting. Particular items may be heard before or after the time estimated on the agenda. This may occur in order to best manage the time at a meeting.

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.	**CONSENT CALENDAR ITEMS** a. Approve Minutes of the Open Session of the Quality Committee Meeting (11/03/2025) b. FY2026 Pacing Plan c. FY2026 Committee Goals	Carol Somersille, MD Quality Committee Chair	**Motion Required**	**5:30 – 5:40**
6.	**COMMITTEE SURVEY RESULTS**	Carol Somersille, MD Quality Committee Chair	Discussion	**5:40 – 5:55**

	AGENDA ITEM	PRESENTED BY	ACTION	ESTIMATED TIMES
7.	**PATIENT STORY**	Cheryl Reinking, DNP, RN NEA-BC, Chief Nursing Officer	Information	**5:55 – 6:05**
8.	**HEALTH EQUITY REPORT**	Shreyas Mallur, MD, Chief Quality Officer	Discussion	**6:05 – 6:20**
9.	**PSI REPORT**	Lyn Garrett, Senior Director, Quality	Discussion	**6:20 – 6:30**
10.	**RECESS TO CLOSED SESSION**	Carol Somersille, MD Quality Committee Chair	**Motion Required**	**6:30 – 6:31**
11.	**QUALITY COUNCIL MINUTES** a. Quality Council Minutes (11/05/2025) *Health and Safety Code section 32155 – Deliberations concerning reports on Medical Staff Quality Assurance Committee*	Carol Somersille, MD Quality Committee Chair	Information	**6:31– 6:36**
12.	**APPROVE MINUTES OF THE CLOSED SESSION OF THE EL CAMINO HOSPITAL QUALITY COMMITTEE (11/03/2025)** *Report involving Gov't Code Section 54957.2 for Closed Session Minutes.*	Carol Somersille, MD Quality Committee Chair	**Motion Required**	**6:36 – 6:41**
13.	**VIZIENT QUALITY PROGRAM UPDATE** *Health and Safety Code Section 32106(b) for a report and discussion involving healthcare facility trade secrets regarding new services or programs.*	Shreyas Mallur, MD, Chief Quality Officer	Discussion	**6:41 – 7:00**
14.	**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**	**7:00 – 7:05**
15.	**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	**7:05 – 7:10**
16.	**EXECUTIVE SESSION** *Gov't Code Section 54957 Report regarding personnel performance – Senior Management*	Carol Somersille, MD Quality Committee Chair	Discussion	**7:10 – 7:20**
17.	**RECONVENE TO OPEN SESSION**	Carol Somersille, MD Quality Committee Chair	**Motion Required**	**7:20 – 7:21**
18.	**CLOSED SESSION REPORT OUT** To report any required disclosures regarding permissible actions taken during Closed Session.	Carol Somersille, MD Quality Committee Chair	Information	**7:21 – 7:22**
19.	**COMMITTEE ANNOUNCEMENTS**	Carol Somersille, MD Quality Committee Chair	Information	**7:22 – 7:30**
20.	**ADJOURNMENT**	Carol Somersille, MD Quality Committee Chair	**Motion Required**	**7:30**

Next Meetings: February 2, 2025; March 2, 2025; May 4, 2025; June 1, 2025

El Camino Health

Minutes of the Open Session of the
Quality, Patient Care, and Patient Experience Committee
of the El Camino Health Board of Directors
Monday, November 3, 2025
El Camino Hospital | 2500 Grant Road, Mountain View, CA 94040

Members Present
Carol Somersille, MD, Chair
Krutica Sharma, MD, Vice Chair
Shahram Gholami, MD (*joined at 5:42 p.m.)*
Erica Jiang
Barbara Pelletreau
Jack Po, MD *(joined at 6:38 p.m.)*
Diane Schweitzer
Steven Xanthopoulos, MD
John Zoglin**

Members Absent
Pancho Chang

**via teleconference

Staff Present
Mark Adams, MD, CMO
Shreyas Mallur, MD, CQO
Tracey Lewis Taylor, COO
Ryan Lockwood, VP, Patient Experience
Lyn Garrett, Senior Director, Quality
Peter Goll, CAO, ECHMN
Jaideep Iyengar, MD, ECHMN
Ken King, CAO **
Deb Muro, CIO **
Kirstan Smith, BSN, VP, Quality Performance
Steven Sun, Director Clinical Quality Analytics
Tracy Fowler, 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 **5:30 p.m.** by Chair Carol Somersille. A verbal roll call was taken. A quorum was present. Committee members Chang, Gholami, and Po were absent at the time of roll call.	**Call to order at 5:30 p.m.**
2. CONSIDER APPROVAL FOR AB 2449 REQUESTS	Chair Somersille asked if any Committee members were participating remotely. Director Zoglin attended remotely in accordance with regular Brown Act teleconferencing requirements. All other Committee members participated in person.	
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 members of the public.	
5. VERBAL INTRODUCTION OF NEW QUALITY COMMITTEE MEMBER	Chair Somersille welcomed a new member of the Quality Committee. Ms. Pelletreau shared her experience in healthcare quality leadership and expressed appreciation for the opportunity to serve the organization and community.	

6. CONSENT CALENDAR	Chair Somersille asked if any Committee member would like to pull an item from the consent calendar. Ms. Schweitzer requested to remove item d) Core Measures for further discussion. **Motion**: To approve consent calendar items (a) Minutes of the Open Session, Minutes of the Quality Committee Meeting (09/08/2025). **Received**: (b) FY2026 Pacing Plan and (c) CDI Dashboard **Movant**: Sharma **Second**: Schweitzer **Ayes**: Somersille, Jiang, Pelletreau, Sharma, Schweitzer, Xanthopoulos, Zoglin **Noes**: None **Abstain**: None **Absent:** Chang, Gholami, Po **Recused**: None Ms. Schweitzer asked for clarification regarding Core Measures tied to patient acceptance, specifically smoking cessation counseling and readiness for substance-use treatment. She noted these measures can be difficult to achieve when patient willingness is variable, and encouraged continued focus on staff coaching and consistent language to support patient engagement. Management affirmed ongoing efforts to strengthen staff education and scripting, including reinforcement in nurse rounding and embedded prompts in workflows. Chair Somersille and Ms. Schweitzer also inquired whether the current cadence of sharing unblinded cesarean section data with nurses — annually — provides adequate transparency and support for improvement. Committee members discussed the importance of frontline visibility in maternal quality metrics. The Committee requested that Maternal Child Health leadership evaluate the reporting frequency and return with a recommendation. **Motion**: To receive consent calendar item (d) Core Measures **Movant**: Sharma **Second**: Somersille **Ayes**: Somersille, Jiang, Pelletreau, Sharma, Schweitzer, Xanthopoulos, Zoglin	***Consent Calendar Approved*** ***Action:*** *Staff to Evaluate increasing frequency of unblinded cesarean data reporting to nursing staff and return to Committee with recommendation*

	Noes: None **Abstain**: None **Absent:** Chang, Gholami, Po **Recused**: None	
7. PATIENT STORY	Mr. Lockwood presented a patient story illustrating the impact of strong interdisciplinary coordination, timely escalation, and compassionate communication. The Committee discussed the importance of sustaining a culture that recognizes frontline contributions and reinforces best practices in patient-centered care. Committee members noted that stories demonstrating clinical excellence and teamwork reinforce trust and community connection. It was suggested that this example may be a meaningful item to highlight in future communications to emphasize staff commitment and organizational values.	
8. SAFETY REPORT FOR THE ENVIRONMENT OF CARE	Mr. King presented the annual evaluation of the Environment of Care and Emergency Management programs. The Committee reviewed increased reporting of workplace violence incidents, which leadership attributed to improved reporting culture and heightened awareness, particularly in dementia and behavioral health settings. Discussion included OSHA reporting criteria, structured response protocols, and ongoing investments in staff training and support resources. The Committee expressed support for continued emphasis on prevention, early identification, and real-time staff support. **Motion**: To approve the annual report and evaluation **Movant**: Pelletreau **Second**: Jiang **Ayes**: Somersille, Gholami, Jiang, Pelletreau, Sharma, Schweitzer, Xanthopoulos, Zoglin **Noes**: None **Abstain**: None **Absent:** Chang, Po **Recused**: None	
9. Q1 FY26 STEEEP DASHBOARD REVIEW/ FY26 ENTERPRISE QUALITY DASHBOARD	Dr. Mallur presented the first-quarter STEEEP Dashboard, highlighting systemwide performance across safety, timeliness, effectiveness, efficiency, equity, and patient-centeredness domains. He noted continued improvement in CAUTI rates and shared progress on readmission reduction efforts, prioritizing post-discharge outreach for high-risk patients and strengthening partnerships with post-acute care providers. Physician champion engagement is expanding, and leaders are tracking sustainability of gains through defined workflows	

	and ongoing monitoring. Committee members discussed ensuring adequate resourcing to support improvement momentum and emphasized aligning priorities with staffing capacity and quality-improvement infrastructure.	
10. VIZIENT CLINICAL DATABASE OVERVIEW	Dr. Mallur and Mr. Sun provided an update on El Camino Health's participation in the Vizient benchmarking program, including its recent movement into the complex-care cohort. He reviewed how Vizient's methodology aligns with CMS star ratings, the importance of accurate clinical risk adjustment, and the benefits of timely performance data to guide improvement work. Committee members discussed the value of trend visibility, transparency in risk-adjustment methodology, and anticipated cadence for future reporting. The Committee looks forward to periodic deep-dive reviews to support strategic oversight.	***Action:*** *Dr. Mallur to bring Vizient quality dashboard and scorecard for a closed session discussion at the next meeting.*
11. EL CAMINO HEALTH MEDICAL NETWORK QUALITY REPORT	Ms. Smith, and Dr. Iyengar presented the El Camino Health Medical Network's performance and quality initiatives. The Committee discussed improvements in MIPS scoring and investments in data infrastructure to enable more timely capture, analysis, and submission of quality metrics. Physicians are engaging in structured improvement work and leveraging real-time dashboards to drive consistency across practices. The Committee emphasized the importance of continued focus on patient experience, care coordination, timely follow-up for high-risk patients, and ensuring ambulatory quality efforts are aligned with enterprise strategic goals and hospital-based quality priorities. Committee members appreciated the continued collaboration between hospital and network quality teams and noted the positive trajectory in MIPS performance and patient access measures.	
12. RECESS TO CLOSED SESSION	**Motion**: To recess to closed session at 6:34 p.m. **Movant**: Gholami **Second**: Sharma **Ayes**: Somersille, Gholami, Jiang, Pelletreau, Sharma, Schweitzer, Xanthopoulos, Zoglin **Noes**: None **Abstain**: None **Absent:** Chang, Po **Recused**: None	***Recessed to Closed Session at 6:34 p.m.***
13. AGENDA ITEM 18: 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 September 8, 2025 meeting.	***Reconvened Open Session at 7:03 p.m.***
14. AGENDA ITEM 20: COMMITTEE ANNOUNCEMENTS	There were no committee announcements.	

15. AGENDA ITEM 22: ADJOURNMENT	**Motion**: To adjourn at 7:06 p.m. **Movant**: Sharma **Second**: Gholami **Ayes**: Somersille, Gholami, Jiang, Pelletreau, Po, Sharma, Schweitzer, Xanthopoulos, Zoglin **Noes**: None **Abstain**: None **Absent:** Chang **Recused**: None	***Meeting adjourned at 7:06 p.m.***

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

_____
Tracy Fowler, Director, Governance Services

Prepared by: Tracy Fowler, Director, Governance Services
Reviewed by: Carol Somersille, MD, Quality Committee Chair

El Camino Health

APPROVED BY QC
06/02/2025

Quality, Patient Care, and Patient Experience Committee
FY26 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						✓						
Leapfrog Education Session						✓						
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

FY26 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.	Q4FY25 review and update which measures to include on the FY26 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.	Q4FY25 review FY26 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 FY26.	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 2026	• Attend a minimum of 5 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 2026	Committee attendance rate at conference and/or session with a subject matter expert of at least 50%. • Verbal/Written report of key learnings to the Quality Committee.

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

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
COMMITTEE MEETING COVER MEMO

To: Quality, Patient Care & Patient Experience Committee
From: Carol Somersille, MD, Chair
Shreyas Mallur, MD, MBA, CQO
Date: December 1, 2025
Subject: FY25 Committee Self-Assessment Results and FY26 Priority Focus Areas

Purpose: To provide an overview of the FY25 Quality Committee self-assessment results, highlight key themes from member feedback, and support the Committee's discussion of potential FY26 focus areas.

Situation: As part of the biennial governance review conducted in partnership with SpencerStuart, QC members completed the FY25 self-assessment survey. Individual interviews with board members supplemented the survey and offered additional qualitative insights. The assessment focused on the Committee's clarity of purpose, effectiveness, culture, leadership, and engagement with management.

Summary: The FY25 assessment indicates that the Quality Committee continues to operate effectively, with strong leadership, engaged members, and a high level of commitment to patient care quality and experience. All eight members participated, resulting in an overall **average score of 3.7 out of 4.0**, reflecting strong performance and alignment with El Camino Health's strategic mission.

Committee governance, meeting effectiveness, and member expertise utilization were rated highly. Members consistently affirmed that discussion is collegial, the Committee is appropriately focused on quality and patient experience, and the Chief Quality Officer maintains strong partnership and transparency with the committee, consistent with feedback shared through the SpencerStuart evaluation process.

Key Strengths:

Committee members emphasized that the Quality Committee continues to operate effectively with strong leadership, thoughtful preparation, and a clear focus on patient care and safety. The Committee is recognized as collegial and well-run, with members comfortable engaging in discussion and offering perspectives that support sound governance. The Chief Quality Officer and quality leadership team are viewed as highly transparent and responsive, fostering a productive partnership that strengthens oversight. Additionally, the recent addition of community experts and the intentional reduction in meeting frequency have been positively received and have contributed to improved engagement and overall effectiveness of the Committee.

Opportunities for Continued Growth:

Committee members also offered thoughtful suggestions to further strengthen the Committee's effectiveness and alignment with the Board's oversight framework. Several comments highlighted a desire to improve the flow of communication and connectivity between the Committee and the full Board to ensure shared understanding of key risks, priorities, and performance drivers. Members also noted the opportunity to deepen alignment with the El Camino Health Medical Network on quality and patient experience goals and reporting.

In addition, feedback suggested value in maintaining focus on governance-level discussion and avoiding operational detail, including exploring guidelines for pre-meeting questions to support strategic dialogue. Some members expressed interest in broadening stakeholder feedback, such

as exposure to patient perspectives, and in enhancing access to external expertise or education to stay current with quality and safety trends. Together, these opportunities reinforce the Committee's commitment to continuous improvement and thoughtful oversight in support of exceptional quality, safety, and patient experience outcomes.

Next Steps: The Quality Committee is encouraged to review and discuss these results and observations at its December 1, 2025 meeting. This discussion will provide an opportunity to reflect on areas of strength, prioritize opportunities for growth, and consider specific actions to enhance the committee's effectiveness in the coming year.

Following the committee's discussion, the Committee Chair, Chief Quality Officer and Governance Services will incorporate member feedback and bring forward a finalized FY26 action plan at a subsequent meeting for review and confirmation. The plan will serve as a tool to guide the QC's work and reinforce its governance oversight in support of El Camino Health's mission and strategic goals.

Attachments: FY25 QC Assessment Results and Draft FY26 Action Plan

SpencerStuart

Quality, Patient Care, and Patient Experience Committee Assessment Report

Prepared for:
Board of Directors
El Camino Health

Prepared by:
George Anderson
Zach Morfín
Meng Li
Barbara Cardona

September 2025

El Camino Health

Contents

Introduction

Overview of Board and Committee Review

Purpose of the Review

The El Camino Health Board of Directors engaged Spencer Stuart in July 2025 to undertake an in-depth review of its effectiveness. The purpose was to assist the board and committees in continuing to improve the governance of the health system and support its long-term success.

The board and committees' commitment to continuous improvement is evident in the board's engagement of a third-party advisor to support the biennial evaluation process. It is also a reflection of the board's dedication to the hospital, its stakeholders, and management.

Assessment Process

As part of the assessment process, Spencer Stuart conducted individual interviews with each hospital director, as well as administered an online survey to all directors, committee members, and the Medical Network Board of Managers.

The interviews focused on a broad range of governance dimensions, including strategic oversight, board composition and succession, board-management relationship, board culture and dynamics, as well as the effectiveness of individual committees, among others.

The survey used a 1-4 Likert scale, where a rating of 1 indicates strong disagreement, and a rating of 4 indicates strong agreement.

Report

The following report presents the survey results of the Quality, Patient Care, and Patient Experience Committee. All committee members (8 out of 8) completed the survey. The open-ended commentary includes the feedback shared via the interviews with the hospital directors who are members of the committee, and the survey responses from the committee members who provided written feedback.

The committee is encouraged to discuss the findings in this report at its next meeting. The board will discuss the results of the board effectiveness review at its October 2025 board meeting.

Survey Dimension and Item Ratings

The table below shows all survey results sorted by dimension.

- **Overall average** = 3.7.
- **Highest rated item**: Committee Leadership and Meetings: *The Committee Chair provides effective leadership* (4.0).
- **Lowest rated item:** Communication and Relationships: *Communication and information flow between the committee and the board are effective* (3.4).

Dimension & Item	Avg	SD	N	1	2	3	4
Committee Leadership & Meetings = 3.8							
• The Committee Chair provides effective leadership.	4.0	0.00	8	0	0	0	8
• The committee materials are appropriate for governance-level decision-making and oversight.	3.8	0.43	8	0	0	2	6
• The committee makes decisions efficiently.	3.8	0.43	8	0	0	2	6
Committee Culture & Engagement = 3.8							
• The committee regularly assesses its own effectiveness and makes improvements.	3.9	0.33	8	0	0	1	7
• Committee members are comfortable expressing their views openly and productively.	3.8	0.43	8	0	0	2	6
• As a committee member, my area(s) of expertise are utilized appropriately within the committee.	3.8	0.43	8	0	0	2	6
• The committee operates with a spirit of collegiality and communicates with mutual respect.	3.6	0.48	8	0	0	3	5
Committee Role & Responsibilities = 3.7							
• The committee's objectives are aligned with the organizational strategic goals.	3.9	0.33	8	0	0	1	7
• The committee is successful in carrying out its designated responsibilities.	3.6	0.48	8	0	0	3	5
• The scope of the committee's authority is clear.	3.6	0.70	8	0	1	1	6
• The committee monitors and adapts to changes in regulatory, financial, or industry landscape relevant to its oversight responsibilities.	3.6	1.36	7	0	1	1	5
Communication & Relationships = 3.6							
• The committee's relationship with management is effective and respectful.	3.6	0.48	8	0	0	3	5
• The committee receives adequate support from management.	3.6	0.70	8	0	1	1	6
• Communication and information flow between the committee and the board are effective.	3.4	1.32	7	0	1	2	4

Open-Ended Feedback: Strengths

Provided below are the comments that were shared via the individual interviews with each ECH director who is also a member of the committee, as well as the written survey feedback across all committee members.

Strengths

Overall, committee members indicated that the committee is run effectively.

- *It is a well-run committee*
- *It is very well-run and collegial.*
- *Quality does a great job.*

One member shared that the Chief Quality Officer has a strong relationship with the committee.

- *The current Chief Quality Officer has had a great relationship with the committee.*

The additional community member expertise on the committee as well as the reduced number of meetings have contributed to the committee's increasing effectiveness.

- *The new reduced number of meetings is a significant improvement.*
- *In the previous survey, it was clear that the committee members wanted more community member expertise. We have added 3 community members to our committee.*

Open-Ended Feedback: Development Areas

Development Areas

Committee members expressed concerns about communication gaps and strategic alignment between the committee and the board.

- *Quality can be confusing. We spend a lot of time on the board relitigating what was discussed in the committee. It's duplicative for executives and the board.*
- *All committees are getting insufficient guidance on what the corporate strategy is from the executives/board.*
- *There is relatively little communication from the board to the committee other than what happens with board members' comments in the committee. I don't know that it is a problem, but it is absent.*

One member expressed a desire for greater alignment between the committee and the Medical Network Board on quality and patient experience, and better engagement with executive leadership.

- *Alignment with ECHMN quality as well as both quality and patient experience responsibilities are challenging. I'm not sure if we are spending enough time with patient experience across the organization. Previous executive staff members have not fully engaged or accepted oversight responsibility of this committee. When we don't meet our goal, what is the plan to turn it around? Sometimes we get push back.*

Members offered ideas to improve committee operations and discussions, including limiting pre-meeting questions, diversifying stakeholder input, and ensuring the discussion remained at the right level of detail.

- *The number of written questions to the Chief Quality Officer in advance of the meeting should be limited to approximately no more than 5. That will allow for more concentration on oversight.*
- *Broaden inputs to diversify responses from a wider range of stakeholders. Consider following former patients or patients from ECH target markets who do not use ECH.*
- *Sometimes doctors on the committee get overly involved and go too deep into the "how."*

There is interest in enhancing committee knowledge and reducing reliance on management for landscape monitoring.

- *We do relatively little monitoring as a committee on the landscape but instead rely on management to do so. It might be a good thing for some committee education from an outside subject matter expert.*

A member emphasized the importance of staying engaged and aligned with the board.

- *Keep providing support, as questions, and stay aligned with the board.*

SpencerStuart

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: December 1, 2025
Subject: Patient Story

Purpose: To provide the Committee with a patient story regarding safe, timely, efficient, effective, equitable, and/or patient-centered care.

Situation: These two stories reflect interventions that occurred for two patients that occurred due to the patient implementation of the social drivers of health (SDOH) screening process completed by nurses

Authority: To provide the committee with written feedback regarding a recent experience with El Camino Health.

Background: Both patients were screened using the SDOH screening tools in the electronic health record. Due to a positive screening result, social worker evaluations were triggered as per the process that has been created at ECH.

Assessment: Upon social worker assessment, food insecurity was identified as a concern for both patients in the story. The social worker arranged community resources to ensure the patients received nutritional support upon discharge from the hospital.

Outcomes: The nurses and social workers worked together to identify these social drivers of health concerns and to ensure patients received the necessary resources.

Attachments: See patient comments.

Suggested Committee Discussion Questions:

1. What are the areas that are screened in the SDOH screening process?

2. What training did the staff receive to conduct this screening process on every admission?

Patient Stories

Story #1

Through our SDOH screening, a new mother bravely shared her worries about food and finances, and our team immediately connected her with compassionate community partners who provided the support she needed. Because of this caring intervention, she could embrace precious moments with her newborn, turning what could have been an overwhelming time into one filled with hope, relief, and joyful bonding. Connecting her with food pantry services and the knowledge that she was not facing these challenges alone or without support.

Story #2

When a 76-year-old came to the hospital with health concerns, our SDOH screening revealed she was quietly struggling with the rising cost of food on her fixed retirement income. Thanks to this compassionate screening, our social worker and Gabby, our health navigator, connected her with essential resources - transforming her hospital visit into a turning point that brought her renewed hope, support, and dignity beyond her medical care. She now gets regular meals delivered to her home with our meals on wheels community partner. She was also connected with our CSA (community service agency) for visits with a case manager to reduce isolation and loneliness.

El Camino Health

EL CAMINO HEALTH
COMMITTEE MEETING COVER MEMO

To: Quality, Patient Care, and Patient Experience Committee
From: Shreyas Mallur, MD, MBA - Chief Quality Officer
Date: December 1, 2025
Subject: CMS SDOH-1 and SDOH-2 Screening and Assessment

Summary:

1. Background: The SDOH-1 (Social Determinants of Health Screening) CMS recommends 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) recommends 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 voluntary reporting to CMS to demonstrate efforts and outcomes in mitigating social health determinants. It also remains a mandatory requirement under California AB 1204 - Hospital Equity Measures Reporting Program as well as Leapfrog Hospital Safety Grade.

2. Assessment: By going live with SDOH on December 19, 2024, El Camino Health successfully implemented and 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:

    - 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.

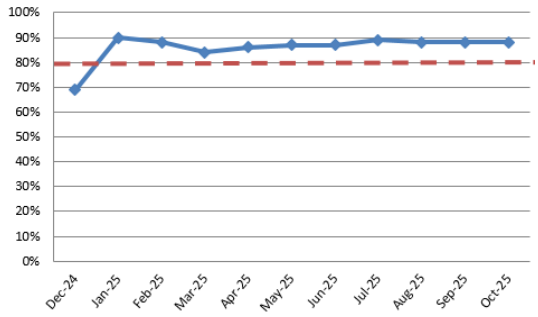
    - Hospital Commitment to Health Equity (HCHE). It measures if the hospital has a strategic plan for advancing health equity, including identifying priority population who currently experiencing health disparities. Identifying health equity goals and discrete action steps to achieve these goals. Outlines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

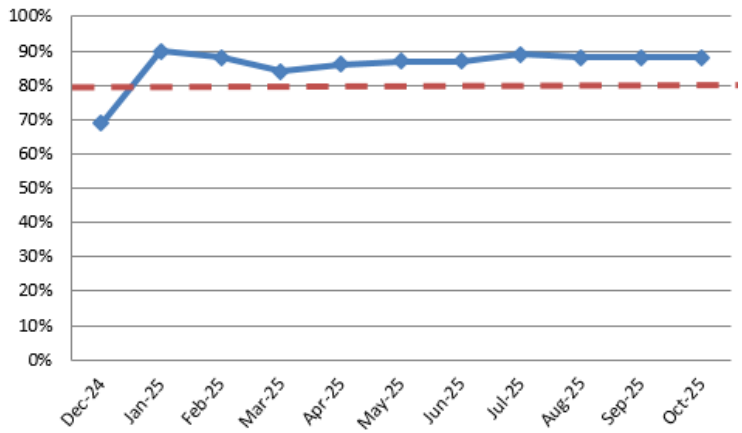
    - Collect demographic information (such as self-reported race, national origin, primary language, and ethnicity data) and social determinant of health information on most of our patients.

- Report on five categories of SDOH:

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

3. Recommendation: The SDOH rates below are provided for discussion purposes. As SDOH went live in December 2024, there is no data to report for calendar year 2024. As demonstrated on the chart below, El Camino Health has successfully achieved a greater than 80% compliance rate for all months to date in calendar year 2025, and as of October 2025, has achieved an overall rate since go-live of 88%. The goal for FY26 is to continue to achieve a greater than 80% rate.

SDOH	Performance		FY2026 goal	
SDOH Screening *Epic Cogito Report* *(Excl. MHAS, Acure Rehab and Outpatient Services)*	Oct 2025 1234/1403 88%	FYTD 88%	>80%	

SDOH	Performance		FY2025	FY2026 goal	
SDOH Screening *Epic Cogito Report* *(Excl. MHAS, Acure Rehab and Outpatient Services)*	Oct 2025 1234/1403 88%	FYTD 88%	51%	>80%	

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
COMMITTEE MEETING COVER MEMO

To: Quality, Patient Care & Patient Experience Committee
From: Lyn Garrett, Senior Director Quality
Date: December 1, 2025
Subject: Patient Safety Indicator (PSI) Scores FY 2025

Purpose: To provide an update on the Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicators.

Situation: The Patient Safety Indicators (PSIs) are a set of indicators providing information on potential in-hospital complications and adverse events for all patients, including the following surgeries, procedures, and childbirth. The PSIs were developed by AHRQ after a comprehensive literature review, analysis of ICD-10-CM codes, reviewed by a clinician panel, implementation of risk adjustment, and empirical analyses.

Authority: The Quality, Patient Care & Patient Experience Committee is responsible for oversight of quality & safety.

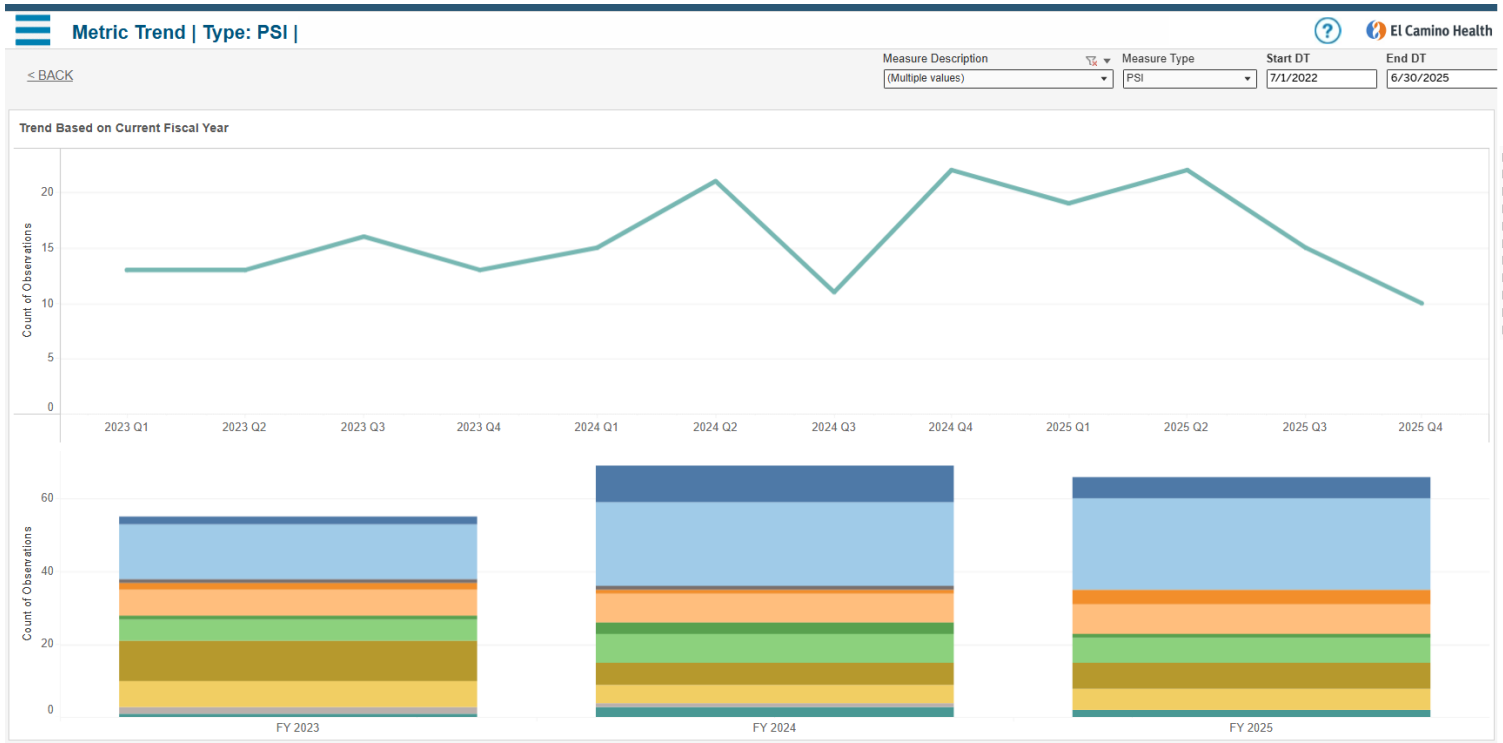
Background: The PSIs can be used to help hospitals identify potential adverse events that might need further study; provide the opportunity to assess the incidence of adverse events and in-hospital complications using administrative data found in the typical discharge record; and include indicators for complications occurring in the hospital that may represent patient safety events. These indicators also have area-level analogs designed to detect patient safety events on a regional level. Additionally, PSIs are embedded in public reported scores and methodologies, like Hospital Compare, Leapfrog, & US News and World report.

Assessment: Each of the identified PSIs are first reviewed and validated by ECH Clinical Documentation Integrity and Coding professionals. If questions arise then clarifications from physicians are obtained. After cases are confirmed, identified cases are sent through the Medical Staff's Peer review process for trending by physician. The collaboration between physicians, clinical documentation specialists and coding team is imperative for an accurate reflection of these patient safety events.

Performance:

- **A.** PSI-12 Perioperative PE and DVT incidents increased, from 6 in FY 2024, to 7 in FY 2025
- **B.** PSI-13 Postop Sepsis increased from 5 cases in FY2024 to 6 cases in FY 2025.
- **C.** PSI-14 Postop Wound Dehiscence was reduced by half, 2 cases in FY2024, to only 1 case in FY 2025
- **D.** PSI-06 Iatrogenic pneumothorax increased from 1 incident in FY 2024 to 4 cases in FY 2025
- **E.** PSI-04 Death in Surgical Pts with treatable complications increased from 23 cases in FY 2024 to 25 in FY 2025 (measure to be retired for IPPS FY 2025)
- **F.** PSI-03 Pressure Ulcer decreased from 10 in FY 2024 to 6 in FY 2025
- **G.** PSI-05 Retained Surgical Item or Unretrieved Device Fragment decreased from 1 event in FY 2024 to no events for FY 2025

List of Attachments: Patient Safety Indicator (PSI) Scores FY23, FY24, and FY25


Metric Trend | Type: PSI |
El Camino Health
< BACK
Measure Description
(Multiple values)
Measure Type
PSI
Start DT
7/1/2022
End DT
6/30/2025
Trend Based on Current Fiscal Year
Count of Observations
0
5
10
15
20
2023 Q1
2023 Q2
2023 Q3
2023 Q4
2024 Q1
2024 Q2
2024 Q3
2024 Q4
2025 Q1
2025 Q2
2025 Q3
2025 Q4
Count of Observations
0
20
40
60
FY 2023
FY 2024
FY 2025
PSI-03 Pressure Ulcer
PSI-04 Death in Surgical Pts w Treatable Complications
PSI-05 Retained Surgical Item or Unretrieved Device Fragment
PSI-06 Iatrogenic Pneumothorax
PSI-09 Postoperative Hemorrhage or Hematoma
PSI-10 Postoperative Acute Kidney Injury Requiring Dialysis
PSI-11 Postop Respiratory Failure
PSI-12 Perioperative PE or DVT
PSI-13 Postop Sepsis
PSI-14 Postop Wound Dehiscence
PSI-15 Abdominopelvic Accidental Puncture or Laceration